Universidade do Minho
Escola de Psicologia

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Reconceptualizing the self in psychotherapy for depression: Latest findings and future directions

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STATEMENT OF INTEGRITY

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University of Minho, _____28 Março 2017_____

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RECONCEPTUALIZING THE SELF IN PSYCHOTHERAPY FOR DEPRESSION: LATEST FINDINGS AND FUTURE DIRECTIONS

ABSTRACT

Our understanding of psychotherapeutic change is still limited, but we need to move from the question of whether psychotherapy works, and start to move towards the question of *how* and *why* change occurs. From a narrative-constructivist point of view, to integrate new meanings into one's experience is fundamental for successful psychotherapy. According to the innovative moments research, reconceptualization (RC), which is an innovative moment associated with successful therapy, is a type of meta-reflection that helps to re-write one's story in a more adaptive way. RC is articulated by two components: 1) a *contrasting self* (CS), i.e., clients' expression of what is shifting in themselves, and 2) the *self-transformation process* (STP), i.e., how/why these shifts were possible to achieve. This dissertation aims to study RCs. Specifically, the current work has the objective to clarify previous innovative moments research findings and to study in depth the components that give form to RC (CS and STP). To do so, we conducted three studies in the context of this dissertation. The first study was carried out on a composite sample of clinical cases diagnosed with major depression disorder undergoing narrative therapy (N=10), cognitive-behavioural therapy (N=6), emotion-focused therapy (N=6) and client centred therapy (N=6). Results indicated that RC was a different phenomenon from its components taken separately (i.e., CS and STP) and also was a better predictor of the treatment outcome (pre-post gains). The second study was carried out with a smaller sample (CBT and NT sub-samples) using a longitudinal design. RC during therapy was not only related to recovered cases as the previous study suggests, but also seemed to facilitate symptom reduction along treatment (i.e., lag +1). In this sense, meaning transformation precedes the reduction of depressive symptomatology. The third study portraits the case of Celia and focused on exploring the evolution of new meanings in successful psychotherapy for major depression. Results suggested that meaning integration was an important element during psychotherapy. New meanings present in innovative moments could be aggregated into themes. Furthermore, RC seemed to be a polythematic innovative moment, which integrated new meanings from different themes into a more adaptive meaning framework. This dissertation is a step forward in the research conducted with the innovative moments coding system and contributes to improve our understanding of fruitful therapeutic work. The ultimate goal of this research is to facilitate for psychotherapists and clients the identification of change

mechanisms during therapy, which could guide them towards subtle changes in their interactions. Therapists of diverse orientations could easily recognize CS, STP or RC, used them as indicators of the process of change and also try to favour meaning integration.

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RECONCEPTUALIZAÇÃO DO *SELF* NA PSICOTERAPIA DA DEPRESSÃO: ÚLTIMOS RESULTADOS E ORIENTAÇÕES FUTURAS

RESUMO

A nosso entendimento da mudança psicoterapêutica é ainda limitado e, nesse sentido, precisamos de ultrapassar a questão de saber se a psicoterapia funciona e avançar para a questão de *como* e *porque* a mudança ocorre. De um ponto de vista narrativo-construtivista, a integração de novos significados na nossa experiência é fundamental para um processo psicoterapêutico bem-sucedido. Segundo a investigação dos momentos de inovação, a reconceptualização (RC), que é um momento de inovação associado ao sucesso terapêutico, é um tipo de meta-reflexão que ajuda a reescrever a nossa história de um modo mais adaptativo. A RC é articulada por dois componentes: 1) um *self contrastante* (CS), isto é, expressões dos clientes sobre o que está a mudar em si mesmos, e 2) o *processo de autotransformação* (STP), ou seja, como/porque foi possível alcançar essas mudanças. Esta tese tem como meta estudar a RC. Especificamente, este trabalho tem o objetivo de esclarecer os resultados prévios encontrados pelos momentos de inovação e estudar em profundidade os componentes que dão forma à RC (CS e STP). Para isso, realizamos três estudos no contexto desta tese. O primeiro estudo foi realizado numa amostra composta por casos clínicos diagnosticados com perturbação depressiva *major* acompanhados com terapia narrativa (N = 10), terapia cognitivo-comportamental (N = 6), terapia focada nas emoções (N = 6) e terapia centrada no cliente (N = 6). Os resultados indicaram que a RC é um fenómeno diferente dos seus componentes (isto é, CS e STP) e também que é um melhor preditor do resultado do tratamento (ganhos pré-pós terapia). O segundo estudo foi realizado numa amostra de menor dimensão (sub-amostras CBT e NT) utilizando um *design* longitudinal. A RC durante a terapia não só estava relacionada com casos de sucesso como o estudo anterior sugere, mas também parece facilitar a redução dos sintomas ao longo do tratamento (i.e., em lag +1). Nesse sentido, a transformação de significados precede a redução da sintomatologia depressiva. O terceiro estudo retrata o caso da Celia e centra-se em explorar a evolução de novos significados num caso de sucesso psicoterapêutico de perturbação depressiva *major*. Os resultados sugeriram que a integração de significados foi um elemento importante durante a psicoterapia. Os novos significados presentes nos momentos de inovação puderam ser agregados em temas. Além disso, a RC parece ser um momento de inovação "politemático", no qual novos significados de diferentes temas parecem integrar um quadro de significado

mais adaptativo. Esta tese é um passo em frente na investigação realizada com o sistema de codificação dos momentos de inovação e contribui para melhorar a nossa compreensão do trabalho terapêutico frutífero. O objetivo final desta tese é facilitar que os psicoterapeutas e os clientes identifiquem mecanismos de mudança durante a terapia, o que poderá orientá-los para mudanças subtis nas suas interações. Terapeutas de diversas orientações poderão facilmente reconhecer CS, STP ou RC, usá-los como indicadores do processo de mudança e também tentar favorecer a integração de significados.

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INTRODUCTION

INTRODUCTION

"Cada uno de nosotros es, sucesivamente, no uno, sino muchos.
Y estas personalidades sucesivas, que emergen las unas de las otras,
suelen ofrecer entre sí los más raros y asombrosos contrastes"

Jose Enrique Rodó, *Motivos de Proteo* (1909)

This dissertation has three interrelated studies conducted within the Innovative Moments research team at the University of Minho, Portugal. We begin with a brief description of the need to treat a considerable number of people who suffer from major depression disorder (MDD) followed by the current situation in psychotherapy research on this topic. We then introduce recent research that shows how meaning-making transformation is present in the process of psychotherapeutic change, and also how changes in meanings can be described from a dialogical self approach. Finally, we draw attention to clients' agentive role in their own change process through the lens of the narrative metaphor describing the research previous to this dissertation that used the Innovative Moment Coding System (IMCS). This research aims to bring forward and deepen our knowledge in respect to the role of reconceptualization innovative moments in the treatment of depression.

MAJOR DEPRESSIVE DISORDER ESTIMATES

Mental disorders represent one third of the total disease burden for non-communicable diseases, that is, chronic or long duration diseases worldwide (WHO, 2014). MDD is one of the most spread non-communicable disorders, and it affects approximately 350 million people worldwide (WHO, 2016), and an estimate of 30.3 million people in Europe (Wittchen et al., 2011). MDD is the largest European mental health burden (Haro et al., 2014), increasing its prevalence after the "Great Recession" of 2008 in which job losses and unemployment rates raised exponentially in most of the western countries (Riumallo-Herl, Basu, Stuckler, Courtin, & Avendano, 2014). An extensive proportion of people who suffer from MDD seek therapy (pharmacotherapy and/or psychotherapy) and find their treatment effective. Many different types of psychotherapies have similar positive results: they reduce depressive

symptomatology and increase wellbeing (Cuijpers, van Straten, van Oppen, & Andersson, 2008). The American Psychological Association (APA) has published all evidence-based treatments that support the efficacy of psychotherapy for MDD (APA, 2006; APA 2012). However, quite a number of people relapse after treatment or abandon therapy without substantial gains. Drop out rates account for approximately 20% (e.g., 17.5%, 19.7%) of people who start, but abandon treatment (Cooper & Conklin, 2015; Lopes, Gonçalves, Sinai, & Machado, 2015; Swift & Greenberg, 2012). Despite the fact that therapeutic treatment for MDD works, due to the significant number of people who suffer from depression and the interest in reducing dropout rates, psychotherapy research is moving towards a better understanding of how psychotherapy works (Castonguay & Beutler, 2006; Doss; 2004; Gennaro, 2011; Kazdin, 2009).

CHANGE PROCESS RESEARCH IN PSYCHOTHERAPY

Research in psychotherapy

The study of psychotherapy is a young discipline that started in the mid-twentieth century. Different research focuses have been guiding psychotherapy research since then. Barkham (2002), and Barkham and Margison (2007) describe four different overlapping generations of research activity. The first generation (1950s-70s onwards) reacted to Eysenk's critique (1952) of psychotherapy, doubting its efficacy. This generation developed the use of meta-analytic techniques with the objective to test the efficacy of psychotherapy. The second generation (1960s-80s onwards) stepped forward towards the specificity of this research. This generation asked which psychotherapies were more effective, in which problem, and under what circumstances. To answer these questions it became popular to use specific randomized clinical trials and specific meta-analyses. The third generation (70s-2000 onwards) attended to the reduction of costs and made treatment more cost-effective. Finally, the fourth and current generation (1984-present) is centred on improving the effectiveness and the quality of the treatment. During these four generations, psychotherapy research was framed in two main domains, dividing psychotherapy researchers into two groups: those who preferred process research and those who chose outcome research (Pachankis & Goldfried, 2007). Generally

(Hill & Corbett, 1993), process researchers are interested in what happens inside psychotherapy sessions (i.e., what the process of change is and how it develops) whereas outcome researches are concerned with the changes that result from psychotherapy (i.e., pre-post treatment assessments). Despite that this dichotomy is still present in today's psychotherapy research, some bridges between these groups, their goals and methodologies have been made. One of the methodological efforts to bring together these two groups was Change Process Research (CPR). CPR has been described as a research process concerned with "identifying, describing, explaining, and predicting the effects of the processes that bring about therapeutic change" (Greenberg, 1986, p. 4). Following this research motto, the present dissertation can be seen as part of this approach to bring a better understanding of the psychotherapeutic process that hopefully will help to improve the treatment of MDD.

The most recent years of evidence-based research in psychotherapy has given different answers to what changed in individuals undergoing psychotherapy. Research has found that change is related to modifications in symptoms, behaviours, inner representations, emotional facets, relationships with significant others, meaning transformations, and narrative reconstructions (Greenberg & Safran, 1990; Krause et al., 2006; Lysaker, Lancaster, & Lysaker, 2003; Wells, Burlingame, Lambert, Hoag, & Hope, 1996). Nevertheless, both scientific and professional communities in psychology have a growing interest in understanding *how* and *how well* psychotherapy works and what appears to interfere with client improvement (Castonguay & Beutler, 2006; Castonguay & Hill, 2007, 2012; Elliott, 2010; Kazdin, 2009; Reisner, 2005). The expanding research on mechanisms and processes of change in the course of psychotherapy have given valuable information to face the question 'how do we change when we change?' (Doss, 2004). Different researchers from different parts of the world have been studying the process of change and symptomatology outcomes in recovered and unchanged cases within different psychotherapies and clinical problems. These studies have expanded CPR into a large variety of methodologies. This dissertation can be included in what Elliott (2010) described as Significant Events Approach in CPR that inquires how helpful and/or hindering events help people to change. This approach usually combines qualitative and quantitative analysis and describes the findings within a theory-building framework. In the next section, the present thesis summarizes an important body of research under the umbrella of Significant Events Approach. Despite the different metaphors to characterize the nature of change, there is one possible common denominator to describe what helps people to

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transform, develop and maintain changes during psychotherapy: the emergence of new meanings during psychotherapy.

Meaning in psychotherapy research

Many researchers (Boritz, Bryntwick, Angus, Greenberg, & Constantino, 2014; Gonçalves, Ribeiro, Mendes, Matos, & Santos, 2011; Krause, Altimir, Pérez, & De la Parra, 2015; Sitles, 2001) have centred their attention on how changes are taking place during psychotherapy. Interestingly, in spite of the different backgrounds and procedures, many studies outline the important role played by new meanings. This section presents three different models as an example of the relevance of meaning-making in psychotherapy: the Assimilation of Problematic Experiences (APES), the Generic Change Indicators (GCI) and Narrative-Emotion Process Coding System (NEPCS). The research on the APES (Stiles, 2001) understands change as the movement of problematic experiences from being initially dissociated, to their eventual integration. This model suggests that people's experiences leave traces (also referred as voices) and explains change in psychotherapy as the progressive integration of problematic traces into a person's self (or community of voices). For that, APES model proposes 8 sequential developmental stages towards the assimilation of the problematic experiences. These stages are numbered from 0 to 7: 0 (warded off / dissociated), 1 (unwanted thoughts / active avoidance), 2 (vague awareness / emergence), 3 (problem statement / clarification), 4 (understanding / insight), 5 (application / working through), 6 (resourcefulness / problem solution), and 7 (integration / mastery). The understanding/insight stage (fourth stage) can be conceived as the creation of meaning bridges that help to make accessible and understandable unwanted traces (Stiles & Brinegar, 2007) and is the motor from which the following stages evolve turning the new meanings over previous problematic experiences into resources. Successful psychotherapy for MMD was associated with stage 4 or higher in APES whereas unchanged cases were related with stages lower than 4 (Detert, Llewelyn, Hardy, Barkham, & Stiles, 2006).

GCI (Krause et al., 2015) states that change in psychotherapy is achieved through the transformation in people's subjective perspective, that is, modifying patterns of interpretation and explanation about their experience. This model, influenced by Kelly's work (1955) on personal constructs, recognizes 19 change markers and is organized in three sequential

stages. The higher the stage, the more elaborated processes of meaning-making. Stage I of GCI, refers to the person in "context of psychological meaning" (Krause et al., 2015, p. 535), in other words, involves the recognition of the present frame of reference and acknowledges the failure of present strategies in order to cope with the current problems. Stage II portrays people's increase in permeability towards new understandings as well as the curiosity to question their problematic frame of reference. Finally, Stage III is characterized by the consolidation of novel meanings and the creation of new subjective constructs. The predominant presence of new meaning in Stage III was related to successful psychotherapy while predominance of Stage I related to unsuccessful psychotherapy (Krause et al., 2015).

The third and final model explored here is based on the idea that the combination of meanings shifts and emotional differentiation during therapy are keys for recovery. The NEPCS (version 2.0; Angus et al., in press) distinguishes four problem markers, four transition markers and two change markers. We will focus here on the markers associated with change. One of the change markers —"Unexpected outcome storytelling"— articulates meaningfully how novelties (new positive emotional responses, behaviours, thoughts, etc.) are expressed with feelings of surprise, pride, relief or contentment. The other change marker —"Discovery storytelling"— refers to the construction of a new account over the experience. This marker encompasses the articulation a novel understanding (i.e., new meanings) related to the self, to others, to behaviour patterns, change processes or key events. The findings with this model suggest a higher proportion of transition and change markers in middle and late sessions for recovered clients (Angus et al., in press).

Thus, according to these three models and also to the later addressed IMCS, a key element in the process of change seems to be related with the construction of more adaptive or healthier meanings during psychotherapy treatment. In the next section we will explore how new meanings may develop during treatment.

THE MULTIPLICITY OF THE SELF

Hermans, Kempen and Van Loon (1992) proposed a theory of the self, taking into account its dynamic multiplicity. They have proposed the idea of a social, dialogical, relational and cultural mind, rather than an individualistic and rational psyche. Along these lines, the self

can shift between different positions in an imaginary landscape. That means that "I" have the possibility to move metaphorically from one position to another within the self. Moreover, Hermans (2002) has suggested that our mind is crowded by different representations of ourselves (e.g., me in the future, the ought to be self) and other people (e.g., my mother, my friend, an abstract other). In this sense, the imaginary landscape of the self can be seen as a "society of mind" in which there are internal and external positions. The focus of this dissertation is on the new meanings that result from negotiation, tension, agreement or disagreement between different positions inside myself (or I-positions) and how these new meanings are normally integrated in the form of narratives (Hermans, 2006).

In research, the multiplicity of the self has been addressed in many ways and called differently. An example of that can be found in Dimagio and Stiles' 2007 synopsis: "*characters* (Bruner, 1990), *roles* (Horowitz, 1987), *imagoes* (McAdams, 1996), *sub-personalities* (Rowan, 1990), *sub-selves* (Markus & Nurius, 1986), *positions or I-positions* (Hermans, 2004), *voices* (Stiles, 1999), and *objects or self- objects* (Kohut, 1977; Modell, 1984)" (p. 120). Under these conceptions, health problems and psychopathology have been related to the excess, or lack of, communication among diverse parts of the self (Dimaggio, Hermans, & Lysaker, 2010). Neimeyer, Herrero, and Botella (2006) described an example of diminished multiplicity when, after a traumatic event, the "traumatized self" over-interprets the majority of our experiences (e.g., "everything is dangerous"), reducing our perspective and the possibility to create alternative meanings and explanations to interpret our reality. We could say that the self could act as an "inflexible ruler" when only a few positions dominate the self, leaving other positions silenced or invisible, and thus reducing the dialog between the parts in favour of a monological experience. In contrast, the self could perform as a "democracy" when different parts of the self that are context-relevant are heard and taken into account, giving the opportunity for new meanings to emerge. As describe by Gonçalves, Ribeiro et al. (in press) our experience and "the consistency of our personal meaning system is the result of the dialogue between different positions and the temporary dominance of one position over the others, in a given moment in time".

Many psychotherapies root their clinical practice in some form of self-dialog, some more implicitly and others more explicitly. Several approaches of psychotherapy engage in some form of internal multiplicity. Following Dimagio and Stiles (2007) and Neimeyer (2006) summaries, the multiplicity of the self can be found in cognitive-behavioural therapy (CBT),

commonly under the notion of the diversity of automatic thoughts; psychodynamic psychotherapies make reference to internal objects, or to the relationships between the different parts of the mental apparatus (id, ego and super-ego); humanistic or client-centred therapy (CCT) pays attention to contradictory aspects of self or unrealized personal potentials; experiential psychotherapies such us gestalt and emotion-focused therapy (EFT) use explicitly tasks (e.g., empty chair work, two chair work) to explore different parts of the self (e.g., promoting dialog between a critical-self and a experiencing-self), or between the self and an important internalized other (e.g., to explore 'unfinished business'); narrative therapy uses externalization techniques to allow the dialog between the self and the problem(s) brought to therapy; constructivist psychotherapy, particularly in grief psychotherapy, uses narrative techniques (such us writing letters to the deceased) to reopen the dialog between the self and the departed significant other. In that vein, it is very common that psychotherapy works with, and works to promote, people's self-reflection, in other words, "building up a part of the self that then becomes the observer of the other parts acting in a scene" (Dimagio & Stiles, 2007, p. 124). That is, self-reflection or meta-cognitive processes promote multiplicity and differentiation within the self as well as integration of different meanings in a coherent narrative.

Summing up, multiplicity can be conceived in terms of diversity of I-positions narrating its own experience, from a particular perspective. The dialogical exchange between different positions of the self will give form and meaning to our experience as we move from one perspective to the other (Hermans 2006). When the multiplicity of the self is impaired and some part of us is being neglected, it can lead to uneasiness and psychological suffering.

NARRATIVE METAPHOR

Our self may be conceived as a narrative structure that organizes everyday events, gives meaning to them and provides a sense of continuity and purpose over one's experience over time (Adler, 2012; McAdams, 1996; McAdams & McLean, 2013; Neimeyer & Buchanan-Arvay, 2004). Several researchers and psychotherapists use the narrative metaphor to conceptualize human experience. The narrative metaphor suggests that people are authors who provide meaning and coherence to their lives and experiences through the construction of

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stories (also called self-narratives) and these stories have an important impact on their life quality (Angus & Kagan, 2013; Sarbin, 1986; Singer & Rexhaj, 2006; White & Epson, 1990). Some psychotherapists employ the narrative metaphor in their clinical practice to understand how the events in people's lives are linked to each other in a sequence —that is, in a story— specially related to the problems that brought them to seek therapy (White, 2001). In that fashion, psychotherapists who use narratives pay attention to the construction of stories and their relation with clinical problems. These stories might expand into a maladaptive framework of experiencing (or problematic self-narratives) deriving in psychological distress (Alves et al., 2014; Gonçalves, Ribeiro, Stiles et al., 2011). Form a narrative point of view, what occurs during a successful psychotherapy is the possibility of "re-writing" this maladaptive framework into a more adaptive one. The narrative metaphor is an approach to psychotherapy that is not interested in solving or eliminating problems but rather works with people to bring forth and elaborate stories that do not support or even contradict these problems in order to balance their power over the experience. Within these new stories clients experience new possibilities, new self-images and/or new futures; empowering unheard parts of the self for them to regain authorship over the experience (Laitila, Aaltonen, Wahlström, & Angus, 2005; Sluzki, 1992; White & Epson, 1990). Along these lines, the narrative approach is rooted in constructivist bases and recounts our lives as not a mere storytelling, but as an interpretation. As Bruner (2004) stated "*we become the autobiographical narratives by which we 'tell about' our lives*" (p. 694).

At this point, it is important to distinguish between two different levels in order to comprehend the narrative metaphor: the macro-narrative level and the micro-narrative level. The macro-narrative level is akin to an autobiography-like narration (Laitila et al., 2005), similar to the notions previously referred to as narrative identity (Adler, 2012; McAdams & McLean, 2013) and self-narrative (Angus, Levitt, & Hardtke, 1999; Gergen & Gergen, 1988; Gonçalves, Ribeiro, Mendes et al., 2011). This level coherently organizes life events in a diachronic manner, linking the past, the present experience and a possible future (Angus & McLeod, 2004). Likewise, the macro-narrative-level is formed of expectations and premises that delimit our interpretation of life events. This is similar to Cantril's notion of "assumptive world," adopted by Frank and Frank (1991), or what Goldfried (2012) described as a pattern or framework of implicit rules of meaning. Goldfried (2012) argued that in psychopathology the "*need for therapy is based on the fact that* [clients'] *current cognitive-emotional-behavioral*

pattern of dealing with various events and the world results in negative consequences" (p. 17). In other words, the meaning framework that we use to see the world greatly affects our interaction with others, the world and ourselves. In contrast, the micro-narrative level refers to single events that may support, be irrelevant, or contradict the macro-narrative level. The micro-narrative level has mainly been studied as the exception to a maladaptive meaning framework that has the potential to modify, improve or expand into a healthier macro-narrative level. This dissertation addresses how new meanings produced at the micro-narrative level influence the course of psychotherapy for MDD. The results of previous research with the Innovative Moment Coding System (IMCS) and the importance to conduct the current study on the new meaning present on client's reconceptualization of the self are presented in the final section of this introduction.

INNOVATIVE MOMENTS RESEARCH

Innovative moments (IMs) research focuses on meaning exceptions —different from a maladaptive framework of meaning— produced during psychotherapy and studies how these exceptions contribute to people's narrative and symptomatic change (Alves et al., 2014; Gonçalves et al., 2012; Gonçalves, Ribeiro, Mendes et al., 2011; Gonçalves, Ribeiro, Silva, Mendes, & Sousa, 2016; Gonçalves, Ribeiro et al., in press; Matos, Santos, Gonçalves, & Martins, 2009; Mendes et al., 2010). White and Epston's (1990) notion of unique outcomes inspired the development of IMs. Unique outcomes are narrative exceptions that do not match with the problematic self-narrative. Despite IMs being inspired by the narrative tradition, all IMs types are present in a varied range of psychotherapies (i.e., CCT, EFT, NT, CBT, time limited psychodynamic therapy and constructivist psychotherapy), and seem to be elicited by different therapeutic strategies such us chair work, Socratic questioning or externalizing questions (Gonçalves, Ribeiro et al., in press; Nasim et al., 2017). Thus, IMs may be a common process in psychotherapy and have the potential to foster a new emergent framework of meaning (Cunha, Gonçalves, Valsiner, Mendes, & Ribeiro, 2012; Montesano, Gonçalves, & Feixas, 2017).

Gonçalves and his research team (see Gonçalves, Ribeiro et al., in press for a complete review) developed the IMCS to study the nature of the IMs. In this endeavour, IMs

were categorized in seven different types and organized in two different levels (see Table I for a detail description of each type and level). Level 1 IMs comprehend events that challenge and create distance from the maladaptive framework of meaning. Level 1 includes action 1, reflection 1 and protest 1 IMs. Level 1 IMs haven't been related to symptomatic change or treatment outcome however, they seem to be the starting point for narrative change to occur. The other level, termed level 2 IMs, refers to events where people elaborate new meanings upon the emerging changes that take place during psychotherapy. Level 2 comprises action 2, reflection 2 and protest 2, and reconceptualization (RC) IMs.

Reconceptualization: Definition and state of the art

Different from other types of IMs, RC has consistently been present in recovered cases and is absent or mostly absent in unchanged cases (Gonçalves, Matos, & Santos, 2009; Gonçalves, Mendes, Ribeiro, Angus, & Greenberg, 2010; Matos et al., 2009; Mendes et al., 2010). RCs rarely appear at the beginning of psychotherapy and normally tend to emerge in the middle of psychotherapy, increasing their presence towards the end of the treatment (Gonçalves, Ribeiro, Mendes et al., 2011; Gonçalves, Silva et al., in press). In that sense, RC appears and re-appears again, repeating itself throughout the change process. This phenomenon suggests that RC is not the result of change but rather its repetition seems to strengthen the change process (Gonçalves & Ribeiro, 2012). So, what is a RC? RCs are people's expressions that articulate two dimensions: 1) a temporal contrast that embodies a shift between two positions, and 2) the attribution of the transformation process that made this shift possible. During a RC, a person is able to describe what is new or different in his/herself and also understand how or why this change took place. The contrast within a RC allows the creation of a sense of self-continuity, as it brings together the past self (what the person was), the present self (what the person is becoming) and sometimes the future self (what the person aims to be) in a coherent manner (Cunha, 2012; Gonçalves & Ribeiro, 2012). This connection helps the person to appropriate what is changing, advocating for a renew sense of agency and authorship over the experience. In other words, this self-contrast contributes to integrate a coherent and meaningful account of the self through time.

Table I

Categories of IMCS (version 8)

Types of IM	Subtypes	Definition	Contents
Creating distance from the problem (level 1 IMs) Moments of critique, thoughts, intentions, interrogations, doubts, desires, strategies and/or behaviours focus on dealing with the problems brought to therapy	Action 1	Performed and intended actions to overcome the problem	- New behavioural strategies to overcome the problem(s) - Active exploration of solutions - Searching for information about the problem(s)
	Reflection 1	New understandings of the problem	- Reconsidering problem(s)' causes - Awareness of the problem(s)' effects - New problem(s) formulations - Adaptive self instructions and thoughts - Intention to fight problem(s)' demands - General references of self-worth and/or feelings of wellbeing
	Protest 1	Objecting the problem and its assumptions	- Rejecting or objecting the problem(s) - Position of critique towards the others who support it - Position of critique towards problematic facets of oneself
Centred on change (level 2 IMs) New aims, experiences, activities, or projects, anticipated or in action, as consequence of change (not directly related with the problematic experience)	Action 2 (Performing change)	Generalization of good outcomes (performed or projected actions) into the future and other life dimensions	- Investment in new projects as a result of the process of change - Investment in new relationships as a result of the process of change - New skills unrelated to the problem - Problematic experience as a resource for new situations
	Reflection 2	Elaborations upon change and its consequences	- What is changing [Contrasting Self] - Meaning making on how/why changes are occurring [Self-Transformation Process] - References of self-worth and/or feelings of wellbeing (as consequences of change)
	Protest 2	Assertiveness and empowerment	- Centring on the self - Affirming right and needs
	Reconceptualization	Meta-reflective process description. Requires a shift between two self-positions and some access to the process underlying this transformation	Contrasting Self (what is changing?) AND Self-Transformation process (how/why change occurred?)

Moreover, according to Cunha (2012), RC "creates a psychological distance that facilitates a retrospective observation and reflection upon oneself while reacting in a problematic situation" (p. 76). In this fashion, RC is related to the adoption of a meta-perspective or a meta-position that facilitates taking a step back from the experience (Gonçalves & Ribeiro, 2012). Kross and Ayduk (in press) argue that positions of self-distance from a problematic experience helps to make sense of a difficult situation (in contrast of being immersed in it). In addition to that idea, when people report a RC they tend to feel it as being positive, motivating, and rewarding (Cunha, 2012); and they also tend to feel less ambivalent towards change (Ribeiro, Gonçalves, Silva, Brás, & Sousa, 2016). It is not clear if less ambivalence towards change favours the emergence of RC or vice versa. However, Alves et al. (2016) argue that the reduction of uncertainty towards change might support the integration of unfamiliar experiences, giving birth to new meanings.

In summary, RC of the self is a process of attributing meaning to the changes experienced during treatment while favouring an integrative account of the self ("before I was... now I am..."). Both RC's appearance in different clinical problems (i.e., depression, complicated grief, domestic violence) and its relation with recovered cases, builds the case for RC as an important meaning-making mechanism in successful psychotherapy.

INTRODUCING THE PRESENT STUDIES

To date there has not been an integrative account of the variety of findings regarding RC in the treatment of depression. Besides, it is not yet clear if RC is an effect of the reduction of symptomatology or a precursor of the reduction of symptomatology. This inquiry can have relevant implications for clinical practice to improve our current knowledge of how successful psychotherapy develops. We assume that narratives of life are important meaning-making structures and that psychotherapy has an impact on symptom reduction as well as an effect on meaning transformation. Thus, this dissertation studies if reconceptualization IMs (and its components, more on this below) are associated with improvement in depressive symptomatology.

The first chapter of this dissertation brings together all the previous data regarding IMs during the treatment of depression. Previous data suggests that in successful psychotherapy

for depression (1) level 1 IMs tend to decrease as therapy develop, (2) level 2 tend to increase, and (3) several moments of RC appear, mainly from the middle towards the end of the therapeutic process. RC coding implies that two components are present: a temporal contrast between two parts of the self, that is, a comparison of a past problematic self towards an emerging adaptive self (Contrasting-Self; CS), and the understanding of the process involved in this transformation (Self-Transformation Process; STP). If only one of these components emerges, a level 2 IM (such as reflection 2) is coded. So an important question is if the articulation of the two components (i.e., RC) is different from the separated components (i.e., level 2 IMs, other than RC). Hence, this first chapter aims to answer if level 2 IMs formulated as CS or STP are the same or a different phenomenon from RC regarding their impact in pre-post symptoms gains.

The second chapter is more specific. It also takes into account CS and STP formulations as well as RC and seeks to have a better understanding of the relation of these IMs with clients depressive symptomatology, not taking into account pre-post change, but a longitudinal design. In that effort, all therapy sessions of a sample that underwent NT or CBT were measured with CS, STP, RC and symptomatology. The objective was to test the relation of symptomatology and the emergence of new meanings (i.e., CS, STP and RC) from one session to the following one. First, we question if symptomatology and CS, STP, and RC are related, and if so, does the occurrence in one session predict a decrease on symptomatology in the next one? (And vice versa: does the decrease of symptoms in one session predict an increase in the occurrence of RC or its components (CS and STP) in the following one?)

The third and last chapter aims to give life to the previous two chapters through the analysis of the intense case study of Celia. As stated before, level 1 IMs tend to decrease while level 2 tend to increase. To know how specific meanings present in this transition are being transformed is yet another interesting issue to research. Theoretically some new meanings — that act as exceptions to a maladaptive meaning framework—, will expand into themes that may transform or develop into a healthier meaning framework. In this sense, this chapter is an exploratory study that looks into the emerging themes that appear in a successful case of MDD undergoing NT. Therefore, our interest lays in understanding how new meanings present on IMs, particularly in CS, STP and RC relate to each other. We will explore how the differentiation and integration of new meaning in Celia's case, that is, how the emergence and interaction of different themes - that challenge the maladaptive framework of meaning - develop across time.

Before concluding this introductory section, notice that the organization of the studies (chapters) combined in this dissertation is presented in a general-to-specific logic. This means that the results and conclusions of one study guide the following one. The first chapter starts with a quantitative design with several samples previously studied to examine the relation between RC (and CS and STP) with pre-post change, the second chapter uses samples that had outcome measures in each session and studies the same relation from one session to the following one; and finally the third chapter studies one single case intensively trying to better understand these processes.

REFERENCES

Adler, J. M. (2012). Living into the story: agency and coherence in a longitudinal study of narrative identity development and mental health over the course of psychotherapy. *Journal of personality and social psychology*, *102*(2), 367-389.

Alves, D., Fernández-Navarro, P., Batista, J., Ribeiro, E., Sousa, I., & Gonçalves, M. M. (2014). Innovative moments in grief therapy: The meaning reconstruction approach and the processes of self-narrative transformation. *Psychotherapy Research*, *24*(1)*,* 25-41.

Alves, D., Fernández-Navarro, P., Ribeiro, A. P., Ribeiro, E., Sousa, I., & Gonçalves, M. M. (2016). Ambivalence in grief therapy: The interplay between change and self-stability. *Death studies*, *40*(2), 129-138.

American Psychological Association (APA). (2006). Evidence-based practice in psychology: APA presidential task force on evidence-based practice. *American Psychologist*, *61*(4), 271-285.

American Psychological Association (APA). (2012). *Recognition of Psychotherapy Effectiveness.* Retrieved from http://www.apa.org/about/policy/resolution-psychotherapy.aspx

Angus, L. E., Boritz, T., Bryntwick, E., Carpenter, N., Macaulay, C., & Khattra, J. (in press). The Narrative-Emotion Process Coding System 2.0: A multi- methodological approach to identifying and assessing narrative-emotion process markers in psychotherapy, *Psychotherapy Research*. doi:10.1080/10503307.2016.1238525

Angus, L. E., & Kagan, F. (2013). Assessing client self-narrative change in emotion-focused therapy of depression: An intensive single case analysis. *Psychotherapy*, *50*(4), 525-534.

Angus, L., Levitt, H., & Hardtke, K. (1999). The narrative processes coding system: Research applications and implications for psychotherapy practice. *Journal of Clinical Psychology, 55*(10), 1255-1270.

Angus, L. E., & Mcleod, J. (Eds.) (2004). *The handbook of narrative psychotherapy: Practice, theory and research.* London: Sage.

Barkham, M. (2002). Methods, Outcomes and Processes in the Psychological Therapies. In W. Dryden (Ed.), *Handbook of Individual Therapy* (pp. 373-433). London: Sage.

Barkham, M., & Margison, F. (2007). Practice-based evidence as a complement to evidence-based practice: From dichotomy to chiasmus. In C. Freeman & M. Power (Eds.), *Handbook of evidence-based psychotherapies: A guide for research and practice* (pp. 443-476). Chippenham, Wiltshire (England): John Wiley & Sons.

Boritz, T. A., Bryntwick, E., Angus, L., Greenberg, L. S., & Constantino, M. J. (2014). Narrative and emotion process in psychotherapy: An empirical test of the Narrative-Emotion Process Coding System (NEPCS). *Psychotherapy Research, 24*(5), 594-607.

Bruner, J. (2004). Life as narrative. *Social research, 71*(3), 691-710.

Castonguay, L. G., & Beutler, L. E. (2006). Principles of therapeutic change: A task force on participants, relationships, and techniques factors. *Journal of clinical psychology*, *62*(6), 631-638.

Castonguay, L. G., & Hill, C. E. (2007). *Insight in psychotherapy*. Washington, DC, US: American Psychological Association.

Castonguay, L. G., & Hill, C. E. (2012). *Transformation in psychotherapy: Corrective experiences across cognitive behavioral, humanistic, and psychodynamic approaches.* Washington, DC, US: American Psychological Association.

Cooper, A. A., & Conklin, L. R. (2015). Dropout from individual psychotherapy for major depression: a meta-analysis of randomized clinical trials. *Clinical psychology review*, *40*, 57-65.

Cuijpers, P., van Straten, A., van Oppen, P., & Andersson, G. (2008). Psychotherapy for depression in adults: A meta-analysis of comparative outcome studies. *Journal of Consulting and Clinical Psychology, 76,* 909-922. doi:10.1037/a0013075

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Cunha, C. A. C. (2012). *Narrative change in emotion-focused therapy: co-constructing innovative self-narratives*. (Doctoral dissertation). University of Minho. Retrieved from http://repositorium.sdum.uminho.pt/handle/1822/19754

Cunha, C., Gonçalves, M. M., Valsiner, J., Mendes, I., & Ribeiro, A. P. (2012). Rehearsing renewal of identity: Reconceptualization on the move. In M. C. Bertau, M. M. Gonçalves, & P. Raggat (Eds.), *Dialogic formations: Investigations into the origins and development of the dialogical self*. Charlotte, NC: Information Age Publishing.

Detert, N. B., Llewelyn, S., Hardy, G. E., Barkham, M., & Stiles, W. B. (2006). Assimilation in good-and poor-outcome cases of very brief psychotherapy for mild depression: An initial comparison. *Psychotherapy Research*, *16*(4), 393-407.

Dimaggio, G., Hermans, H. J., & Lysaker, P. H. (2010). Health and adaptation in a multiple self: The role of absence of dialogue and poor metacognition in clinical populations. *Theory & Psychology*, *20*(3), 379-399.

Dimaggio, G., & Stiles, W. B. (2007). Psychotherapy in light of internal multiplicity. *Journal of clinical psychology*, *63*(2), 119-127.

Doss, B. D. (2004). Changing the way we study change in psychotherapy. *Clinical Psychology: Science and Practice*, *11*(4), 368-386.

Elliott, R. (2010). Psychotherapy change process research: Realizing the promise. *Psychotherapy research*, *20*(2), 123-135.

Eysenck, H. J. (1952). The effects of psychotherapy: an evaluation. *Journal of consulting psychology*, *16*(5), 319.

Frank, J. D., & Frank, J. (1991). *Persuasion and healing: A comparative study of psychotherapy* (3rd ed.). Baltimore, MD: Johns Hopkins University Press.

Gennaro, A. (2011). The building of models as pathway to understand the therapeutic process. *Integrative Psychological and Behavioral Science*, *45*(3), 355-365.

Gergen, K. J., & Gergen, M. M. (1988). Narrative and the self as relationship. *Advances in experimental social psychology, 21*(1), 17-56. London: Academic Press Inc.

Goldfried, M. R. (2012). On entering and remaining in psychotherapy. *Clinical Psychology: Science and Practice, 19*(2), 125-128. doi:10.1111/j.1468-2850.2012.01278.x

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

Gonçalves, M. M., Mendes, I., Cruz, G., Ribeiro, A. P., Sousa, I., Angus, L., & Greenberg, L. S. (2012). Innovative moments and change in client-centered therapy. *Psychotherapy Research, 22*(4), 389-401.

Gonçalves, M. M., Mendes, I., Ribeiro, A. P., Angus, L. E., & Greenberg, L. S. (2010). Innovative moments and change in emotion-focused therapy: The case of Lisa. *Journal of Constructivist Psychology*, *23*(4), 267-294.

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

Gonçalves, M. M., Ribeiro, A. P., Mendes, I., Alves, D., Silva, J., Rosa, C., ... Oliveira, J. T. (in press). Three narrative-based coding systems: Innovative moments, ambivalence and ambivalence resolution. *Psychotherapy Research.* doi:10.1080/10503307.2016.1247216

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

Gonçalves, M. M., Ribeiro, A. P., Silva, J. R., Mendes, I., & Sousa, I. (2016). Narrative innovations predict symptom improvement: Studying innovative moments in narrative therapy of depression. *Psychotherapy Research, 26*(4), 425-435. doi:10.1080/10503307.2015.1035355

Gonçalves, M. M., Ribeiro, A. P., Stiles, W. B., Conde, T., Matos, M., Martins, C., & Santos, A. (2011). The role of mutual in-feeding in maintaining problematic self-narratives: Exploring one path to therapeutic failure. *Psychotherapy Research*, *21*(1), 27-40.

Gonçalves, M. M., Silva, J. R., Mendes, I., Rosa, C., Ribeiro, A. P., Batista, J., ... Silva, C.F. (in press). Narrative changes predict symptoms decrease in cognitive-behavioral therapy for depression: An exploratory study. *Clinical Psychology & Psychotherapy.* doi:10.1002/cpp.2048

Greenberg, L. S. (1986). Change process research. *Journal of Consulting and Clinical Psychology, 54*, 4-9.

Greenberg, L. S., & Safran, J. D. (1990). Emotional-change processes in psychotherapy. In R. Plutchik and H. Kellerman (Eds.), *Emotion, psychopathology, and psychotherapy* (pp. 59-84). San Diego, California: Academic Press, Inc.

Haro, J. M., Ayuso-Mateos, J. L., Bitter, I., Demotes-Mainard, J., Leboyer, M., Lewis, S. W., ... & Robbins, T. W. (2014). ROAMER: roadmap for mental health research in Europe. *International journal of methods in psychiatric research*, *23*, 1-14.

Hermans, H. J. (2002). The dialogical self as a society of mind introduction. *Theory & Psychology*, *12*(2), 147-160.

Hermans, H. J. (2006). The self as a theatre of voices: Disorganization and reorganization of a position repertoire. *Journal of Constructivist Psychology*, *19*(2), 147-169.

Hermans, H. J., Kempen, H. J., & Van Loon, R. J. (1992). The dialogical self: Beyond individualism and rationalism. *American psychologist*, *47*(1), 23-33.

Hill, C. E., & Corbett, M. M. (1993). A perspective on the history of process and outcome research in counseling psychology. *Journal of Counseling Psychology, 40*, 3-24.

Kazdin, A. E. (2009). Understanding how and why psychotherapy leads to change. *Psychotherapy research*, *19*(4-5), 418-428.

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

Krause, M., Parra, G. D. L., Arístegui, R., Dagnino, P., Tomicic, A., Valdés, N., ... & Altimir, C. (2006). Indicadores genéricos de cambio en el proceso psicoterapéutico. *Revista Latinoamericana de Psicología*, *38*(2), 299-325.

Krause, M., Altimir, C., Pérez, J. C., & De la Parra, G. (2015). Generic change indicators in therapeutic processes with different outcomes. *Psychotherapy Research*, *25*(5), 533-545.

Kross, E., & Ayduk, O. (in press). Self-Distancing: Theory, Research, and Current Directions. *Advances in Experimental Social Psychology*. doi:10.1016/bs.aesp.2016.10.002

Laitila, A., Aaltonen, J., Wahlström, J., & Angus, L. (2005). Narrative process modes as a bridging concept for the theory, research and clinical practice of systemic therapy. *Journal of family therapy*, *27*(3), 202-216.

Lopes, R. T., Gonçalves, M. M., Sinai, D., & Machado, P. P. (2015). Predictors of dropout in a controlled clinical trial of psychotherapy for moderate depression. *International Journal of Clinical and Health Psychology*, *15*(1), 76-80.

Lysaker, P. H., Lancaster, R. S., & Lysaker, J. T. (2003). Narrative transformation as an outcome in the psychotherapy of schizophrenia. *Psychology and Psychotherapy: Theory, Research and Practice*, *76*(3), 285-299.

Matos, M., Santos, A., Gonçalves, M., & Martins, C. (2009). Innovative moments and change in narrative therapy. *Psychotherapy Research, 19*(1), 68-80.

McAdams, D. P. (1996). Personality, modernity, and the storied self: A contemporary framework for studying persons. *Psychological Inquiry, 7,* 295-321.

McAdams, D. P., & McLean, K. C. (2013). Narrative identity. *Current Directions in Psychological Science*, *22*(3), 233-238.

Mendes, I., Ribeiro, A., Angus, L., Greenberg, L., Sousa, I., & Gonçalves, M. (2010). Narrative change in emotion-focused therapy: How is change constructed through the lens of the Innovative Moments Coding System? *Psychotherapy Research, 20*, 692-701.

Montesano, A., Gonçalves, M. M., & Feixas (2017). Self-narrative reconstruction after dilemma-focused therapy for depression: A comparison of good and poor outcome cases. *Psychotherapy Research*, *27*(1), 112-126.

Nasim, R., Shimshi, S., Ziv-Beiman, S., Peri, T., Fernández-Navarro, P., & Gonçalves, M. M. (2017) *How is change constructed in Time Limited Psychodynamic Psychotherapy? An Innovative Moments' Perspective*. Manuscript in preparation.

Neimeyer, R. A. (2006). Narrating the dialogical self: Toward an expanded toolbox for the counselling psychologist. *Counselling Psychology Quarterly*, *19*(1), 105-120.

Neimeyer, R. A., & Buchanan-Arvay, M. (2004). Performing the self: Therapeutic enactment and the narrative integration of traumatic loss. In H. J. M. Hermans & G. Dimaggio (Eds.), *The dialogical self in psychotherapy* (pp. 173-189). New York: Brunner-Routledge.

Neimeyer, R.A., Herrero, O., & Botella, L. (2006). Chaos to coherence: Psychotherapeutic integration of traumatic loss. *Journal of Constructivist Psychology*, *19*, 127-146.

Pachankis, J. E., & Goldfried, M. R. (2007). On the next generation of process research. *Clinical Psychology Review, 27*, 760-768.

Reisner, A. D. (2005). The common factors, empirically validated treatments, and recovery models of therapeutic change. *The Psychological Record*, *55*(3), 377-399.

Ribeiro, A. P., Gonçalves, M. M., Silva, J. R., Brás, A., & Sousa, I. (2016). Ambivalence in Narrative Therapy: A Comparison Between Recovered and Unchanged Cases. *Clinical Psychology & Psychotherapy, 23,* 166-175. doi:10.1002/cpp.1945

Riumallo-Herl, C., Basu, S., Stuckler, D., Courtin, E., & Avendano, M. (2014). Job loss, wealth and depression during the Great Recession in the USA and Europe. *International journal of epidemiology, 43*(5), 1508-1517.

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

Singer, J. A., & Rexhaj, B. (2006). Narrative coherence and psychotherapy: A commentary. *Journal of Constructivist Psychology, 19*(2), 209-217.

Sluzki, C. (1992). Transformations: A Blueprint for Narrative Changes in Therapy. *Family Process, 31*, 217-230.

Stiles, W. B. (2001). Assimilation of problematic experiences. *Psychotherapy, 38*(4), 462-465.

Stiles, W. B., & Brinegar, M. G. (2007). Insight as a Stage of Assimilation: A Theoretical Perspective. In L. G. Castonguay & C. E. Hill (Eds.), *Insight in psychotherapy* (pp. 101-118). Washington, DC, US: American Psychological Association.

Swift, J. K., & Greenberg, R. P. (2012). Premature discontinuation in adult psychotherapy: A meta-Analysis. *Journal of Consulting and Clinical Psychology, 80*, 547-559.

Wells, M. G., Burlingame, G. M., Lambert, M. J., Hoag, M. J., & Hope, C. A. (1996). Conceptualization and measurement of patient change during psychotherapy: Development of the Outcome Questionnaire and Youth Outcome Questionnaire. *Psychotherapy: Theory, Research, Practice, Training, 33*(2), 275-283.

Wittchen, H. U., Jacobi, F., Rehm, J., Gustavsson, A., Svensson, M., Jönsson, B., ... & Fratiglioni, L. (2011). The size and burden of mental disorders and other disorders of the brain in Europe 2010. *European Neuropsychopharmacology, 21*(9), 655-679.

White, M. (2001). The narrative metaphor in family therapy: an interview with Michael White. In D. Denborough (Ed.), *Family therapy: Exploring the field's past, present and possible futures* (pp. 131-138). Dulwich Centre Publications.

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

World Health Organization (WHO). (2014). *Global Status Report on Non-communicable Diseases.* Geneva, Switzerland.

World Health Organization (WHO). (2017, February 13). Depression - Fact sheet. Retrieved from http://www.who.int/mediacentre/factsheets/fs369/en/

CHAPTER ONE

RECONCEPTUALIZATION AND TREATMENT OUTCOME IN DEPRESSION: A COMMON FACTOR WITHIN FOUR TYPES OF PSYCHOTHERAPIES

CHAPTER ONE

RECONCEPTUALIZATION AND TREATMENT OUTCOME IN DEPRESSION: A COMMON FACTOR WITHIN FOUR TYPES OF PSYCHOTHERAPIES[1]

ABSTRACT

Reconceptualization innovative moments (RC) are events that facilitate the transformation of client's maladaptive framework of meaning and are related to successful psychotherapeutic change. RC is formed by a temporal contrast between a past and a new perceived self (contrasting self component; CS), and a description of how or why this transformation has occurred (self-transformation process component; STP). The aim of this study is to analyse the impact of RC's components (CS or STP) and RC (CS + STP) with treatment outcome. Innovative moments and depressive symptomatology were previously assessed. The coders identified the presence or absence of CS, STP and RC in every session in a sample of 28 cases of cognitive-behavioural therapy (N=6), emotion-focused therapy (N=6), client centred therapy (N=6) and narrative therapy (N=10) for major depression disorder. Generalized linear mixed modelling was conducted to explore which of the variables (CS, STP or RC) predicted better treatment outcome. Results suggested that RC is a better predictor of treatment outcome compared to CS and STP. New meanings related to RC of the self might help clients to differentiate themselves from the problematic experience and to create a coherent account of the changes produced during psychotherapy. We speculate that prompting RC during treatment of depression could be easily implemented in different psychotherapeutic practices.

INTRODUCTION

The exploration of maladaptive frameworks of meaning in psychotherapy helps people to examine painful experiences in order to promote the emergence of new meanings and self-understandings (Boritz, Bryntwick, Angus, Greenberg, & Constantino, 2014; Dimaggio, Salvatore, Azzara, & Catania, 2003; Frank & Frank, 1991; Goldfried, 2012; Neimeyer, Burke,

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[1] This study was submitted with the following authors: P. Fernández-Navarro, C. Rosa, I. Sousa, H. Ventura, A. P. Ribeiro, & M. M. Gonçalves.

Mackay, & van Dyke Stringer, 2010). Along these lines, psychotherapeutic change is supported not only by symptom reduction or behavioural modifications alone, but also by the production of new meanings (Gonçalves, Ribeiro, Silva, Mendes, & Sousa, 2016; Neimeyer & Bridges, 2003). We give meaning to everyday events in form of coherent and adaptive narratives. From this perspective, we are motivated storytellers who narrate stories about our lives (Baumeister & Newman, 1994; Hermans, 2002). An illustration of this notion can be exemplified in cases with major depression disorder (MDD). Clients give meaning to life experiences in a hegemonic way, having reduced flexibility (i.e., "I am depressed" or "life has no value"), preventing alternative accounts to be developed. To overcome such restrictions and the specific problems that could be associated (e.g., low self-esteem, pessimistic view of the world, rumination) is necessary to open other meaning possibilities. These new possibilities may allow alternative frameworks of meaning to emerge influencing peoples' life quality, their sense of wellbeing and identity (Angus & Kagan, 2013; Angus & McLeod, 2004; Gonçalves, Matos, & Santos, 2009; White & Epson, 1990).

Innovative Moments

The experience of exceptions to the maladaptive framework of meaning - in which a person is able to develop alternative meanings - were empirically operationalized as innovative moments (IMs) by Gonçalves, Ribeiro, Mendes, Matos and Santos (2011). IMs are markers of meaning transformation that were examined in different psychotherapies such as narrative therapy (NT; Gonçalves et al., 2016; Matos, Santos, Gonçalves, & Martins, 2009), emotion-focused therapy (EFT; Mendes et al., 2010), client-centred therapy (CCT; Gonçalves et al., 2012), constructivist grief therapy (CGT; Alves, Fernández-Navarro, Batista, et al., 2014), cognitive-behavioural therapy (CBT, Gonçalves, Silva et al., in press) and time limited psychodynamic therapy (Nasim et al., 2017). Besides IMs presence in different models of psychotherapy, they were also studied within different clinical problems, namely, MDD (Mendes et al., 2010), complicated grief (Alves, Fernández-Navarro, Ribeiro, et al., 2014) and victims of domestic violence (Matos et al., 2009). These findings, - that is, the presence in different therapies and in different conditions and disorders - suggest that IMs may be a common ingredient in psychotherapeutic change (Gonçalves et al., 2016).

We summarize here the major findings from these studies on IMs emergence. First, IMs are significantly more present in recovered than unchanged cases. Second, we can differentiate seven different types of IMs (see Table I for a full description) and organize them in two developmental levels (Gonçalves et al., 2016; Gonçalves, Ribeiro et al., in press): level 1 IMs, representing client's ways to challenge and create distance from the maladaptive framework of meaning (action 1, reflection 1 and protest 1) and level 2 IMs (action 2, reflection 2, protest 2 and RC) centred on the elaboration of ongoing changes. Third, level 2 IMs are more present in recovered than in unchanged cases. Finally, RC occurs incipiently in unchanged cases while it is often the dominant type of IM in successful psychotherapy after mid-treatment (Gonçalves et al., 2009; Gonçalves et al., 2012; Matos et al., 2009; Mendes et al., 2011). The only exception to this last finding was found on the CBT sample in which RC occurred in a low frequency. This exception is discussed in more detail below.

Reconceptualization Innovative Moments

RC consists of a narrative structure formed by two different components: contrasting self (CS) and self-transformation process (STP; Cunha, Spínola, & Gonçalves, 2012; Gonçalves et al., 2016; Gonçalves & Silva, 2014). CS refers to a person's description of *what* is changing, or different, in him/herself. It is expressed as a temporal contrast between a problematic characteristic of the self in the past (e.g., *I was...*) towards a more adaptive emerging present self (e.g., *I am...*). STP describes an understanding of the process of *how* and/or *why* this shift was possible to achieve. When these components of RC occur separately, they are coded as other level 2 IMs (i.e., action 2, reflection 2 or protest 2). Only when both components are present and articulated in the same utterance, they are coded as RC (for a more in depth look see Table I). The following clinical vignette (translated from one of the cases analysed in the present study) illustrates RC's components. The client was diagnosed with MDD and she was struggling with the opinion of significant others:

Therapist: So you didn't take the critics...
Client: *No. Before, any time people said something, even though it wasn't directed at me, I would take everything so personally... and now, it didn't bother me at all and I thought 'you've come a long way'!* [CS]

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Therapist: A very different kind of interaction from what occurred before...

Client: Mm-hm, I guess *it's because I learned to be more self-confident, letting others to know what the limits are* [STP].

In this example, the client is capable of noticing something new in herself ("I don't take critics so personally") and she was also aware of how this shift was possible from a meta-reflective position ("because I learned to be more self-confident and to express to others what the limits are"). Gonçalves and Ribeiro (2012) suggested that RCs increase their presence from the middle to end of therapy as an effort to consolidate and stabilize emerging changes. They proposed that these repetitions of RC are clients' attempts to identify themselves progressively with the emergent changes, starting to consolidate in this way a new framework of meaning. Singer, Blagov, Berry and Oost (2013) introduce a similar idea when they stated that recurrent self-defining memories might form a new narrative script, somehow equivalent to the alternative meaning framework mentioned before. From self-defining memories, people build their life-story by connecting significant memories across their lifetime in a way to incorporate in their narrative identity, specific memories and adaptive meaning-making, in order to attain wellbeing. In this sense, RC could be understood as a connection of self-defining memories that bridges the present self with the past self. Gonçalves and Ribeiro (2012) also observed that the more developed narrative structure of RC (i.e., the articulation of CS and STP), compared to others IMs, might facilitate a progressive integration of psychotherapeutic change. This narrative structure is clearly visible in the 3 positions that can be observed in RC: the self in the past (problematic position), the more adaptive self in the present (these two positions form the CS) and a decentred position from which the process that allowed changing from the past to the present (that is, STP) is observed (Gonçalves & Ribeiro, 2012; Gonçalves, Ribeiro et al., in press).

Related processes and concepts: Are we talking about the same experience?

In this section we discuss the similarities between RC and other psychotherapy concepts, namely, insight, corrective experiences (CE), and self-distance perspective. These notions have a common denominator with RC: they all refer to meaning shifts during psychotherapy.

Table I

Categories of IMCS (version 8)

Types of IM	Subtypes	Definition	Contents
Creating distance from the problem (level 1 IMs) Moments of critique, thoughts, intentions, interrogations, doubts, desires, strategies and/or behaviours focus on dealing with the problems brought to therapy	Action 1	Performed and intended actions to overcome the problem	- New behavioural strategies to overcome the problem(s) - Active exploration of solutions - Searching for information about the problem(s)
	Reflection 1	New understandings of the problem	- Reconsidering problem(s)' causes - Awareness of the problem(s)' effects - New problem(s) formulations - Adaptive self instructions and thoughts - Intention to fight problem(s)' demands - General references of self-worth and/or feelings of wellbeing
	Protest 1	Objecting the problem and its assumptions	- Rejecting or objecting the problem(s) - Position of critique towards the others who support it - Position of critique towards problematic facets of oneself
Centred on change (level 2 IMs) New aims, experiences, activities, or projects, anticipated or in action, as consequence of change (not directly related with the problematic experience)	Action 2 (Performing change)	Generalization of good outcomes (performed or projected actions) into the future and other life dimensions	- Investment in new projects as a result of the process of change - Investment in new relationships as a result of the process of change - New skills unrelated to the problem - Problematic experience as a resource for new situations
	Reflection 2	Elaborations upon change and its consequences	- What is changing [Contrasting Self] - Meaning making on how/why changes are occurring [Self-Transformation Process] - References of self-worth and/or feelings of wellbeing (as consequences of change)
	Protest 2	Assertiveness and empowerment	- Centring on the self - Affirming right and needs
	Reconceptualization	Meta-reflective process description. Requires a shift between two self-positions and some access to the process underlying this transformation	Contrasting Self (what is changing?) AND Self-Transformation process (how/why change occurred?)

Starting with insight, several authors reached a consensual definition and described insight as a "conscious meaning shift involving new connections" (Hill et al., 2007, p. 442). RC share with insight the idea of clients constructing meaning with some sense of causality as well as being able to make connections between events, particularly between past and present events. However, not all meaning shifts are included in RC. For instance, events focused on the maladaptive framework of meaning (i.e., *"now I realize that my problem is that I am not being respected. I want to be respected"*) are not enough to be regard as a RC. This example would be regarded as a reflection 1 in IM research, but not a RC. Furthermore, turning something previously unconscious conscious usually would be considered a form of insight, yet, if it is presented without the elaborated structure of RC (the presence of its components CS and STP), it cannot be count as a RC. Following the comparison with other concepts, consider now CE. These experiences involve "a disconfirmation of a client's conscious or unconscious expectations as well as an emotional, interpersonal, cognitive and/or behavioural shift [where] clients reencounter previously unresolved conflicts [...] or previously feared situations [...] but reach a new outcome" (Hill et al., 2012, pp. 355-356). Both RC and CE express that something about one's self is different from the current frame of reference. Nonetheless, a CE could emerge without any sign of awareness (although an insight or another kind of awareness could come before or after, or even be part of a CE; Castonguay & Hill, 2012), whereas for RC, a conscious meaning elaboration is always needed as reflected on the STP component.

Kross and Ayduk (2011, in press), and also Habermas, Ott, Schubert, Schneider, and Pate (2008), pinpointed the importance of meaning-making process, especially from a self-distance perspective in situations with an intense negative emotion as in MDD. Kross and Ayduk (2011) found that a self-immersed perspective could maintain the problematic experience, leading people to narrowly recount concrete details (i.e., what happened?), whereas to make meaning stepping back from a negative experience would facilitate the reconstruction of the experience, rather than just merely recall it, in ways that would reduce distress. In this sense Habermas et al. (2008) compared 17 depressed with 17 non-depressed clients, finding that the depressed group was more immersed in past experiences. They evaluated the participant's life narratives finding that the clinical group deviate more from a "linear temporal narration" (i.e., compared less frequently the past with the present), employing more past than present evaluations and more experience-near evaluations than

distance evaluations. This distance perspective has obvious similarities with the STP, since a distance perspective (or decentred perspective) is needed to describe the process of transformation from the past into the present.

Summarizing the similarities and differences between RC and other related concepts, we may say that transformation in psychotherapy seems to be accompanied by some sort of meaning making that shifts clients previous framework of thinking, behaving and/or feeling. However these concepts differ on the relevance of awareness (secondary to CE) and on the content of awareness since RC only attends to events related to the development of a new meaning framework, disregarding new conceptions about the previous maladaptive framework. Furthermore, RC seems to capture the ability to step back from just recounting the experience, allowing a meta-reflective understanding of how/why and what happened. In this fashion RC might be understood as specific operationalization of a self-distance process.

The present study: Reconceptualization components

Reconceptualization components, CS and STP, appear more frequently in therapy than RC and they are coded as other level 2 IMs (e.g., reflection 2). Interestingly, the CBT sample in Gonçalves, Silva et al.'s (in press) study was the only one with low prevalence of RC, and instead of RC appearing associated with successful outcomes, it was reflection 2 that discriminated recovered from unchanged cases. In another study (Gonçalves et al., 2016), different level 2 IMs such as reflection 2, action 2 and RC were predictors of symptom reduction. Maybe the reason why sometimes other level 2 IMs, besides RC, appear associated to recovered cases is that some of these level 2 IMs are indeed CS or STP. Thus, one interesting empirical question is if the components of RC taken separately (CS and STP) have the same potential for change as RC. From the sample of CBT, it would seem that only the individual components are necessary, but we think that a more exhaustive empirical examination is needed. This study pretends to bring some light to the question if CS and STP are basic processes present in IMs that promote change. This information could be crucial for clinicians as a marker of how new meanings are being integrated during the course of therapy.

METHOD

Sample

The sample of this study comprises 28 participants diagnosed with MDD from two different clinical trials. One clinical trial was conducted in a university clinic at Braga, Minho, Portugal, comparing the effectiveness of narrative therapy (NT) and cognitive-behavioural therapy (CBT) for MDD (Lopes et al., 2014), and the other clinical trial contrasted emotion-focused therapy (EFT) with client-centred therapy (CCT) in the York I depression study in Canada (Greenberg & Watson, 1998). The participants had a protocol of maximum 20 weekly sessions in EFT and CCT subsamples, and for the NT and CBT subsamples the protocol included 16 weekly sessions and four biweekly sessions (17 up to 20).

York I depression study. The participants were diagnosed with MDD as specified by DSM-III-R (American Psychiatric Association, 1987) and were excluded if they had three or more prior episodes of MDD or if they were currently in treatment (either psychotherapeutic or pharmacological). The exclusion criteria also extended to those who had suffered incest, lost a loved one within the last year, had a suicidal attempt, were abusing alcohol or drugs, or had comorbidities with antisocial, borderline, bipolar, psychotic or eating disorders. In the original study, 34 clients constituted the final sample, 17 in EFT and 17 in CCT. For this study 12 cases were chosen (six in each condition) that were previously selected for process research (Greenberg & Watson, 1998). Six cases were considered unchanged and six recovered, taking into consideration the Beck Depression Inventory (BDI; Beck, Steer & Carbin, 1988) cut-off and the calculation of the reliable change index (RCI; Jacobson & Truax, 1991).

Minho depression study. The participants in this study were diagnosed with MDD according to the DSM-IV-TR (American Psychiatric Association, 2002). Similarly, participant with co-occurring diagnosis from Axis I or II were excluded as well as participants with severe suicidal ideation, psychotic symptoms or bipolar disorder (Lopes et al., 2014). The final sample comprised 63 participants (34 in NT ad 29 in CBT), however only 40 were completers (20 in each sample). Considering the BDI-II cut-off and the RCI, the completers were classified as unchanged or recovered. The subsamples for this study consisted of six CBT clients (three

unchanged and three recovered) and 10 NT clients (five unchanged and five recovered) that were randomly selected from the completers and were previously selected for purposes of process research (see Gonçalves et al., 2016; Gonçalves, Silva et al., in press).

Therapists

Eleven therapists participated in the York I depression study, three males and eight females, with different levels of education: six were doctoral students at the time, four had PhDs and one was a psychiatrist. On average, all therapists had at least two years of training in CCT, and 5.5 years of experiential therapy. Nevertheless, all therapists received a 24-week period of additional training both in CCT and in experiential techniques, following Greenberg, Rice and Elliot (1993) manual, and had weekly supervision throughout the study to help them to adhere to the manual.

Ten therapists participated in the Minho depression study but only two are included in the present sample. Both of them were PhD students and had three years of clinical experience at the time of the clinical trial. Therapists' adherence was assessed according to the Adherence and Competence Scale for Narrative and Cognitive-Behavioural Therapy (ACS-N-CBT, Gonçalves, Bento, Lopes, & Salgado, 2009), and they chose the model they prefer (CBT or NT) in order to control allegiance.

Treatment

CCT treatment implemented attitudes of empathy, positive regard, and congruence as well as a position of validation and valuation towards the client as a worthwhile person, avoiding an evaluative point of view. The manual (Greenberg et al., 1993) emphasizes an empathic understanding of the client's internal frame of reference, checking with the client if this understanding fits to their experience. Likewise, therapists are instructed to symbolize their own experience and offer it to the client when that could be useful and facilitative during psychotherapy.

EFT treatment took into account client-centred relational attitudes and added marked-guided and process directive experiential techniques. Psychotherapy structure started with a

set of three first sessions based on CCT treatment, followed by experiential techniques (self-evaluative conflicts, systematic evocative unfolding, focusing, gestalt empty chair dialog or two-chair work), depending on the problems presented. The treatment focuses on activating dysfunctional emotion schemes in order to restructure them with primary adaptive feelings, that is, changing emotion (maladaptive) with emotion (adaptive) and confront dysfunctional beliefs connected with them (Greenberg & Watson, 2006).

The **NT** treatment manual (Gonçalves and Bento, 2008) is rooted in the intervention model of White and Epston (1990; White, 2007). The NT standpoint claims that psychological problems and suffering are the effect of dominant and rigid life narratives (White & Epston, 1990). The narrative approach brings forth and thickens alternative stories that do not support or contradict the problems presented in therapy in order to balance its power over the experience (Freedman & Combs, 1996). Narrative therapists work within two main objectives: the deconstruction of the dominant narrative, and the (re)construction of an alternative one that is not problem-saturated (White & Epston, 1990). Deconstruction starts detaching the problem from the client's identity and mapping its influence in the client's life, mainly through externalizing conversations (White, 2007). Reconstruction focuses on the identification and elaboration of unique outcomes, that is, exceptions to the problematic self- narrative. Therapists may use re-authoring conversations, scaffolding, letters and other techniques to promote the emergence of unique outcomes (White, 2007).

CBT treatment followed protocol for depression that involves five phases (Beck, Rush, Shaw, & Emery, 1979; Leahy & Holland, 2000): psychoeducation, case formulation, behavioural activation, cognitive restructuring and termination. In that order, the therapist first establishes what are the therapy goals and offers information about how depression works; secondly, a treatment plan is set up; in the third phase, behavioural strategies such us reinforcement or problem-solving skills are introduced; the fourth phase focuses on recognizing distorted automatic thoughts and underlying dysfunctional beliefs; and, lastly, the client is prepared for the end of treatment and works on relapse prevention.

Measures

Outcome measure. Depression outcome was measured with the BDI self-report questionnaire. The York depression study used the first version of the inventory (Beck, Steer & Carbin, 1988) and the Minho depression study used the second version of the BDI (BDI-II; Beck, Steer, & Brown, 1996). The BDI and the BDI-II have a 4-point Likert scale ranged from 0 to 3 and 21 items grouped in three subscales: cognitive symptoms, affective symptoms and somatic symptoms. Total score vary from 0 to 63 where higher values correspond to greater depressive symptomatology. The inventory presented good internal consistency ($\alpha = .91$; Steer et al., 2001) and construct validity (Beck et al., 1996; Steer et al., 2001). For the Minho study, the BDI-II version used was translated and validated for use in Portugal (Campos & Gonçalves, 2011; Coelho, Martins, & Barros, 2002). The Reliable Change Index (RCI) (Jacobson & Truax, 1991) was calculated from meta-analyses of diverse samples (Seggar, Lambert, & Hansen, 2002) to calculate the index (RCI = 8.46) and the cut-off score (14.29).

Process Measure. Emerging new meanings during psychotherapy were tracked using the Innovative Moments Coding System (IMCS; Gonçalves, et al., 2011). This system is a qualitative procedure that identifies seven mutually exclusive categories of IMs and their proportion, that is, the percentage of words (transcripts) or time (videotape) involved in each IM relative to the total amount of words or time in each session. IMs proportion takes into account client and therapist interventions under the assumption that change is co-constructed. Reliability has proved to be strong at both recognizing IMs proportion, ranging from 84% to 94%, and identifying IMs types with Cohen's Kappa ranging from .80 to .97 (Alves, Fernández-Navarro, Batista, et al, 2014; Gonçalves et al., 2012; Matos et al., 2009; Mendes et al., 2010),

Procedures

Regarding the York study, the BDI was administered one week before treatment, after session eight, and at treatment termination; whereas the BDI-II in the Minho study was completed at the first session and then at every fourth sessions, including the last one. Considering the IMs coding, all coders were trained following the protocol advised for this

procedure (see Gonçalves et al., 2011) and only started coding after they were considered reliable; achieving Cohen's kappa values higher than .75. The IMCS was previously applied to all samples (see Gonçalves, et al., 2012 for CCT; Gonçalves et al., 2016 for NT; Gonçalves, Silva et al., in press for CBT and Mendes et al., 2010 for EFT). The purpose of this study falls on the identification of RC's components (CS and STP) present in all the IMs previously coded. All coders that participated in the coding of IMs, as well as in the identification of CS and STP, were unaware of the study's hypotheses and the case outcome.

Coding of IMs (archival data). All samples were analysed by two independent coders. All samples were considered to have high reliability (Hill & Lambert, 2004), with a percentage of agreement in IMs' proportion that varied from 85.9% to 90%, and an agreement in IMs types measured with Cohen's kappa that ranged from .86 to .97.

Identification of CS and STP (current study). Another group of coders worked on the identification of CS and STP. Previously to that task, all coders undertook an intensive training guided by the authors of the manual based on three steps. First, coders were introduced to the coding of CS, STP and RC. For that, coders read the IMCS manual specialized in those elements and had a coding example from a clinical session. Second, coders assessed other sessions that had the IMs coded, and CS and STP were already marked. The coder's task consisted of identifying which RC component was present. Finally, the last step involved the identification of the emergence CS, STP and RC in several sessions. Weekly meetings were organized to discuss the manual, review the coding of the transcripts and discuss disagreements and misunderstandings. Coders were considered reliable after they achieved a Cohen's kappa higher than .75. Reliability was assessed comparing trainees' codes with the codes of expert coders at the end of the second and third steps.

For the coding of the present study, Coder 1 coded the entire sample and four other coders participated in the process. Coders checked all the IMs previously coded and identified weather CS or STP was present. Reliability measured by Cohen's kappa coefficients for CS and STP ranged from .80 to .90. See Table II for a detailed description.

Table II

Reliability for the Identification of CS and STP

Coders	Treatment	Sessions	Average Cohen's Kappa
Coder 1	All	28	-
Coder 2	NT	4	.85
Coder 3	NT	6	.80
Coder 4	CBT	6	.90
	EFT	6	.85
Coder 5	CCT	6	.84

Generalised linear mixed modelling analyses. The data was analysed using a generalised linear mixed model (GLMM). The GLMM is a type of regression that takes into account subject-specific random effects and allows for the response variables to have arbitrary distributions, which is better for unbalanced data (McCullagh & Nelder, 1989). The proportion of CS, STP and RC were considered predictors and the response variable employed was the improvement in depressive symptomatology (BDI scores pre-therapy - BDI scores post-therapy). A regression model was described as a linear function of the explanatory variables. Outcomes varied from 0 to 1 corresponding with the occurrence (or non-occurrence) of the response variables (i.e., RC proportion). A GLMM was fitted, taking into account a subject-specific random effect, assuming variability among individuals and correlation coming form the measurements of the same individual.

The analyses were made in order to study the relation of the mean proportion of CS, STP and RC —each variable separately— with treatment outcomes (BDI scores), which corresponded to three different models. Besides, a more complex analysis where CS, STP and RC were included in one model to account for their combined prediction was also observed. Linear, generalized linear, and nonlinear mixed models (lme4) package for R (version 3.2.4, R Development Core Team, 2016) were used to perform the analyses.

RESULTS

Innovative Moments descriptive data

A total of 10108 IMs were analysed in this sample in which 1662 were coded as CS or STP (16.45%) and 238 were RC (2.35%). The mean proportion of IMs per session was 17.33%, that is, in average, around 17% of the dialog between therapist and client involved IMs. There were several differences between unchanged and recovered cases (see table III below). Overall, IMs in unchanged cases tended to appear half of the time compared with recovered cases. Moreover, in unchanged cases, Level 1 and 2 IMs had a very similar proportion and RC is almost inexistent (0.64%). In contrast, in recovered cases, the total proportion of IMs is nearly twice as the one in unchanged cases (22.64% vs. 12.02%). Furthermore, in recovered cases, Level 2 IMs are much more present than Level 1 IMs (14.76% vs. 7.88%) and RC is much more predominant (4.45%). Interestingly, looking at the whole sample, most of the Level 2 IMs were in fact CS, STP or RC (7.25% from a total 9.94%).

Table III

Reliability for the Identification of CS and STP

IMs / Cases	Mean Proportion per session		
	Unchanged	Recovered	Sample
Total IMs	12.02%	22.64%	17.33%
Level 1	6.90%	7.88%	7.39%
Level 2	5.13%	14.76%	9.94%
CS & STP	2.63%	6.79%	4.71%
RC	0.64%	4.45%	2.54%
Other level 2	1.86%	3.52%	2.69%

Attending the evolution of the IMs, the proportion of CS, STP and RC increased as treatment evolved in recovered cases, but remained stable and low in unchanged cases (see Figures 1, 2 and 3). The solid line in the graphs of figure 1 to 3 represent a smooth spline.

Figure 1. CS evolution for recovered cases (left) and unchanged cases (right)
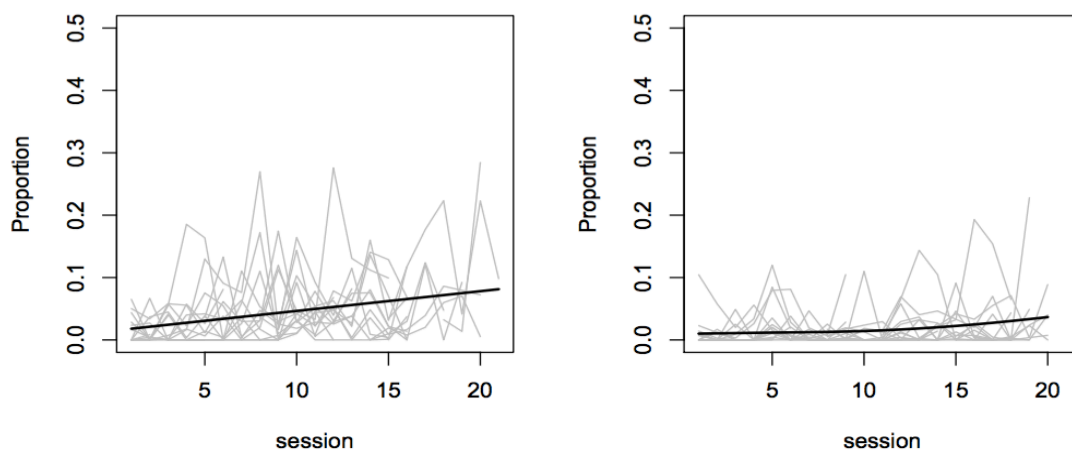
Figure 2. STP evolution for recovered cases (left) and unchanged cases (right)
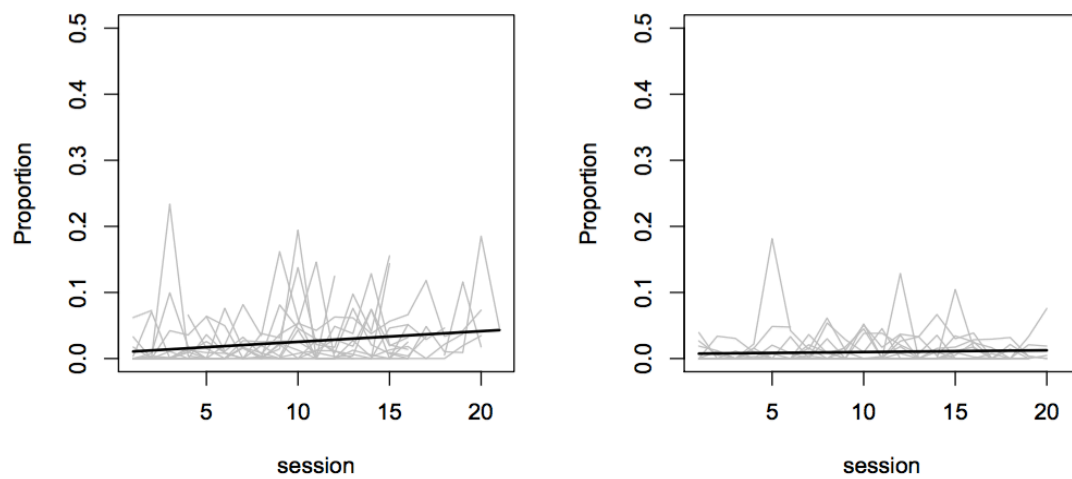
Figure 3. RC evolution for recovered cases (left) and unchanged cases (right)
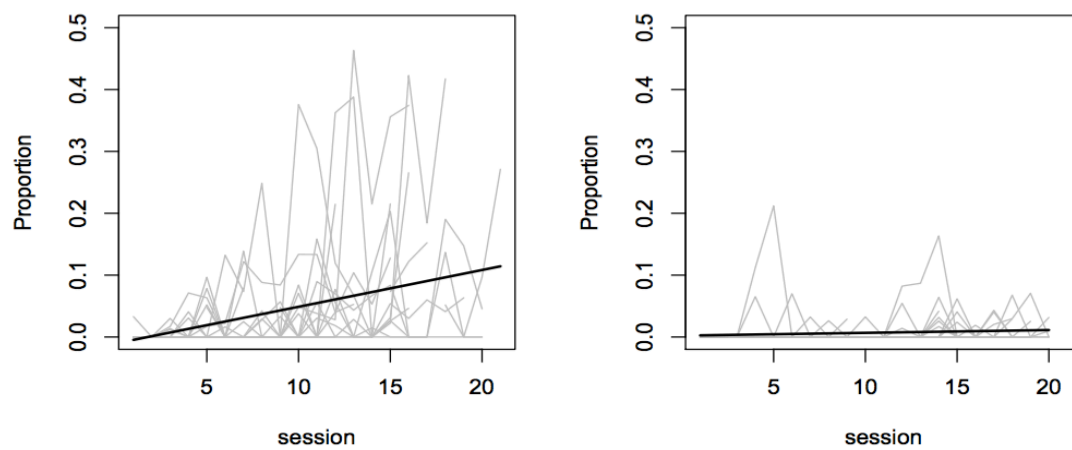
Innovative Moments as predictors of depressive symptomatology

In the analysis of each variable (i.e., CS, STP and RC) separately, higher proportion of CS (p = .0001; R^2_{adj} = .29), STP (p = .007; R^2_{adj} = .22) and RC (p < .001; R^2_{adj} = .30) during psychotherapy predicted a higher difference in the pre-post treatment scores in the BDI for MDD (see Table IV). That is, both RC's components and RC are good predictors of treatment outcome in the direction expected. In other words, higher proportion of CS, STP, and RC were predictors of symptom improvement with a variance explained of 28.88%, 21.55%, and 30.52% respectively. Then, a model with the 3 variables, instead of 3 different and separate models, was considered. Intriguingly, the model that account for the variance of the three variables together predicted that only RC (p = .03; R^2_{adj} = .38) is related to outcome and explained more variance compared with the three previous models.

Table IV

GLMM of CS, STP and RC Proportion as Predictors of Symptomatology Variability (pre-post BDI treatment scores)

Models and Fixed Effects	Coefficient	*SE*	*t*	*p*
Contrasting Self predicting BDI Model				
Intercept (β 00)	3.36	3.36	1.00	.01
Contrasting Self (β 01)	3.09	.89	3.46	.0001
Self-Transformation Process predicting BDI Model				
Intercept (β 00)	6.04	3.12	1.94	.06
Self-Transformation Process (β 01)	3.99	1.37	2.90	.007
Reconceptualization IMs predicting BDI Model				
Intercept (β 00)	7.04	2.53	2.78	.01
Reconceptualization (β 01)	2.19	.61	3.59	.001
CS + STP + RC predicting BDI Model				
Intercept (β 00)	2.41	3.16	.76	.45
Contrasting Self (β 01)	1.29	1.31	.98	.33
Self-Transformation Process (β 02)	1.48	1.80	.82	.42
Reconceptualization (β 03)	1.52	.66	2.30	.03

DISCUSSION

This study aimed to clarify the relation of RC and its individual components, CS and STP, with symptom outcome. As expected, most of Level 2 IMs were formulated as CS, STP or as RC (CS + STP). In order to discriminate if CS, STP and RC are the same phenomenon, we compared the predictive value of these variables in relation to depressive symptomatology. The first set of models replicated the generalised linear analyses used in previous studies (see Gonçalves et al., 2016; Gonçalves, Silva et al., in press) where only one variable at a time was examined. As expected, RC predicted higher difference in pre-post treatment BDI scores, but also CS and STP were predictors of this difference. However, when an analysis was done including the three predictors (RC, CS and STP) in the same model, only RC was related to symptom outcome. From these results it may be inferred that RC (that is, CS and STP articulated together), in spite of its lower appearance (238 RC over 1662 IMs), has a clear influence over depressive symptomatology and ultimately over recovery. Thus, RC's structure (CS + STP) appears to have a stronger relation to symptom improvement rather than the components apart (CS or STP). The famous dictum from Koffka (1935/2013) seems to apply here: "the whole is other than the sum of the parts" (p. 176), that is, RC seems a different phenomenon when compared with CS or STP. Overall, these findings give further support to the idea that RC of the self is an important path to change in psychotherapy (Gonçalves et al., 2016; Gonçalves & Ribeiro, 2012), and particularly in MDD.

The present results suggest that RC might be a helpful event in psychotherapy, due to its relation with symptom outcome. As CE or insight, it cannot be concluded if RC is just an outcome of the therapeutic process or part of the process of change. Along this line, some authors characterize insight as a type of treatment outcome and for others it is part of the change process (Castonguay & Hill, 2012). We speculate that RC may be a process that people undergo to identify themselves with current changes rather than being a mere outcome. RC repetition through therapy might contribute to progressively combine the diversity of events and new life experiences with an integrative account of oneself. Following this reasoning, RC could be a source of coherence that facilitates a sense of connection and continuity, acting as a narrative bridge between "what my experience is now," and "how my story is changing". That is, when RC starts emerging, this might not refer directly to the end of the maladaptive framework, but to the beginning of a new one. The process of reconceptualising the self

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integrates memory specificity (as CS does) with an adaptive meaning-making (the STP), which for Singer et al. (2013) are signals of a healthy narrative identity. RCs may help the person in a way to familiarize him/herself with ongoing changes, reducing distress, ambivalence (Alves et al., 2016; Ribeiro, Gonçalves, Silva, Brás, & Sousa, 2016), and ultimately symptom severity. Despite these arguments, the question of RC, and other helpful events, being part of the process that leads to a good outcome, or being therapy outcomes in themselves, remains unanswered. Above all, the study of events that helps the treatment to work, understanding how therapy leads to therapeutic transformation, should promote ways to facilitate and optimize change in clinical practice (Kazdin, 2009).

In general, the present study gives further support to the claim that new meanings are important for change in psychotherapy (Gonçalves et al., 2016; Neimeyer & Bridges, 2003). In this case, the research objective was centred on changes in depressive symptomatology and the new meanings associated with the RC of the self. New meanings in which people reconceptualise their experience could be detected in other models as new personal constructs (Krause, Altimir, Pérez, & De la Parra; 2015), new accounts over the experience (Boritz et al., 2014), or as meaning bridges in the assimilation of the problematic experience (APES; Stiles, 2001). In fact, high-level APES stages (stage 4 or higher) have been associated with level 2 IMs, particularly with RC and action 2, suggesting convergent identification of change experiences (Gonçalves et al., 2014). The authors (Gonçalves et al., 2014) advocate that both models share the underlying implication of the construction of a meta-perspective. As previously mentioned, RC IMs are possible through a position that enables the client to look upon the experience and extract what is changing (CS) and how or why these changes are possible (STP), which is very similar to the meaning-making processes from a self-distance perspective (Habermas et al., 2008; Kross & Ayduk, 2011, in press). Recently, Bernstein et al. (2015) discussed several related concepts (i.e., cognitive distancing, meta-cognitive awareness, mindfulness, reperceiving, self-distance perspective, among other concepts) referring to them as a decentring phenomenon. The decentring phenomenon is described as "the capacity to shift experiential perspective —from *within* one's subjective experience *onto* that experience—" (Bernstein et al., 2015, p. 599) and several concepts associated with this description have been connected with improvements in mental health, mainly linked to depressive, anxiety and mood symptoms. RCs of the self, as presented in this article, can be

seen as an operationalization, narrative-based instrument to study this phenomenon during psychotherapy. Further study will be needed to prove this point.

Limitations and further studies

Generalization of the present study should be avoided due to the small sample size and due to the focus on a population with MDD. The current study provides further support to the importance of the creation of new meanings during psychotherapy to improve depressive symptomatology. The major contribution of the present study lies on RC structure (CS + STP) as something that facilitates symptom's decrease; nonetheless, the direction of this relation needs more research. Is it symptom reduction that promotes more RC or is it a higher proportion of RC that facilitates symptom reduction? Finally, if reconceptualizing the self proves to be an important element for recovery, the implementation of questions or techniques to elicit them during treatment should be addressed.

REFERENCES

Alves, D., Fernández-Navarro, P., Batista, J., Ribeiro, E., Sousa, I., & Gonçalves, M. M. (2014). Innovative moments in grief therapy: The meaning reconstruction approach and the processes of self-narrative transformation. *Psychotherapy Research*, *24*(1)*,* 25-41.

Alves, D., Fernández-Navarro, P., Ribeiro, A. P., Ribeiro, E., & Gonçalves, M. M. (2014). Ambivalence and Innovative Moments in Grief Psychotherapy: The Cases of Emily and Rose. *Psychotherapy, 51*(2)*,* 308-21*.*

Alves, D., Fernández-Navarro, P., Ribeiro, A. P., Ribeiro, E., Sousa, I., & Gonçalves, M. M. (2016). Ambivalence in grief therapy: The interplay between change and self-stability. *Death studies*, *40*(2), 129-138.

American Psychiatric Association. (1987). *Diagnostic and statistical manual of mental disorders*, 3rd ed., revised (DSM-III-R). Washington DC: American Psychiatric Association.

American Psychiatric Association. (2002). *DSM-IV-TR: Manual de diagnóstico e estatística das perturbações mentais* [DSM-IV-TR: Diagnostic and statistical manual of mental disorders] (4th ed.). Lisboa: Climepsi Editores.

Angus, L. E., & Kagan, F. (2013). Assessing client self-narrative change in emotion-focused therapy of depression: an intensive single case analysis. *Psychotherapy, 50*(4), 525-34.

Angus, L., & McLeod, J. (2004). *The handbook of narrative and psychotherapy: Practice, theory, and research.* Thousand Oaks, CA: Sage.

Baumeister, R. F., & Newman, L. S. (1994). How stories make sense of personal expe- riences: Motives that shape autobiographical narratives. *Personality and Social Psychology Bulletin, 20,* 676-690. doi:10.1177/0146167294206006

Beck, A. T., Rush, A. J., Shaw, B. F., & Emery, G. (1979). *Cognitive Therapy of Depression.* Guilford Press, New York.

Beck, A. T., Steer, R. A., & Brown, G. K. (1996). *Manual for Beck Depression Inventory II.* San Antonio. TX: Psychological corporation.

Beck, A. T., Steer, R. A., & Carbin, M. G. (1988). Psychometric properties of the Beck Depression Inventory: Twenty-five years of evaluation. *Clinical psychology review, 8*(1), 77-100.

Bernstein, A., Hadash, Y., Lichtash, Y., Tanay, G., Shepherd, K., & Fresco, D. M. (2015). Decentering and Related Constructs: A Critical Review and Metacognitive Processes Model. *Perspectives on Psychological Science, 10*(5), 599-617.

Boritz, T. A., Bryntwick, E., Angus, L., Greenberg, L. S., & Constantino, M. J. (2014). Narrative and emotion process in psychotherapy: An empirical test of the Narrative-Emotion Process Coding System (NEPCS). *Psychotherapy Research, 24*(5), 594-607.

Castonguay, L. G., & Hill, C. E. (2012). *Transformation in psychotherapy: Corrective experiences across cognitive behavioral, humanistic, and psychodynamic approaches.* Washington, DC, US: American Psychological Association.

Campos, R. C., & Gonçalves, B. (2011). The Portuguese version of the Beck Depression Inventory-II (BDI-II). *European Journal of Psychological Assessment, 27,* 258-264.

Coelho, R., Martins, A., & Barros, H. (2002). Clinical profiles relating gender and depressive symptoms among adolescents ascertained by the Beck Depression Inventory II. *European Psychiatry, 17,* 222-226.

Cunha, C. A. C., Spínola, J., & Gonçalves, M. M. (2012). The emergence of innovative moments in narrative therapy for depression: Exploring therapist and client contributions. *Research in Psychotherapy: Psychopathology, Process and Outcome, 15*(2), 62-74.

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

Frank, J. D., & Frank, J. (1991). *Persuasion and healing: A comparative study of psychotherapy* (3rd ed.). Baltimore, MD: Johns Hopkins University Press.

Freedman, J., & Combs, G. (1996). *Narrative therapy: The social construction of preferred realities*. New York: Norton.

Goldfried, M. R. (2012). On entering and remaining in psychotherapy. *Clinical Psychology: Science and Practice, 19*(2), 125-128. doi:10.1111/j.1468-2850.2012.01278.x

Gonçalves, M.M., Bento, T., 2008. Manual Terapêutico Psicoterapia Narrativa de Re- Autoria. Braga, Portugal

Gonçalves, M. M., Bento, T., Lopes, R., & Salgado, J. (2009). *Manual da escala de adesão e competência*. Braga, Portugal.

Gonçalves, M. M., Gabalda, I. C., Ribeiro, A. P., Pinheiro, P., Borges, R., Sousa, I., & Stiles, W. B. (2014). The Innovative Moments Coding System and the Assimilation of Problematic Experiences Scale: A case study comparing two methods to track change in psychotherapy. *Psychotherapy Research, 24*(4), 442-455.

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

Gonçalves, M. M., Mendes, I., Cruz, G., Ribeiro, A. P., Sousa, I., Angus, L., & Greenberg, L. S. (2012). Innovative moments and change in client-centered therapy. *Psychotherapy Research, 22*(4), 389-401.

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

Gonçalves, M. M., Ribeiro, A. P., Mendes, I., Alves, D., Silva, J., Rosa, C., ... Oliveira, J. T. (in press). Three narrative-based coding systems: Innovative moments, ambivalence and ambivalence resolution. *Psychotherapy Research*. doi:10.1080/10503307.2016.1247216.

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

Gonçalves, M. M., Ribeiro, A. P., Silva, J. R., Mendes, I., & Sousa, I. (2016). Narrative innovations predict symptom improvement: Studying innovative moments in narrative therapy of depression. *Psychotherapy Research, 26*(4), 425-435. doi: 10.1080/10503307.2015.1035355.

Gonçalves, M. M., & Silva, J. R. (2014). Momentos de inovação em psicoterapia: Das narrativas aos processos dialógicos. *Análise Psicologica, 1*, 27-43.

Gonçalves, M. M., Silva, J. R., Mendes, I., Rosa, C., Ribeiro, A. P., Batista, J., ... Silva, C.F. (in press). Narrative changes predict symptoms decrease in cognitive-behavioral therapy for depression: An exploratory study. *Clinical Psychology & Psychotherapy*. doi:10.1002/cpp.2048.

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

Greenberg, L., & Watson, J. (1998). Experiential therapy of depression: Differential effects of client-centered relationship conditions and process experiential interventions. *Psychotherapy Research, 8*(2), 210-224.

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

Habermas, T., Ott, L.-M., Schubert, M., Schneider, B., & Pate, A. (2008). Stuck in the past: Negative bias, explanatory style, temporal order, and evaluative perspectives in life narratives of clinically depressed individuals. *Depression and Anxiety, 25*, E121-E132.

Hermans, H.J.M. (2002). The person as a motivated storyteller. In R.A. Neimeyer and G.J. Neimeyer (Eds.), *Advances in Personal Construct Psychology*, Vol. 5 (pp. 3-38). Westport, CT: Praeger.

Hill, C. E., Castonguay, L. G., Angus, L., Arnkoff, D. B., Barber, J. P., Bohart, A. C., ... & Crits-Christoph, P. (2007). Insight in Psychotherapy: Definitions, Processes, Consequences, and Research Directions. In L. G. Castonguay & C. E. Hill (Eds.), *Insight in psychotherapy*. Washington, DC, US: American Psychological Association.

Hill, C. E., Castonguay, L. G., Farber, B. A., Knox, S., Stiles, W. B., Anderson, T., ... & Sharpless, B. A. (2012). Corrective experiences in psychotherapy: Definitions, processes, consequences, and research directions. In L. G. Castonguay & C. E. Hill (Eds.), *Transformation in psychotherapy: Corrective experiences across cognitive*

behavioral, humanistic, and psychodynamic approaches. Washington, DC, US: American Psychological Association.

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

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

Kazdin, A. E. (2009). Understanding how and why psychotherapy leads to change. *Psychotherapy research*, *19*(4-5), 418-428.

Koffka, K. (2013). *Principles of Gestalt psychology* (Vol. 44). Routledge.

Krause, M., Altimir, C., Pérez, J. C., & De la Parra, G. (2015). Generic change indicators in therapeutic processes with different outcomes. *Psychotherapy Research*, *25*(5), 533-545.

Kross, E., & Ayduk, O. (2011). Making Meaning out of Negative Experiences by Self-Distancing. *Current Directions in Psychological Science, 20*(3), 187-191.

Kross, E., & Ayduk, O. (in press). Self-Distancing: Theory, Research, and Current Directions. *Advances in Experimental Social Psychology*. doi:10.1016/bs.aesp.2016.10.002

Leahy, R. L., & Holland, S. J. (2000). *Treatment Plans and Interventions for Depression and Anxiety Disorders*. New York: Guilford Press.

Lopes, R., Gonçalves, M., Machado, P. P., Sinai, D., Bento, T., & Salgado, J. (2014). Narrative Therapy vs. Cognitive-Behavioral Therapy for moderate depression: Empirical evidence from a controlled clinical trial. *Psychotherapy Research, 24,* 662-674.

Matos, M., Santos, A., Gonçalves, M., & Martins, C. (2009). Innovative moments and change in narrative therapy. *Psychotherapy Research, 19*(1), 68-80.

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

Nasim, R., Shimshi, S., Ziv-Beiman, S., Peri, T., Fernández-Navarro, P., & Gonçalves, M. M. (2017) *How is change constructed in Time Limited Psychodynamic Psychotherapy? An Innovative Moments' Perspective*. Manuscript in preparation.

Mendes, I., Ribeiro, A., Angus, L., Greenberg, L., Sousa, I., & Gonçalves, M. (2010). Narrative change in emotion-focused therapy: How is change constructed through the lens of the

Innovative Moments Coding System? *Psychotherapy Research, 20*, 692-701.

Neimeyer, R. A., Burke, L. A., Mackay, M. M., & van Dyke Stringer, J. G. (2010). Grief therapy and the reconstruction of meaning: From principles to practice. *Journal of Contemporary Psychotherapy*, *40*(2), 73-83.

Neimeyer, R. A., & Bridges, S. K. (2003). Postmodern approaches to psychotherapies. In A. Gurman and S. Messer (Eds.) *Essential Psychotherapies: theory and practice* (2nd ed., pp. 272-316). New York: Guilford.

R Development Core Team. (2016). The R Foundation for statistical computing. Retrieved from www.Rproject.org

Ribeiro, A. P., Gonçalves, M. M., Silva, J. R., Brás, A., & Sousa, I. (2016). Ambivalence in Narrative Therapy: A Comparison Between Recovered and Unchanged Cases. *Clinical psychology & psychotherapy*, *23*(2), 166-175.

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

Singer, J. A., Blagov, P., Berry, M., & Oost, K. M. (2013). Self-Defining memories, scripts, and the life story: Narrative identity in personality and psychotherapy. *Journal of personality*, *81*(6), 569-582.

Steer, R. A., Brown, G. K., Beck, A. T., & Sanderson, W. C. (2001). Mean Beck Depression Inventory-II scores by severity of major depressive episode. *Psychological Reports*, *88*(3c), 1075-1076.

Stiles, W. B. (2001). Assimilation of problematic experiences. *Psychotherapy 38*(4), 462-465.

White, M. (2007). *Maps of narrative practice*. New York: W. W. Norton

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

CHAPTER TWO

MEANING MAKING CHANGES PRECEDES SYMPTOMATOLOGY

IMPROVEMENT: THE ROLE OF RECONCEPTUALIZATION

INNOVATIVE MOMENTS

CHAPTER TWO

MEANING MAKING CHANGES PRECEDES SYMPTOMATOLOGY IMPROVEMENT: THE ROLE OF RECONCEPTUALIZATION INNOVATIVE MOMENTS[2]

ABSTRACT

This brief report studies the temporal relation of depressive symptomatology with the emergence of new meanings in psychotherapy. Reconceptualization innovative moments (RC) and its specific components are markers of meaning transformation. RC is a meta-reflection that contains two components: a contrasting self (CS) (*I was... now I am...*) and a self-transformation process (STP), that is, an understanding of the process attributed to *how* and/or *why* this shift was achieved. CS or STP can appear separately. In fact, they are common expressions in successful psychotherapy and are much more frequent than RC. However, a previous study on the treatment of major depression suggested that when we considered the joint contributions of CS, STP and RC on the pre-post difference of the BDI, only RC emerged as a predictor. The aim of this study is to attain a better understanding of these meaning making markers and their relation with clients' symptomatology evolution, session by session. To achieve this goal, RC, CS and STP were tracked along treatment in a sample of 16 cases, treated through cognitive-behavioural therapy (CBT; N=6) and narrative therapy (NT; N=10) for major depression disorder. A total of 291 sessions were coded and symptomatology was measured with the Outcome Questionnaire 10.2. Hierarchical linear modelling was conducted. The results suggest that RC (CS + STP) is a stronger predictor of symptom reduction than when its components taken separately. Moreover, symptomatology was not related to the emergence of new meanings (i.e., CS, STP or RC). These findings suggest that RC may be more therapeutic than its individual components taken separately and seem to preceded symptom improvement. As a practical implication we may speculate that therapists could prompt the other component of RC, when one of the components emerge separately, in order to support the connections between these two components.

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[2] This study was submitted with the following authors: P. Fernández-Navarro, C. Rosa, V. Moutinho, A. Antunes, I. Sousa, A. P. Ribeiro, & M. M. Gonçalves.

INTRODUCTION

Reconceptualization Innovative Moments

Innovative moments (IMs) are "exception[s] to the inflexible meaning systems present in psychopathological suffering" (Gonçalves, Ribeiro et al., in press). Seven types of IMs have been described and organized in two different levels (see Table I for a complete description of all IMs' types and levels). After the study of several case studies and samples in different psychotherapeutic models —namely client-centred (CCT), cognitive-behavioural (CBT), emotional-focused (EFT), narrative (NT), time limited psychodynamic and constructivist grief therapy— and different problems (i.e., depression, grieving, domestic violence), one type of level 2 IMs called reconceptualization (RC) clearly appeared related to successful psychotherapy (Fernández-Navarro, 2017; Gonçalves et al., 2014; Gonçalves & Ribeiro, 2012; Gonçalves Ribeiro et al., in press; Gonçalves, Ribeiro, Mendes, Matos, & Santos, 2011; Nasim et al., 2017). Two different components are associated in RC (Cunha, Spínola, & Gonçalves, 2012; Fernández-Navarro, 2017; Gonçalves et al., 2016; Gonçalves & Silva, 2014): 1) a contrasting self (CS) component that describes what is changing or different in the person attending psychotherapy and is commonly expressed as a past problematic self (e.g., *I was worried about the future*) that contrasts with a present, more adaptive self (e.g., *now I am able to enjoy the present and I do not worry much about what the future holds*); and 2) the self-transformation process (STP) component which refers to an understanding or attribution related to how and/or why the emerging shift between the past and present self has become possible to achieve (e.g., *I enjoy the present because I realized that is possible to have time for myself and also time for looking for a job... to be worried about finding a job 24 hours every day is counter-productive!*). McAdams (2006), suggested something similar when he described that people observe themselves and make sense of their life "in terms of self-defining life stories [...] that reconstruct the past and anticipate the future in such a way as to provide life with identity, meaning, and coherence" (pp. 109-110). In this fashion, we suggest that RCs are important resources of meaning making mediating the reconstruction of a new self-defining life story, reflecting over current problems, and promoting adjustment and healthy living (Gonçalves, Ribeiro et al., in press).

Table I

Categories of IMCS (version 8)

Types of IM	Subtypes	Definition	Contents
Creating distance from the problem (level 1 IMs) Moments of critique, thoughts, intentions, interrogations, doubts, desires, strategies and/or behaviours focus on dealing with the problems brought to therapy	Action 1	Performed and intended actions to overcome the problem	- New behavioural strategies to overcome the problem(s) - Active exploration of solutions - Searching for information about the problem(s)
	Reflection 1	New understandings of the problem	- Reconsidering problem(s)' causes - Awareness of the problem(s)' effects - New problem(s) formulations - Adaptive self instructions and thoughts - Intention to fight problem(s)' demands - General references of self-worth and/or feelings of wellbeing
	Protest 1	Objecting the problem and its assumptions	- Rejecting or objecting the problem(s) - Position of critique towards the others who support it - Position of critique towards problematic facets of oneself
Centred on change (level 2 IMs) New aims, experiences, activities, or projects, anticipated or in action, as consequence of change (not directly related with the problematic experience)	Action 2 (Performing change)	Generalization of good outcomes (performed or projected actions) into the future and other life dimensions	- Investment in new projects as a result of the process of change - Investment in new relationships as a result of the process of change - New skills unrelated to the problem - Problematic experience as a resource for new situations
	Reflection 2	Elaborations upon change and its consequences	- What is changing [Contrasting Self] - Meaning making on how/why changes are occurring [Self-Transformation Process] - References of self-worth and/or feelings of wellbeing (as consequences of change)
	Protest 2	Assertiveness and empowerment	- Centring on the self - Affirming right and needs
	Reconceptualization	Meta-reflective process description. Requires a shift between two self-positions and some access to the process underlying this transformation	Contrasting Self (what is changing?) AND Self-Transformation process (how/why change occurred?)

Previous analyses

In a previous study with a sample of NT treating depression, Gonçalves et al. (2016) found that higher proportion of RC, action 2 and reflection IMs (no differentiation between types 1 and of reflection were made in this study) in a given session predicted a decrease in symptomatology measured by the Outcome Questionnaire-10.2 (OQ-10.2; Lambert et al., 1998) in the next session. These findings had a higher R square than the other way around, that is, OQ-10.2 as predictor of RC in the following session. On the other hand, a study with a CBT sample (Gonçalves, Silva et al., in press) using precisely the same design used in the NT study, found that reflection 2 IMs were predictive of symptom change (evaluated with the OQ-10.2), although this did not occur for RC. The authors proposed that the low presence of RC could be specific of this sample, and because of that, level 2 IMs were precursors of change in depressive symptomatology. In a recent study, Fernández-Navarro et al. (2017) analysed if CS and STP were associated to pre-post change in a sample of 28 cases of different sub-samples undergoing NT, CBT, EFT and CCT. However, when studied as single variables, CS and STP were found to be predictors of symptomatology reduction in the scores of the Beck Depression Inventory (BDI; Beck, Steer, & Brown, 1996), when they were set on the same model with RC. Only RC was found to be a significant predictor of symptom reduction.

The present study

This brief report aims to attain a better understanding of the role RC plays in the evolution of treatment outcome. To date, when CS and STP appear separately they are coded as level 2 IMs and when they emerge articulated together, that is in the same utterance, they are coded as RC (see Table I). Nevertheless, it is yet to be determined if RC components by themselves could promote change or if they actually need to be linked together in a RC to have a transformative therapeutic effect. This question is relevant for two reasons: first, CS and STP appear more frequently in therapy than RC (Fernández-Navarro et al., 2017); secondly, if these ingredients promote change, then they are probably very easy to teach to therapists, facilitating the integration of this knowledge into their usual approaches. This study is a reanalysis of three previous studies. First, in Fernández-Navarro et al., 2017 study the NT and CBT samples were used together with EFT and CCT in order to test if RC and its components were related to pre-

post change, as described above. We were not able to use HLM as in EFT and CCT, because we did not have measures for all the sessions. Moreover, two other studies related to the current one were published, one with NT and another one with CBT. In the study with the NT sample (Gonçalves et al., 2016), RC was predictive of OQ-10.2 in the following session, but the individual components of RC were not tested. Likewise, in the CBT study (Gonçalves, Silva et al., in press), the individual components of RC were also not tested, but reflection 2 (which is most of the time CS or STP, see Table I) emerged as predictor of OQ-10.2 in the following session. This study, despite being a reanalysis of two previous studied samples, is the first one that studies the individual components of RC (CS and STP) relating them to symptom improvement session by session and aim to clarify the previous results. Grounded on these previous findings, this study explores: 1) whether CS and STP in a given session are predictors of symptom (OQ-10.2) reduction in the following session, 2) and if so, which one is the strongest predictor (CS, STP, or RC), and 3) whether the therapeutic model (NT and CBT) is a moderator for these findings, given the previous findings with the individual samples.

METHOD

Clients

Clients were part of a larger study comparing 34 narrative therapy (NT) and 29 cognitive-behavioural therapy (CBT) cases in the treatment of MDD during a clinical trial (for a complete revision on the inclusion and exclusion criteria and other details see Lopes et al., 2014; and Lopes, Gonçalves, Sinai and Machado, 2015). Individual psychotherapy comprised a 20 sessions manual, carried out in a university clinic in the north of Portugal. The NT group involved 14 dropouts (41.2%) and 20 completers (58.8%). From the 20 completers, seven cases were considered the recovered group and 13 constituted the unchanged group. The cases' classification in recovered or unchanged followed two criteria: 1) clients must move from a dysfunctional to a functional range in a given outcome measure (cut off criterion), and 2) change should be greater than the Reliable Change Index (RCI; reliable criterion) (Jacobson, Roberts, Berns, and McGlinchey, 1999; Jacobson and Truax, 1991). These criteria were applied according to both the Beck Depression Inventory II (BDI-II) and the Outcome

Questionnaire 45.2 (OQ-45.2). The samples that constitute the NT and CBT groups of this research were previously selected for purposes of process research (see Gonçalves et al., 2016; Gonçalves, Silva et al., in press). Five recovered and five unchanged cases were randomly selected to integrate the NT group (Gonçalves et al., 2016). Seven women and three men constituted this group; their mean age was 41 years old (M = 41.00, SD = 14.97); four were single, three married, two divorced, and one widowed. All of them completed at least 9 years of academic education, but some clients had up to 24 years of academic education (M = 13.90, SD = 5.07). Their professional status also varied: four clients were unemployed, two employed, two students, and one was retired.

The CBT group had nine dropouts (31%) and 20 completers (69%). From the 20 completers, five cases recovered and the other 15 were unchanged. Three unchanged and three recovered cases were randomly selected (Gonçalves, Silva et al., in press) and included in the current study. The CBT sub-sample was composed of five women and one man; their mean age was approximately 34 years old (M = 34.5, SD = 8.48); two were single, three married, and one divorced. All of them completed at least the ninth grade but most of the clients had 16 years of academic education (M = 14.18, SD = 2.96). Their professional status also varied, three were employed, two were students and one was unemployed.

Therapists and Treatment

The therapists of these cases were PhD students in clinical psychology at the time of the clinical trial. Both therapists had 3 years of clinical experience. To control allegiance, therapists chose the model they prefer (CBT or NT). Therapists adherence to the therapeutic model was assessed according to the Adherence and Competence Scale for Narrative and Cognitive-Behavioural Therapy (ACS-N-CBT) (Gonçalves, Bento, Lopes, & Salgado, 2009), and proved to be adequate (for further details, see Lopes et al, 2014). NT intervention was based on the model of White (2007; White & Epston, 1990) and CBT intervention followed a cognitive-behavioural manual based on Beck (Beck, Rush, Shaw, & Emery, 1979; Leahy & Holland, 2000).

Measures

Outcome measures

Beck Depression Inventory II (BDI-II; Beck et al., 1996). This self-report questionnaire assesses symptoms of depression using a 4-point Likert scale (from 0 to 3; total scores range from 0 to 63) grouped in three subscales: cognitive symptoms, affective symptoms, and somatic symptoms. This instrument has displayed both good internal consistency (α = .91; Steer, Brown, & Beck al., 2001; α =.89 in this sample see Lopes et al., 2014) and construct validity (Beck et al., 1996; Steer et al., 2001). It was translated and validated for the Portuguese population with similar results to the ones observed in the American population (Campos & Gonçalves, 2011; Coelho, Martins, & Barros, 2002). Given that the Reliable Change Index (RCI) (Jacobson & Truax, 1991) could not be found across Portuguese studies, normative data gathered from meta-analyses of diverse samples (Seggar et al., 2002) was used to calculate the proportion of clinical change (RCI = 8.46; cut-off score = 14.29).

Outcome Questionnaire 45.2 (OQ-45.2; Lambert et al., 1996). The OQ-45.2 was designed to evaluate clients' symptomatology throughout therapy. It assesses three dimensions: subjective discomfort, interpersonal relationships, and social role functioning. Items are rated on a 5-point Likert scale (from 0 to 4; total scores ranged from 0 to 180). Cronbach's alpha of .93 indicates high internal consistency in various clinical samples (de Jong et al., 2007; Lambert et al., 1996). Machado and Fassnacht (2015) found similar results in the Portuguese population (α = .89; RCI of 15 points and cut-off of 62 points).

Outcome Questionnaire 10.2 (OQ-10.2; Lambert, et al., 1998). The OQ-10.2 is a brief version (only 10 items) of the OQ-45.2 with analogous values of internal consistency (α = .87; Goates-Jones & Hill, 2008) and test-retest reliability (Pearson *r* =.62; Lambert, Finch, Okiishi, & Burlingame, 2005).

Process Measures

Innovative Moments Coding System (IMCS; Gonçalves, Ribeiro, Mendes, Matos, & Santos, 2011). The IMCS is a qualitative procedure that identifies

seven mutually exclusive categories of IMs and their proportion. Proportion is calculated as the percentage of words involved in each IM relative to the total amount of words in each transcribed session. Regarding IMs proportion, each IM contained both client and therapist interventions since the IMCS understands that change is co-constructed. IMs inter-judge agreement is calculated as the overlapping proportion identified by two judges divided by the total proportion identified by either judge. After that, judges identify independently IMs types presented on the agreed proportion. Cohen's Kappa agreement is calculated over the seven mutual exclusive categories of IMs. The IMCS was used in several researches and proved reliable: the average percentage of proportion agreement ranged from 84% to 94% and the average Cohen's Kappa ranged from .80 to .97, showing a strong agreement between judges (for a complete review of previous studies see Gonçalves, Ribeiro et al., in press).

Procedures

Outcome measures. The outcome measures BDI-II and OQ-45.2 were administered at the first session and then at every fourth session including the last session. The OQ.10.2 was used in the remaining sessions. For purposes of comparability with the sessions in which the OQ-45.2 was used (1st, 4th, 8th, 12th, 16th and 20th), the items relative to the OQ-10.2 were extracted. All outcome measures were provided at the beginning of each therapeutic session.

IM coding and reliability. All coders were unaware of the case outcome and the hypotheses of the study. Two independent coders (PhD students) analysed the transcripts of all NT sessions (*N* = 180 sessions) and all CBT sessions (*N* = 111 sessions). Prior to the sessions coding, all coders completed a pre-defined training protocol and were considered reliable when they reached Cohen's kappa values higher than .75 (for full report of the training procedure see Gonçalves et al., 2011). For the NT group the percentage of agreement on the IM's identification was 89.9% and Cohen's kappa was .91 On the CBT group the percentage of agreement on the identification of IMs was 90% and the kappa of Cohen was .94. Both samples were considered to have high reliability (Hill & Lambert, 2004).

Both samples were previously coded with the IMCS (see Gonçalves et al., 2016; Gonçalves, Silva et al., in press) and, for the purpose of this study, the coding was reviewed

attending on the identification of RC's components (CS and STP) and their respective proportion in all the IMs previously coded. RC was already coded in previous studies, given that this coding is part of the IMCS. Four different coders participated in the task of identifying CS and STP; all of them were unaware of the case outcome and the hypotheses of the study. For the NT group, the first coder analysed all the transcripts (PhD student), the second coder (master student) analysed 40% of cases, and the third coder (master student) worked on the remaining 60% of the cases. Considering the CBT group, the first coder and the forth coder (post-doctoral researcher) analysed all transcripts. All coders underwent a previous intensive training directed by the authors of the manual. The training consisted in 3 main steps. First, coders were familiarized with the part of IMCS manual that focused on the codification of CS, STP and RC and they were introduced to a psychotherapeutic session already coded that served as a coding example. In the second step coders had access to other psychotherapeutic sessions with IMs already coded. Some IMs were marked and the task of the coder was to decide if CS or STP were present. In the last step, coders were presented with several psychotherapeutic sessions were they need to identify the emergence of CS, STP and RC. Weekly meetings were organized to discuss the manual, review the coding of the transcripts, and discuss disagreements and misunderstandings.

In sum, in the coding process, coders read all the IMs previously coded and identified the presence of CS and STP. The reliability of the coders was assessed at the end of the second and third steps comparing their codes with the codes of expert judges. Coders were considered to be reliable only if they achieved a Cohen's kappa higher than .75. The coding of the current sample started after the end of the training process. Reliability for CS and STP assessed by Cohen's kappa was .85 between coders 1 and 2, .80 between coders 1 and 3, and .90 between coders 1 and 4.

Hierarchical linear modelling analyses. Hierarchical linear modelling (HLM) was used to assess the relation between longitudinal values of CS, STP, and RC proportion and outcomes (OQ-10.2). In this study data collected at different times (i.e., sessions) were nested within each participant. Among other repeated measures methods, HLM has several advantages, particularly for the analysis of nested or hierarchically structured data, letting simultaneous estimations within and between client effects (Osborne 2000; Woltman, Feldstain, MacKay, & Rocchi, 2012). In this study, as it was proposed in a previous one

(Gonçalves et al., 2016), HLM was fitted into a regression model with two hierarchies: hierarchy 1 (within-participants) outcomes were estimated to be a function of time and hierarchy 2 (between-participants). Variability in hierarchy 1 coefficient was modelled as a function of participant-level time-invariant covariates. Two different sets of models were estimated to test the hypothesis. The first set of models used CS (first model), STP (second model), and RC (third model) proportion in each session as predictors and symptomatology in the following session (OQ-10-2 score) as the response variable. In this first set, a fourth model accounting for joint prediction of the three variables (CS, STP and RC) related to clients' OQ-10.2 score in the following session was also included. The second set of models estimated the opposite: outcome in each session as predictor of the proportion of CS, STP, and RC (fifth, sixth and seventh model respectively) in the following session. Nonlinear mixed-effects modelling (nlme) package for R (version 3.2.4, R Development Core Team, 2016) were used to perform the analysis.

RESULTS

Description of CS, STP and RC on the sample

From a total of 7848 IMs coded in the sample, 2608 IMs (33.23%) were level 2 IMs, 1248 were CS or STP (15.90%), and only 105 were RC (1.34%). As expected, recovered cases had a higher total IMs proportion, particularly in Level 2 IMs, when compared to unchanged cases. This difference was especially predominant regarding the emergence of CS, STP, and RC compared to other level 2 IMs (see Table V). Overall, the sample presented less proportion of RC (1.95%) compared to the proportion of CS and STP (5.96%).

First set of models: Are RC and RC components predictors of symptomatology improvement in the following session?

Findings (see Table VI) from the first, second, and third model of HLM analyses suggest that both RC ($p < .00001$; $R^2_{adj} = .59$), and each of its components separately, CS ($p = .0001$; $R^2_{adj} = .59$) and STP ($p = .0021$; $R^2_{adj} = .58$), emerged as significant predictors of clients' symptomatology in the following session.

Table V

Mean Innovative Moments Proportion per Session

IMs / Cases	Mean Proportion per session		
	Unchanged	Recovered	Sample
Total IMs	13.72%	23.96%	19.70%
Level 1	7.70%	9.75%	9.20%
Level 2	6.03%	14.22%	10.50%
CS & STP	3.16%	8.35%	5.96%
RC	0.75%	3.06%	1.95%
Other level 2	2.11%	2.81%	2.59%

Table VI

HLM with CS, STP and RC Proportion as Predictors of Symptomatology (OQ-10.2 scores)

Models and Fixed Effects	Coefficient	*SE*	*t*	*p*
Contrasting Self predicting OQ-10.2 (1st Model)				
Intercept ($\beta\ 00$)	18.78	2.55	7.34	<.00001
Contrasting Self ($\beta\ 01$)	-.28	.07	-4.12	.0001
Treatment ($\beta\ 02$)	3.23	3.23	1.00	.33
Self-Transformation Process predicting OQ-10.2 (2nd Model)				
Intercept ($\beta\ 00$)	18.37	2.64	6.95	<.00001
Self-Transformation Process ($\beta\ 01$)	-.27	.08	-3.13	.0019
Treatment ($\beta\ 02$)	3.36	3.34	1.00	.33
Reconceptualization IMs predicting OQ-10.2 (3rd Model)				
Intercept ($\beta\ 00$)	18.14	2.62	6.91	<.00001
Reconceptualization ($\beta\ 01$)	-.27	.06	-4.29	<.00001
Treatment ($\beta\ 02$)	3.54	3.32	1.07	.30
CS + STP + RC predicting OQ-10.2 (4th Model)				
Intercept ($\beta\ 00$)	18.83	2.52	7.48	<.00001
Contrasting Self ($\beta\ 01$)	-.15	.08	-1.97	.05
Self-Transformation Process ($\beta\ 02$)	-.16	.09	-1.85	.07
Reconceptualization ($\beta\ 03$)	-.18	.07	-2.49	.01
Treatment ($\beta\ 04$)	3.59	3.17	1.13	.28

The higher proportion of these variables in one session tended to be associated with client's symptoms (scores in OQ-10.2) reduction in the next one. However, the results for the fourth model —that accounts for the three variables in the same model— pointed out that only RC ($p = .02$; $R^2_{adj} = .60$) had a clear effect on outcome (see Table VI): higher proportion of RC in one session tended to be related with lower OQ-10.2 scores in the next session but, CS and STP only seemed to have a marginal effect on outcome scores ($p = .05$ and $p = .07$ respectively). No differences between treatments (CBT and NT) were found in these models.

Second set of models: Is symptomatology related to the proportion RC and RC components in the following session?

On the second set of HLM analyses (see Table VII), symptomatology (OQ-10 scores) was not associated with either RC or with CS or STP in the next session. Therefore, an increase or decrease of symptoms in one session does not appear to affect the production of RC and RC components in the following session. As in the first set of models, there were no differences between treatments.

Table VII

HLM with Symptomatology (OQ 10.2 scores) as Predictors of CS, STP and RC Proportion in the Following Session

Models and Fixed Effects	Coefficient	*SE*	*z*	*p*
OQ-10.2 predicting Contrasting Self (5th model)				
Intercept ($\beta\ 00$)	-2.31	.83	-2.77	.005
OQ-10.2 ($\beta\ 01$)	-.06	.04	-1.53	.12
Treatment ($\beta\ 02$)	.28	.69	.41	.68
OQ-10.2 predicting Self-Transformation Process (6th model)				
Intercept ($\beta\ 00$)	-3.22	1.10	-2.92	.003
OQ-10.2 ($\beta\ 01$)	-.04	.05	-.87	.39
Treatment ($\beta\ 02$)	.50	.88	.56	.57
OQ-10.2 predicting Reconceptualization (7th model)				
Intercept ($\beta\ 00$)	-2.85	1.13	-2.53	.011
OQ-10.2 ($\beta\ 01$)	-.09	.05	-1.70	.09
Treatment ($\beta\ 02$)	.82	1.01	.81	.42

DISCUSSION

The present study aimed at attaining a better understanding of RC IMs and its relation with depressive symptomatology. Specifically, this research enquired about RC and its components CS and STP. Replicating the results of the previous study from Gonçalves et al. (2016), the third model showed that RC in one session predicts symptom reduction in the following one. Besides, when clients express CS or STP in a given session, the level of symptoms tended to decrease in the next one (first and second models). This is similar to what Gonçalves, Silva et al. (in press) found, relating reflection 2 and action 2 to symptom reduction (as stated before, CS and STP are present in level 2 IMs). We think that level 2 IMs might be connected to symptomatology through RC's components. Interestingly, no treatment differences were found in the present study. Whereas in Gonçalves et al. (2016) RC, reflection and, action 2 were presented as predictors of symptomatology reduction in the next session, in Gonçalves, Silva et al. (in press) only reflection 2 predicted a decrease of symptomatology in the following session. We think that the small sample size of the previous studies could explain these differences but further exploration of this phenomenon is recommended. Besides, in Gonçalves et al. studies (2016; in press) only one variable at a time was chosen as the guiding criteria to investigate its relation with the outcome. However, when the three variables CS, STP, and RC were set on the same model (fourth model), only RC predicted symptom reduction on the next session. As in the previous study from Fernández-Navarro et al. (2017), the structure of RC (CS + STP) had a higher impact on symptomatology reduction in this sample, despite its lower occurrence (only 105, out of 7848 IMs) and proportion (3.06% in recovered cases) in comparison with CS and STP. RC structure - that is, CS and STP articulated together - have been argued to be something else than just the sum of the parts and also seemed important to consolidate new meanings (Fernández-Navarro et al., 2017, Gonçalves et al., 2016).

Furthermore, looking to the second set of models, symptomatology (OQ-10.2 scores) did not have any relation to the emergence of RC, CS, or STP in the following session and no treatment differences were found. This result is surprising, as the results from Gonçalves et al. (2016) found that an increase of symptoms predicted a lower proportion of RC ($R^2_{adj} = .10$) in the following session using the NT group of the current sample. Perhaps the small sample used in that study overrepresented the effect of symptomatology over RC (the model only explained a small variance) given that in the present study there were no treatment differences.

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More research should be conducted to clarify this point. Nevertheless, both studies and the present set of results are in line with the assumption that meaning transformation precedes symptom reduction rather than the opposite. Precedence does not prove causality, but precedence is a necessary condition for causality. These results are congruent with previous findings relating new meanings on narrative identity (that is, the story of the self that provides a person with purpose and unity) with mental health and psychological wellbeing (Adler, 2012; Adler, Harmeling, & Walder-Biesanz, 2013; Bauer, McAdams & Pals, 2008; Lilgendahl & McAdams, 2011; McAdams & McLean, 2013). We theorize that CS and STP might be acting as progressive meaning consolidation of level 1 IMs and also as precursors of RC. Nevertheless, further research is needed to test this notion. It is possible that meaning changes could evolve in a progressive, developmental manner. Based on the present study and on previous results (e.g., Fernández-Navarro et al., 2017), IMs seem to occur in three different stages or levels. Level 1 IMs that are not directly related to successful psychotherapy but are the first steps in challenging the maladaptive framework of meaning. Level 2 IMs, mainly formed by CS and STP —when taken separately— appear to be related to symptom improvement and represent new meanings focused on emerging changes. Lastly, a Level 3 IMs composed solely by RC, being a more elaborated form of meaning innovation (in which CS and STP are integrated and articulated) and, as the present results suggested, being a precursor of symptom improvement. Futures studies should address the relation and differences between those levels.

Knowing more about these narrative processes could be helpful to psychotherapists as a feedback tool representing how clients are doing during the course of therapy. Moreover, it might be interesting to explore if clients identify RC as significant moments during the psychotherapy process. Additionally, to study therapist's contribution in the appearance of RC might improve our knowledge of how new meanings are co-constructed in psychotherapy. The small size of this sample and the specificity of working only with a MDD population limit the generalizability of this study. Moreover, the fact that some of these findings were obtained using samples that were used to develop IMs theory makes even more important that these findings should be replicated with new samples. Obviously, the use of the same samples was due to the intricate and time consuming nature of the coding procedures (e.g., finding CS and STP in previous IMs). These results replicate previous findings pointing to meaning making (level 2 IMs, and more importantly RC) as a predecessor of symptomology decrease. The

major contribution of the present study lies on the discovery that RC structure (CS + STP) as something that facilitates symptom's decrease in the next therapy session.

REFERENCES

Adler, J. M. (2012). Living into the story: agency and coherence in a longitudinal study of narrative identity development and mental health over the course of psychotherapy. *Journal of personality and social psychology*, *102*(2), 367.

Adler, J. M., Harmeling, L. H., & Walder-Biesanz, I. (2013). Narrative meaning making is associated with sudden gains in psychotherapy clients' mental health under routine clinical conditions. *Journal of consulting and clinical psychology*, *81*(5), 839.

Bauer, J. J., McAdams, D. P., & Pals, J. L. (2008). Narrative identity and eudaimonic wellbeing. *Journal of Happiness Studies*, *9*(1), 81-104.

Beck, A.T., Rush, A.J., Shaw, B.F., Emery, G. (1979). *Cognitive Therapy of Depression.* Guilford Press, New York.

Beck, A. T., Steer, R. A., & Brown, G. K. (1996). *Manual for Beck Depression Inventory II*. San Antonio. TX: Psychological corporation.

Campos, R. C., & Gonçalves, B. (2011). The Portuguese version of the Beck Depression Inventory-II (BDI-II). *European Journal of Psychological Assessment, 27*, 258-264.

Coelho, R., Martins, A., & Barros, H. (2002). Clinical profiles relating gender and depressive symptoms among adolescents ascertained by the Beck Depression Inventory II. *European Psychiatry, 17*, 222-226.

Cunha, C. A. C. (2012). *Narrative change in emotion-focused therapy: co-constructing innovative self-narratives*. (Doctoral dissertation). University of Minho. Retrieved from http://repositorium.sdum.uminho.pt/handle/1822/19754

Cunha, C. A. C., Spínola, J., & Gonçalves, M. M. (2012). The emergence of innovative moments in narrative therapy for depression: Exploring therapist and client contributions. *Research in Psychotherapy: Psychopathology, Process and Outcome*, *15*(2), 62-74.

de Jong, K., Nugter, M. A., Polak, M. G., Wagenborg, J. E. A., Spinhoven, P., & Heiser, W. J. (2007). The outcome Questionnaire (OQ-45) in a Dutch population: A cross-cultural validation. *Clinical Psychology & Psychotherapy, 14*, 288-301.

Fernández-Navarro, P., Rosa, C., Sousa, I., Ventura, H., Ribeiro, A. P., & Gonçalves, M. M. (2017). *Reconceptualization association with treatment outcome in depression: a common factor within four types of psychotherapies*. Manuscript in preparation.

Goates-Jones, M., & Hill, C. E. (2008). Treatment preference, treatment-preference match, and psychotherapist credibility: Influence of session outcome and preference shift. Psychotherapy: *Theory, Research, Practice, Training, 45*, 61-74.

Gonçalves, M. M., Bento, T., Lopes, R., & Salgado, J. (2009). *Manual da escala de adesão e competência*. Braga, Portugal.

Gonçalves, M. M., Caro Gabalda, I., Ribeiro, A. P., Pinheiro, P. Borges, R., Sousa, I., & Stiles, W. B. (2014). The Innovative Moments Coding System and the Assimilation of Problematic Experiences Scale: A case study comparing two methods to track change in psychotherapy. *Psychotherapy Research, 24*(4)*,* 442-455.

Gonçalves, M. M., Ribeiro, A. P., Mendes, I., Alves, D., Silva, J., Rosa, C., ... Oliveira, J. T. (in press). Three narrative-based coding systems: Innovative moments, ambivalence and ambivalence resolution. *Psychotherapy Research*. doi:10.1080/10503307.2016.1247216.

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

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

Gonçalves, M. M., Ribeiro, A. P., Silva, J. R., Mendes, I., & Sousa, I. (2016). Narrative innovations predict symptom improvement: Studying innovative moments in narrative therapy of depression. *Psychotherapy Research, 26*(4), 425-435. doi: 10.1080/10503307.2015.1035355

Gonçalves, M. M., & Silva, J. R. (2014). Momentos de inovação em psicoterapia: Das narrativas aos processos dialógicos. *Análise Psicológica, 1*, 27-43.

Gonçalves, M. M., Silva, J. R., Mendes, I., Rosa, C., Ribeiro, A. P., Batista, J., ... Silva, C.F. (in press). Narrative changes predict symptoms decrease in cognitive-behavioral therapy for depression: An exploratory study. *Clinical Psychology & Psychotherapy*. doi:10.1002/cpp.2048

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

Jacobson, N. S., Roberts, L. J., Berns, S. B., & McGlinchey, J. B. (1999). Methods for Defining and Determining the Clinical Significance of Treatment Effects Description, Application, and Alternatives. *Journal of Consulting and Clinical Psychology, 67*, 300-307.

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

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

Lambert, M. J., Finch, A. M., Okiishi, J., & Burlingame, G. M. (2005). *Administration and scoring manual for the OQ-30.2*. Orem: American Professional Credentialing Services, LLC.

Lambert, M. J., Finch, A. M., Okiishi, J., Burlingame, G. M., McKelvey, C., & Reisinger, C. W. (1998). *Administration and scoring manual for the OQ-10.2: An adult outcome questionnaire for screening individuals and population outcome monitoring*. American Professional Credentialing Services LLC.

Leahy, R. L., & Holland, S. J. (2000). *Treatment Plans and Interventions for Depression and Anxiety Disorders*. New York: Guilford Press.

Lilgendahl, J. P., & McAdams, D. P. (2011). Constructing stories of self-growth: How individual differences in patterns of autobiographical reasoning relate to well-being in midlife. *Journal of personality*, *79*(2), 391-428.

Lopes, R., Gonçalves, M., Machado, P. P., Sinai, D., Bento, T., & Salgado, J. (2014). Narrative Therapy vs. Cognitive-Behavioral Therapy for moderate depression: Empirical evidence from a controlled clinical trial. *Psychotherapy Research, 24,* 662-674.

Lopes, R., Gonçalves, M. M., Sinai, D., & Machado, P. P. (2015). Predictors of dropout in a controlled clinical trial of psychotherapy for moderate depression. *International Journal of Clinical and Health Psychology, 15*, 76-80.

Machado, P. P., & Fassnacht, D. (2015). The Portuguese version of the Outcome Questionnaire (OQ-45): Normative data, reliability, and clinical significance cut-offs scores. *Psychology*

and *Psychotherapy: Theory, Research and Practice, 88*(4), 427-437.

McAdams, D. P. (2006). The problem of narrative coherence. *Journal of Constructivist Psychology, 19*, 109-125.

McAdams, D. P., & McLean, K. C. (2013). Narrative identity. *Current Directions in Psychological Science*, *22*(3), 233-238.

Nasim, R., Shimshi, S., Ziv-Beiman, S., Peri, T., Fernández-Navarro, P., & Gonçalves, M. M. (2017) *How is change constructed in Time Limited Psychodynamic Psychotherapy? An Innovative Moments' Perspective*. Manuscript in preparation.

Osborne, J. W. (2000). Advantages of hierarchical linear modeling. *Practical Assessment, Research, and Evaluation, 7*(1), 1-3.

R Development Core Team. (2016). The R Foundation for statistical computing. Retrieved from www.Rproject.org

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

Steer, R. A., Brown, G. K., Beck, A. T., & Sanderson, W. C. (2001). Mean Beck Depression Inventory-II scores by severity of major depressive episode. *Psychological Reports*, *88*(3c), 1075-1076.

White, M. (2007). *Maps of narrative practice*. New York: W. W. Norton

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

Woltman, H., Feldstain, A., MacKay, & Rocchi, M. (2012). An introduction to hierarchical linear modeling. *Tutorials in Quantitative Methods for Psychology, 8*(1), 52-69.

CHAPTER THREE

RECONCEPTUALIZING THE SELF IN PSYCHOTHERAPY: AN
EXPLORATORY STUDY ON MEANING DIFFERENTIATION AND
INTEGRATION IN DEPRESSION TREATMENT

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ABSTRACT

Innovative moments (IMs) are new meanings in the psychotherapeutic conversation that contrast with the maladaptive framework of meaning that brought the client to therapy. In this case study we organized IMs in three development levels. Level 1 IMs are meaning exceptions that challenge the maladaptive framework of meaning and facilitate creating a distance from the problematic experience. Level 2 IMs are events focused on bringing meaning to the emerging changes. They appear in two different forms 1) a *contrasting self* (CS) (before *I was... now I am...*) or 2) the understanding of the *self-transformation process* (STP). Usually, IMs that have both CS and STP articulated, which we termed reconceptualization IMs, are the most developed type of level 2 IMs, which, previous studies have suggested, precedes symptom improvement. The aim of this exploratory study was to track the evolution and aggregation into themes of the IMs content and also to study the interaction between IMs levels and these themes, trying to understand how they evolve along the different levels referred above and also from CS and STP to reconceptualization. To do so, we carried out a thematic analysis of the content of IMs, previously coded using Innovative Moment Coding System, in a case of depression treated with narrative therapy. The findings suggest that IMs have similar themes across the levels and that IMs were in their majority monothematic, whereas reconceptualization tended to be polythematic and increased across sessions. Thus, we discuss that RC may be a third level of IMs because not only does it articulate the two components of the previous level, but also it seems to favour the integration of two or more different meanings. Implications for future research are discussed at the end of the article.

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[3] This study was submitted with the following authors: P. Fernández-Navarro, A. P. Ribeiro, & M. M. Gonçalves.

INTRODUCTION

Innovative moments (IMs) are events in psychotherapy that challenge the maladaptive framework of meaning that brought clients to therapy and have the potential to foster an alternative framework of meaning (Gonçalves, Ribeiro, Mendes, Matos, & Santos, 2011; Gonçalves, Silva et al., in press). IMs are assumed to be transtheoretical (see Gonçalves, Ribeiro et al., in press for a detail revision) and could be prompted by an array of therapeutic strategies from different traditions (e.g., chair work, cognitive restructuring) or emerge spontaneously in the client's speech. A framework of meaning can be conceptualized as implicit rules (e.g., 'the world is a dangerous place'; 'people are inherently good') that impact the way each of us conceive ourselves, interact with other people, and experience the world (Frank & Frank, 1991; Goldfried, 2012). As an example from depression, an implicit rule could be 'everything I do is worthless' which would greatly impact behaviours, emotions, cognitions and so forth, creating psychological distress. During the course of psychotherapy, the person in therapy and the therapist will work on challenging these rules, aiming to create some differentiation or distance from them. Exceptions to these rules, such us new behaviours, thoughts and feelings that emerge during this distancing process, are called level 1 IMs. Following the previous example of an implicit rule, an example of this level could be a new understanding of the problem (*"I realize that I feel worthless specially when I do new things. Everything began when I started my new job"*).

As therapy unfolds, level 1 IMs are still present, but other kinds of exceptions, termed level 2 IMs, start to emerge and increase as therapy progresses. Level 2 IMs represent how people develop, maintain, expand or consolidate new meanings (i.e., *"Now I have started believing in my work, not everything I do is good but I'm happy with the results")*. Level 2 IMs are expressed in two distinctive formulations: *contrasting self* (CS) and *self-transformation-process* (STP). CS involves a contrast between a past and problematic self-position towards a present, more adaptive one. An example of this type of formulation might be *"compared to how felt one month ago, it is a huge difference. I was a scaredy-cat, always frightened to talk to strangers, and now, when I'm in a new social situation, I'm the first one to start a conversation. I am much more confident, and it feels good"*. CS usually refers to what is different in the clients' life and could be formulated as an emotional or embodied shift (e.g., *"I feel lighter than before"*). STP involves an account of how and/or why change is occurring. For

that, clients often use verbs that represent new understandings or sensations (to realize, to think, to see, to understand, to be conscious, to be aware, to know, to believe, to learn, to perceive, to feel, to wake up, to get a click, etc.). Normally these verbs appear to be associated with terminology that articulates reconstruction, attribution, or elaboration upon change, such as expressions of causality, reason, or purpose (e.g., that is, why, because) as a way to explain how changes in clients life come to be. For instance, a client might say: *"I realize that it's not going to be straight uphill all the time and that sometimes you are going to slide backwards. I'm aware that I've made quite a few steps forward because I learned to be patient with myself"*.

Reconceptualization Innovative Moments

The presence of both components in an articulated form (CS + STP) is termed reconceptualization IM (RC), and no particular sequence (CS followed by STP or vice-versa) is needed to produce a RC (Gonçalves et al., 2011). An example of a RC might be *"I am more confident, now I am capable of taking the bull by the horns* [CS], *and that's because I realize that the only one sabotaging me it was myself. I feel that I am improving* [STP]". A typical profile of a successful case would be represented by a decrease tendency in level 1 IMs, an increase tendency on level 2 IMs, and particularly the emergence of RC, in mid-treatment, increasing its emergence towards the end of therapy (Gonçalves et al., 2009; Gonçalves et al., 2011; Gonçalves et al., 2012; Gonçalves, Ribeiro et al., in press; Gonçalves, Silva et al., in press; Gonçalves, Ribeiro, Silva, Mendes, & Sousa, 2016; Matos, Santos, Gonçalves, & Martins, 2009; Mendes et al., 2011). Thus, until now, RC has been considered a particular type —albeit more powerful— of level 2 IMs (Gonçalves et al., 2016).

Previous analyses (Fernández-Navarro, Rosa, Moutinho et al., 2017; Fernández-Navarro, Rosa, Sousa et al., 2017) focused on the relation of level 2 IMs formulated as CS, STP, or RC (i.e., CS and STP articulated) with depressive symptomatology. The results from major depression disorder (MDD) samples suggest that RC is a better predictor than its components of treatment outcome (pre-post gains) and also a better predictor of symptom improvement in the following session. The first analyses (Fernández-Navarro, Rosa, Sousa et al., 2017) comprised 28 case studies form diverse samples, namely, narrative therapy (NT), cognitive-behavioural therapy (CBT), emotional-focused therapy (EFT) and client-centred

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therapy (CCT). The variables CS, STP, and RC were set in a generalized linear model to predict treatment outcome measured with pre-post treatment Beck Depression Inventory (BDI; Beck, Steer, & Brown, 1996) scores. The results indicated that only RC was a good predictor for treatment outcome. Likewise, the second analyses (Fernández-Navarro, Rosa, Moutinho et al., 2017) tested the relation between the emergence of CS, STP, and RC in a given session with client's symptomatology measured in the next one. When a RC appeared in one session it was associated with symptom reduction in the following one. Furthermore, there was no association between symptomatology and the emergence of CS, STP or RC in the next session. Although RC has a lower frequency in therapy compared with CS and STP, its structure (CS + STP) appears to have a stronger connection with symptom improvement. The studies presented, despite being exploratory given the small samples size, suggest that new meanings (represented here as CS, STP, and RC) seem to preceded symptom reduction rather than the opposite. In addition, the authors (Fernández-Navarro, Rosa, Moutinho et al., 2017) argue that RC may act as a link between different level 2 IMs and could be treated as a more elaborated form of IMs. These results lead us to suggest that RC is the highest level of change in the IMs model and should be differentiate from level 2 IMs.

Innovative Moments as developmental levels

The IMs model emerged through a theory-building effort based on a bottom-up approach to the clinical setting (Gonçalves et al., 2011). The IMs model is usually portrayed as two different levels in the process of meaning-making during psychotherapy (Gonçalves, Ribeiro et al, in press). These two levels are somehow similar to some of the phases of the theoretical model of Freeman and Robinson (1990) about the "development within". They, as the IM model, considered that giving meaning to our experience is an interpretative process "of reconstructing one's past and the self in which it has culminated" (Freeman & Robinson, 1990, p. 61). Freeman and Robinson (1990) defend a four-phase developmental model. For the sake of their conception, when we use the word "phase" in this model, it won't be referring to a stage or a sequence, but a way to differentiate different sub-process constitutive of development as a whole. In short, phase one is called "recognition" and points to a mismatch between the current experience and an ideal one. That is, without recognizing that something is wrong in one's life, we couldn't take action to transform it (e.g., to search for psychotherapy

treatment). The second phase, "distanciation," is described as a withdrawal from one's current experience. This phase is quite similar to the concept of level 1 IMs that also implies a distanciation from the problems brought to therapy (in means of questioning, criticizing and/or behaving differently from the maladaptive framework of meaning). The third phase, "articulation," is the identification of a "difference between the new and the old [where] one's narrative and, by extension, one's self in being reconstructed" (Freeman & Robinson, 1990; p. 65). Following the comparison with the IMs model, articulation's phase is alike to the formulation of CS in level 2 IMs. One difference with the IM model is that level 2 IMs also take into account *how* the articulation of past self into a new one is produced through the formulations of STP. However, both CS and STP could be seen from the Freeman and Robison developmental point of view as revisions or evaluations of previous ends (e.g., emotions, desires, congruencies, etc.). Finally, "appropriation" is the fourth phase and makes mention of the process of incorporating the new articulated ends of the previous phase. In the IMs model, RC articulates different forms of CS and STP and has been described as a form of identification with the emerging changes (Gonçalves & Ribeiro, 2012), similar to the idea of appropriation. If meaning-making in psychotherapy can be described as a developmental process, it would be interesting to follow how new meanings appear, which ones are left behind, and how these meanings are appropriated into a more adaptive framework of meaning. Following the idea of RC being an especial form of IMs based on the results of the previous section, in conjunction with the Freeman and Robinson developmental model, we could consider RC as another step in our meaning-making development.

Present study

Our aim in this exploratory study is to investigate how new meanings within the IMs evolve and are aggregated into different themes throughout therapy. In addition, we would like to observe how new meanings evolve from level 1 to level 2 IMs and then to RC (see table VIII). For that purpose, the IMs were exhaustively researched in a clinical case of NT for MDD. A thematic analysis (TA; Braun & Clarke, 2006) was used to define and classify the new meanings —opposite to the maladaptive framework of meaning— attending to IMs content.

Table VIII

Description of Innovative Moments Levels and Types

Level	IMs types	Definition
1	New action New reflections about the problem Challenging the problem (protest)	Meaning exceptions centred in challenging, differentiating, recognizing or distancing from the problematic experience Include moments of critique, thoughts, intentions, interrogations, doubts, desires, strategies, and/or behaviours focus on dealing with the problems brought to therapy
2	Contrasting-Self (CS) OR Self-Transformation Process (STP)	Self-observing phenomenon centred in give meaning to the emerging changes Include new aims, experiences, activities, projects, emotional shifts, elaborations upon change and its consequences, new or re-emerge self-versions, new learnings, etc.
	Reconceptualization (CS + STP)	Meta-reflective process description. Requires a shift between two self-positions and some access to the process underlying this transformation

Our research questions are the following: (1) Can IMs' content (i.e., new meanings, different form the maladaptive framework of meaning) be aggregated into themes? If so, (2) how do IMs levels and the themes interact with each other? (3) What are the differences between CS, STP, and RC?

METHOD

Client

Celia (pseudonym) was part of a clinical control trial for major depression held in the University of Minho (Lopes et al., 2014) comparing CBT with NT. Celia had a diagnosis of major depression disorder in Axis I, in the absence of other major psychiatric disorders or any comorbidity with Axis II. She participated in the NT condition and her case was selected from a pool of 16 clients previously chosen for process research (Gonçalves et al., 2016). Three criteria guided the selection of her case: 1) To be considered a recover case, meeting the

criteria for reliable change index (RCI, Jacobson & Truax, 1991); 2) to have manifested the highest frequency of RC during treatment, in order to assure the presence of the phenomenon needed for the study; and 3) not to have been published as a case study yet. Celia was a Portuguese woman who was 39 years old at the time of the therapy. She had 12 years of education, was married, and had two sons and a daughter. She worked with her husband administering a family restaurant. Prior to the beginning of psychotherapy, she had been taking Cipralex for approximately 3 ½ years. Celia reported having sleeping difficulties and feelings of isolation, insecurity, and sadness. She complained of not being able to manage all of her work duties and daily life activities, and blamed herself for not doing so. She felt she needed to assert herself in a better way at work in order to be respected by her employees. One of her main fears was not being able to help her kids grow up properly, doubting her role as a mother.

Therapist and Treatment

The therapist was a Portuguese male doctoral student in clinical psychology with three years of clinical experience prior to the start of the therapy sessions. An experienced narrative therapist with over 15 years of experience (third author) supervised the treatment weekly and ensured allegiance to the model.

Before the psychotherapy treatment started, the client was informed about the research's goals and signed an informed consent form regarding the use of her data. The treatment protocol consisted of 20 sessions that were videotaped and later transcribed with the exception of the 20th session, as the data was corrupted, and it wasn't possible to retrieve. The NT intervention was based on the model of White (2007; White & Epston, 1990) and followed the guidelines of a treatment manual designed for this study (Gonçalves and Bento, 2008). From White's point of view, the therapeutic process allows clients to re-write (to reconstruct) their experience. Within this new story, the problem or problems brought to psychotherapy cease to make sense or to have power in the client's life. Thus, a narrative therapist works on both deconstructing a problematic narrative and creating an alternative one, free of the problem's influence. Following Montesano's (2012) general description, in the first phase, the therapist attunes with the client to map the problem-saturated narrative. In the second phase, the main efforts are located in separating the problem from the client's identity.

One of the main techniques to achieve this goal is called externalization. In short, externalization is when therapists treat the problem-saturated narrative as an outside entity and asks the client to name, visualize and track the problem's influence in his or her life. In Celia's case, since the early stages of therapy, the therapist used externalization to help her to distance herself from her depression. Accordingly, Celia named her depression a "parasite" that sucked her energy and joy, and also wanted to make her feel insecure, filling her with fears and doubts. Along this paper we will be referring to Celia's problems as she did, as a parasite, and how this parasite affected her in different dimensions of her life. In the third phase, therapy is then centred on the identification and elaboration of unique outcomes to expand an alternative narrative to the problem-saturated one.

Measures and Procedures

Archival data

Outcome measures. The Beck Depression Inventory II (BDI-II; Beck et al., 1996) and the Outcome Questionnaire 45.2 (OQ-45.2; Lambert et al., 1996) were used to measure symptom severity and treatment outcomes. The BDI-II and OQ-45.2 were filled in at the beginning of the sessions and were administered at the first session and then at every fourth session including the last one. The BDI was the primary outcome measure and consist in 21 self-reported items, assessing depressive symptoms using a 4-point Likert scale from 0 (absence of depressive symptomatology) to 3 (severe depressive symptomatology) with a maximum score of 63. This self-report questionnaire has good internal consistency with an α of .91 (Steer, Brown, & Beck al., 2001) and good construct validity (Beck et al., 1996; Steer et al., 2001) in the American population. The BDI was also translated and validated for the Portuguese population, and its psychometric results are comparable to the American studies (see Campos & Gonçalves, 2011; Coelho, Martins, & Barros, 2002). However, the Portuguese studies failed to calculate the Reliable Change Index (RCI; Jacobson & Truax, 1991) and, following the suggestion of Lopes et al. (2014), the normative data gathered from meta-analyses of diverse samples (Seggar, Lambert, & Hansen, 2002) was used to calculate the proportion of clinical change (RCI for improvement = 8.46; cut-off score = 14.29).

The OQ-45.2 is another self-report questionnaire that aims to assess client's progress in three dimensions: subjective discomfort, interpersonal relationships, and social role

functioning. It is composed of 45 questions on a 5-point Likert scale ranged from 0 to 4. Cronbach's alpha of .93 indicates high internal consistency in various American clinical samples (de Jong et al., 2007; Lambert et al., 1996) as well as in the Portuguese population (α = .89; Machado & Fassnacht; 2015). The RCI found for the Portuguese population was 15 points and the cut-off was 62 points.

Process Measures. To measure the emergence of new meanings through psychotherapy, the Innovative Moments Coding System (IMCS; Gonçalves, et al., 2011) was used. This coding system is a qualitative procedure that identifies seven mutually exclusive categories of IMs. These seven categories were organized in previous research in two different levels, level 1 IMs and level 2 IMs, as previously referred to. IM proportion refers to the percentage of words involved in each IM, relative to the total amount of words in each transcribed session. An IM can contain client and therapist interventions, as the IMCS background assumes that change is co-constructed. The coding's reliability is calculated with an inter-judge agreement following the next formula: the overlapping IMs proportion identified by both judges, divided by the total proportion identified by either judge. After that, judges independently identify IMs types presented on the agreed proportion. This case was previously coded with the IMCS for a process research study (see Gonçalves et al., 2015 for a description of the coding procedure). Celia's case proved reliable with 93.6% of agreed proportion and a Cohen's Kappa of .89. Also, in a previous study (Fernandez-Navarro, Rosa, Sousa et al., 2017), two coders independently revised all IMs to identify contrasts (CS) and transformation process (STP) while they were separated or articulated (i.e., RC). The Kappa of Cohen for this identification was .82

Data analysed

Thematic Analysis (TA). TA is a qualitative method analysis that allows identifying and organizing patterns or themes in a systematic way across a data set in order to answer a particular research question (Braune & Clarke, 2006; 2012). As referred before in our research questions, our interests lay in studying the themes evolution from the more elementary IMs towards the more complex forms of IMs (i.e., from level 1 to level 2 IMs). In accordance with the Braun and Clarke (2006) TA decision tree, the present study attended the following decisions previous to the initiation of the coding. First, we decided that codes and

themes will derive from the content of the data, that is, we used a bottom-up approach rather than a deductive or theoretical one. Second, the codes identified are semantic (and not latent) in order to minimize the level of inference from the client's experience. Third, we assumed a realistic method to study the client's subjective view of their change (i.e., IMs). We were interested in knowing the reality of the participant and not interested in observing other social discourses that could be present in Celia's case. All decisions were taken as the best fit for answering the current research questions. After setting the ground for the analysis, the selection of codes and themes took place in a sequential manner.

The first phase of the analysis involved the familiarization with the data and setting the first codes. Our interest fell back into a better understanding of the emergence and evolution of the themes present in a successful case of psychotherapy. Thus, the data set for the TA includes all IMs previously coded in Celia's case. To each IM, a code or codes were added in order to allow IMs to be able to hold more than one theme. The codes' meaning focus was related to Celia's main worries to be overcome or main achievement attained during the therapy sessions. The codes were formulated using Celia's own words to maintain inferences at a minimum. In the same vein, if the codes were not clear just by reading the IM excerpt, to avoid speculation, the coder read the talks immediately before the IM until it was clear what the therapist and client were referring to.

The second phase of the TA referred to a review of the data set guided by codes of the previous phase. Before the new reading of the data, a first revision of the codes was made in order to homogenize the wording related to the same phenomenon. During this phase, with a deeper knowledge of the case, some codes were re-named, others were created or deleted, and others were maintained. For example, expressions such as, "I want to have time to read again," "I miss going to the cinema," or "I'm riding my bike once more" were clustered in "regaining time for pleasurable activities". At the end, 33 codes were selected as representative of Celia's case. Within this process, the first clusters started to emerge: subordinated themes or sub-themes. Previous codes and clustered codes were organized into sub-themes. For instance, the previous example "regaining time for pleasurable activities" was incorporated into a wider sub-theme "organizing my time" where other codes such as "leaving the work at work" or "not feeling incapable and out of time" were also included. The end of this phase resulted in a total 8 sub-themes.

The third phase of the TA consisted in the identification of resemblance and overlap between the sub-themes under a unifying feature. This phase was carried out based on the assumption that instead of multiple and disconnected themes, Celia's narratives were a coherent conglomerate that organized the data. Thus, the objective of this last phase was to seek a structure of superordinate or main themes that would organize, link, and give meaning to the sub-themes of the previous phase. The coder presented the resulting themes and the integrated sub-themes to the research group he was collaborating with to discuss the organization and naming of the themes in several occasions. This last phase finished when the themes and the organization of the sub-themes succeeded in providing internal coherence as well as external diversity (Braun & Clarke, 2006; Patton, 1990). For example, one sub-theme named "felling capable," and its codes, were incorporated into the sub-theme "organizing my time" due to the proximity between sub-themes. The final organization showed three themes, seven sub-themes and 31 codes.

RESULTS

Archival data

Outcome measures

Celia started therapy with a score of 22 in the BDI-II; at session four her score was 18; at session eight, 12; at session 12 it went down to 4; at session 16, 1; and in the last session, 2. Celia was considered recovered at post-therapy with a BDI below the cut-off (14.29) with a difference between pre and post-therapy higher than the RCI (8.46). She was also evaluated at a 20 and 30 months follow-up and the BDI-II scores were still very low (1 and 2, respectively). The OQ-45.2 confirmed the change in the BDI: her pre-treatment score of 89 decreased to 14 at post-treatment (OQ.45.2 cut-off for the Portuguese population of 63 and RCI of 14) and the gains were maintained at the follow-ups (28 at 20 months and 37 at 30 months).

Innovative moments main results

In average, from session 1 to session 19, IMs represented 20.25% of Celia's dialog with the therapist per session. Level 1 IMs presented a decrease tendency during therapy; level

2 IMs had an irregular tendency, first increasing, decreasing in the middle treatment, and increasing again at the end; and RC IMs increased mainly form the middle of the therapy until the end (see Table IX for a summary).

Table IX

Emergence of IMs during therapy

IMs		Mean Proportion		
Results (Average per session)		1st Session	19th Session	Therapy (All sessions)
Total IMs		20.29%	23.13%	20.25%
	Level 1	12.23%	1.70%	5.70%
	Level 2	8.06	15.06%	11.58%
	RC	0%	6.37%	2.98%

In detail, despite the fact that in the last session Level 2 IMs had a proportion of 15.06%, generally they have a higher proportion between session one and ten with an average of 15.51% (excluding session six where no level 2 IMs were found), and reduced their presence from session 11 to 19 with an average of 8.93%, though in the last three sessions, level 2 IMs increased again (12.82%, 18.80%, and 15.06% respectively). RC IMs started in session three (1.70%) with an increasing proportion during therapy (6.37% in the last session). RC was present intermittently in session three, four, five, ten, twelve, and kept repeating itself from session 15 to the last session. Celia's IMs profile shows the features related to recovered cases (Gonçalves et al., 2011, Gonçalves, Ribeiro et al., in press): presented a high overall IMs proportion, a higher proportion of level 2 compared to level 1, and RC appeared in several sessions, increasing its proportion, especially from the middle to end of the treatment.

Data from this study

Description of the themes

Celia presented different meanings within the IMs and it was possible to organize these meanings into themes. We identified 31 meaning categories, or codes, that were

possible to aggregate in seven sub-themes, and later in three themes (see Table X). As stated before, Celia alluded to her depression as a parasite that affected her in different parts of her life. The three themes represent these parts: (1) trusting myself, (2) being capable and (3) improving relationships with others. The theme named *trusting myself* referred to Celia's need of *feeling confident* (sub-theme) and lack of *valuing myself* (sub-theme). To feel confident, Celia wanted to reject what makes her feel down, small, or weak, and looked for strength to fight her depression. In addition, she began to look after herself and tried to be of help to others. Basically this theme reflects how Celia sees herself and how she is struggling to combat her fears and sadness that she externalized as a parasite. She described her "parasite" as something that *"limits me, it seems that it binds me. I do not know how to explain it, but this is what is happening. It seems that something is here to say 'no, don't go', 'no, don't do it', 'no, you can not'"*. As therapy evolved, she began to value herself, making her feel good while thinking more about herself: "*I began to value myself a little more, I am thinking more about myself. Because I had not thought of myself until now, I thought of others, and now I will continue thinking about others and start thinking about myself*".

Another theme, *being capable,* identified Celia's need of *not overwhelming myself* (sub-theme), or not stress too much, hoping to not anticipate problems before they arrived, being able to manage all her tasks: *"Whatever happens, happens. I don't have to worry on the eve"*. In the other hand, *being capable* also refers to how Celia could be *organizing her time* (sub-theme) better, that is, preventing her from bringing work at home, and finding space for the things she missed and have been neglecting: *"Work is work, home is home. I don't want to think about work when I get home"*; *"I try not to take things home".* Furthermore this theme alluded principally to Celia's need to feel competent and able.

The last theme reflects Celia's attempts at *improving relationships.* While this theme contemplates Celia's need for *opening myself up* (sub-theme) to avoid feeling isolated, it also reflects how to improve the relations that she already has, specifically with her kids and her employees. Celia doubted herself as *being good mother* (sub-theme) and longed to establish a healthy relationship with her children. She wanted her children to rely on her and, at the same time, she wanted to depend less on them, wishing that they could be able to grow to be able to stand for themselves. Moreover, *being assertive* (sub-theme) was very important to for her, to establish boundaries, and feel respected by others. She wanted to learn to be in charge and be taken seriously by her employees.

Table X

*Thematic Analysis over Celia's Innovative Moments*

Theme	Sub-theme	Codes	IMs Level
Trusting myself	Feeling confident	- Rejecting what makes me feel down, small or weak - Overcoming fears - Understanding and fighting depression/parasite	1
		- Being strong and independent - Self-confidence	2
	Valuing myself	- Being of help to others - Looking after myself	1
		- Feeling good with myself - Thinking in myself - Self-value	2
Being capable	Not overwhelming myself	- Not anticipating problems or dangers - Being playful - Not being nervous or stressed and sleep better	1
		- Perceiving differently her work, problems or tasks - Being lucid (seeing with "clarity," not having a "dark vision" of things) - Being calm and serene	2
	Organizing my time	- Leaving work at work - Not feeling incapable and out of time	1
		- Regaining time for pleasurable activities (read, go to the cinema, ride a bike) - Feeling able (to drive, concentrate, manage tasks)	2
Improving relationships	Opening myself up	- Avoiding isolation	1
		- Talking to others - Meeting new people	2
	Being a good mother	- Role as a mother (not feeling irresponsible) - Inspiring confidence and not being too controlling	1
		- Autonomy from and for my kids - Giving confidence	2
	Being assertive	- Being a good boss / learn how to be in charge - Talking calmly	1
		- Relaying in others (not solve everything myself) - Establishing boundaries (work and kids)	2

Evolution of themes and sub-themes

Regarding the evolution of the themes, all were present since the first session of therapy. The themes *trusting myself* and *improving relationships* were the most frequent (overall proportion of 39.06% and 38.76% respectively) followed by *being capable* (22.18%), but their presence on therapy varied as therapy progressed (see Figure 4). From the beginning up to session seven, Celia's main concern was focused on *trusting herself*. From session eight

up until the end of therapy, the main theme shifted to *improving relationships*. Finally, the theme *being capable* is more stable throughout therapy, seemingly as an intermediate topic between the other two. Most of the sub-themes were already present in the first session with the exception of the sub-themes *valuing myself* (from the theme *trusting myself*), that started appearing in session two, and the sub-themes *being assertive* and *being a good mother* (from the theme *improving relationships*), that surfaced at session four.

Figure 4. Themes development
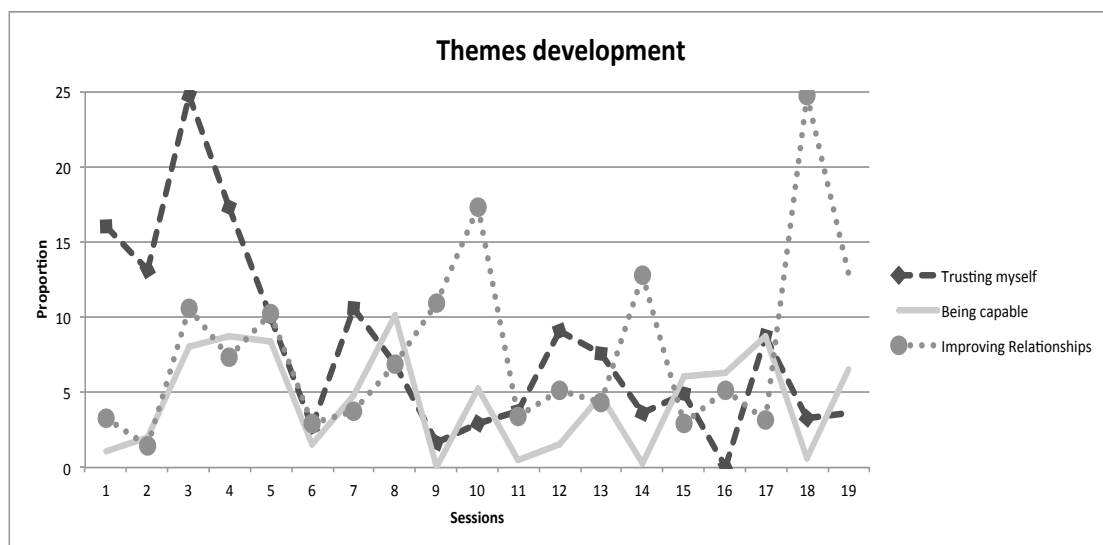
In the first three sessions, and in the sixth and seventh, *feeling confident* was the predominant sub-theme alternating in session four and five with *valuing myself* (both from the theme *trusting myself*). Also, in the first four sessions, but not as predominant as the other sub-themes, Celia is also concerned about *opening herself up* to others (theme *improving relationships)*. In session eight, the predominant sub-theme is *organizing my time* (theme *being capable*). From session eight until session 15 she expended more time worrying about her children and *being a good mother* (theme *improving relationships*) to be able to help them. Only in sessions 12 and 13 she focused again on the sub-theme *feeling confident* (theme *trusting myself).* In the remaining sessions, Celia shared her unease about being taken more seriously and *being* more *assertive* (theme *improving relationships*). Those last therapy sessions covered both how to establish some boundaries with her children and her employees, and learn how to be in charge. Finally, the theme *being capable* is not as predominant as the other two and there were no clear differences between its sub-themes. Overall, up to session 9

organize my time is a more recurrent subject, and from session 10, *not overwhelm myself* became more frequent; nevertheless, both sub-themes are very close in their proportion. A detail evolution of Celia's themes and sub-themes, and their relationship with IMs, are described in the next section.

Innovative moments and themes

To study how IMs levels are present in the emerging themes, the codes were organized following IMs levels. All the themes, subthemes and codes have both level 1 and level 2 IMs. First, the organization of the codes following the IMs levels allowed tracking the evolution within the themes and the differentiation of meanings within IMs levels 1 and 2. In this sense, it's easy to follow Celia's distancing from a concrete problem (level 1 IMs) and how she started making changes and consolidating them in her life (level 2 IMs) in a particular sub-theme (see Table X). We now present this evolution for the three themes, starting with the theme *trusting myself.* At the beginning of therapy, Celia understood that her parasite made her believe that the world was dangerous and she was weak and tried to "*forget about him* [the parasite] *and try not to think about it*" (code: understanding and fighting depression/parasite; Level 1 IMs). She wanted to be less fearful and "*more realistic. We all know that the world is dangerous, that dangers are real, but we can't live at the expense of that*" (code: overcoming fears; Level 1 IMs). As therapy evolved, in session seven, Celia reported that "*I feel good, light, relieved. It seems that I don't have that burden, that discomfort* [...] *I used to feel bad about myself* [weak]. *I feel more, I breathe better*" (code: feeling good with myself; Level 2 IMs) and that "*the fact that I start valuing myself gave me more confidence, I already feel more assure*" (code: self-value; Level 2 IMs). Combining the codes with IMs levels is possible to follow both the process and content of the Celia's change. For instance, in this case of the sub-theme *feel confident* Celia moved from overcoming fears to feeling self-confidence.

The same occurs in the theme *being capable*. In the first sessions Celia disclosed how, since the "parasite" appeared in her life, she "*stopped expending time with her friends, reading, going to the cinema*" and took advantage of "*the little time*" she had, accusing her of being unable of doing everything on time (session one). In session three, she started recognizing how the "parasite" filled her with doubts about her capabilities telling her, "*you have to do more and better, and better, and better*" (code: Not feeling incapable and out of time; Level 1 IMs), making her afraid of things that she used to do, like driving. As therapy

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evolved, she started confronting those fears, managing to overcome some, "*not everything, but I feel good driving and in many other things, I am sure of my abilities*" (session 11; code: Feeling able; Level 2 IMs). Furthermore, Celia tried to avoid anxiety related to her duties, "*all in due time* [...] *if I am not able to do it all today, I'll do it another day*" (session 3; code: Not being nervous or stressed; Level 1 IMs), managing to "*not shake now when doing certain things, I am calmer, less stressed*" (session 15; code: Being calm and serene; Level 2 IMs) and making boundaries between "*what is the work space and the family space*" (session 16; code: Leaving work at work; Level 2 IMs). Thanks to that she found some time to "*finish a task and change, read a book and be absorbed into the book,*" and once a week she would "*ride* [her] *bike and feel so much relief*" (sessions 17 and 18 respectively; code: Regaining time for pleasurable activities; Level 2 IMs). Again, following the codes, combined with the IMs levels, it is easy to see how Celia differentiated and expanded meanings. As the previous example shows, Celia shifted in the way she organized her time (sub-theme) from leaving work at work and to regain time for pleasurable activities.

As in the previous themes, the codes found in level 1 and level 2 IMs can describe how Celia was *improving* her *relationships*. In this fashion we can follow how Celia was *opening herself up* (sub-theme). During the first four sessions, Celia observed that, "*the more I was isolated and the less time I spent with the people I love, the more I became sad*" (session 2; code: avoiding isolation; Level 1 IMs). Since her grandmother died, she didn't find anybody trustworthy to talk to. As Celia's remembered in session 19, she used to keep her thoughts and emotions to herself: "*if something happened, I kept it inside a 'box'. I saved it there. Saved everything there and the box filled up. I hid it, closed the window and no more light came in* [...] *I collected everything, kept everything hidden and I didn't open myself up*" and presently, "*I talk more, I opened myself up more with my husband, my children, my mother-in-law* [...] *and my parents*" (code: Talking to others; Level 2 IMs). During the middle of therapy, *opening myself up* became less predominant and the sub-theme *being a good mother* gained relevance. Celia was worried with her role "*I would like my children to trust me, not to see me as a mother, but a mother and a friend, a companion*" (session 9; code: Role as a mother; Level 1 IMs). Also, she was concerned with the development of her children, especially with the school results of her youngest son: "*I do not have to be pushing him. He has to do it on his own initiative, on his own volition*" (session 10; code: Inspiring confidence and not being too controlling; Level 1 IMs). Soon, Celia realized that she was very attached to her children and

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she didn't give them much space to grow, and decided to *"give them more responsibility"* in an attempt to *"cut the umbilical cord"* (session 14; code: Autonomy from and for my kids; Level 2 IMs). For that, she adapted her relation with her children: *"[The relationship] is the same, but my initiatives and behaviours are different"* and offered *"all that is in my power [...] to give them confidence"* (session 14; code: Giving confidence; Level 2 IMs). At session 15, she was more satisfied with her children because they *"inspire* [her] *self-confidence"* still, she was worried with her youngest son, but she doesn't *"feel guilty anymore"* for not being the best teacher and felt that, in general terms, she was doing well as a mother. From session 16 onward Celia shifted and *being assertive* was the most predominant sub-theme. She and her husband paid attention to the wellbeing of their employees and she often acted as a colleague, other times as comrade, and others as the boss. She was concerned that they weren't respecting her enough and felt that, "*in the context of the employees, there should be that barrier... a bit that barrier 'in this moment I'm the boss, at that moment I'm a colleague' to let them know what the difference is"* (session 16; code: Being a good boss / learn how to be in charge; Level 1 IMs). She wanted to be respected and at the same time maintain a good relationship with them. In the last sessions she was feeling content since she was able to say "enough" to one of her employees that was constantly arriving late at work: *"You have to meet schedules, you have to be responsible for the restaurant. I do not have to be paying attention to everything!"* (session 18; establishing boundaries; Level 2 IMs). Also it was difficult for her to delegate to others, and started to trust her father and mother-in-law with the restaurant when she needed to be absent (session 18; code: relaying in others; Level 2 IMs). To summarize, the combination of the thematic analysis and the IMs cluster enabled a better grasp of the main changes in Celia's narrative and the meaning transitions between level 1 and level 2 IMs.

Furthermore, we were interested if there were differences between level 2 IMs and the RC IMs. Interestingly for this issue, the results showed that 91% of IMs were monothematic (i.e., each IM stands for only one of the three main themes describe above) and 9% were polythematic —two or more themes were integrated into the same IM— (see figure 5 for a graphical representation of this phenomenon). Curiously, the majority of RC IMs (93.33%) were polythematic.

Figure 5. Representation of reconceptualization integrating different IMs levels and themes
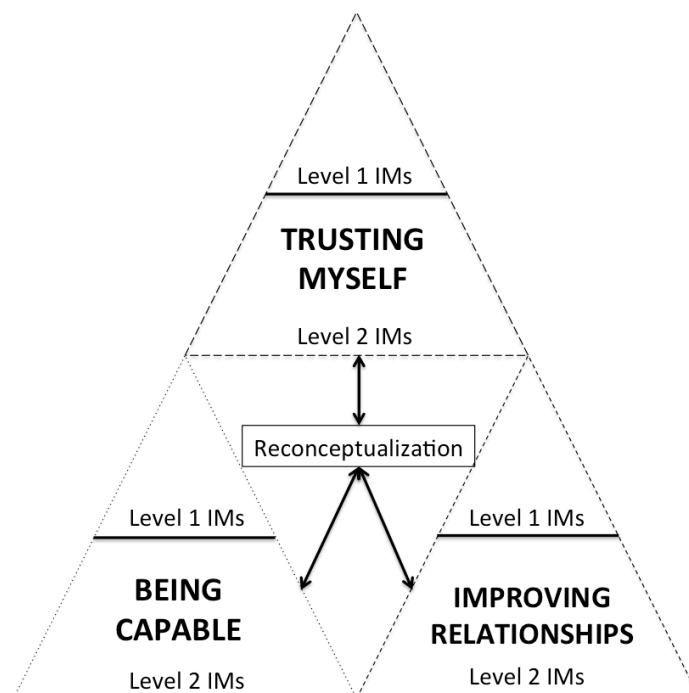
For instance, while in the initial phase of therapy *trusting myself* was the predominant theme, in session five Celia expressed in a reconceptualizing manner how *valuing herself* (sub-theme) was affecting other parts (themes) of her life:

    "C: It was important to value myself, I feel more confident. Because of that confidence, I feel safer.

    T: In what way was it was important, for example, in the next days after the situation [outburst] with your son?

    C: It was important because the fact of valuing myself... [Theme: Trusting myself, sub-themes: Feeling confident and Valuing myself] *because after all, I see I am not such a bad mother as I picture myself, am I? I'm starting to think in other way!* [Theme: Improving relationships, sub-theme: Being a good mother]

    T: That surprises you, Celia?

    C: (laugh) I am starting to think something interesting, I have been checking on certain things that two months ago made me very unsettled, very stressed and anxious, and... I think about them and I am starting to de-valorise problems, some things that could be paltriness...

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T: And the parasite said those things are important

C: Yes, yes. And now I confront everyday situation more rationally [...] *I remain more relieved, I don't fill my time with insignificant things that upset me. I see things with another's eyes"* [Theme: Being capable; sub-theme: not overwhelming myself].

As in this example, RC IMs not only served as a link between different level 2 IMs such as CS (*"I feel more confident"*; *"now I confront everyday situation more rationally, I remain more relief"*) and a STP (*"because of that confidence I feel safer"*; *"because after all, I see I am not such a bad mother as I picture myself, am I? I'm starting to think in other way!"*), but also as a connection between different themes (*"the fact of valuing myself"* [Theme: Trusting myself], *"I see I am not such a bad mother"* [Theme: Improving relationships], *"And now I confront everyday situations more rationally"* [Theme: Being capable]). From a total of 15 RC IMs, one was monothematic and 14 polythematic. Most RC IMs associated two themes (12 RCs), and only some connected three themes (two RCs). Celia reconceptualised the themes *trusting myself* and *being capable* seven times, the themes *trusting myself* and *improving relationships* four times, and the themes *being capable* and *improving relationships* one time.

DISCUSSION

Celia changed substantially during her psychotherapy according to the quantitative (outcome measures) and qualitative (process and content measures) data. She moved from the clinically depressed population to a non-clinical population, reducing her symptoms and modifying her meaning framework. At the end of therapy, Celia didn't have any more sleeping difficulties, was able to open herself up with her family, gained confidence, and reduced her sadness. These changes were tracked using the IMCS and a thematic analysis over the IMs present during psychotherapy. The results of this exploratory study showed that IMs could be aggregated into themes. IMs were organized in three different themes that varied in predominance throughout treatment. From session one to session seven, *trusting myself* was the predominant theme, first working on *feeling confident* (sub-theme) and from session four onwards, she started *valuing myself* (sub-theme) more. After gaining some trust in herself, from session 8 to the end of therapy, the principal theme of therapy was *improving*

relationships. Within the theme *improving relationships,* Celia evolved in the working phase of therapy from fighting her fears of not *being a good mother* (sub-theme) towards generalizing some changes in her work life, being able to create some boundaries as a boss in her restaurant (sub-theme *being assertive*) in the last sessions. Furthermore, the relation between IMs levels and themes allowed Celia's progression to be observed. It appeared important that all themes were represented by level 1 and level 2 IMs and that there were different predominant themes in different phases of therapy. In that sense, meanings from level 1 IMs seemed to evolve in level 2 IMs from the same sub-theme (e.g., from "overcoming fears" towards "self-confidence"). These results suggest that the reconstruction of Celia's meaning framework may depend on meaningful transitions between IMs, rather than on the mere accumulation of IMs. One could speculate that in unchanged cases, some themes or sub-themes may never develop towards level 2 IMs, which could make meaningful change difficult to achieve. That is, perhaps it is not the mere reduced presence of level 2 IMs that was already observed in previous studies, but the absence of plausible themes at level 2, from the client's perspective, that impedes meaningful change. If a level 1 IM emerges, but somehow the theme contained in it is not transformed into level 2 IMs, perhaps meaningful change is harder to achieve.

One of the main results of this exploratory study is that RC tended to capture more than one theme. Likewise, RC captured more than one type of IM (i.e., CS and STP) and it could be argued that RC might serve as an integrative bridge, not only between other types of IMs, but also among different themes, favouring the construction of a more adaptive meaning framework. The increasing tendency in Level 2 IMs in the first half of therapy, before RC started appearing and repeating itself, suggests that several articulations of CS and STP in different themes might be necessary before a RC emerges. In the clinical setting, therapists may need to first facilitate several level 2 IMs before trying to promote the emergence of RC in order to help clients to appropriate and expand new meanings. It is perhaps true that the appearance of one RC does not imply an instant gain in psychotherapy but that its repetition is needed. In that sense, RC can be seen as a process rather than a result where different new conceptions of self meet and combine. This gradual integration of new meanings might develop in a renewed and healthier meaning framework.

The results presented here support the idea of IMs as three developmental levels, akin with Freeman and Robinson's (1990) phases: distanciation, articulation and appropriation.

Level 1 IMs seem to differentiate new meanings (described in the codes) from the maladaptive framework of meaning that brought Celia to therapy (distantiation-differentiation phase). Codes from level 2 IMs, formulated as CS or STP, helped to articulate the problematic experience with the emergence of new meanings (articulation phase). Finally, RC seems to incorporate diverse meanings from different themes in a coherent way. The integration of different themes in RC could also be described as an appropriation of new meaning-making formulas in the construction of one's narrative (Dimaggio, Hermans, & Lysaker, 2010). Following this reasoning, RC could be considered as a third level of IMs (appropriation-integration phase). In the same way that RC starts appearing and repeating itself (although with different content), the phase of appropriation generates further cycles of devolvement when the new ends start to become part of the old and new, future ends start to emerge.

In summary, each theme evolved from a focus related to the problem towards an emphasis centred on change. The research of the content of the IMs in this case study supports the idea that IMs level 2 may be developing level 1 IMs into a more stable narrative, and that these changes may start to be integrated into a broader and more flexible meaning framework through RC IMs. The results of this case study support the idea of three developmental levels within the IMs. So, RC might be understood as a tool that expands or integrates gained changes from one theme to another. As Celia gained trust in herself at the beginning of therapy, she was able to improve, progressively, other parts of her life (e.g., other themes), such us being more capable and able to promote her relations with others. Nevertheless further research will be needed to test this notion. The emergence of this integration during Celia's therapy may have an impact on the reduction of symptomatology, the same way RC is related to symptom reduction (Fernández-Navarro, Rosa, Sousa et al., 2017). It could be interesting to test if neglected or isolated themes in psychotherapy could prevent change from developing. Even though narratives or reports of change don't imply change just by themselves, narrating change to ourselves and appropriating new meanings to our lives might be the first steps towards making a difference from what we believe, what we do, or who we are. Comparative studies with recovered and unchanged cases are recommended to deeply observe how new meanings are integrated, and to also be aware of how some themes do not develop. Generalization of these results should be avoided due to the specificity of one case and the particularities of NT and MDD. Nevertheless, further research related to the production

and integration of new meanings is encouraged as an open door to improve our knowledge of how psychotherapy works and how it could be improved.

REFERENCES

Beck, A. T., Steer, R. A., & Brown, G. K. (1996). *Manual for Beck Depression Inventory II*. San Antonio. TX: Psychological corporation.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative research in psychology, 3*(2), 77-101.

Braun, V., & Clarke, V. (2012). Thematic Analysis. In H. Cooper (Ed.), *APA handbook of research methods in psychology. Volume 2: Research Designs: Quantitative, Qualitative, Neuropsychological, and Biological* (pp. 57-71). Washington, DC: American Psychological Association.

Campos, R. C., & Gonçalves, B. (2011). The Portuguese version of the Beck Depression Inventory-II (BDI-II). *European Journal of Psychological Assessment, 27*, 258-264.

Coelho, R., Martins, A., & Barros, H. (2002). Clinical profiles relating gender and depressive symptoms among adolescents ascertained by the Beck Depression Inventory II. *European Psychiatry, 17*, 222-226.

de Jong, K., Nugter, M. A., Polak, M. G., Wagenborg, J. E. A., Spinhoven, P., & Heiser, W. J. (2007). The outcome Questionnaire (OQ-45) in a Dutch population: A cross-cultural validation. *Clinical Psychology & Psychotherapy, 14*, 288-301.

Dimaggio, G., Hermans, H. J., & Lysaker, P. H. (2010). Health and adaptation in a multiple self: The role of absence of dialogue and poor metacognition in clinical populations. *Theory & Psychology, 20*(3), 379-399.

Fernández-Navarro, P., Rosa, C., Moutinho, V., Antunes, A., Sousa, I., Ribeiro, A. P., & Gonçalves, M. M. (2017). *Meaning making changes precedes symptomatology improvement: The role of reconceptualization innovative moments*. Manuscript in preparation.

Fernández-Navarro, P., Rosa, C., Sousa, I., Ventura, H., Ribeiro, A. P., & Gonçalves, M. M. (2017). *Reconceptualizing the self during treatment for depression: Latest findings and future directions*. Manuscript in preparation.

Frank, J. D., & Frank, J. (1991). *Persuasion and healing: A comparative study of psychotherapy* (3rd ed.). Baltimore, MD: Johns Hopkins University Press.

Freeman, M., & Robinson, R. E. (1990). The development within: An alternative approach to the study of lives. *New Ideas in Psychology, 8*(1), 53-72.

Goldfried, M. R. (2012). On entering and remaining in psychotherapy. *Clinical Psychology: Science and Practice, 19*(2), 125-128. doi:10.1111/j.1468-2850.2012.01278.x

Gonçalves, M.M., Bento, T., 2008. Manual Terapêutico Psicoterapia Narrativa de Re- Autoria. Braga, Portugal.

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

Gonçalves, M. M., Ribeiro, A. P., Mendes, I., Alves, D., Silva, J., Rosa, C., ... Oliveira, J. T. (in press). Three narrative-based coding systems: Innovative moments, ambivalence and ambivalence resolution. *Psychotherapy Research.* doi:10.1080/10503307.2016.1247216

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

Gonçalves, M. M., Ribeiro, A. P., Silva, J. R., Mendes, I., & Sousa, I. (2016). Narrative innovations predict symptom improvement: Studying innovative moments in narrative therapy of depression. *Psychotherapy Research, 26*(4), 425-435. doi: 10.1080/10503307.2015.1035355

Gonçalves, M. M., Silva, J. R., Mendes, I., Rosa, C., Ribeiro, A. P., Batista, J., ... Silva, C.F. (in press). Narrative changes predict symptoms decrease in cognitive-behavioral therapy for depression: An exploratory study. *Clinical Psychology & Psychotherapy.* doi:10.1002/cpp.2048

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

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

Lopes, R., Gonçalves, M., Machado, P. P., Sinai, D., Bento, T., & Salgado, J. (2014). Narrative Therapy vs. Cognitive-Behavioral Therapy for moderate depression: Empirical evidence from a controlled clinical trial. *Psychotherapy Research, 24,* 662-674.

Machado, P. P., & Fassnacht, D. (2015). The Portuguese version of the Outcome Questionnaire (OQ-45): Normative data, reliability, and clinical significance cut-offs scores. *Psychology and Psychotherapy: Theory, Research and Practice, 88*(4), 427-437.

Matos, M., Santos, A., Gonçalves, M., & Martins, C. (2009). Innovative moments and change in narrative therapy. *Psychotherapy Research, 19*(1), 68-80.

Mendes, I., Ribeiro, A., Angus, L., Greenberg, L., Sousa, I., & Gonçalves, M. (2010). Narrative change in emotion-focused therapy: How is change constructed through the lens of the Innovative Moments Coding System? *Psychotherapy Research, 20*, 692-701.

Montesano, A. (2012). La perspectiva narrativa en terapia familiar sistémica. *Revista de Psicoterapia*, *89*, 5-50.

Ribeiro, A. P., & Gonçalves, M. M. (2011). Maintenance and transformation of problematic self-narratives: A semiotic-dialogical approach. *Integrative Psychological and Behavioral Science*, *45*(3), 281-303.

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

Steer, R. A., Brown, G. K., Beck, A. T., & Sanderson, W. C. (2001). Mean Beck Depression Inventory-II scores by severity of major depressive episode. *Psychological Reports*, *88*(3c), 1075-1076.

White, M. (2007). *Maps of narrative practice*. New York: W. W. Norton.

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

CONLUSION

CONCLUSION

Over the last 30 years, the knowledge on psychotherapy research has grown exponentially in topics related to the contribution of the therapist, client, and therapy to treatment outcomes (Lambert, 2013). However, there is little evidence that accounts for how the process of change develops (Kazdin, 2009). This dissertation intends to bring some light into the emergence of and effects of novelties in meaning-making (i.e., IMs) during psychotherapy. Along the current work, attention was focused on RC IMs. RCs were described as moments in therapy related to successful psychotherapy (Gonçalves, Ribeiro, Mendes, Matos, & Santos, 2011) and seemed to appear in a diverse variety of psychotherapies (Gonçalves et al., in press). Throughout, this dissertation has 1) clarified previous results with IMs research corroborating that most of level 2 IMs are CS and STP formulations; 2) broken down RC into smaller components (i.e., CS and STP) to clarify that the whole is more than the sum of its parts; 3) studied RC and its components in four different psychotherapies (i.e., NT, CBT, EFT and CCT) to address its relationship with pre-post change in MDD; 4) related the emergence of RC in one session to the decrease of symptomatology in the next one, that is, the precedence of new meanings over the reduction of depressive symptoms; and 5) followed how new meanings (i.e., themes within IMs) were integrated in RCs.

This chapter summarizes the main conclusions of the previous chapters and suggests new paths for future research. While doing so, the relation of RC with some of the characteristics present in MDD is discussed. It is also speculated how the present findings and concepts like CS, STP and RC can contribute to psychotherapy practice and research. Finally, some final remarks, limitations of this work, and future paths for new research, are discussed.

CHAPTER'S MAIN CONCLUSIONS

This dissertation can be understood as an effort to integrate the latest results in IMs methodology, to attain a better understanding of the relation of new meanings and symptomatology during the course of therapy for MDD, and the interest to move forward towards clinical application. The first chapter outlined all previous work done by the IMs research in MDD and aimed to make sense of those past results. Prior findings were

ambiguous regarding which IMs (i.e., reflection 2, action 2, RC) were most strongly associated with symptomatic change. This was the first study that investigated RC components: CS and STP. First, the results helped to clarify that the majority of level 2 IMs (i.e., action 2, reflection 2 and protest 2) were formulated as CS and STP. Second, and one of the major finding of this dissertation, CS and STP seemed to have a minor impact on outcome when compared to RC. When CS, STP and RC, were set in the same model to predict symptom gain from pre to post-treatment, only RC was able to predict it. Third, and finally, some similarities and differences between RC and other mechanisms of change, such us insight, CE were discussed. One common point of these elements is probably the person's ability to "self-distance" or "decenter" from an experience (Bernstein et al., 2015, Kross & Ayduk, 2011; in press). This distancing seems to open the space to create new meanings over the experience and has been related with mental health improvements (Bernstein et al., 2015, Dimaggio, Hermans, & Lysaker, 2010; Habermas et al., 2008).

The second chapter explored further the relation between RC and its components (CS and STP) with symptom improvement, this time using a longitudinal design. In particular, how symptomatology and CS, STP, and RC were related between consecutive therapy sessions. First, as in the previous chapter, only RC was a predictor of symptom reduction, compared to CS and STP, when the model considered the three variables. Second, symptomatology measured in one session was unrelated with the emergence of CS, STP or RC. Third, and the other major finding of this dissertation, the emergence of RC in one session predicted symptomatology improvement in the next session. Thus, meaning transformation (i.e., RC) preceded symptomatology improvement. And fourth, the type of therapy (CBT or NT) was not a moderator of the results reinforcing the notion that RC could be a common factor (Gonçalves et al., in press).

The third chapter was an exploratory study aiming to improve our understanding of the evolution of new meanings in a case study of successful psychotherapy for MDD. We followed Celia's case, paying attention to how new meanings were assembled into three themes. The findings suggested that, first, IMs could be grouped together in themes and sub-themes. Second, different themes were predominant in different therapy phases, making possible to follow Celia's meaning-making transformation. Celia started therapy looking into "trusting myself" and ended up focusing in "improving relationships". Third, the interaction between themes and IMs suggested that most of the meanings present in level 1 IMs transitioned to

new related content in level 2 IMs within the same sub-theme. Fourth, RC was found to be a polythematic IM and we speculated that RCs tended to integrate CS and STP from different themes, maybe helping the development of a new meaning framework. Fifth, IMs could be described as three developmental levels, RC being a third level that integrates together different level 2 IMs from different themes.

RECONCEPTUALZING THE SELF IN DEPRESSION

According to Worthan (2000), "while telling their stories, autobiographical narrators often enact a characteristic type of self, and through such performances they may in part become that type of self" (p. 159). The IMCS "records" the repetition of these new self-enactments, making possible to follow and preserve evidence of a person's way to become familiar with the emerging self-changes. There are some implicit aspects of these markers that may help the consolidation of the new self-positions (or as Worthan described it, "self-enactments") and are worth bringing up for discussion, especially since RC might be a key mechanism for successful psychotherapy. When RCs are being formulated, they indirectly may fulfil three purposes: to give awareness of the specificity of the change, to allow a distancing position from the problematic experience, and to rehearse the characteristic possibility of a new self.

Depressive populations have the tendency to use more over-generalized memories and usually have difficulties in recalling specific memories (Watkins, Teasdale, & Williams, 2000). One of the elements that characterize the coding of a CS or a STP, and therefore RC, is to recognize the specificity of the change. To name and identify changes plays an important role in psychotherapy, especially with MDD. To consider CS, STP, or RC is not enough just to expresses that something is different; it is crucial to express, in an explicit and clear way, what this difference consists of or how emerging novelties came to be. In this fashion, RC helps in recounting specific past memories and reintegrates them with newer experiences. Accessing specific memories could support a re-evaluation of the representation of the self and its history, favouring a new articulation and differentiation in the construction of clients' experience (Conway & Holmes, 2004).

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In addition, several studies (Rude, Gortner, & Pennebaker, 2004; Tausczik, & Pennebaker, 2010) correlate a higher self-focus (i.e., the use of more first-person singular pronouns like "I" or "me") and the use of fewer positive and more negative emotion words with depressive symptomatology. That is, people with depression are *immersed* in their depressive experience (Kross & Ayduk, in press). To be able to look upon what is happening in ourselves or to realize if we are changing, it is necessary to position ourselves outside the problematic experience. This phenomenon related to RC was discussed in the first chapter of this dissertation and was referred to as: a self-distancing position (Kross & Ayduk, 2011; in press), a decentring process (Bernstein et al., 2015), yet we could also refer to it as meta-position (Hermans and Konopka, 2010) or as a metacognition (Lysaker et al., 2013; Semerari et al., 2003). All these concepts allude to an observing position that allows monitoring inner reflections or to "think about another thought" (Lysaker et al., 2013, p. 104). Concretely in this dissertation, specific attention has been paid to the context of psychotherapy, to the ability to see ourselves aware of the progression of change or the lack of it ("am I different? Am I changing?" —CS), and, simultaneously, to enable the conditions for learning or linking different ideas ("how 'these' events relate? Do I know how to maintain my wellbeing?" —STP). This observer position found in RC can be compared to what Hermans and Konopka (2010) described as a unifying function for meta-positions. The unifying function link different self-positions, as the RC does, in detriment of an account of ourselves that is disconnected or fragmented. In other words, the unifying function brings coherence to the narration of our life story. The notion of the self as a narrative account (McAdams & Mclean, 2013; Singer, Blagov, Berry, & Oost, 2013), suggests that the continuity in the life story is made by self-defining memories. Moreover, replaying memories from our personal past and linking them with our present may be a self-regulation process that helps us to readjust our behaviour towards our present situation and goals. Moffitt and Singer (1994) understood that people could use memories as means to warn or comfort themselves. Based on the content and affect of previous experiences, one can employ past memories to self-encourage or to dishearten in order to achieve present goals. In this sense, RC could boost our sense of efficacy, creating a new account of the past as a useful resource for the present needs in a positive way. Thus, a RC could be seen as self-regulatory mechanism that unifies a coherent account of the self, which can be promoted by facilitating and observing position. In fact, Gonçalves and Ribeiro (2012) suggested that self-continuity is one of the functions of RC.

Furthermore, according to Gonçalves and Ribeiro (2012), RC goes beyond a self-observation and "entails a performance of agency and compromise" (p. 89). In this sense, they suggested that the repetition of RCs during psychotherapy may be an identity rehearsal mechanism, that is, RC may enable clients to experience change until it becomes integrated, or as they termed it, familiar. As the third chapter of this dissertation showed, RC is a polythematic IM that integrates meanings from different themes. The integration of new meanings can be considered an agentic feature. We are not passive observers of our change, but rather are participants in the way changes are being integrated and constructed (even if we are not aware of this constructive effort).

To put the notion of reconceptualising the self in a nutshell for MDD, RC may help clients to be specific and to reintegrate past memories, to recount these experiences from a distance or an observing position contributing to the creation of self-continuity, and to integrate new meanings in an agentic way.

WHAT RECONCEPTUALIZATION HAS TO OFFER TO PSYCHOTHERAPY AND PSYCHOTHERAPY RESEARCH?

This section highlights the contributions that this dissertation might bring. Though not yet tested, these are promising goals and suggestions for clinicians and researchers. The following are reflections and speculations on how RC can assist the work within psychotherapy, psychotherapy research and particularly how we could develop further studies with the IMCS.

Contribution to psychotherapy

Usually, clinicians pay attention to people's narrations that include a temporal contrast (e.g., "before... but now..."), a sense of novelty, and/or causal attributions about what they are learning or what is being helpful. These language cues could promote the emergence of new meanings formulated as CS, STP, or RC. However, sometimes these narrations may be left unattended because, in some cases, the therapist's intervention is focused on exploring other issues in the session (e.g., the problematic experience), and other times, these narrations are acknowledged but not further explore. It could be interesting to keep track of CS and STP

formulations and to reflect them back to the client in the same or in the following therapy sessions. The findings of this dissertation suggest that the combined work of client and therapist in the reflective talks that promote CS, STP or RC opens different paths to reconceptualise the client's life story. If a CS or a STP formulation appears, the therapist could easily ask for the missing component, trying to bring forward a RC. Data suggest that CS and STP seem to precede RC (see results of chapter III), and it may be possible that some sessions are needed with CS and STP before a more integrated narrative form (i.e., RC) could emerge. All forms of IMs can be spontaneous, but more often they are co-constructed with the therapist (Gonçalves & Ribeiro, 2012). If therapists start to be aware of CS and STP formulations, that could be helpful to facilitate the integration of emerging changes in a narrative account (Grafanaki & McLeod, 1999). In addition, if therapists become sensible to the emergence or lack of RC, they could use this information as a feedback tool, to evaluate the course of psychotherapy. As RC is present in a variety of therapies and clinical problems, this could be implemented in a diverse range of protocols and treatments.

Contribution to psychotherapy research

As mentioned in the introduction of this dissertation, in recent years, psychotherapy researchers have been exploring how change emerges and progresses in psychotherapy with a variety of methodologies. The concept of RC is a contribution in the study of significant events (i.e., significant events approach; Elliott, 2010) in the pursuit of improving our understanding of fruitful therapeutic work (Elliott & Shapiro, 1988, see Timulak, 2007 and 2010 for an intensive review on helpful events). In the last decade there has been a growing interest in bringing forward some significant events such as insight (Castonguay & Hill, 2007) and CE (Castonguay & Hill, 2012). As described in Chapter I, RC shares some similarities and some differences with these concepts. Remembering the similarities, it was stated that *"transformation in psychotherapy seems to be accompanied by some sort of meaning making that shifts clients previous framework of thinking, behaving and/or feeling"*. Despite the fact that the three concepts (i.e., insight, CE and RC) refer to different mechanisms of change, we believe that they are a common feature in the change process related to all successful psychotherapies. Following the concept of common factors introduce by Rosenzweig (1936) that gave relevance to "pantheoretical elements that made various treatments effective" (Sparks, Duncan, & Miller,

2008, p. 454), RC brings a conceptualization that consistently appears in successful psychotherapy and seems to precede symptom reduction in a different treatment for MDD. In spite of being inspired in the narrative tradition, RC is a notion of easy translation to other therapeutic backgrounds, similarly to insight and CE, born in the psychodynamic tradition and now largely extended. In addition, RCs could be easily identified both by researchers and therapist, thanks to its operationalization (that is, the articulation of its two components CS and STP), making the communication between professionals more straightforward.

Contribution to innovative moments research

This dissertation is also a step forward in the research conducted with the IMCS. One of the major and common limitations to deep case studies research is the time consumption of these procedures, forbidding the research from using bigger samples. The findings presented here could lead to a reduction in the time of coding IMs. The IMCS recognizes 7 categories of IMs (action types 1 and 2, reflection types 1 and 2, protest types 1 and 2 and RC) that are very useful to track the evolution of new meanings as presented here in chapter III. However, in order to study bigger samples (e.g., chapter I) it is possible and desirable to reduce these categories for different reasons. First, action, reflection and protests type 1 (i.e., level 1 IMs) did not differentiate recovered from unchanged cases. Second, most of level 2 IMs are articulated as CS or STP. Third, the most important IM, for all the reasons and findings presented during this dissertation, is RC. Putting together all this data, it could be interesting to develop an abbreviation of the coding system that would bring similar information, but simplify the coding and reduce the working time. Following this idea, an IMCS for bigger samples could be compacted in three levels (see table XI). A first level of IMs would incorporate indifferently all level 1 IMs. It could be understood as events (e.g., actions, reflections) or meaning exceptions centred in challenging the problematic experience and open alternatives for change to emerge. A second level would incorporate all level 2 IMs, except for RC (i.e., action 2, reflection 2, protest 2) that are formulated as CS and STP. This second level could be seen as a self-observing phenomenon centred in giving meaning to the emerging changes. The results of this dissertation pointed out a clear difference between RC components and RC itself, and RC could be referred to as a third level. This third level, as the second one, is a self-observing

phenomenon centred on change, and could be speculated that it also facilitates the integration of new meanings in a broader more flexible narrative.

Table XI

IMCS abbreviation for bigger samples

Level	IMs types	Definition
1	Action, Reflection, Protest	Meaning exceptions centred in challenging the problematic experience and distancing from the problematic experience Include moments of critique, thoughts, intentions, interrogations, doubts, desires, strategies, and/or behaviours focusing on dealing with the problems brought to therapy
2	Contrasting-Self (CS) OR Self-Transformation Process (STP)	Self-observing phenomenon centred on giving meaning to the emerging changes Include new aims, experiences, activities, projects, emotional shifts, elaborations upon change and its consequences, new or re-emerged self-versions, new learnings, etc.
3	Reconceptualization (CS + STP)	Meta-reflective process description. Requires a shift between two self-positions and some access to the process underlying this transformation

FINAL REMARKS: LIMITATIONS AND FUTURE DIRECTIONS

These final comments address the common limitations of the studies presented — specific limitations of each study were commented in the corresponding chapter— and draw some departing points for future directions. Overall, research conducted under case study methodology and detailed coding systems (e.g., IMCS, NECPS, Core Conflictual Relationship Theme) are time consuming and restrain the possibility the study of bigger samples. Thus, the small sample size presented in this dissertation prevents the generalization of the findings previously discussed. Furthermore, the sample analysed in this work was previously used for process research with the IMCS in different periods of time. In spite of this fact, all samples

were re-examined to study the emergence of CS and STP, an original feature of this dissertation. Nonetheless, caution is recommended in the interpretation of the results and further studies with new samples are urged to replicate the methodology and test the present results. We do not know if the results found in MDD would be similar in other samples with different clinical problems (e.g., anxiety, trauma, grieving). Another limitation of the present work is our focus on psychotherapy sessions through an observers' point of view. The use of self-report questionnaires to signal important moments in psychotherapy for clients and therapist (e.g., the post-treatment Change Interview, Elliott, Slatick & Urman, 2001; the post-session open-ended questionnaire Helpful Aspects of Therapy Form, Llewelyn, Elliott, Shapiro, Firth, & Hardy, 1988) could have enriched the present data and have been compared with the emergence of CS, STP, and RC. Lastly, all clinical data was accessed via transcripts with no visualization or hearing of therapy videos. This fact could have limited the interpretation of the data since we only relied on verbal or transcribed interactions.

Departing from the findings and limitations described, future lines of research can be depicted. Picking up on the limitation related to the format of the data, it would be interesting to explore if these findings are replicated with access to therapy videos. This dissertation may have provided the bases to the study of larger samples with the simplification of the IMCS in three levels instead of seven types. It is compelling to investigate if results with 3 levels are similar to previous results with the IMCS. One of the most interesting future applications regarding CS, STP, and RC is to incorporate these notions in the training and practice of psychotherapy. Training clinicians in recognizing and attending to these markers could enhance their interventions. Likewise, it may be interesting to study if CS, STP, and RC can be translated into self-reports for therapists and clients to use as a feedback tool or post-treatment interviews to prevent relapse. Another issue that should be addressed is the replication of the results found in MDD (i.e., an important role of RC in symptom reduction, the precedence of RC before a decrease in symptomatology) in other clinical problems such as anxiety, eating disorders or personality disorders.

To conclude, this dissertation allowed us to understand in more detail the notion of RC, the importance of the emergence and integration of new meanings in new accounts about the self in transformation, and suggests the precedence of narrative change over symptom reduction in the treatment of depression. I'd like to finish translating the quote that opened this

dissertation, remembering that change may be within ourselves because we are full of possibilities:

"*Each one of us is, successively, not one but many. And these successive personalities that emerge one from the other tend to present the strangest, most astonishing contrasts among themselves*"

Jose Enrique Rodó, *Motivos de Proteo* (1909)

REFERENCES

Adler, A. (1931). *What life should mean to you.* New York: Grosset and Dunlap

Bernstein, A., Hadash, Y., Lichtash, Y., Tanay, G., Shepherd, K., & Fresco, D. M. (2015). Decentering and Related Constructs: A Critical Review and Metacognitive Processes Model. *Perspectives on Psychological Science*, *10*(5), 599-617.

Conway, M. A., & Holmes, A. (2004). Psychosocial stages and the accessibility of autobiographical memories across the life cycle. *Journal of personality*, *72*(3), 461-480.

Dimaggio, G., Hermans, H. J., & Lysaker, P. H. (2010). Health and adaptation in a multiple self: The role of absence of dialogue and poor metacognition in clinical populations. *Theory & Psychology*, *20*(3), 379-399.

Elliott, R. (2010). Psychotherapy change process research: Realizing the promise. *Psychotherapy research*, *20*(2), 123-135.

Elliott, R., & Shapiro, D. A. (1988). Brief structured recall: A more efficient method for studying significant therapy events. *British Journal of Medical Psychology*, *61*(2), 141-153.

Elliott, R., Slatick, E., & Urman, M. (2001). Qualitative Change Process Research on Psychotherapy: Alternative Strategies. In J. Frommer and D.L. Rennie (Eds.), *Qualitative psychotherapy research: Methods and methodology* (pp. 69-111). Lengerich, Germany: Pabst Science Publishers.

Gonçalves, M. M., Ribeiro, A. P., Mendes, I., Alves, D., Silva, J., Rosa, C., ... Oliveira, J. T. (in press). Three narrative-based coding systems: Innovative moments, ambivalence and ambivalence resolution. *Psychotherapy Research*. doi:10.1080/10503307.2016.1247216

Gonçalves, M. M., Ribeiro, A. P., Mendes, I., Matos, M., & Santos, A. (2011). Tracking novelties in psychotherapy process research: The innovative moments coding system. *Psychotherapy Research, 21*, 497-509.

Grafanaki, S., & McLeod, J. (1999). Narrative processes in the construction of helpful and hindering events in experiential psychotherapy. *Psychotherapy Research*, *9*(3), 289-303.

Habermas, T., Ott, L.-M., Schubert, M., Schneider, B., & Pate, A. (2008). Stuck in the past: Negative bias, explanatory style, temporal order, and evaluative perspectives in life narratives of clinically depressed individuals. *Depression and Anxiety, 25*, E121-E132.

Hermans, H. J. M., & Hermans-Konopka A. (2010). *Dialogical self theory. Positioning and Counter-Positioning in a Globalizing Society* Cambridge, UK: Cambridge University Press.

Kazdin, A. E. (2009). Understanding how and why psychotherapy leads to change. *Psychotherapy Research, 19*(4-5), 418-428. doi:10.1080/10503300802448899

Kross, E., & Ayduk, O. (2011). Making Meaning out of Negative Experiences by Self-Distancing. *Current Directions in Psychological Science, 20*(3), 187-191.

Kross, E., & Ayduk, O. (in press). Self-Distancing: Theory, Research, and Current Directions. *Advances in Experimental Social Psychology*. doi:10.1016/bs.aesp.2016.10.002

Lambert, M. J. (2013). Outcome in psychotherapy: the past and important advances. *Psychotherapy (Chicago, Ill.), 50*(1), 42-51.

Llewelyn, S. P., Elliott, R., Shapiro, D. A., Firth, J., & Hardy, G. (1988). Client perceptions of significant events in prescriptive and exploratory periods of individual therapy. *British Journal of Clinical Psychology, 27,* 105-114.

Lysaker, P. H., Vohs, J. L., Ballard, R., Fogley, R., Salvatore, G., Popolo, R., & Dimaggio, G. (2013). Metacognition, self-reflection and recovery in schizophrenia. *Future Neurology*, *8*(1), 103-115.

McAdams, D. P., & McLean, K. C. (2013). Narrative identity. *Current Directions in Psychological Science*, *22*(3), 233-238.

Moffitt, K. H., & Singer, J. A. (1994). Continuity in the Life Story: Self-Defining Memories, Affect, and Approach/Avoidance Personal Strivings. *Journal of Personality*, *62*(1), 21-43.

Rosenzweig, S. (1936). Some implicit common factors in diverse methods of psychotherapy. *American journal of Orthopsychiatry*, *6*(3), 412.

Semerari, A., Carcione, A., Dimaggio, G., Falcone, M., Nicolò, G., Procacci, M., & Alleva, G. (2003). How to evaluate metacognitive functioning in psychotherapy? The metacognition assessment scale and its applications. *Clinical Psychology & Psychotherapy*, *10*(4), 238-261.

Singer, J. A., Blagov, P., Berry, M., & Oost, K. M. (2013). Self-defining memories, scripts, and the life story: Narrative identity in personality and psychotherapy. *Journal of personality*, *81*(6), 569-582.

Sparks, J. A., Duncan, B. L., & Miller, S. D. (2008). Common factors in psychotherapy. In J. L. Lebow (Ed.), *Twenty-first century psychotherapies: Contemporary approaches to theory and practice* (pp. 453-497). Hoboken, New Jersey: John Wiley & Sons.

Tausczik, Y. R., & Pennebaker, J. W. (2010). The psychological meaning of words: LIWC and computerized text analysis methods. *Journal of language and social psychology*, *29*(1), 24-54.

Timulak, L. (2007). Identifying core categories of client-identified impact of helpful events in psychotherapy: A qualitative meta-analysis. *Psychotherapy Research*, *17*(3), 305-314.

Timulak, L. (2010). Significant events in psychotherapy: An update of research findings. *Psychology and Psychotherapy: Theory, Research and Practice*, *83*(4), 421-447.

Watkins, E., Teasdale, J. D., & Williams, R. M. (2000). Decentring and distraction reduce overgeneral autobiographical memory in depression. *Psychological medicine*, *30*(4), 911-920.

Wortham, S. E. (2000). Interactional positioning and narrative self construction. *Narrative Inquiry*, *10*(1), 157-184.