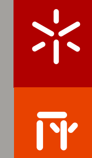

Narrativas ocultas no encontro terapêutico:
O que terapeutas e clientes não revelam
em psicoterapia

Armanda Paula Cunha Gonçalves

UMinho|2008

Universidade do Minho
Instituto de Educação e Psicologia

Maria Anita Carvalho dos Santos

A Mudança Narrativa no Processo Terapêutico de Re-Autoria

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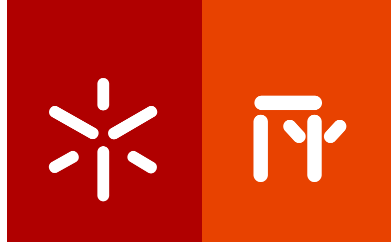

Universidade do Minho
Instituto de Educação e Psicologia

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A Mudança Narrativa no Processo Terapêutico de Re-Autoria

Tese de Doutoramento em Psicologia
Área de Conhecimento de Psicologia Clínica

Trabalho efectuado sob a orientação do
Professor Doutor Miguel M. Gonçalves

Agosto 2008

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A MUDANÇA NARRATIVA NO PROCESSO TERAPÊUTICO DE RE-AUTORIA

RESUMO

De acordo com a terapia narrativa de re-autoria (White & Epston, 1990), a mudança ocorre pela construção de narrativas identitárias alternativas que decorrem da identificação e elaboração, na conversação terapêutica, de *resultados únicos*. Estes abarcam todos os momentos em que o/a cliente narra algo que é novo ou diferente (e.g., pensamentos, projectos, emoções) em relação à narrativa que traz para a terapia, constituindo-se, assim, como oportunidades para que a mudança ocorra. Uma investigação anterior (Matos, 2006) permitiu perceber o seu carácter dinâmico e processual, pelo que se optou pela substituição do termo resultado único pela designação de *Momentos de Inovação* (MIs) (cf. M. Gonçalves, Matos, & Santos, no prelo). Assim, o *Sistema de Codificação dos Momentos de Inovação: versão 1* (SCMI; M. Gonçalves, Matos, & Santos, 2006) permite identificar cinco tipos de MIs: acção, reflexão, protesto, reconceptualização e novas experiências. A partir dos resultados de Matos (2006) foi proposto um modelo no qual a mudança parece desenvolver-se a partir da elaboração da acção, reflexão e protesto na fase iniciais da terapia. Seguidamente, nas fases intermédia e final, emergem a reconceptualização e as novas experiências. Estes MIs são predominantes nos casos com bons resultados terapêuticos, promovendo o desenvolvimento de uma posição de autoria sobre as narrativas identitárias das mulheres vítimas de violência (M. Gonçalves et al., no prelo).

No primeiro estudo deste trabalho pretendeu-se replicar o estudo de Matos (2006), analisando os MIs numa amostra de dez casos clínicos de mulheres vítimas de violência na intimidade. Foi utilizado o SCMI, identificando-se a tipologia dos MIs, bem como a sua respectiva saliência (tempo envolvido na elaboração dos MIs). O contraste de dois grupos terapêuticos, um com sucesso e outro com insucesso, permitiu encontrar diferenças significativas ao nível da saliência, que é mais elevada no grupo com bons resultados, nomeadamente no que diz respeito aos MIs de reconceptualização e de novas experiências, apesar da emergência dos MIs ocorrer nos dois grupos. Estes dados parecem indicar que a emergência dos MIs tem um papel importante na construção de novas narrativas na conversação terapêutica no grupo com bons resultados terapêuticos.

A partir destes resultados, o segundo trabalho orientou-se para o estudo do desenvolvimento dos MIs num caso com bons resultados terapêuticos da mesma amostra, no sentido de perceber a sua congruência em relação ao modelo de construção da mudança proposto anteriormente (M. Gonçalves et al., no prelo). Após a realização de análises quantitativas e qualitativas, os dados apontam para uma emergência dos MIs ao longo do processo de uma forma diferenciada, tal como o modelo prediz. Assim, a mudança parece desenvolver-se a partir da elaboração nas primeiras sessões dos MIs de acção e de reflexão, com reduzida saliência. Seguidamente, na fase intermédia emerge o protesto, que parece ter um papel importante na subsequente emergência da reconceptualização. Por último, as sessões finais distinguem-se pelos MIs de reconceptualização e de novas experiências, caracterizando-se pela elevada saliência.

No que diz respeito ao grupo com insucesso terapêutico, os dados indicam que, nestes casos, surgem sobretudo os MIs de acção, reflexão e protesto. Sugeriu-se, então, que poderia estar presente um processo de *alimentação mútua* (*mutual in-feeding;* Valsiner, 2002) entre o macro organizador dos significados que a cliente trouxe para a terapia e os MIs (M. Gonçalves et al., no prelo). Assim, procedeu-se a um estudo intensivo de um caso com insucesso terapêutico da mesma amostra. Os resultados mostraram, com efeito, que a reflexão e o protesto são os MIs predominantes, emergindo desde a fase inicial e mantendo a sua saliência relativamente estável ao longo do processo. Recorrendo à análise dialéctica (Josephs & Valsiner, 1998; Josephs, Valsiner, & Surgan, 1999) dos MIs, foi possível perceber de que modo emergem e como o seu significado é imediatamente contornado, assistindo-se a um movimento de retorno ao macro organizador dos significados. Este ciclo de alimentação mútua parece estar na origem da manutenção do sistema de significados da cliente, impedindo o desenvolvimento dos MIs.

Por último, os MIs, enquanto oportunidades de construção de novos significados e promotores da mudança terapêutica, são analisados sob uma perspectiva desenvolvimental. Assim, exploram-se os mecanismos dialécticos que parecem favorecer a resolução da alimentação mútua e também os processos passíveis de promover o desenvolvimento dos MIs, nomeadamente, o progressivo aumento da sua saliência e da sua diversidade nos processos terapêuticos com insucesso. Sugere-se também que a reconceptualização emerge a partir de um processo de síntese, tornando-se um MI com funções de regulação e mediação do sistema de significados dos clientes, favorecendo de forma determinante a mudança terapêutica.

NARRATIVE CHANGE IN THE THERAPEUTIC PROCESS OF RE-AUTHORSHIP

ABSTRACT

According to re-authorship narrative therapy (White & Epston, 1990), change occurs by the construction of alternative self narratives from the identification and elaboration, in the therapeutic conversation, of *unique outcomes*. These are all the moments when the client narrates something new or different from the narrative that he/she brought to therapy (e.g., a project, a feeling). They constitute, therefore, opportunities for change to happen. In a previous research (Matos, 2006), they were found to have a dynamic and process feature, so the term unique outcomes was replaced by *Innovative Moments* (i-moments) (cf. M. Gonçalves, Matos & Santos, in press). The *Innovative Moments Coding System: version1* (IMCS; Sistema de Codificação dos Momentos de Inovação, M. Gonçalves, Matos & Santos, 2006) allows to identify five types of IMS: action, reflection, protest, re-conceptualization and new experiences. Following Matos' (2006) results, it was proposed a model, in which change seems to develop from the emergence of action, reflection and protest in initial therapeutic phases. Then, in middle and final sessions re-conceptualization emerges, followed by new experiences i-moments. These i-moments characterize good outcome cases, promoting the development of an authorship position over these women self's narratives (M. Gonçalves, Matos & Santos, in press).

In the first study of this work, Matos (2006) research is replicated, analyzing i-moments in a sample of ten women victim of intimate violence. The IMCS was used to identify the types of i-moments and also their salience (time of i-moments' elaboration). The contrast between two therapeutic groups, one with a good outcome and the other with a poor outcome, allowed finding significant differences regarding salience, which was higher in the good outcome group, namely in what concerns re-conceptualization and new experiences i-moments, despite the occurrence of i-moments in both groups. Findings suggested that i-moments play an important role in the construction of new self narratives in good outcome cases.

Following these data, in the second study, we intend to study i-moments development in a good outcome therapeutic case from the previous sample and to understand whether they match the change model proposed before (M. Gonçalves et al., in press). Following quantitative and qualitative analyses, data show that i-moments

emerge differently throughout the process. So being, change seems to develop from the elaboration in the first sessions of action and reflection i-moments with a reduced salience. Then, in the middle phase protest emerge and seems to play an important role in subsequent re-conceptualization emergence, although with a moderate salience. Final sessions are distinguished by the re-conceptualization and new experiences i-moments, characterized by high salience. These findings were found to be congruent with the change model.

Regarding the poor outcome group, data showed that they were characterized by the emergence of mainly action, reflection and protest i-moments. It was proposed that a process of *mutual in-feeding* (Valsiner, 2002) was presented between the macro organizer of meanings that was brought by the client to the therapy and the i-moments (M. Gonçalves et al., in press). Consequently, aiming to understand this process, we analyze a poor outcome case from the same sample. Results show that the most salient i-moments, in this case, are reflection and protest, emerging ever since the initial sessions, with a relatively stable salience throughout the process. I-moments are studied by a dialectical analysis (Josephs & Valsiner, 1998; Josephs, Valsiner & Surgan, 1999), that allow to find how i-moments emerge and how their meaning is circumvented, allowing a movement of return back to the previous macro organizer. This feedback loop seems to maintain the current system of meanings and restrain the development of the i-moments.

I-moments, understood as opportunities of constructing new meanings and promoters of change, are analyzed within the scope of a developmental framework. We explore dialectical mechanisms that seem to promote the resolution of mutual in-feeding and also the processes that can account for the development of i-moments, specifically the increase of their salience and their diversity in processes with good therapeutic outcomes. We also suggest that re-conceptualization emerges from a synthesis process, becoming an i-moment with regulation and mediation functions in the self's system of meanings, favoring therapeutic change in a determinant way.

ÍNDICE

INTRODUÇÃO 1
CAPÍTULO I - MUDANÇA TERAPÊUTICA E MOMENTOS DE INOVAÇÃO...... 13
1. RESUMO 15
2. RESULTADOS ÚNICOS E MUDANÇA 15
3. MÉTODO 22
3.1. Participantes 22
3.1.1. Clientes 22
3.1.2. Terapeuta 23
3. 2. Avaliação dos resultados terapêuticos 23
3.2.1. Avaliação da sintomatologia clínica. 24
3.2.2. Vitimação recebida pelo parceiro. 24
3.2.3. Aliança terapêutica. 24
3.2.4. Crenças face à violência conjugal. 24
3. 3. Avaliação do processo terapêutico 25
3. 4. Procedimentos 27
3.5. Fidelidade 28
4. RESULTADOS 29
4.1. Medidas do resultado terapêutico nos grupos com sucesso e com insucesso . 29
4.2. A emergência dos MIs nos grupos com sucesso e com insucesso terapêutico 30
4.3. Perfis dos MIs nos grupos com sucesso e insucesso terapêutico 31
4.3.1. A saliência dos MIs de reconceptualização e de novas experiências 31
5. DISCUSSÃO 33
5.1. A relevância dos MIs de reconceptualização e de novas experiências 34
6. LIMITAÇÕES 38
7. IMPLICAÇÕES 38
8. REFERÊNCIAS 39
CHAPTER II - INNOVATIVE MOMENTS AND CHANGE PATHWAYS: A GOOD OUTCOME CASE OF NARRATIVE THERAPY 43
1. ABSTRACT 45

2. INNOVATIVE MOMENTS AND THERAPEUTIC CHANGE 45
3. METHOD 52
3.1. Client 52
3.2. Therapist and therapy 54
3.3. Process measures 54
3.4. Procedures 56
3.5. Reliability 56
3.6. Procedures of analysis 57
4. RESULTS 58
4.1. Salience of IMs and symptoms 58
4.2. Emergence and salience of i-moments types 59
4.3. Combinations of IM types: BCA and CA output 62
4.4. Qualitative analysis 64
5. DISCUSSION 72
6. CONCLUSION 75
7. REFERENCES 76

CHAPTER III - INNOVATIVE MOMENTS AND THERAPEUTIC FAILURE IN NARRATIVE THERAPY 79
1. ABSTRACT 81
2. INTRODUCTION 81
2.1. Innovative moments 82
2.2. Therapeutic failure 85
3. METHOD 89
3.1. Client 89
3.2. Therapist and therapy 91
3.3. The Innovative Moments Coding System 92
3.4. Coding procedures 93
3.5. Reliability 94
3.6. Data analysis 95
4. RESULTS 95

4.1. IMs emergence and salience 95
4.2. IMs emergence and the problematic narrative 97
4.3. I-moments emergence and mutual in-feeding 100
4.3.1. Reflection i-moments 100
4.3.2. Protest i-moments 105
5. DISCUSSION 110
6. REFERENCES 117

CHAPTER IV - INNOVATIVE MOMENTS AND CHANGE PROCESSES IN PSYCHOTHERAPY: AN EXERCISE IN NEW METHODOLOGY 121
1. ABSTRACT 123
2. NARRATING IN PSYCHOTHERAPY 123
3. INNOVATIVE MOMENTS IN NARRATIVE THERAPY 124
3.1. Innovative moments (i-moments) 129
3.2. I-moments and psychotherapeutic outcome in narrative therapy 134
4. DIALECTICAL APPROACH TO I-MOMENTS 136
4.1. The emergence of i-moments 136
4.2. Therapeutic failure and dynamic stability of meaning-making 141
5. FROM DYNAMISM TO DEVELOPMENT 146
5.1. Resolving mutual in-feeding processes through takeover 147
5.2. Resolving mutual in-feeding processes by focusing on social validation 149
6. THE EMERGENCE OF I-MOMENTS AND THE DEVELOPMENT OF A NEW SELF-NARRATIVE 152
6.1. I-moments development through constructive elaboration 153
6.2. I-moments content development 154
6.3. Development of i-moments by circumvention strategies of meaning 156
7. RE-CONCEPTUALIZATION OF THE EMERGENCE OF I-MOMENT THROUGH THE NOTION OF SYNTHESIS 159
8. CONCLUSION 165
9. FINAL REMARKS 168
10. REFERENCES 169

CONCLUSÃO ... 173

REFERÊNCIAS BIBLIOGRÁFICAS ... 183

ANEXOS ... 195

ANEXO I - SISTEMA DE CODIFICAÇÃO DOS MOMENTOS DE INOVAÇÃO: VERSÃO 1 . 197

ANEXO II - INNOVATIVE MOMENTS CODING SYSTEM: VERSION 7 ... 209

ÍNDICE DE TABELAS

Tabela I - 1. Tipologia e exemplos de MIs. ... 21

Tabela I - 2. Saliência global dos diferentes tipos de MIs ao longo da terapia. ... 31

Table II - 1. Outcome measures in Susan's case. ... 53

Table II - 2. Types of i-moments and examples. ... 55

Table II - 3. Salience (%) of i-moments in different phases of the therapeutic process. 60

Table III - 1. Outcome measures evolution in the case of Maria. ... 91

Table III - 2. Types of i-moments and examples. ... 93

Table IV - 1. I-moments types and examples. ... 130

ÍNDICE DE FIGURAS

Figura I - 1. Saliência dos tipos de MIs nos grupos com sucesso e com insucesso terapêutico. 30
Figura I - 2. Saliência dos MIs de reconceptualização e de novas experiências e dos valores do I.G.S. no grupo com sucesso terapêutico, relativamente às sessões de avaliação dos resultados terapêuticos. 32
Figura I - 3. Saliência dos MIs de reconceptualização e de novas experiências e dos valores do I.G.S. no grupo com insucesso terapêutico, relativamente às sessões de avaliação dos resultados terapêuticos. 33
Figura I - 4. Modelo da mudança terapêutica. 37

Figure II - 1. Model for therapeutic change. 51
Figure II - 2. Salience (%) of i-moments through therapeutic process and GSI scores. 59
Figure II - 3. Salience mean (%) of action, reflection and protest i-moments through therapeutic process phases. 61
Figure II - 4. Salience mean (%) of reconceptualization and new experience i-moments through therapeutic process phases. 62
Figure II - 5. Projection of i-moments and session on the bidimensional space defined by the main two factorial dimensions. 62

Figure III - 1. Action, reflection and protest i-moments and mutual in-feeding.. 87
Figure III - 2. Salience (%) of i-moments through therapeutic process and GSI scores for poor outcome case. 96
Figure III - 3. Evolution of reflection and protest i-moments salience (%) throughout the process. 97
Figure III - 4. Mutual in feeding: a dialectical perspective over meaning maintenance.. 111
Figure III - 5. Mutual in feeding: a dialectical perspective over meaning maintenance with a case example. 112
Figure III - 6. Mutual in-feeding throughout therapeutic process. 113
Figure III - 7. I-moments development: A dialectical perspective over meaning construction.. 115

Figure IV - 1. Model for therapeutic change. 136
Figure IV - 2. Mutual in-feeding: a dialectical perspective over meaning maintenance. 143
Figure IV - 3. Mutual in-feeding along therapeutic process... 145
Figure IV - 4. Resolving mutual in-feeding. 149
Figure IV - 5. Resolving mutual in-feeding through a takeover process. 152
Figure IV - 6. Development of i-moments. 154
Figure IV - 7. Synthesis process and the emergence of re-conceptualization. 163

INTRODUÇÃO

“All the world’s a stage,

And all the men and women merely players:

They have their exits and their entrances;

And one man in his time plays many parts…”

William Shakespeare

INTRODUÇÃO

A mudança em psicoterapia é um tema que cativa clínicos e investigadores. Uns e outros vêm-se permanentemente assaltados por questões acerca da natureza da mudança: *Como é que o cliente mudou? Quais os processos envolvidos nesta mudança? O que foi mais importante para o cliente chegar a esta transformação? Como intervir para potenciar a mudança?* Rapidamente se conclui que, para responder a estas questões, é necessário compreender as especificidades inerentes ao processo de mudança terapêutica. Desde logo a mudança afigura-se como um objecto de estudo de elevado interesse, mas ao mesmo tempo, altamente complexo.

A investigação no processo terapêutico é uma área de interesse fulcral para a compreensão da mudança, que tem sido analisada sob diferentes ângulos, reflectindo-se em várias contribuições teóricas e metodológicas. A evolução do conhecimento acerca do processo terapêutico tem permitido retratar a psicoterapia de acordo com diversos parâmetros e perspectivas. Assim, têm sido alvo de investigação as variáveis associadas a um e a outro interveniente, nomeadamente o cliente (e.g. Patterson & Forgatch, 1985) e o terapeuta (e.g. Blatt, Sanisloww, Zuroff, & Pilkonins, 1996). As experiências durante o processo terapêutico por parte do cliente também têm sido alvo de atenção (e.g. Rennie, 1992; Rhodes, Hill, Thompson, & Elliot, 1994), bem como as dos terapeutas, como por exemplo, as suas intenções (e.g. Hill & O´Grady, 1985). A análise das sessões terapêuticas tem permitido explorar os acontecimentos significativos em terapia, tal como os que são identificados como os mais e os menos importantes durante o processo (e.g. Llewelyn, Elliot, Shapiro, Hardy, & Firth-Cozens, 1998), bem como os acontecimentos terapêuticos cobertos, como os não ditos sob o ponto de vista de ambos os participantes (e.g. Hill, Thompson, Cogar, & Demman, 1993). Outros estudos reportam a importância da aliança terapêutica estabelecida e do seu papel ao nível dos resultados clínicos (e.g. Luborsky, Chris-Cristoph, Leslie-Alexander, Margolis, & Cohen, 1983). O processo terapêutico tem sido também abordado do ponto de vista interpessoal (e.g. Hilliard, Henry, & Strupp, 2000). Uma outra forma de estudar a evolução terapêutica tem passado pela sua classificação em termos de estádios, partindo de uma abordagem transteórica (e.g. Prochaska & DiClemente, 1882; Mergenthaler, 1996; Stiles, 2006). Estes são apenas alguns exemplos das diferentes formas possíveis

de analisar o processo terapêutico, percebendo-se, desde logo, uma panóplia diversa de orientações que informam as actuais investigações.

As raízes teóricas deste trabalho situam-se na abordagem narrativa à psicoterapia, nomeadamente a partir do modelo de re-autoria de White e Epston (1990). Paralelamente, a psicoterapia é entendida também enquanto actividade dialógica (cf. Hermans & Dimaggio, 2004). Neste enquadramento, a mudança, mais concretamente, a mudança narrativa corresponde à transformação das narrativas de vida dos indivíduos, potenciando o desenvolvimento de novas vozes[1] que veiculam significados alternativos. Neste sentido, a terapia é uma oportunidade de *re-autoriar* a narrativa de vida pela identificação de acontecimentos, sentimentos, intenções e pensamentos que diferem da narrativa dominante e problemática, o que White e Epston (1990) designam por *resultados únicos*.

A metáfora narrativa tem promovido o estudo da mudança em vários modelos terapêuticos. Estes estudos tendem a identificar narrativas (micro-narrativas, episódios narrativos) e extraí-las do contexto terapêutico para posterior análise, de acordo com o seu tema, conteúdo, estrutura, modo de processamento, entre outros. Salientamos apenas algumas conclusões genéricas destes estudos que apontam, por exemplo, para a importância do desenvolvimento no sentido de maior complexidade, multiplicidade de conteúdos e coerência das narrativas dos clientes no contexto da terapia cognitiva narrativa bem sucedida (Ó. Gonçalves, Henriques & Machado, 2004). Na terapia experiencial parece ser importante o papel do terapeuta na promoção da mudança do modo de processamento narrativo externo para os modos reflexivo e interno, permitindo novas construções de significados nos clientes com bons resultados terapêuticos (Angus, Levitt, & Hardtke, 1999). A intervenção terapêutica no sentido de promover as capacidades metacognitivas e auto-reflexivas, no âmbito da terapia cognitiva construtivista, tem vindo a ser defendida como promotora da organização narrativa dos casos com sucesso (Dimaggio, Salvatore, Azzara & Catania, 2003). A assimilação das experiências problemáticas na narrativa identitária observada nas psicoterapias de carácter breve com orientação cognitiva comportamental e psicodinâmica interpessoal

[1] Dialogicamente, o indivíduo é entendido enquanto multivocal. Ou seja, a identidade é composta por diversas posições (cf. Hermans & Kempen, 1993) ou vozes (cf. Stiles, 1997) em simultâneo, que são o resultado das experiências dos indivíduos e que envolvem determinados significados acerca de si próprio. Estes conceitos são habitualmente entendidos como sinónimos ao longo deste trabalho.

parece estar associada a resultados terapêuticos positivos ao nível do bem-estar psicológico dos indivíduos (Detert, Llewelyn, Hardy, Barkham, & Stiles, 2006).

No entanto, Angus e McLeod (2004) alertam para a necessidade do desenvolvimento métodos para compreender a mudança narrativa, mais concretamente para responder a uma questão de investigação específica em relação ao modelo de re-autoria: «Como é que a história de vida é re-autoriada?» (p.373). Assim, na nossa perspectiva, importa, sobretudo, perceber quais os mecanismos envolvidos na mudança (Kazdin, 2007) que promovem e viabilizam a construção de narrativas alternativas. Deste modo, este estudo pretende "olhar" para a mudança narrativa no processo terapêutico de re-autoria enquanto um processo desenvolvimental de transformação das histórias que os indivíduos narram acerca das suas experiências, dos significados que lhes atribuem e das narrativas alternativas que a partir daí lhes é possível construir.

Um estudo pioneiro (Matos, 2006), elaborado a partir de um enquadramento narrativo, permitiu salientar o papel dos resultados únicos na construção de novas narrativas. Estes, introduzidos por White e Epston, a partir de Goffman (1961, cit. por White & Epston, 1990), têm um papel preponderante na terapia narrativa de re-autoria, uma vez que se configuram como excepções à narrativa problemática e como ponto de partida para a construção de uma nova narrativa. O terapeuta narrativo, através da identificação e da ampliação destes momentos, promove a elaboração progressiva de novos significados inerentes a uma narrativa preferencial.

No trabalho de Matos (2006) foi analisado o processo terapêutico, segundo a orientação narrativa de re-autoria (Matos & M. Gonçalves, 2004; White & Epston, 1990), de acordo com a *Grelha dos Resultados Únicos* (Matos & M. Gonçalves, 2000), posteriormente ampliada e designada de *Sistema de Codificação dos Momentos de Inovação* (versão 1; M. Gonçalves, Matos, & Santos, 2006). Os resultados únicos são actualmente denominados por nós de *Momentos de Inovação* (MIs) (cf. M. Gonçalves, Matos & Santos, no prelo). Os MIs correspondem, então, a uma categorização que distingue cinco tipos:

i) MIs de acção: dizem respeito, como o próprio nome indica, a comportamentos que desafiam a narrativa problemática e os seus significados trazidos pelo/a cliente;

ii) MIs de reflexão: relacionam-se com pensamentos, interrogações, dúvidas, intenções, que são novos ou diferentes em relação à forma como o/a cliente pensava anteriormente e que não legitimam o problema;

iii) MIs de protesto: podem integrar acções e reflexões, mas encerram uma atitude de oposição e de assertividade face aos outros ou a facetas de si próprio/a que possam estar a servir de suporte à manutenção da narrativa problemática e dos seus efeitos;

iv) MIs de reconceptualização: envolvem dois componentes principais, a saber, a presença de um contraste entre as facetas da identidade do/a cliente relativas ao passado e ao presente, bem como uma descrição processual da transformação ocorrida;

v) MIs de novas experiências: referem-se a aprendizagens ou comportamentos que decorrem da mudança e permitem uma expansão para o futuro, como projectos, planos ou novos investimentos.

No estudo realizado por Matos (2006), foram analisados dez casos de uma amostra composta por mulheres vítimas de violência na intimidade, nomeadamente a primeira, a quarta, a oitava, a décima segunda e a décima sexta sessõe, e a sessão de *follow-up*. No que diz respeito à metodologia, os MIs foram identificados momento a momento, através da visualização das sessões terapêuticas, pela terapeuta e por um observador externo em simultâneo. Após a sinalização consensual de um MI, os codificadores categorizaram-no ao nível da sua tipologia: acção, reflexão, protesto, reconceptualização e novas experiências. Seguidamente, foi registado o tempo que a cliente dedicava à sua narração. Assim, para cada sessão e para cada caso foram identificadas a saliência (percentagem de tempo dedicada à narração dos MIs, medida a partir do tempo de cada um dividido pelo tempo total da sessão em segundos) e a tipologia dos MIs. Posteriormente, foram identificados e analisados dois grupos contrastantes: um com sucesso e outro com insucesso terapêutico. Ao nível dos resultados, foram encontradas diferenças significativas ao nível da saliência dos MIs (mais elevada no grupo com sucesso) e também em relação à tipologia, uma vez que a reconceptualização e as novas experiências surgiram com uma saliência mais elevada nos casos bem sucedidos. No entanto, todos os tipos de resultados únicos foram narrados em ambos os grupos terapêuticos, sendo que os casos de insucesso se caracterizaram sobretudo pelos tipos de MIs de acção, reflexão e protesto.

O carácter diverso dos tipos de MIs presentes nos casos de sucesso e a sua progressiva saliência ao longo da terapia, sugeriu um modelo de mudança terapêutica (M. Gonçalves et al., no prelo), que se descreve de forma sintética. Nesta concepção, os primeiros sinais de que a mudança está a ocorrer manifestam-se pela emergência dos MIs de acção e reflexão, seguida do protesto, que também se torna saliente nas primeiras sessões terapêuticas. A partir das sessões intermédias e finais, surgem os MIs de reconceptualização que parece permitir o acesso a uma metaposição que avalia o processo de transformação subjacente, e os de novas experiências, indiciando a projecção no futuro da nova narrativa identitária. Por outro lado, de acordo com os dados do grupo com insucesso terapêutico, a recorrência dos mesmos tipos de MIs ao longo dos casos, aliada a uma menor saliência, foi explicada a partir do conceito de *alimentação mútua* (*mutual in-feeding,* Valsiner, 2002). Assim, o insucesso relaciona-se com a presença de duas vozes, nomeadamente a da narrativa problemática e a dos MIs, que parecem alimentar-se mutuamente, mantendo-se ambas ao longo do processo terapêutico com insucesso, embora sem desenvolvimento. Assim, a emergência dos MIs de acção, reflexão e protesto não se constituem como uma narrativa alternativa, uma vez que o seu carácter de oposição ao problema acaba por facilitar a sua presença e manutenção.

É sobre os MIs que o presente estudo incide, num progressivo movimento de curiosidade acerca da emergência dos mesmos, decorrente dos resultados descritos anteriormente (Matos, 2006). Deste modo, num primeiro momento, o nosso objectivo foi o de replicar os resultados obtidos por Matos (2006) através de uma investigação sistemática dos processos terapêuticos, ou seja, da análise de todas a sessões terapêuticas que compõem a mesma amostra de mulheres vítimas de violência na intimidade. Numa fase posterior as questões de investigação conduziram-nos para uma análise em profundidade dos casos clínicos, no sentido de explorar os processos envolvidos na emergência dos MIs, em situações de sucesso e de insucesso terapêutico.

Esta dissertação é composta por quatro estudos, três de carácter empírico e um trabalho final de âmbito teórico. A opção por esta apresentação na dissertação prende-se com a rentabilização dos esforços de investigação no sentido da divulgação dos trabalhos (submetidos para publicação). Assim, os estudos apresentados foram conduzidos sequencialmente, em diferentes momentos temporais, correspondendo ao

retrato da evolução da própria investigação. Deste modo, as linhas orientadoras de pesquisa foram surgindo de acordo com as questões de investigação levantadas face aos resultados obtidos nos trabalhos anteriores. Não será, de todo, estranho assistir a uma evolução ao nível da conceptualização dos MIs ao longo dos estudos, bem como a um aprofundamento da análise ao nível do objecto de estudo, a mudança terapêutica. Também se esclarece que, na introdução de cada estudo, está patente uma breve descrição do enquadramento teórico da investigação em causa, mas também do sistema de codificação e da clarificação do mesmo, algo paralelo aos quatro estudos que se pode revestir de alguma redundância para o leitor, mas que se justifica pelo carácter distinto dos trabalhos e pelo rigor científico dos mesmos.

Como já referimos, os estudos incidem sobre a mesma amostra de casos clínicos de mulheres vítimas de violência na intimidade. A partir dos resultados de investigação do trabalho de Matos (2006), surgiu a questão que guiou o primeiro estudo (Capítulo I): *Os padrões de MIs encontrados nos grupos de sucesso e insucesso terapêutico no trabalho de Matos mantêm-se quando analisadas todas as sessões da mesma amostra?* Consequentemente, os dez casos que compõem a amostra de mulheres vítimas de violência na intimidade foram analisados com o SCMI. A saliência e a tipologia dos MIs são os índices estudados para diferenciar os perfis dos MIs nos dois grupos terapêuticos contrastantes.

Na sequência destes resultados, pretendeu-se analisar de que forma o modelo de mudança proposto a partir de M. Gonçalves, Matos e Santos (no prelo) reflectia o processo de desenvolvimento dos MIs no decurso do processo terapêutico com sucesso. Isto é: *Como é que os MIs emergem e progridem ao longo do processo terapêutico com sucesso?* Assim, de acordo com estes objectivos, procedeu-se ao estudo de um caso de sucesso terapêutico da mesma amostra (Capítulo II). Neste estudo foram utilizadas metodologias quantitativas e qualitativas de análise dos dados, de forma complementar. A análise quantitativa obedece ao princípio da procura de padrões a partir dos MIs observados, sendo que foram posteriormente ilustrados com excertos clínicos dos MIs que os exemplificam e conferem validade.

Um aspecto dos resultados que se revelou interessante no primeiro estudo foi o facto de os MIs surgirem desde o início da terapia nos casos de insucesso, contrariamente ao que, de algum modo, é proposto pela teoria (White & Epston, 1990).

Por outro lado, estes MIs apresentavam contornos idênticos aos de sucesso nas fases iniciais, não se desenvolvendo, no entanto, no sentido de uma progressiva diferenciação e maior saliência. Assim, colocou-se a questão: *Quais os processos subjacentes à emergência de MIs nos casos de insucesso que constrangem a sua progressão (aumento da saliência) e diferenciação (diferentes tipos de MIs)?* A proposta de compreensão dos casos com reduzidos resultados terapêuticos (M. Gonçalves, Matos & Santos, no prelo) através da mútua alimentação (Valsiner, 2002) foi avaliada num estudo de caso de insucesso (Capítulo III) através da análise dialéctica (Josephs & Valsiner, 1998; Josephs, Valsiner & Surgan, 1999) dos MIs.

Finalmente, o capítulo IV apresenta um esforço teórico no sentido de compreender a natureza desenvolvimental dos MIs. Os dados do estudo anterior fizeram-nos questionar acerca da possibilidade de perceber o desenvolvimento dos MIs através das ferramentas de análise dialéctica (Josephs & Valsiner, 1998; Josephs e tal., 1999). Após percebermos como operava a manutenção dos significados em psicoterapia, a questão de investigação que se levantou foi: *Quais os processos envolvidos na superação da alimentação mútua de significados dos MIs e como é que estes se desenvolvem nos processos terapêuticos de sucesso?* As propostas teóricas são ilustradas a partir de excertos de casos clínicos da mesma amostra analisada anteriormente.

CAPÍTULO I
MUDANÇA TERAPÊUTICA E MOMENTOS DE INOVAÇÃO

CAPÍTULO I
MUDANÇA TERAPÊUTICA E MOMENTOS DE INOVAÇÃO[2]

1. RESUMO

De acordo com White e Epston (1990), a construção da mudança em psicoterapia ocorre a partir da ampliação de *resultados únicos*, que são excepções à história saturada pelo problema que podem viabilizar uma nova narrativa. Estes *Momentos de Inovação* (MIs), como se denominam neste estudo, podem ser de cinco tipos: acção, reflexão, protesto, reconceptualização e novas experiências. Neste estudo, analisam-se os MIs em cinco casos com bons resultados terapêuticos e cinco casos com reduzido sucesso terapêutico, utilizando o *Sistema de Codificação dos Momentos de Inovação: versão 1* (M. Gonçalves, Matos, & Santos, 2006). Os resultados revelam que há diferenças significativas ao nível da saliência (tempo de elaboração dos MIs na sessão), sendo que é mais elevada no grupo com bons resultados terapêuticos, e em relação aos MIs de reconceptualização e novas experiências, tipos de MIs que estão quase ausentes no grupo com insucesso. Sugere-se um modelo de construção de novas narrativas em que os MIs de reconceptualização possibilitam o desenvolvimento de uma metaposição sobre o próprio processo de mudança. Deste modo, promove-se o desenvolvimento do sentido de autoria da narrativa de vida e também de novos guiões para a mesma (MIs de novas experiências).

2. RESULTADOS ÚNICOS E MUDANÇA

A terapia narrativa de re-autoria, iniciada por White e Epston (1990), deu origem a várias formas de intervenção terapêutica, tendo-se tornado num dos mais influentes modelos de terapia narrativa (ver Freedman & Combs, 1996; Monk, Winslade, Crocket, & Epston, 1997; Parry & Doan, 1994; Smith & Nylund, 1997; White, 2004, 2007; Winslade & Monk, 1999; Zimmerman & Dickerson, 1996). Na perspectiva deste modelo, bem como de outras terapias discursivas (e.g., Angus & McLeod, 2004; Hoyt,

[2] Este estudo foi submetido para publicação na revista Psicologia em co-autoria com Miguel M. Gonçalves, Anita Santos, Marlene Matos, Inês Mendes e Carla Martins.

1998; Neimeyer & Raskin, 2000; Omer & Alon, 1997), os clientes mudam as suas narrativas de vida, não porque a terapia permita corrigir processos psicológicos disfuncionais, mas porque possibilita a construção de novas narrativas identitárias, mais adaptativas.

Assim, de acordo com o modelo narrativo de re-autoria (White & Epston, 1990), a construção de narrativas de vida novas e preferenciais resultam da identificação e da elaboração de *Resultados Únicos* (RUs). A definição de RU consiste na emergência na terapia de um detalhe narrativo (e.g., episódio) que não é congruente com a narrativa saturada pelo problema (e.g., depressão, ansiedade). White (2007) refere-se inúmeras vezes ao conceito de narrativa saturada pelo problema (ou narrativa totalitária) dado que, na larga maioria de situações de sofrimento, as pessoas vêm, de algum modo, as suas vidas reduzidas a um tema totalizador, que impede ou dificulta a emergência de novidade e de diversidade, isto é de RUs. Weakland caracteriza bem esta ideia ao afirmar: «*Life is just one damn thing after another. (...) But people who seek therapy are no longer experiencing that – life for them has become the same damn thing over and over and over*» (cit. por O'Hanlon, 1998, p. 143-144). Um RU pode assumir uma grande diversidade de formas (e.g., um pensamento, uma recordação, uma acção, um projecto) mas é sempre algo que se situa, de algum modo, fora da influência da narrativa saturada pelo problema, ou nas palavras de Weakland, fora do âmbito da «*same damn thing over and over and over*».

Apesar do grau de persistência dos problemas, todos os clientes vivenciam RUs. No entanto, estes habitualmente não conduzem espontaneamente à emergência de uma nova história porque são desvalorizados ou ignorados. A narrativa problemática é dominante e não permite que o indivíduo contemple novas formas de agir, sentir e pensar. Os RUs, em termos terapêuticos, são considerados como pontos de partida para a construção de novas histórias e constituem-se, assim, como oportunidades para que a mudança terapêutica ocorra.

Bruner (1986) distingue dois modos narrativos de pensamento, a paisagem de acção e a paisagem de consciência. Para este autor, as boas histórias são escritas nestas duas paisagens. A paisagem da acção descreve o *setting*, as personagens envolvidas e as suas acções, enquanto a paisagem da consciência descreve os sentimentos, os valores, as crenças e os projectos das personagens, que conferem um sentido mais coerente à

narrativa. Deste modo, na sequência da proposta de White e Epston (1990), Freedman e Combs (1996) sugerem que, após a desconstrução de narrativas problemáticas, o terapeuta deve enfatizar a conversação em torno dos RUs na paisagem da acção (e.g., o terapeuta coloca questões do tipo "como é que esta novidade ocorreu? O que aconteceu, em que sequência, envolvendo que personagens?") e relacioná-los com RUs na paisagem da consciência (e.g., "Que características suas se evidenciaram nesta situação? Quais os valores que se tornaram visíveis face a este novo acontecimento?"). Quando o terapeuta e o cliente conversam acerca dos significados envolvidos nestas sequências de RUs que foram elaborados na paisagem da acção, passam a construir a história na paisagem da consciência. Nesta construção, a elaboração de RUs envolve expectativas, desejos, valores ou crenças. Freedman e Combs (1996) propõem uma estrutura terapêutica em que a consolidação de uma nova história se faz através do questionamento em torno dos RUs. As questões oscilam entre elementos da paisagem da acção e elementos da paisagem da consciência, partindo de um determinado tempo (e.g., presente) e articulando-o com outros tempos (e.g., passado), incrementando assim a plausibilidade narrativa (para uma descrição técnica deste processo ver Freeman & Combs, 1996, e White, 2007). De acordo com os autores, este processo leva à transformação dos RUs em novas histórias e novos significados acerca de si próprio. Metaforicamente, estas três dimensões – tempo, acção e consciência – actuam como vectores na matriz narrativa, uma vez que promovem a emergência de uma nova história. Assim, na conversação terapêutica, terapeutas e clientes necessitam de desenvolver estas três dimensões, de modo a que a nova história adquira consistência e se torne numa alternativa viável à história saturada pelo problema. A dimensão temporal é fundamental para permitir o desenvolvimento coerente dos acontecimentos, sem a qual a história se tornaria caótica. Mas apenas a dimensão temporal não é suficiente para que uma boa história se desenvolva – também são necessárias acções e emoções, valores e pensamentos, assim como outros elementos das paisagens da acção e da consciência. Estes componentes são centrais para que uma história seja significativa e plausível para a pessoa que a está a construir (e a viver, à medida que a construção vai progredindo).

De modo análogo, Steve de Shazer (1991, 1994) sugere que o terapeuta deve evitar uma conversação centrada no problema e ser capaz de transformar a forma

tradicional de entrevistar clientes numa que se centre nas excepções. De Shazer (1991) adverte para o facto de não confundir um diálogo em torno das excepções com a conversação sobre as excepções com o problema em plano de fundo. Assim, em vez de falar sobre a ausência do problema, o terapeuta procura entrevistar o cliente sobre a presença de algo que se torna possível porque o problema está ausente (cf. M. Gonçalves, 2008). É, pois, a presença de algo diferente do problema (e também diferente da sua ausência) que permite a construção de novidade e a "dissolução" das histórias problemáticas.

A principal diferença entre White e Epston (1990) e De Shazer (1991) é que, do ponto de vista do último, as excepções não requerem uma "textura" narrativa para que a mudança ocorra. Deste modo, o terapeuta centrado nas soluções não enfatiza a construção de uma nova história segundo a matriz narrativa referida anteriormente. O terapeuta preocupa-se com a criação de uma narrativa progressiva em torno do contexto terapêutico, ou seja, o cliente deverá sentir que a terapia o levará a algum lado e que está a fazer progressos. Por outro lado, White (1994, 2007) considera os RUs como sendo mais do que excepções aos problemas, uma vez que estes são compreendidos como excepções à narrativa problemática.

Apesar das suas diferenças, quando comparados com abordagens mais tradicionais (e.g., psicodinâmica, cognitiva), estes dois modelos de terapia partilham uma característica principal: em vez de tentar resolver problemas ou corrigir disfunções, eles tentam construir a mudança através das excepções em si mesmas, quer sejam narrativamente estruturadas ou não. Por outras palavras, a mudança terapêutica ocorre pela elaboração narrativa de novidades e não pela modificação de padrões disfuncionais.

Do nosso ponto de vista, a terapia narrativa é útil na intervenção com mulheres vítimas de violência na intimidade (população alvo deste estudo) por diversas razões (cf. Matos & M. Gonçalves, 2004). Em primeiro lugar, a violência conjugal é uma experiência que produz diversos efeitos prejudiciais que moldam a narrativa da mulher acerca de si própria, usualmente dominada pela auto-culpabilização, vergonha, confusão, cepticismo e hesitação perante a possibilidade de mudança (Martin et al., 2000; Matos, 2006). Em segundo lugar, estas dificuldades são alimentadas pela fusão entre o problema e a identidade (e.g., "a culpa dos maus-tratos é minha", "se eu fosse melhor esposa ele não me batia"). As práticas de externalização do problema, propostas

pela terapia narrativa, permitem precisamente criar a distinção entre o que o problema "quer" para a vida da cliente e o que a pessoa prefere, criando um novo espaço de desenvolvimento da agência pessoal. Em terceiro lugar, a proposta narrativa centra-se na desconstrução de discursos sociais e culturais, sendo a violência na intimidade um domínio em que os discursos sociais (e.g., de género, da família tradicional) suportam claramente a violência do parceiro e frequentemente dificultam a mudança pessoal (Madigan & Law, 1998). Tornar estas práticas e valores sociais explícitos permite que as clientes se reposicionem face a estes discursos dominantes, descobrindo neste movimento novas práticas e valores (e.g., tolerância, igualdade).

Baseados na terapia narrativa e numa anterior investigação (Matos, 2006), construímos o *Sistema de Codificação dos Momentos de Inovação: versão 1* (SCMI, M. Gonçalves, Matos, & Santos, 2006) (Anexo I) que nos permite identificar diferentes tipos de MIs. Foram discutidas previamente (M. Gonçalves et al., no prelo) as razões pelas quais preferimos a designação de *Momentos de Inovação* (MIs) em vez de RUs. Em primeiro lugar, não parece existir algo de "único" nos RUs, pois, tal como a teoria sugere e a prática reitera, eles ocorrem frequentemente na psicoterapia (ver de Shazer, 1991, para uma crítica semelhante). Em segundo lugar, a noção de "resultado" é algo contraditória com o que a literatura sugere, pois estas ocorrências são parte do processo de construção de uma nova narrativa. Assim, preferimos a designação MIs.

Os MIs dividem-se, então, em cinco tipos: (1) acção, (2) reflexão, (3) protesto, (4) reconceptualização e (5) novas experiências (ver tabela I - 1):

(1) Os MIs de Acção envolvem acções específicas face à narrativa problemática e às suas consequências; (2) Os MIs de Reflexão implicam a emergência de novas compreensões ou de pensamentos diferentes da narrativa dominante; (3) Os MIs de Protesto podem envolver acções ou pensamentos (tal como os MIs anteriores), mas requerem mais do que meras acções ou pensamentos, uma vez que envolvem uma forma de reposicionamento de si próprio e, dessa forma, emerge um processo de maior proactividade através de um protesto face à história saturada pelo problema e suas especificações (e.g., tomar uma decisão que reduz o poder da história problemática); (4) Os MIs de Reconceptualização são mais complexos, implicando uma compreensão a um nível metacognitivo, em que o cliente percebe algo de diferente em si próprio em relação ao passado, mas também é capaz de descrever quais os processos envolvidos na

transformação. Envolvem a distinção entre uma posição anterior e uma presente, bem como os processos que deram origem a essa transformação; (5) Os MIs de Novas Experiências referem-se ao planeamento ou experiência de novos projectos, actividades, ou relacionamentos interpessoais, que estavam impedidos pelos constrangimentos da narrativa problemática.

Tabela I - 1. Tipologia e exemplos de MIs. Retirado do Sistema de Codificação dos Momentos de Inovação (M. Gonçalves, Matos, & Santos, 2006).

Tipos de MI	Exemplos
MIs de Acção: Acções ou comportamentos específicos de desafio ao problema.	▪ Novos desempenhos face à antecipada ou efectiva reinstalação de um obstáculo; ▪ Resolução de problemas não-resolvidos; ▪ Exploração activa de soluções específicas (e.g., recurso a técnicos ou instituições, procura de apoio efectivo); ▪ Restauração da autonomia (e.g., não interferência do problema no domínio profissional, financeiro) e do auto-controlo (e.g., separar domínio profissional e pessoal); ▪ Procura de informação sobre o problema.
MIs de Reflexão: Excepções de carácter cognitivo ou produtos cognitivos (ex. pensamentos, intenções, interrogações, dúvidas) que indiciam a compreensão de algo novo e que não legitimam o problema.	▪ Novas formulações do problema e consciência dos seus efeitos; ▪ Reconsiderações acerca das causas do problema (ex. gravidade, intensidade, reiteração, intencionalidade, etiologia); ▪ Articulação de dilemas cognitivos e afectivos; ▪ Reflexão face às prescrições culturais/sociais/religiosas; ▪ Referências a crenças de auto-valorização (e.g., força para lutar, pensamentos positivos); ▪ Auto-instruções (e.g., “tens que lutar”); ▪ Reflexão sobre a intenção de combater prescrições do problema (e.g., vergonha).
MIs de Protesto: Momentos de dissidência atitudinal, concretizados, planeados ou projectados.	▪ Posição de crítica/confronto face às prescrições do problema ou dos aliados do problema; ▪ Manifestações assertivas genéricas face a outros; ▪ Reposicionamento face às prescrições culturais, sociais, religiosas, e educacionais.
MIs de Reconceptualização: Descrição processual, a nível metacognitivo (i.e., não só surgem pensamentos e/ou desempenhos fora da lógica do problema, como emerge também o processo subjacente).	▪ Redefinição das versões de si (e.g., evidência de renovação pessoal; bem-estar a vários níveis; libertar-se da versão vítima; preservação de capacidades); ▪ Releitura da sua relação com os outros; ▪ Reapropriação de experiências na base do desenvolvimento do problema (e.g., reflexão sobre etiologia, escala, interferência/ custos, aprender a desvincular-se); ▪ Redefinição da versão acerca dos outros (e.g., enquanto aliados da mudança ou do problema no processo de mudança).
MIs de Novas Experiências: Referências a novas projectos, actividades ou investimentos, em curso ou antecipados, como consequências da mudança.	▪ Generalização no futuro de ganhos para outras dimensões da vida; ▪ Reutilização da experiência problemática para novas situações (e.g., problema como recurso ou aprendizagem; renovação de significados – transversalidade do problema); ▪ Reinvestimentos em novos projectos, posturas, imagem pessoal no espaço público e privado (e.g., profissionais, lazer); ▪ Reinvestimentos relacionais (e.g., íntimo, colegas).

Nesta investigação explora-se o modo como os MIs contribuem para o desenvolvimento de narrativas preferenciais na psicoterapia. Trata-se de um estudo inserido num projecto de investigação mais amplo, cujo objectivo é analisar o papel dos MIs na mudança psicoterapêutica.

Neste artigo procuramos perceber (1) se, tal como prediz a teoria, os MIs são importantes para o sucesso psicoterapêutico, ou seja, se emergem mais MIs em casos com bons resultados terapêuticos do que em casos com reduzido sucesso psicoterapêutico, (2) se diferentes tipos de MIs (e.g., acção, reflexão) emergem de forma diferente nos casos com sucesso e com insucesso psicoterapêutico, e (3) se diferentes MIs aparecem de um modo mais predominante em diferentes fases do processo terapêutico (e.g., início, fim da terapia).

3. MÉTODO

3.1. Participantes

Nesta investigação participaram mulheres vítimas de abuso por parte do parceiro, que foram alvo de psicoterapia individual de orientação narrativa (White & Epston, 1990).

3.1.1. Clientes

As clientes foram atendidas no serviço de consulta de uma universidade portuguesa, tendo assinado uma declaração de consentimento informado, na qual constavam os objectivos da investigação. O acompanhamento terapêutico foi realizado gratuitamente.

A amostra é constituída por dez mulheres, com idades compreendidas entre os vinte e dois e os cinquenta e sete anos. Quatro destas mulheres não tinham filhos e as restantes tinham entre um a quatro filhos. No que respeita à sua qualificação académica, verificou-se uma grande variabilidade entre elas, desde o nível básico de ensino até ao ensino pós-graduado. Relativamente às profissões exercidas pelas participantes registou-se também uma grande variabilidade, desde profissões qualificadas até outras indiferenciadas. As relações abusivas tinham uma duração que variava entre um e vinte anos: quatro participantes foram alvo de vitimação prolongada (mais de cinco anos) e as restantes de uma vitimação mais breve (inferior a cinco anos). A violência psicológica

estava presente em todos os casos. Simultaneamente, cinco mulheres eram vítimas de violência física e sexual.

Cinco mulheres foram conduzidas para a psicoterapia por outros psicólogos, duas foram enviadas pelo sistema judicial (polícia e tribunais), uma surgiu por iniciativa própria e duas foram encaminhadas por técnicos que apoiam vítimas de crime.

A maioria das clientes era casada, uma delas coabitava com o parceiro e duas namoravam (sem coabitação). No final da psicoterapia, quatro clientes terminaram a relação de intimidade.

Quatro parceiros foram acompanhados simultaneamente por outro psicoterapeuta. Dois deles terminaram o processo terapêutico com sucesso, outro desistiu e outro ainda permanecia na intervenção aquando do término deste estudo.

3.1.2. Terapeuta

Todos os casos foram atendidos pela mesma terapeuta que possuía o grau de mestre em Psicologia no momento do estudo e cinco anos de experiência em psicoterapia com vítimas de violência conjugal. O modelo terapêutico foi desenvolvido a partir da terapia de re-autoria de White and Epston (1990, ver também White, 2007) envolvendo (1) a externalização do problema, que não o abuso (e.g., medo, tristeza, características pessoais que suportam o abuso), (2) a identificação das prescrições culturais e sociais que apoiam a violência sobre as mulheres (e.g., poder patriarcal, crítica acerca das mulheres que saem da relação), (4) o questionamento terapêutico acerca dos resultados únicos no sentido da criação de um novo guião, alternativo ao que foi anteriormente externalizado, e (5) a consolidação das mudanças alcançadas através da validação social (e.g., rituais de mudança, escrita de cartas dirigidas a mulheres com o mesmo problema). A prática foi supervisionada com o intuito de monitorizar a adesão da terapeuta ao modelo narrativo.

3. 2. Avaliação dos resultados terapêuticos

De modo a avaliar os resultados terapêuticos, estabeleceu-se um protocolo de avaliação administrado em diferentes momentos ao longo da terapia: na primeira sessão, na quarta, na oitava, na décima segunda, na décima sexta, na última e na sessão de *follow-up* (após seis meses). Essa avaliação contemplou a sintomatologia clínica, a

vitimação por parte do parceiro, a aliança terapêutica e as crenças associadas à violência conjugal. Os resultados deste protocolo foram particularmente importantes para constituir os grupos (sucesso e insucesso terapêutico), como será explicitado nos procedimentos. As medidas utilizadas foram:

3.2.1. Avaliação da sintomatologia clínica. O Inventário de Sintomas Psicopatológicos (*Brief Symptom Inventory - BSI*, Derogatis, 1982; versão portuguesa adaptada por Canavarro, 1999) foi utilizado na avaliação da sintomatologia clínica. Trata-se de um instrumento de auto-relato, composto por 53 itens, organizado numa escala tipo *likert*, desde 1 a 5, desde "nunca" a "muitíssimas vezes". A medida utilizada nesta investigação foi o Índice Geral de Sintomas (IGS). Esta escala foi administrada a cada quatro sessões, com início na primeira sessão.

3.2.2. Vitimação recebida pelo parceiro. De forma a avaliar esta dimensão, procedeu-se a um registo clínico acerca da violência recebida pelo parceiro. As clientes eram questionadas, de quatro em quatro sessões, sobre os comportamentos de abuso recebidos (físico, psicológico e/ou sexual), a sua frequência e gravidade, avaliados sob a forma de uma escala qualitativa (reduzido, médio, elevado).

3.2.3. Aliança terapêutica. O Inventário da Aliança Terapêutica (IAT; *Working Alliance Inventory – WAI*, Horvath, 1982; versão portuguesa adaptada por Machado e Horvath, 1999) foi utilizado com o intuito de avaliar a qualidade da aliança terapêutica. Este instrumento é composto por 3 sub-escalas – tarefa, objectivo e relação – cada uma com 12 itens. As clientes respondiam através de uma escala de tipo *likert* que variava entre 1 e 7, desde "nunca" a "muito frequentemente". Foram aplicadas duas versões do instrumento, uma para os clientes e outra para os observadores (dois observadores independentes cotaram o instrumento a partir da visualização das sessões). Esta escala foi administrada a cada quatro sessões, com início na quarta sessão.

3.2.4. Crenças face à violência conjugal. A Escala de Crenças sobre Violência Conjugal (ECVC, Matos, Machado, & M. Gonçalves, 2000) foi aplicada para avaliar as crenças das clientes face à violência. Esta escala é composta por 25 itens, que consistem em afirmações que se referem à legitimação da violência conjugal. As clientes respondiam de acordo uma escala de tipo *likert*, desde 1 a 5 (de "totalmente em desacordo" a "totalmente de acordo"). A pontuação total foi utilizada em três momentos de avaliação (primeira sessão, última e *follow-up*). Esta escala evidencia uma elevada

fidelidade (*alpha de Cronbach* de 0.90) e estudos anteriores demonstraram uma forte associação positiva entre actos de agressão por parte do parceiro e a pontuação global da escala (cf. Machado, Matos e M. Gonçalves, 2004).

3. 3. Avaliação do processo terapêutico

Todas as sessões foram codificadas a partir do SCMI. Apresentamos de seguida ilustrações dos cinco diferentes tipos de MIs, tal como foram descritos previamente.

(1) MI de Acção: Codifica-se quando a cliente descreve acções ou comportamentos específicos de desafio ao problema, tal como se ilustra de seguida (a negrito está assinalado o que foi codificado como MI).

> **Cliente:** *Entretanto em Agosto, não sei porquê, ele começa a tirar… à frente da miúda, com 2 anos e tal... a tirar satisfações da minha vida de solteira. E eu a não lhe responder. A minha filha ali... eu acho que estava a arrumar coisas no armário e ele dava-me estaladas e empurrões e mais coisas que eu não me lembro. "Porque é que fizeste aquilo? Tens que me explicar isso!".* ***E eu continuei sem lhe responder. Eu só lhe dizia "leva-a (à filha) daqui. Pega na tua filha e vai a qualquer sítio! Eu não lhe respondia.*** *Entretanto eu vou à cozinha, ele vem atrás de mim e bate-me na cara. Fiquei com um hematoma enorme no olho negro. Entretanto... talvez ele tenha visto o que fez...*
>
> **Terapeuta:** *Pediu desculpa?*
>
> **Cliente:** *Não. Ele nunca me pediu desculpa. Ele finalmente pegou na miúda e saiu de casa.* ***Eu saí também… sem saber muito bem o que havia de fazer… fui a uma bomba de gasolina e comprei uma máquina descartável e entretanto fui ao centro de saúde falar com uma médica. Ela registou o que aconteceu e tirou-me uma fotografia. Depois falamos sobre isso.*** [MI de acção]

(2) MI de Reflexão: Referem-se a excepções de carácter cognitivo ou produtos cognitivos (ex. pensamentos, intenções, interrogações, dúvidas) narrados pela cliente na sessão que indiciam a compreensão de algo novo e que não legitimam o problema.

> **Cliente:** ***De há uns tempos para cá comecei a pensar um bocado mais em mim!*** [MI de reflexão]

(3) MI de Protesto: O protesto é codificado quando a cliente narra episódios de dissidência atitudinal, que envolvem, de algum modo, confronto (endereçado a outrem ou a facetas de si próprio). Podem compreender comportamentos, pensamentos e sentimentos, projectados ou concretizados.

> **Cliente:** *Por exemplo, na semana passada até se estava bem. Mas ele dizia "dá-me mais uma oportunidade" e eu disse* ***"dei-te quatro anos delas, não tenho mais para te dar. Desculpa, não acredito nem confio em ti, e tiveste quatro anos para mudar."*** [MI de protesto]

(4) MI de Reconceptualização: Este MI é mais complexo do que os anteriores e codifica-se a partir da verificação de dois critérios: a cliente identifica o contraste entre posições identitárias anteriores e actuais, e também descreve o respectivo processo de mudança.

> **Terapeuta:** *Até que ponto é um recurso para si recordar o passado?*
> **Cliente:** ***Por exemplo, mesmo em relação a mim mesma, às atitudes que eu tomo no dia-a-dia, no relacionamento com as pessoas, eu começo… eu às vezes olho para trás e penso, vejo o que fiz agora e olho para trás e penso… engraçado há dois anos atrás eu era incapaz de fazer isto! Não tinha… parecia que tinha o cérebro parado, enquanto eu agora reajo, penso eu, adequadamente às coisas. Tenho tido situações esporádicas, de mal entendidos, que se fosse há uns tempos atrás ficava caladinha, quietinha no meu canto e não dizia nada. Agora não, agora***

levanto-me e falo, não deixo que me passem por cima, que era uma coisa que eu deixava que me fizessem. [MI de re-conceptualização]

(5) MI de Novas Experiências: Este MI surge quando são relatadas referências a novas pretensões, actividades ou projectos. Estes surgem em resultado da mudança alcançada e podem estar já em curso ou simplesmente antecipados.

Cliente: ***Eu estava há tanto tempo ansiosa por esta mudança, embora nunca pensasse que acontecesse como aconteceu… que há uma vontade tremenda de… há muitas coisas que eu gostava de conseguir, mesmo a nível pessoal, coisas que agora quero mudar, muitas coisas mesmo. Uma delas passa por… porque eu sou uma pessoa um bocado desorganizada… e isso há muito tempo que fazia parte dos meus planos começar a tentar modificar, a organizar-me.***
Terapeuta: *Agora está numa posição para mudar isso...*
Cliente: ***É uma das coisas que eu quero começar fazer!*** [MI de novas experiências]

3. 4. Procedimentos

As sessões foram analisadas com o SCMI de forma sequencial (sessão primeira, segunda, … até à ultima e *follow-up*), após finalizados os processos terapêuticos. A codificação envolveu a visualização de cada sessão terapêutica em vídeo e consequente registo, momento a momento, da emergência dos MIs à medida que surgiam na sessão. Para cada tipo de MI foram registados o tipo (e.g., acção, reflexão) e a saliência (i.e., duração de cada um). Para cada sessão calculou-se o índice da saliência de cada MI, em percentagem, a partir da divisão do tempo dedicado a cada MI na sessão pelo tempo total de cada sessão. Depois determinou-se o valor da saliência para cada tipo de MI na sessão, e também o valor total dos MIs para cada sessão e para cada caso.

Posteriormente, e de acordo com a avaliação dos resultados terapêuticos, foram identificados dois grupos contrastantes - um grupo com sucesso e um grupo com

insucesso. Esta diferenciação foi efectuada a partir da verificação de dois critérios: considerou-se que a mudança terapêutica ocorreu quando se verificou 1) uma redução significativa nos sintomas clínicos tal como avaliados pelo IGS e 2) a cessação ou uma mudança significativa na vitimação recebida pelo parceiro, do início para o final da terapia. Este último critério envolve uma alteração importante no padrão de vitimação, tal como passar para formas "menores" de violência (e.g., insultar, gritar), e também uma modificação na prevalência dos episódios – passar de uma frequência contínua para uma natureza ocasional.

Assim, o grupo com sucesso terapêutico foi constituído por cinco participantes que evoluíram para uma condição de sintomatologia clínica não relevante, e, simultaneamente, a vitimação cessou (em três casos), ou sofreu uma mudança significativa (em dois casos). O grupo com insucesso integrou, igualmente, cinco clientes. Duas das mesmas mantiveram, no final da terapia, sofrimento psicológico, e as restantes não reportaram uma mudança significativa nos padrões e prevalência da violência. Neste grupo incluíram-se ainda três casos que não completaram o processo terapêutico *(drop-outs).*

Não se verificaram diferenças entre os grupos em relação à idade (U=7.50, p=0.293), à duração do relacionamento (U=8.00, p=0.282) e à duração da vitimação (U=7.500, p=0.221). No que diz respeito ao nível educacional, encontrou-se uma diferença marginalmente significativa entre os grupos (U=4.000, p=0.065), apresentando o grupo de sucesso um nível educacional mais elevado.

No total foram codificadas 127 sessões em formato vídeo. Os grupos com sucesso e com insucesso terapêutico registaram uma média de 15 e de 11 sessões, respectivamente.

3.5. Fidelidade

Os dados foram codificados por dois juízes, respectivamente o juiz A (a autora desta dissertação) e o juiz B (uma equipa composta pela terapeuta e outro juiz, estudante de Doutoramento). O juiz A codificou todas as sessões da amostra (sem informação relativa aos resultados terapêuticos, em termos de sucesso e insucesso), enquanto o juiz B codificou apenas as sessões em que os instrumentos de avaliação foram aplicados (primeira, quarta, oitava, décima segunda e décima sexta sessões, e na sessão de *follow-*

up). Os juízes codificaram as sessões após ter sido recolhida toda a amostra de modo a evitar enviesamentos no processo terapêutico. O cálculo da fidelidade do acordo inter-juízes foi realizado com os dados relativos a 30% da amostra (nomeadamente, 30% de cada caso), codificados pelos juízes A e B. A percentagem de acordo inter-juízes foi de 86% para a saliência (85% e 87%, relativos respectivamente aos grupos com sucesso e de insucesso). A fidelidade inter-juízes relativamente à tipologia de MIs foi calculada pelo *Kappa* de Cohen, obtendo-se o valor de 0.89. Devido ao elevado nível de fidelidade inter-juízes, a análise dos dados baseou-se na codificação efectuada pelo juiz A.

4. RESULTADOS

O número de participantes em cada grupo (N=5) da amostra aponta para a utilização de testes não paramétricos. No entanto, utilizou-se a estratégia de calcular ambos, testes paramétricos e os seus equivalentes não paramétricos, como aconselha Fife-Shaw (2006). Uma vez que as conclusões retiradas dos dois conjuntos de testes são as mesmas, optou-se por apresentar os resultados dos testes paramétricos. Estes são mais robustos e permitem utilizar análises multivariadas reduzindo, deste modo, o número de testes a efectuar e, logo, também a probabilidade do erro de Tipo I.

4.1. Medidas do resultado terapêutico nos grupos com sucesso e com insucesso

No que diz respeito ao IGS avaliado no início da intervenção, não houve diferenças quando se compararam os grupos com sucesso e com insucesso terapêutico (t (8) = -.78, p =.46).

No ECVC todas as clientes revelaram, nos três momentos de avaliação, uma tendência para discordar da maioria dos itens que compõem esta escala, demonstrando assim uma reduzida tolerância face à violência por parte do parceiro. As atitudes face à violência conjugal não foram significativamente diferentes em cada grupo (U = 5.50, p = .14).

Relativamente ao IAT, os resultados mostraram que os valores para a aliança terapêutica eram elevados para os dois grupos e para todas as sessões avaliadas (entre

182 e 252). Na quarta sessão, a qualidade da aliança terapêutica foi comparada nas três perspectivas avaliadas. Encontraram-se diferenças estatisticamente significativas entre os grupos com sucesso e de insucesso apenas de acordo com um observador (U = 0,000; p = 0,009), para o qual a aliança terapêutica era mais elevada no grupo de sucesso. Não se registaram diferenças significativas na perspectiva do outro observador (U = 5,000; p = 0,117) e na dos clientes (U = 8,500; p = 0,402).

4.2. A emergência dos MIs nos grupos com sucesso e com insucesso terapêutico

Para testar diferenças estatisticamente significativas entre os grupos ao nível da saliência dos MIs (cf. Figura I - 1), procedeu-se à análise univariada da covariância (ANCOVA) utilizando o número de sessões como covariante (dado o número diverso de sessões em que estiveram envolvidas as clientes). O grupo de sucesso (*MME* = 153.05, *EP* = 23.46) evidenciou uma saliência dos MIs significativamente elevada, F (1,7) = 7.08, p = .032, η^2=.50, relativamente ao grupo de insucesso (*MME* = 56.99, *EP* = 23.46).

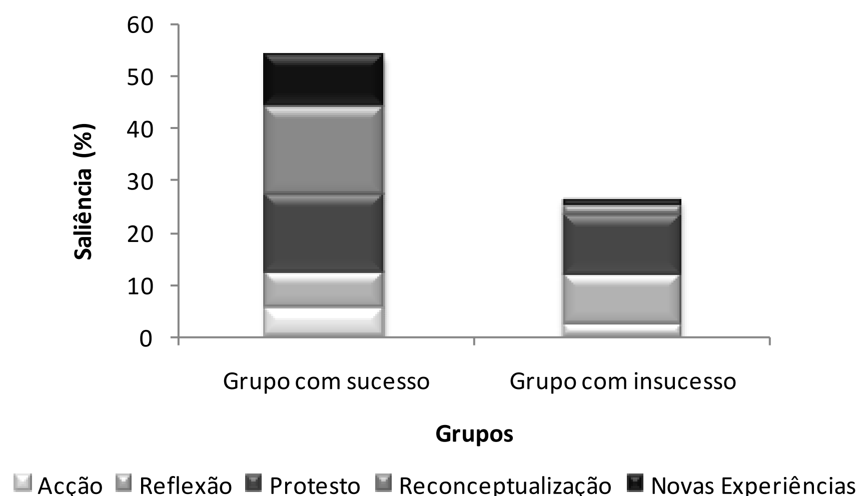

Figura I - 1. Saliência dos tipos de MIs nos grupos com sucesso e com insucesso terapêutico.

4.3. Perfis dos MIs nos grupos com sucesso e insucesso terapêutico

Uma análise multivariada da covariância (MANCOVA) foi calculada de modo a testar as diferenças entre os grupos no que respeita à saliência dos diferentes tipos dos MIs, utilizando o diferente número de sessões como covariante (ver Tabela I - 2).

Tabela I - 2. Saliência global dos diferentes tipos de MIs ao longo da terapia.

	Grupo com Sucesso Terapêutico (N=5)	Grupo com Insucesso Terapêutico (N=5)		
	MME (EP)	*MME (EP)*	F (1,7)	η^2
Acção	14.83 (4.49)	5.23 (4.49)	1.92	.22
Reflexão	19.20 (4.68)	19.12 (4.68)	.001	.00
Protesto	39.33 (6.75)	30.38 (6.75)	.74	.10
Reconceptualização	49.51 (10.96)	3.75 (10.96)	7.37*	.51
Novas experiências	30.19 (8.15)	-1.48 (8.15)	6.37*	.48

* p <.05

Não se verificaram diferenças significativas entre os dois grupos terapêuticos (Wilks' Lambda = .20, F (5,3) = 2.47, p = .24), mas o grupo com sucesso terapêutico apresentou uma saliência significativamente elevada dos MIs de reconceptualização ($MME_{sucesso}$ = 49.51, $MME_{insucesso}$ = 3.75, EP = 10.96, F (1,7) = 7.37, p = .03, η^2=.51) e novas experiências ($MME_{sucesso}$ = 30.19, $MME_{insucesso}$ = -1.48, EP = 8.15, F (1,7) = 6.37, p = .04, η^2=.48), comparativamente com o grupo de insucesso.

4.3.1. A saliência dos MIs de reconceptualização e de novas experiências

Dadas as diferenças significativas encontradas anteriormente, apresenta-se a evolução da saliência dos MIs de reconceptualização e de novas experiências (figuras I - 2 e I - 3) nos dois grupos. Os gráficos seguintes ilustram os dados relativos à saliência dos MIs de reconceptualização e de novas experiências, bem como aos valores do IGS, nas sessões nas quais foi aplicado o protocolo de avaliação. A saliência é apresentada

em termos da saliência média para cada grupo relativamente aos MIs de reconceptualização e de novas experiências, para estas sessões em particular. Os dados demonstraram que a evolução destes MIs no grupo de sucesso era claramente diferente do grupo de insucesso. Na maioria dos casos com sucesso, os MIs de reconceptualização e de novas experiências surgiram na fase intermédia da psicoterapia, aumentando a sua saliência ao longo do processo. Os dados apontaram que a tendência de redução dos níveis do IGS ao longo do processo era paralela à tendência crescente da saliência da reconceptualização e das novas experiências.

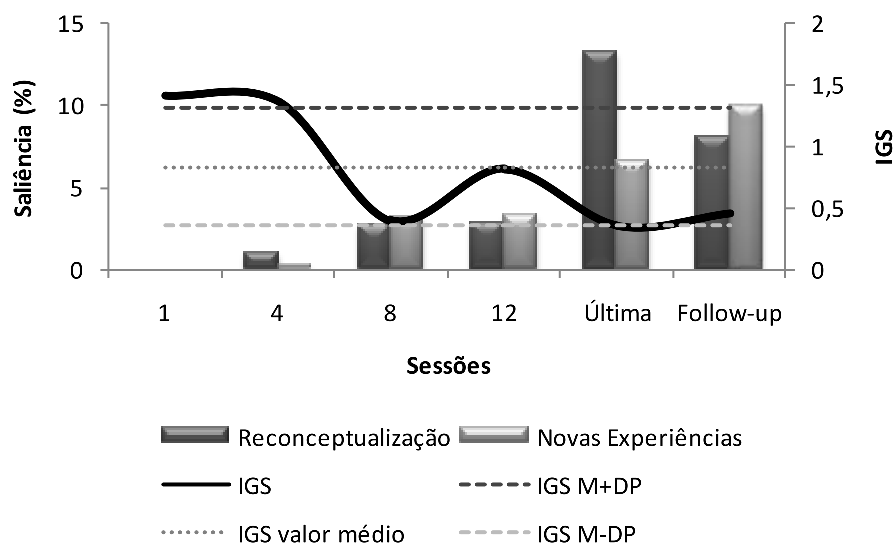

Figura I - 2. Saliência dos MIs de reconceptualização e de novas experiências e dos valores do IGS no grupo com sucesso terapêutico, relativamente às sessões de avaliação dos resultados terapêuticos.

Nos casos com insucesso (ver figura I - 3), a saliência dos MIs de reconceptualização e de novas experiências era mais discreta e por vezes até ausente. Os níveis do IGS diminuíram na sessão quatro, momento em que estes dois tipos de MIs surgiram, mas voltaram a aumentar na sessão oito, onde os mesmos MIs estiveram ausentes.

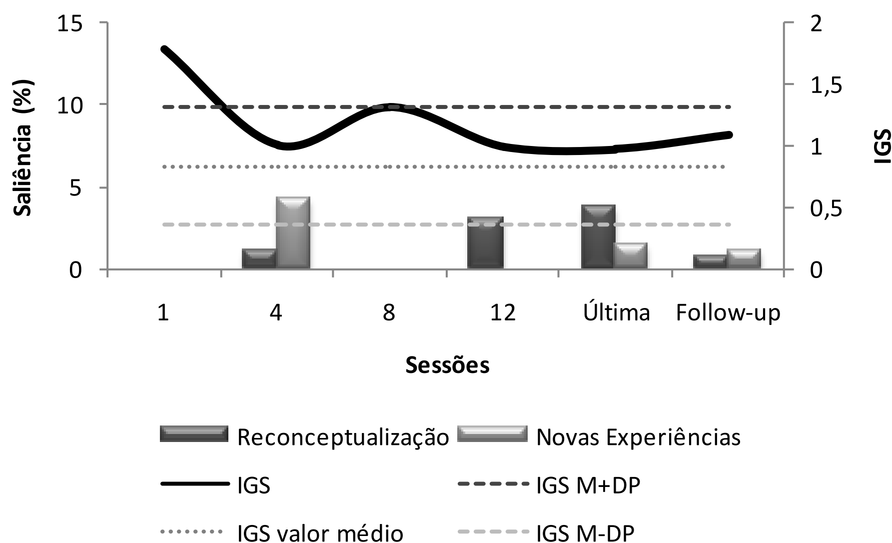

Figura I - 3. Saliência dos MIs de reconceptualização e de novas experiências e dos valores do IGS no grupo com insucesso terapêutico, relativamente às sessões de avaliação dos resultados terapêuticos.

5. Discussão

Os resultados sugerem que os MIs são importantes na mudança psicoterapêutica.

Os grupos com sucesso e insucesso apresentam, globalmente, uma diferença significativa na saliência de MIs, estando esta dimensão relacionada com uma maior elaboração narrativa dos mesmos no grupo com sucesso. Este argumento também suporta a ideia de que um importante ingrediente na mudança é a elaboração narrativa da novidade e não a novidade por si só, como referem alguns terapeutas (ver, por exemplo, Freedman & Combs, 1996, 2002, White & Epston, 1990). Assim, o cliente pode relatar um MI, mas é devido às questões que o terapeuta coloca e aos detalhes que o cliente refere que um dado MI é elaborado narrativamente, aumentando a sua saliência.

Os MIs de reconceptualização e de novas experiências apresentam diferenças evidentes nos dois grupos. De facto, esses dois tipos praticamente não emergem nos casos com insucesso, sendo a sua saliência reduzida (ver figura I - 3). Os resultados também sugerem que as diferenças na saliência global dos MIs entre os grupos derivam

essencialmente das diferenças verificadas ao nível dos MIs de reconceptualização e novas experiências.

Os resultados sugerem ainda uma evolução distinta dos MIs ao longo da terapia, atendendo às diferenças entre casos com sucesso e insucesso nas fases iniciais e finais do processo terapêutico. A evolução dos MIs de reconceptualização e novas experiências é claramente distinta: na maioria dos casos com sucesso, esses dois tipos emergem na fase intermédia da terapia e desenvolvem-se ao longo da fase final; por contraste, estão praticamente ausentes ao longo de todo o processo nos casos com insucesso.

Apresentamos de seguida uma proposta preliminar de interpretação dos dados, que estamos presentemente a procurar verificar se se replica noutros estudos e com diversas metodologias.

5.1. A relevância dos MIs de reconceptualização e de novas experiências

Contrariamente ao que é proposto pelo modelo narrativo, a elaboração dos MIs não parece ser suficiente para a mudança ocorrer, tendo em conta os resultados acima descritos. Assim, dois tipos específicos de MIs são necessários para a mudança terapêutica ter lugar. Sugerimos anteriormente (M. Gonçalves et al., no prelo) que os MIs de reconceptualização permitem que o cliente seja não só o *actor* da sua auto-narrativa, mas também e mais importante o seu *autor* (de acordo com a distinção proposta por Sarbin, 1986). Deste modo, a reconceptualização envolve um processo reflexivo acerca do próprio processo de mudança, uma vez que a pessoa consegue aceder ao mesmo. Como se pode constatar pela própria definição, estes MIs são os mais complexos, dado o envolvimento de uma metaposição sobre a mudança, que permite uma descentralização do cliente e a capacidade de este observar o que se está a tornar diferente do "guião" anterior e os novos caminhos que pode percorrer na narrativa em construção. Estes MIs são proactivos e criativos, denotando uma preferência clara do cliente por esta nova história. Na nossa perspectiva, estes ingredientes são fundamentais para o desenvolvimento de uma posição de autoria sobre a mudança.

A emergência dos outros tipos de MIs é também importante, enquanto marcadores de que algo novo está em desenvolvimento (e.g., novas acções, novos pensamentos, novas experiências), mas é a reconceptualização que permite a expansão

de novidades mais ou menos elementares (i.e. episódicas) no sentido do desenvolvimento de novas e consolidadas auto-narrativas. Esta é uma hipótese que necessita de ser amplamente estudada em futuras investigações, mas que pode explicar a ausência de diferenças nos MIs de acção, reflexão e protesto, entre os dois grupos. Em ambos os grupos estes MIs parecem representar que algo novo está a ser desenvolvido, mas a reconceptualização apenas ocorre com saliência relevante no grupo com sucesso, facilitando a transformação e integração dos MIs anteriores numa nova narrativa. A reconceptualização parece assim actuar como um campo gravitacional que liga os outros MIs (acção, reflexão e protesto), conferindo-lhes uma estrutura e significado narrativo, devido à metaposição que permite "olhar" para o processo de mudança e ligar a história "anterior" e a "nova". Sem estas dimensões, dificilmente qualquer MI se pode transformar numa nova história, dada a ausência de coerência e complexidade narrativa. Acções, reflexões ou protestos face uma vida dominada pelo problema podem ser facilmente esquecidos, levando a que a novidade se desvaneça.

Outros investigadores têm vindo a estudar aquilo que nós designamos por reconceptualização a partir de outras perspectivas. Por exemplo, Angus, Lewin, Bouffard e Rotondi-Trevisan (2004), a propósito do processamento narrativo, sugerem que «a descentralização reflexiva e o posterior reenvolvimento com situações de vida difíceis … facilita a articulação de novas compreensões acerca do *self* em relação aos outros» (p. 90). A maior diferença entre o modo reflexivo e a reconceptualização é que no anterior todas as posições reflexivas do cliente são cotadas, enquanto no último apenas se codificam momentos de novidade (ou seja, MIs).

Tendo em conta o modelo de assimilação de Stiles (2006) e a sua perspectiva desenvolvimental acerca do processo terapêutico, os MIs de reconceptualização parecem relacionar-se com o estádio de *insight*/compreensão na sequência de assimilação das experiências problemáticas (APES - Assimilation of Problematic Experiences Sequence; Stiles, 2006). Esta fase em particular tem sido associada com resultados terapêuticos positivos e com a melhoria da sintomatologia (Detert, Llewelyn, Hardy, Barkham, & Stiles, 2006; Stiles, 2006). A emergência dos MIs de reconceptualização e a sua elaboração ao longo do processo no grupo com sucesso terapêutico parece coincidir com uma diminuição da sintomatologia, medido pelo IGS Assim, sugere-se que a evolução dos MIs de acção, reflexão e protesto reflectem os

estádios de assimilação que precedem o movimento de transição para o *insight*/compreensão da experiência problemática (Brinegar, Salvi, Stiles, & Greenberg, 2006; Detert et al., 2006). Esta fase do processo terapêutico implica que a voz problemática é assimilada na comunidade de vozes dominante pela construção de "pontes de significado". Estas definem-se pela forma como ligam as vozes através da mútua compreensão, envolvendo-se em acções conjuntas e constituindo-se como futuros recursos para o cliente (Brinegar et al., 2006). Deste modo, a emergência dos MIs de reconceptualização parece favorecer o desenvolvimento de uma "ponte de significado" entre as posições anteriores (e.g. vítima) e (re)emergentes (e.g. profissional, companheira) das clientes, promovendo a compreensão do problema e do processo envolvido na sua superação.

De uma perspectiva diferente, Hermans (2003) sugere que um processo dialógico importante ocorre na terapia bem sucedida: a emergência de uma metaposição, uma posição a partir da qual as outras auto-posições podem ser observadas e avaliadas (ver também Dimaggio, Salvatore, Azzara, & Catania, 2003; Leiman & Stiles, 2001). De facto, para codificar um MI de reconceptualização, tal como se referiu anteriormente, duas posições precisam de estar presentes: o *self* anterior e o *self* emergente, o que significa que uma metaposição é necessária.

A coerência e a estrutura que o MI de reconceptualização permite estão certamente relacionadas com a emergência de novas experiências. Note-se que as novas experiências estão quase ausentes nos casos de insucesso. Os MIs de novas experiências representam a expansão das narrativas emergentes para o futuro. A pessoa necessita de ser capaz de se imaginar em posições futuras para que o movimento para o futuro ocorra (ver, por exemplo, Markus & Nurius, 1986). Como Valsiner (2004) propõe, «a pessoa está constantemente a criar significado antecipado em relação à altura em que este pode ser necessário» (p. 14).

Do nosso ponto de vista, para que a história seja expandida para o futuro, uma metaposição como a que a reconceptualização permite é necessária. A partir dela torna-se possível imaginar um futuro com outras possibilidades fora da narrativa problemática.

Os dados sugerem que a mudança ocorre através de um processo cíclico, de forma congruente com a investigação anterior (Matos, 2006; M. Gonçalves et al., no

prelo). Em suma, o processo de mudança parece ter início com os MIs de acção, reflexão e protesto, como sinais para o próprio e para os outros de que algo diferente está a acontecer. Os MIs de reconceptualização ocupam a fase seguinte do ciclo, permitindo a criação de uma metaposição, que permite que a pessoa se distancie e se veja a si própria a mudar, assim como as diferenças entre auto-narrativa "anterior" e "emergente". Diversos movimentos desde acção, reflexão e protesto através da reconceptualização, e de novo de volta à acção, reflexão e protesto (isto é, sinais de que a mudança está realmente a acontecer) podem ser necessários para validar a mudança, antes de a pessoa ser capaz de se projectar no futuro com uma nova narrativa. Cada ciclo pode ser amplificado pela validação de outros significativos, o que pode promover novos ciclos de exploração de novidade (ver figura I - 4).

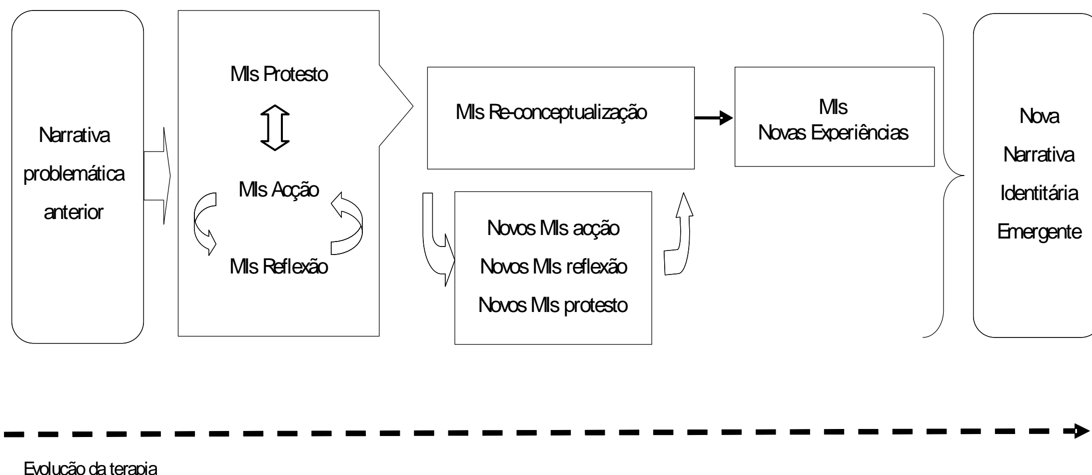

Figura I - 4. Modelo da mudança terapêutica (adaptado de M. Gonçalves et al., no prelo).

Evidentemente, outras linhas de desenvolvimento são plausíveis, sendo particularmente necessário investigar diferentes possibilidades de mudança. Por exemplo, entendemos que é possível um processo de mudança ser iniciado pelo protesto, desenvolvendo posteriormente MIs de acção e reflexão e, a partir daí, reconceptualização e novas experiências. Ou, pode também começar por se vislumbrar uma nova narrativa (MI de reconceptualização) e daí desenvolver os MIs de acção e

reflexão, embora até ao momento não tenhamos nas nossas investigações casos em que isto aconteça.

Independentemente do "ponto de partida", a nossa proposta é que uma *gestalt* de MIs é necessária para o desenvolvimento de uma história significativa, a qual se desenvolve através de num processo cíclico, semelhante ao descrito na figura I - 4, apesar de esse caminho não ser, provavelmente, o único possível.

6. LIMITAÇÕES

No que se refere à amostra, uma das limitações deste estudo prende-se com a diferença marginalmente significativa entre os grupos contrastantes relativamente ao nível educacional e ainda as cotações da aliança terapêutica por um dos observadores. Assim, as diferenças entre os grupos podem ser parcialmente explicadas por estas discrepâncias em detrimento das diferenças encontradas nos MIs. Por outro lado, dado o tamanho reduzido da amostra e o foco nas vítimas de violência na intimidade, as conclusões são necessariamente limitadas e a possibilidade de generalização a outros processos de mudança é restrita.

Também é importante referir que, apesar da conclusão de que os MIs promovem a mudança terapêutica, outras condições podem ter interferido com o desenvolvimento da terapia (e.g., hesitação perante a mudança, falta de validação social dos MIs, papel das audiências). Além disso, embora tenha sido realizada uma sessão de *follow-up*, teria sido importante avaliar os casos novamente (e.g., um ano após o término da terapia) para corroborar os resultados terapêuticos.

O facto de os processos terem sido acompanhados sempre pela mesma terapeuta é outra importante limitação, embora tenham sido tomadas todas as precauções para evitar enviesamentos no processo de codificação (e.g., codificação sem conhecimento dos resultados terapêuticos, codificação após o término das sessões).

7. IMPLICAÇÕES

Este estudo exploratório é pioneiro na análise da mudança terapêutica através de uma nova metodologia – o Sistema de Codificação dos Momentos de Inovação. Este método permite-nos identificar, de forma consistente, detalhes narrativos que são

excepção à narrativa dominante e apontar as diferenças entre os grupos com sucesso e com insucesso terapêutico.

Neste momento, estamos a desenvolver outros estudos empíricos, que replicam esta metodologia com modelos terapêuticos diversos (e.g., cognitivo, experiencial) e diferentes populações (e.g., pacientes com depressão). Assim, é nosso intuito comparar diferentes estudos ao nível do processo terapêutico, para testar se os padrões já encontrados se repetem e, eventualmente, identificar outros padrões de construção da mudança em psicoterapia.

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CHAPTER II

INNOVATIVE MOMENTS AND CHANGE PATHWAYS: A GOOD OUTCOME CASE OF NARRATIVE THERAPY

CHAPTER II
INNOVATIVE MOMENTS AND CHANGE PATHWAYS: A GOOD OUTCOME CASE OF NARRATIVE THERAPY[3]

1. ABSTRACT

Our aim is to explore the development of *Innovative Moments* (i-moments) in therapeutic conversation and to study how they match our tentative model that accounts for the development of change (M. Gonçalves, Matos, & Santos, in press), drawn from a previous empirical research (M. Gonçalves, Santos, Matos, Mendes, & Martins, 2008; Matos, Santos, M. Gonçalves, & Martins, in press). In this therapeutic process research we analyze a good outcome case of narrative therapy with a woman victim of partner violence.This case, composed of twelve sessions, was analyzed with the *Innovative Moments Coding System: version1* (IMCS; *Sistema de Codificação dos Momentos de Inovação: versão 1*, M. Gonçalves, Matos, & Santos, 2006). Five types of i-moments were coded - action, reflection, protest, re-conceptualization and new experiences - and an index of salience (percentage of time spend narrating i-moments in the session) was computed. Our analysis procedures provided a quantitative and also a complementary qualitative approach. Data showed that i-moments types emerge differently throughout the process. So, first sessions were characterized mainly by action and reflection i-moments (low salience), middle sessions were found to have mainly protest i-moments (low or middle salience), and final sessions were characterized by the combination of high salient re-conceptualization and new experiences i-moments. Our findings suggest that narrative change seems to develop in a cyclical way, as the model for therapeutic change predicted.

2. INNOVATIVE MOMENTS AND THERAPEUTIC CHANGE

Narrative therapy, namely the re-authoring model proposed by White and Epston (1990), conceives change as the construction of new and preferred life narratives. The change process is, therefore, allowed by the identification and elaboration of narrative novelties, or *unique outcomes*, that is, narrative episodes outside the influence of the

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main self-narrative plot. These can be actions, thoughts, feelings, projects, or any details that are novelties, bringing a new opening to the redundancy that the narrative plot often encapsulates (White & Epston, 1990). These are usually trivialized or ignored, which results in their deflection and the maintaining of the problematic narrative. Based on the assumption that new narratives are the outcome of the elaboration of narrative novelties or exceptions, the *Innovative Moments Coding System: version1* (IMCS; *Sistema de Codificação dos Momentos de Inovação: versão 1*, M. Gonçalves, Matos, & Santos, 2006) is a method elaborated to analyze change in psychotherapy. We prefer the concept of *Innovative Moment* instead of unique outcome, for a question of terminological clarity. As we suggested before (M. Gonçalves, Matos, & Santos, in press) unique outcomes are not, from our perspective, *outcomes* but processes; and as De Shazer (1991) has also pointed out, they are hardly *unique*. Of course, White and Epston (1990) do not suggest that they are unique, but for an unfamiliar reader this term can be misleading. Our coding system is thus inspired by the notion of unique outcome as it was proposed by White and Epston (1990, see also White, 2007), but we prefer the term i-moment.

I-moments can occur in five different types: (1) action, (2) reflection, (3) protest, (4) re-conceptualization and (5) new experiences.

(1) Action i-moments refer to specific actions that are not predicted by the problem-saturated story. The following example illustrates an episode of violence, in which the client performed some actions trying to prevent her husband from continuing the escalation of violence and she also sought for help after the incident (i-moments are bold).

> **Client:** *So, in August he started talking about my single life, in front of our two-year-old child!* ***I kept not answering him.*** *And my daughter was there… I was putting some clothes in the closet and he was slapping and pushing me, kicking me and some other things I don't remember. "Why did you do that? You have to explain that to me!"* ***I kept not answering him. I just told him "take her (the child) away from here. Take her somewhere else". But I kept not answering.*** *Meanwhile I went to the kitchen and he assaulted me*

> *and slapped me in the face. I got a huge bruise in my eye. Then… maybe he saw what he had done…*
>
> **Therapist:** *Did he apologize?*
>
> **Client:** *No, he never apologizes. But he finally took the child and went out.* ***I also went out… I didn't know what to do… I went to a gas station store and bought a camera and went to health center to see a doctor. The doctor recorded what had happened and took a picture of me. Then we talked about it.*** [Action i-moment]

(2) Reflection i-moments are all the moments in which the person thinks differently than what one could expect from the problematic story, or when he/she understands something new, that contradicts the problematic story. Below is an example of a reflection i-moment. The client explains to the therapist that the feeling of guilt is vanishing. This feeling resulted from pressing charges against her husband. She also states a wish "*to move forward*".

> **Therapist:** *Do you think there was a reason for the guilt that was dominating you?*
>
> **Client:** ***I think not. I've been thinking about it… I think that the guilt is vanishing… now I feel sorrow, not for him, but for myself. But now, what is done, is done. I can't go back and I have to try to move forward!*** [Reflection i-moment]

(3) Protest i-moments can be an action (like action i-moments) or a thought (like reflection i-moments), but they are more than mere actions or thoughts, reflecting a protest against the problematic narrative and its detrimental effects. They allow the person to protest against the problem, separating the problem from him/her. In this sense, they not only imply resistance but also a re-assessment of the client's position in relation to the problem. In the following example, a woman tells the therapist that she is able to say *"no"* to other person's demands.

Last session

Therapist: *Does it happen only with your husband, or with other people?*

Client: With other people too. It happens with my mother-in-law. If I have to say I won't do it, I'm not going, if she asks something that I don't want to do, I don't do it. I feel that I don't fear her or my husband anymore. I'm capable of saying "I'm not doing it and I'm not going". [Protest i-moment]

(4) Re-conceptualization i-moments are more complex than the previous ones. These i-moments involve two components: the contrast between the past self (problematic narrative) and the present self, and the description of the processes that allowed the self's transformation from the past to the present. This implies a meta-level, from which the person can see the difference between the old plot and the (anticipated) new one, and is able to construct the development of the new story. To code these i-moments we need two distinct elements: a contrast between a past self and a present self and some elaboration about the process of transformation from one to the other.

Client: ***Yes, it is. For instance, regarding everyday attitudes, or relationships… sometimes I look back and I think, I see what I do know and think "it's funny; two years ago I couldn't do that". It seems that I had my brain switched off, and didn't know how to react. I have been in occasional situations that… like misunderstandings… that if it was some time ago I just stood quiet and still, and wouldn't say a word. Now, I stand up and speak; I don't let anyone go over me, which I actually did.*** [Re-conceptualization i-moment]

(5) New experiences are i-moments that reveal new projects, activities or experiences, which were impossible before, given the constraints of the problem-saturated narrative. These i-moments represent the expansion of the new story into the future. In fact, as Valsiner (2004) suggests "The person is constantly creating meaning ahead of the time when it might be needed – orienting oneself towards one or another

side of anticipated experience, and thus preparing oneself for it." (p. 14). In the following example, the client describes how she may apply the new skills learned to new experiences and situations.

> **Therapist:** *What new things have you been doing?*
> **Client:** ***I started to wear colors in my clothes that I didn´t use. I started to care about what I like, and not what others may think about it. I've been investing in myself! Not only clothes, but in my space also. I'm making some changes in my house to make it more comfortable for me and my daughter. Now our home is warm and cozy, something that it wasn't a few months ago.*** [New experience i-moment]

In our previous empirical research with a narrative therapy sample (M. Gonçalves, Santos, Matos, Mendes, & Martins, 2008; Matos, Santos, M. Gonçalves & Martins, in press) we analyzed two contrasting groups – one poor and one good outcome group – with the IMCS. Results suggested that all i-moments emerged in both groups. However the good outcome group had a higher proportion of salience (i.e. time in therapy that clients and therapists spent elaborating i-moments). Moreover, the types of i-moments that emerged during the therapeutic process were also different. Two specific i-moments – re-conceptualization and new experiences – had a significant salience in the good outcome group and were poorly represented, or almost absent, in poor outcome cases. These poor outcome cases were characterized by the emergence of mainly action, reflection and protest i-moments. These i-moments were also present in good outcome cases, being related to initial phases of therapy. In contrast, re-conceptualization and new experiences appear at the middle stages and have an increasing salience as therapy evolves to the final sessions. We believe that the re-conceptualization i-moment had an important role in the change process since it seemed to involve a meta-position over change, enabling the client to see what is becoming different from the old plot and what new paths may occur in the new narrative. In these therapeutic processes, i-moments of action, reflection and protest continued to occur, as they were signs that something new was underway (e.g., new actions, new thoughts).

Re-conceptualization seemed to act like a gravity field that connected other i-moments (action, reflection, protest) providing them with meaning and organizing them into a new gestalt, and somehow assimilating the old plot into the new story. From this position, it had also become possible to expand the new narrative into the future, as new experience i-moments emerged. We believe that without this coherence provided by the re-conceptualization i-moments it would be difficult for any i-moments to be elaborated and to sustain an enduring change, as we can observe in poor outcome cases.

In our theoretical model, the construction of a new self narrative in narrative therapy (M. Gonçalves et al., in press), starts with the identification that something new is under development with action and reflection i-moments. Then, protest i-moments emerge and trigger the process of differentiating the old narrative (dominated by the problem) and the new one (by asserting new self positions). The next movement in this process is the narration of re-conceptualization. As the client steps back and sees him/herself changing, he/she achieves a meta-position over the change process. The emerging re-conceptualization i-moments enable the client to examine and evaluate if this change is a preferred one. It also enables the flow of other i-moments (action, protest and reflection) to be organized and meaningful connections to be made between them in order to achieve a new understanding of the change process. Several cycles of action, reflection and protest through re-conceptualization might be needed to validate change. The person is then able to project him/herself into the future with a secure narrative, giving rise to new experience i-moments (see figure II - 1). Each cycle could be amplified by the validation of the significant others, which could trigger new cycles of novelty exploration.

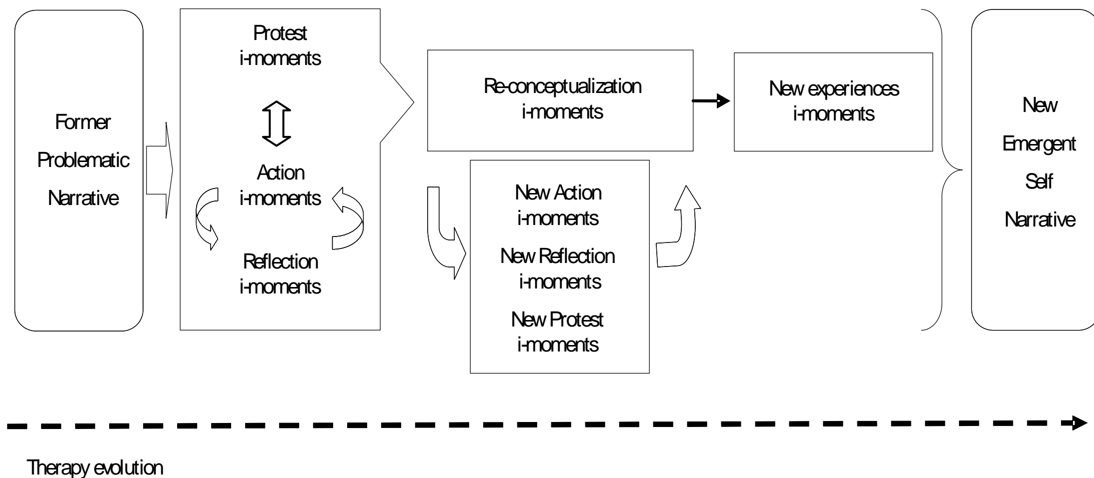

Figure II - 1. Model for therapeutic change (adapted from M. Gonçalves et al., in press).

The assimilation model (Stiles, 2006), which accounts for psychotherapeutic change, provides us with a developmental framework of psychotherapeutic change process that might help to make our model clearer. Clients achieve a good therapeutic outcome when they assimilate traces of their problematic experiences. So, assimilation is a process of change through a sequence of stages, the Assimilation of Problematic Experiences Sequence (APES, Stiles, 2006). As the therapeutic process evolves towards success, the client progresses to higher stages of APES and the problematic voice becomes assimilated into the community of voices. At first, the problematic experience could be *warded off-dissociated* (stage 0) associated with negative symptoms; then the nondominant voice emerges in the form of *unwanted thoughts - active avoidance* (stage 1); as clients acknowledge their problematic experience they enter stage 2, as *vague awareness - emergence*; the *problem statement-clarification* (stage 3) means that clients are able to clearly state the problem; stage 4 is a very important one, because it entails a new understanding of the problematic voice *(understanding - insight)*; then, the stage of *application - working through* (5) enables clients to work on a problem; finally, consolidation and integration are achieved in stages 6 and 7 *(resourcefulness - problem solution* and *integration - mastery)*, when clients are able to use problematic experience as a resource in new situations. From this perspective, re-conceptualization i-moments seem to converge with the concept of understanding/insight of APES, which has

similarly been differentially associated with favorable outcomes on standard assessment instruments (Detert et al., 2006; Stiles, 2006).

We have previously discussed findings regarding good and poor outcome groups' i-moments profiles (Matos et al., in press; M. Gonçalves et al., 2008). In this study we intend to explore in depth the development of i-moments in a good outcome case of narrative therapy. We will describe the emergence and evolution of i-moments, emphasizing how our observations do (or do not) match the tentative change model proposed elsewhere (M. Gonçalves et al., in press). Specifically, we intend to track development of i-moments across therapy sessions, grounding this pathway with examples to further illustrate the change processes.

3. METHOD

3.1. Client

Susan was a client originally included in a broader sample of victims of intimate violence collected in a previous research work (Matos et al., in press; M. Gonçalves at al., 2008). She attended individual narrative therapy (White & Epston, 1990) in a Portuguese university counseling service. She signed a written consent after being informed of the research objectives. Treatment was provided with no charge.

Susan was thirty two years old at the beginning of therapy. She was a nurse, married four years earlier and with a three-year-old daughter. Her request for psychotherapy was related to her relationship with John, her husband. During the last two years, he had recurrently subjected her to physical, sexual and psychological violence. As a result of those occurrences, she had to seek medical aid several times. At the beginning of the therapeutic process she talked about fear as her main problem (e.g., fear of the partner, fear to disclose and fear to interact with others). Partner abuse produced mainly anxiety problems (e.g., apprehension, alarm state, distress, confusion, lack of control, memory and social avoidance, sleep disturbances), associated with some depressive symptoms (e.g., sadness, hopelessness, lack of interest, work disinvestment, lack of autonomy). When she came to therapy she reported that "fear" was disturbing

her mostly, being the problem that was the target of externalization in therapy (see White, 2007).

This case evolved through eleven sessions (weekly in the first four sessions and twice a month in the others) plus one follow-up session (after six months). Table II - 1 presents Susan's results on clinical measures, collected in the first, fourth, eight, last and follow-up sessions. The measures involved were: the Brief Symptom Inventory (BSI; Derogatis, 1982; Portuguese version adapted by Canavarro, 1999), namely the Global Severity Index (GSI); a regular clinical monitoring concerning the abusive actions received (physical, psychological and/or sexual), their frequency and severity; the Working Alliance Inventory (WAI; Horvath, 1982; Portuguese version adapted by Machado and Horvath, 1999); and the Scale of Beliefs about Partner Violence (Escala de Crenças sobre Violência Conjugal - ECVC; Matos, Machado & M. Gonçalves, 2000).

Table II - 1. Outcome measures in Susan's case.

	Sessions				
	1	4	8	Last	Follow-up
GSI	1.48	1.07	0.28	0.01	0.05
Victimization received	Physical and psychological			Absent	
WAI	-	6.94	6.94	7	7
ECVC	27	-	-	25	26

After evaluating therapeutic outcomes, Susan's case was included in the good outcome group as it verified the following two criteria: i) she evolved along therapeutic process towards no symptomatic condition assessed by GSI at the end of the therapy (GSI score dropped from 1.48 to 0.05) and ii) the victimization ceased. Regarding the severity of the abuse, after session four there was no longer physical abuse, and after session eight psychological abuse ceased. Therapeutic alliance indexes presented high

values throughout the process. Susan also showed at all times low tolerance regarding violence.

This case was selected from a group of five good outcome cases as it was the therapeutic process that showed the lowest value for GSI in the last and follow-up sessions. At the same time, this case presented the highest values for i-moments salience. We consider that this successful case analysis can provide a clear understanding of the development of i-moments across successful cases.

3.2. Therapist and therapy

The therapist who treated Susan had a masters degree in Psychology when the research was carried on, and five years of experience in psychotherapy with battered women.

The therapeutic model was developed from the narrative model of White and Epston (1990, see also White, 2007) and involved the (i) externalization of problems (a narrative practice of deconstruction that invites the client to see the problem as an external "entity"), other than the abuse (e.g., fear, sadness, personal characteristics that support the abuse), (ii) identification of the cultural and social assumptions that support women's abuse (e.g., patriarchal power, critical view toward women that leave their partners), (iii) identification of unique outcomes (or, as we prefer, i-moments), (iv) therapeutic questioning around these unique outcomes, trying to create a new plot, alternative to the one that was externalized, (v) consolidation of the changes through social validation (e.g., rituals of change, writings letters to women in similar situations), trying to make the way change happened more visible. Therapist adherence to the narrative model was supervised.

3.3. Process measures

The IMCS was used to analyze the psychotherapeutic case. As mentioned earlier, IMs can be of five different types: (1) Action i-moments, (2) Reflection i-moments, (3) Protest i-moments, (4) Re-conceptualization i-moments and (5) New experiences i-moments.

Table II - 2. Types of i-moments and examples. From the Innovative Moments Coding System: version1 (IMCS; Sistema de Codificação dos Momentos de Inovação: versão 1, M. Gonçalves et al., 2006)

Types of i-moments	Examples
Action i-moments: Specific actions or behaviours that defy the problem.	▪ New coping behaviours facing obstacles; ▪ Effective resolution of unsolved problems; ▪ Active exploration of solutions; ▪ Restoring autonomy; ▪ Searching for information about the problem.
Reflection i-moments: Thinking processes that indicate the understanding of something new that makes the problem illegitimate (e.g., thoughts, intentions, interrogations, doubts)	▪ New problem formulations and/or re-formulation of its effects; ▪ Reconsidering problems causes (e.g., severity, intensity, intentionality, aetiology); ▪ Consideration of life dilemmas; ▪ Considering cognitive and affective dilemmas; ▪ Reflecting about cultural, social and religious demands; ▪ References of self worth (e.g., strength to fight, positive thinking, positive feelings, well-being references…); ▪ Self instructions (e.g., "you have to fight"); ▪ Reflecting about the intention to fight problems demands (e.g., shame).
Protest i-moments: Resistance, defiance or protest that can be planned or concretized behaviours, thoughts, or/and feelings.	▪ Defiance position toward the problem and problems allies; ▪ Assertive attitudes towards others; ▪ Public repositioning towards culturally dominant values.
Re-conceptualization i-moments: Process description, at a meta-cognitive level (the client not only manifests thoughts and behaviours out of the problem dominated story, but also understands the processes that are involved in it)	▪ References to new/emergent identity versions; ▪ Re-evaluation of relationships; ▪ Re-evaluation of experiences within problem development frame (e.g. aetiology, interference, costs…).
New experiences i-moments: References to new projects, activities or investments planned or underway, as a consequence of change.	▪ Generalization into the future and other life dimensions of therapeutic gains; ▪ Problematic experience as a resource to new situations; ▪ Investment in new projects and personal image in private and public spaces; ▪ Investment in new relationships.

3.4. Procedures

Coding of i-moments was conducted by viewing each session in video and recording the type and the time duration of each i-moment as it appeared in the session. Duration was assessed by recording the beginning and the end of each i-moment, to the nearest second. For each session, we computed an index of salience (the percentage of time in the session devoted to that i-moment) for each of the five i-moments. We also computed an index of salience of i-moments for each session, as the sum of the saliencies' of the five i-moments in every session. The sessions were coded in a sequential order (session one, two ... and so forth).

3.5. Reliability

Session recordings were coded by two trained judges. Judge A was the author of this study and judge B was a team composed of the therapist and another judge, a Ph.D. student. Judge A, who was unaware of the outcomes, coded all the sessions, while judge B coded only the sessions in which the outcome assessment instruments were applied (sessions one, four, eight, last and follow-up). Reliability indexes were computed on these sessions (30% of the sessions).

After judges got acquainted with the case through session's visualization, the first coding procedure was to discuss and consensually define their understanding of the client's main problem (the "rule" or the problematic narrative) in order to code the i-moments (the exceptions to the "rule"). In this particular case, the clinical practice of problem's externalization (see White & Epston, 2000; White, 2007) allowed Susan to define, in early sessions, "fear" as the problem, since it had been the most severe effect of abuse. Then, judges proceeded to an independent coding, after the entire sample was collected.

Overall salience was calculated as the proportion of the total time in sessions that was devoted to any i-moment on which both judges agreed. Interjudge agreement on overall salience was calculated as the time identified by both judges divided by the time identified by either judge (or, equivalently, twice the time spent on agreed IMs divided by the sum of i-moment times independently identified by the two judges). The percentage of agreement on overall i-moments salience was of 84%.

Reliability of distinguishing i-moment categories, assessed by Cohen's kappa, was of .87. Because of the high interjudge reliability, we based our analyses on judge's A coding.

3.6. Procedures of analysis

A quantitative and a qualitative analysis of the evolution of the i-moments types throughout the course of Susan's psychotherapy were performed. As far as the quantitative analysis is concerned, the following analyses were made:

i) A visual inspection of the trends of all the five i-moments types was performed;

ii) Then, sessions were divided into three blocks (from session one to four, from session five to eight, from session nine to twelve), and the average levels of salience of the five i-moments in the blocks was compared.

iii) A Binary Correspondence Analysis (BCA) was applied, implemented by the statistical package SPAD (Systeme Portable d'Analyse des Données: version 4.4). BCA is a multidimensional procedure that makes possible to describe how the modalities of two qualitative variables are combined, by means of the study of the associations (the correspondence) between their profiles of frequencies (Benzecrì, 1995). BCA is based on the chi-square metric and it is used with descriptive aims, rather than confirmatory ones, that is, with the goal of creating a multidimensional map of the data. These characteristics make it suitable for the explorative purposes of our analysis. More particularly, BCA was performed on the bi-dimensional matrix made of sessions (rows) x i-moments types (columns). We also included salience (banded in low: <0.34; middle: 0.35 - 0.71; and high: >0.71) as an illustrative variable. In so doing, we enabled the BCA to depict which associations among i-moments types tend to characterize the various sessions, therefore, to map the evolution of the patterns of i-moments combinations across the course of the psychotherapy. It is worth noticing that the BCA disarticulates the overall variance of the data matrix (in technical terms: *inertia*) in factorial dimensions, each of them representing a specific pattern of associations between the modalities of the two variables. The findings of a BCA can be depicted in a geometrical way, using the main factorial dimensions as the axes of a Cartesian space. In the following discussion we use the first two out of the four factors extracted.

BCA is focused on the row/column profiles of frequencies. Given the limited number of observations, it tends to focus on the main patterns of combinations among the modalities. In order to get a more synthetic map of the combinations among i-moment types, we performed a Cluster Analysis (CA, hierarchical procedure, based on Ward's criterion of aggregation, implemented by SPAD, cf. Lebart, Morineau, & Piron, 1995, p. 175-195). CA is a multidimensional procedure aimed to group the units of analysis (the rows) according to their similarity on a set of continuous variables (the columns). Our analysis has been applied to the 12 x 5 data matrix given by the 12 sessions as rows and the 4 factorial dimensions produced by the previous BCM and the salience as columns. (We used the 4 dimensions because they are synthetic continuous variables efficiently summarizing the way the i-moments' types combine with each other.) In the second step, the CA describes the clusters (carried out in the first step) in terms of the unit of analysis and modalities most significantly associated with each of them (a chi square derived statistic is used for this purpose). Particularly, in this case, the second step produces a description of the clusters in terms of the sessions they consist of, as well as the i-moment types and the level of salience (the latter banded as described in the previous point) they are characterized by (these discrete variables were inserted in the analysis as illustrative ones). Accordingly, each cluster can be interpreted as a specific group of sessions characterized by a pattern of i-moment types' combination, with a certain prevailing level of salience.

The qualitative analysis was performed with the aim of identifying the contents of the therapeutic process corresponding to the patterns depicted by the quantitative measurement, grounded on session's transcripts. By doing so, we intend to make the quantitative analysis clinically meaningful as well as improve our understanding of Susan's case.

4. RESULTS

4.1. Salience of IMs and symptoms

An overview of i-moments salience and GSI index evolution is given in figure II - 2. The findings showed that i-moments salience had an increasing profile as the process evolved. The recurrent elaboration of i-moments seemed to amplify their salience, as is shown in the tenth session onwards. The symptoms index had a falling

profile, being clinically relevant in session one but decreasing to below cutoff point in session four. I-moments salience increased progressively as the symptoms' severity decreased at the end of the therapy. I-moments elaboration throughout the process increased along with salience and in the second half of the process seemed to be negatively related to the symptoms' severity.

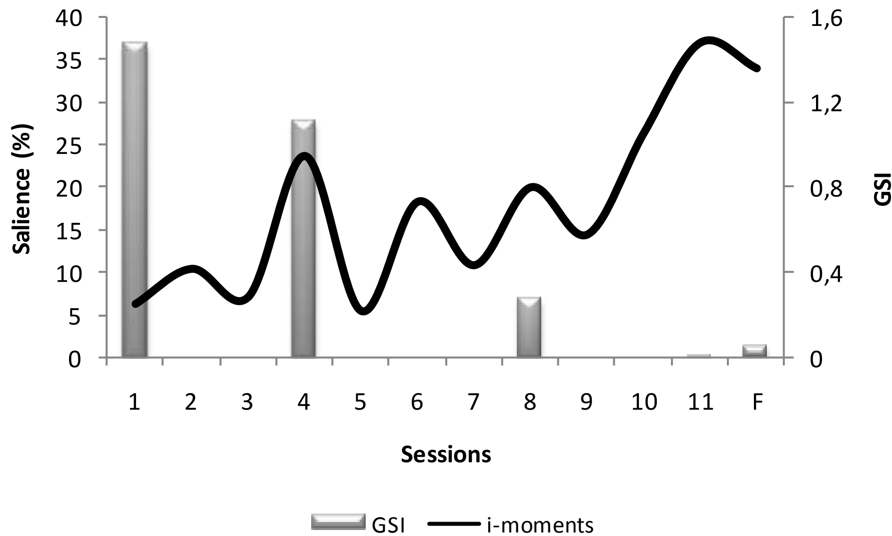

Figure II - 2. Salience (%) of i-moments through therapeutic process and GSI scores.

4.2. Emergence and salience of i-moments types

In what concerns the i-moments categories, all five types emerged during the psychotherapeutic process, although with different saliencies. There was an increase in global salience as the process evolved to the final phase (see table II - 2). However, i-moments salience differed across phases. So, in the initial phase the most salient i-moments were action, protest and reflection. In the middle phase (from session five to eight), re-conceptualization and protest had the highest salience values. Finally, the last sessions showed new experiences and re-conceptualization as the most salient i-moments. The most salient i-moments in this case were re-conceptualization and new experiences (with mean scores of 5.04% and 5.65%). Comparatively, protest, action and reflection had a reduced salience (3.10%, 2.63% and 1.45% scores for mean salience,

respectively). This i-moments profile was congruent with our previous findings, where re-conceptualization and new experiences distinguished good outcome cases due to their higher salience.

Table II - 3. Salience (%) of i-moments in different phases of the therapeutic process.

I-moments' types	Salience in Process Phases		
	Initial (Session1-4)	Middle (Session 5-8)	Final (Session 9-12)
Action	5.78 %	0.84 %	1.26 %
Reflection	2.59 %	0.89 %	0.87 %
Protest	3.03 %	4.31 %	1.97 %
Re-conceptualization	0.44 %	5.79 %	8.89 %
New Experiences	0.06 %	1.84 %	15.05 %
Total	11.89 %	13.67 %	28.04 %

The next graphic (figure II – 3) shows how action, reflection and protest i-moments developed in terms of salience throughout the case. As therapy progressed, action i-moments, which were predominant initially, had a diminished occurrence at the end of therapy. Reflection occurred with the highest salience in the initial phase, decreasing in the middle and final ones. Protest i-moment seemed to increase in salience from the fourth to the eight session (except the fifth session), while decreasing in session nine.

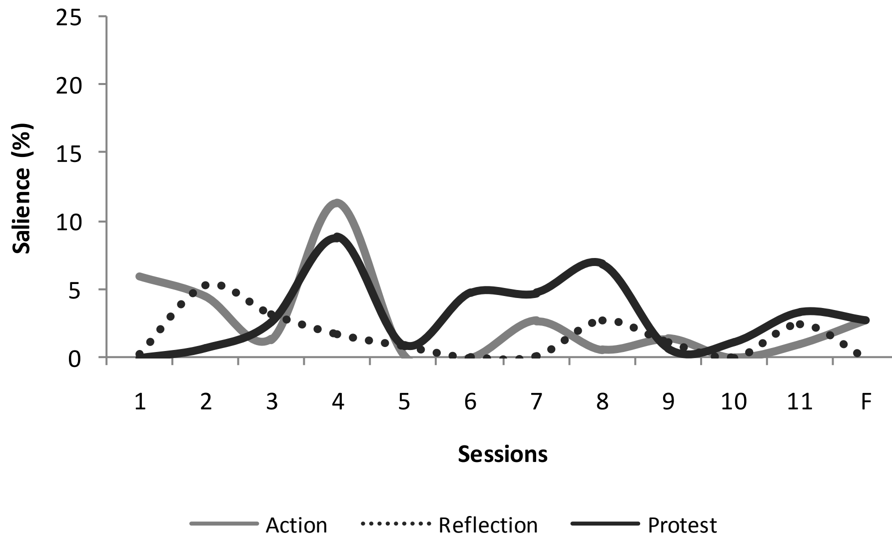

Figure II - 3. Salience mean (%) of action, reflection and protest i-moments through therapeutic process phases.

Figure II - 4 presents new experiences and re-conceptualization i-moments salience, which emerged in middle sessions and showed an increasing profile, becoming predominant in the final sessions, contributing to the high salience levels at this stage. Re-conceptualization was the most salient of these two i-moments until session ten, where new experiences become the i-moment that was narrated for longer periods of time.

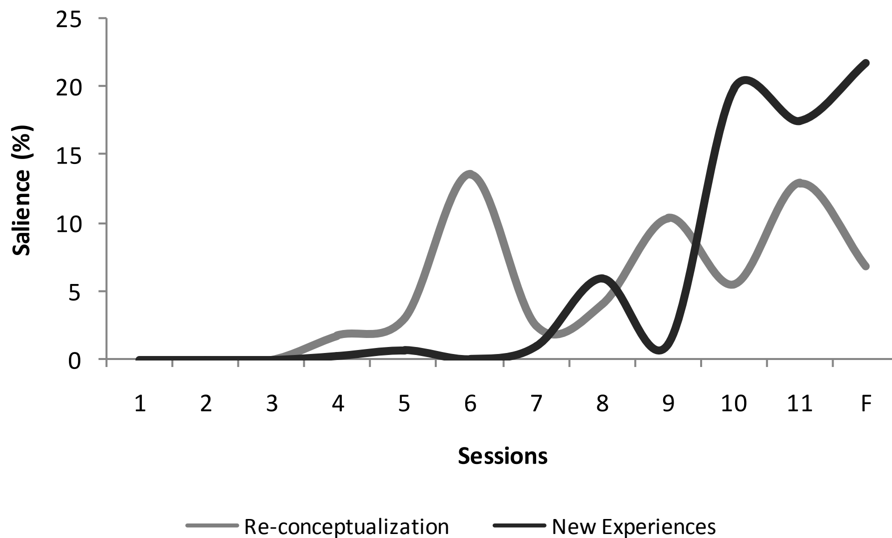

Figure II - 4. Salience mean (%) of reconceptualization and new experience i-moments through therapeutic process phases.

4.3. Combinations of IM types: BCA and CA output

The two main factorial dimensions extracted by the BCA explained 76.74% of the whole inertia (respectively 58.62% and 18.13%). This allowed to focus the analysis on these factorial dimensions using them to map the relation between sessions and i-moment types in terms of a bi-dimensional space (see figure II - 5). In order to interpret this space, one has to take into account that, roughly speaking, as one moves away from the point of origin, the association between the modality and the factorial dimension is higher, and the closer the two modalities are positioned on the space, the more they are associated in the data matrix.

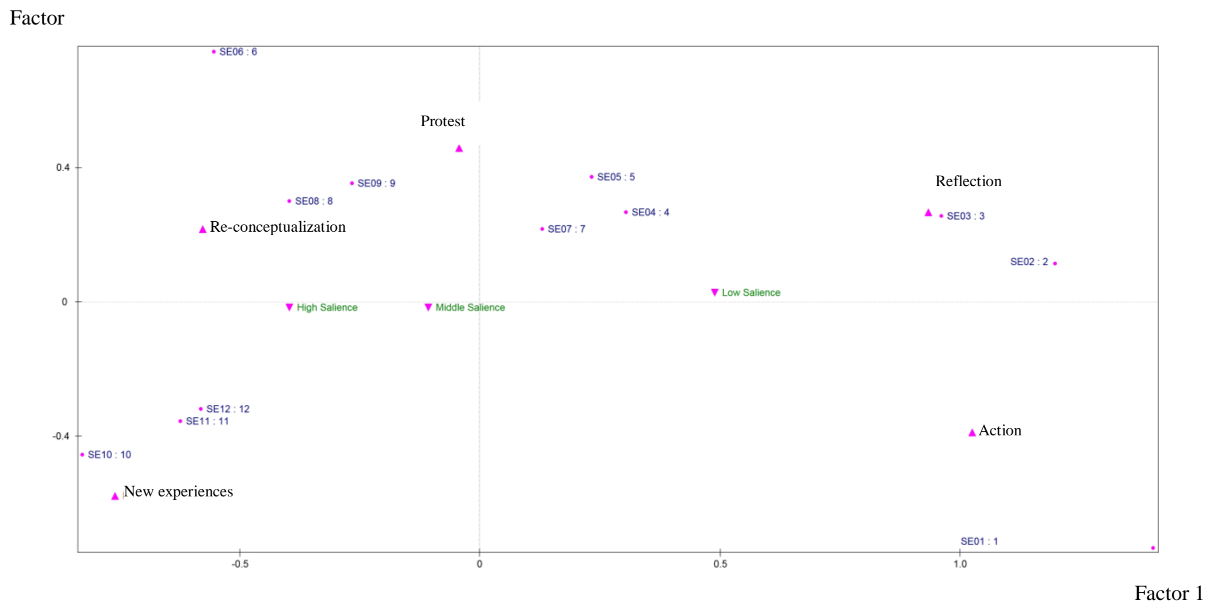

Figure II - 5. Projection of i-moments and session on the bidimensional space defined by the main two factorial dimensions.

Firstly, BCA analysis identified a main factor (explaining more than half the inertia: 58.62%) that showed an opposition between, on the one hand, action and reflection i-moments and, on the other hand, new experiences and re-conceptualization, with protest in a middle position. Secondly, on the first factor opposition was found between the first half of the therapy (right side, sessions one to five and seven) and the second half (left side, sessions six, eight to twelve). Thirdly, one could observe that this factor seemed strongly associated with the salience of the i-moments. Taken together, these results meant that: a) the major trend in the data matrix was defined by the opposition between the i-moments subset having a function of "rupture" (action and reflection i-moments) of the patient's canonical narrative and the i-moments subset with a function of assimilating and developing the novelty (re-conceptualization and new experience i-moments); b) this trend corresponded to the unfolding of the course of the psychotherapy, since the first i-moments subset corresponded to the first half of its course and the second subset to the second half; c) over the course of the psychotherapy, the salience of the i-moments increased, passing from low, to middle, and to high in the final sessions.

On the second factorial dimension an opposition was found that, generally speaking, seemed to reflect a distinction between the i-moments characterized in terms of acting (action and new experiences) and the i-moments characterized by the description of states of mind (protest, reflection and re-conceptualization). Moreover, this opposition corresponds to the opposition between the "marginal" sessions (initial and conclusive ones) and the middle ones.

In sum, taking into account the position of the modalities on the bi-dimensional space as a whole, it was possible to identify a reversed U curve drawn by the sessions and the i-moment modalities. This finding marked a peculiar and systematic evolution of the psychotherapy associated to a change in the relevant i-moments. More particularly, it could be observed that:

i) First sessions (one to three) were strongly characterized by the prevalence of low salience of action and reflection i-moments;

ii) Middle sessions (four, five, seven, eight and nine) were characterized by the prevalence of protest i-moments, with low or middle salience;

iii) Final sessions (six, eight, nine, ten, eleven and twelve) were characterized by the combination of high salience of re-conceptualization and new experiences i-moments.

In accordance with these three patterns, we can draw up a global picture of the dynamic characterizing Susan's psychotherapy process: the client brought a specific problem (abuse) into psychotherapy and she engaged in pragmatic efforts to overcome it (action i-moments); then, as therapy progressed, she developed through a semiotic process that enabled her to elaborate a different representation of the problem (reflection, protest and reconceptualization i-moments); this elaboration produced, in the last stage, new pragmatic consequences, in terms of new plans and strategies for the future (new experiences i-moments).

The CA analysis identified three clusters. The composition of the clusters confirmed the BCA findings, overlapping them to the three patterns mentioned above. Cluster 1 (21.89% of the cases) was associated with sessions three, two and one (with a decreasing order of association), and identified a pattern combining action and reflection i-moments, characterized by low salience. Cluster 2 (44.15% of the cases) was related to sessions eight, seven, five, four, six and nine (with a decreasing order of association) showed that the middle sessions were homogeneously characterized by the prevalence of protest and re-conceptualization with moderate salience. Cluster 3 (33.96% of the cases) was associated with sessions eleven, twelve and ten (with a decreasing order of association,) characterized the ending and follow-up sessions by the prevalence of highly salient new experiences and re-conceptualization i-moments.

4.4. Qualitative analysis

Quantitative analysis pointed out to a combination between action and reflection i-moments in initial therapeutic sessions. At this stage, action was the most salient i-moment. Susan elaborated self-security plans with the therapist and she was engaged in a search for help, either medical, or judicial, or among friends. As Susan had already pressed charges against her husband, it was necessary to ensure her and their daughter's safety. At the same time, she started raising questions about possible solutions for this problematic situation, as we can see in reflection i-moments in initial sessions. The relation between action and reflection i-moments can be seen in the next example.

First session:

Client: ***I usually don't answer*** *(to verbal violence). When I do it he becomes more violent, it doesn't mean that is physically, but it's the same…*

Therapist: And when you answer, how do you do it?

Client: ***Initially I always start answering quietly, asking him to be calm: - let's sit, let's talk.*** [Action i-moment]

Therapist: *You try to have control…*

Client: ***I always try to establish a relation, like "sit here, look at me, calm down", but it's impossible. Completely impossible. And… I remember… I took the kid and left home with him. What was concerning me was that the kid was seeing all of that.*** [Action i-moment]

Therapist: *So, you left home…*

Client: ***I went out with my daughter on a bike and I ended up in a medical centre, I phoned… phoned… some friends*** [Action i-moment] *because* ***I started thinking "I have to get separated, I have to do something"***. [Reflection i-moment]

Susan started narrating protest i-moments in session three, and they turned out to have a relevant salience from session four to eight, becoming a specific pattern in CA analysis. Within this i-moment, discipline issues with her daughter become a kind of protest since the aggressor had been manipulating her. Lack of rules, gifts and innuendo about the mother's character were frequent behaviors on the part of Susan's husband. Protest i-moments involved mainly an active and firm positioning when facing her husband or persons that maintained or supported the presence of the problem, as we can see in the following excerpt.

Third session

Therapist*: I was suggesting that you spend the least time possible with him at this stage… being separated … try to spend the least time possible with him, not be with him in the same space during the day…*

> ***Client**: Last week it was ok. But then he kept saying "give me one more chance". **And there was a time when I said "I gave four years of chances, I don't have any more to give you". "I know you don't believe me, but", "I'm sorry, I don't believe you nor do I trust you, and you had four years to… well, I gave you four years of chances, I don't have any more to give you".*** [Protest i-moment]

As we can see, the theoretical model presented before states that the initial phase would have mostly action, reflection and protest i-moments. Data from Susan's case showed that in early sessions, action and reflection corresponded to new actions and thoughts against fear and the other harmful effects of being a victim. Then, protest i-moments emerged and became the most salient among these three i-moments. It seemed that the protest i-moment, in this particular case, provided more than a mere sign that the client had moments in which she was able to stand outside the dominant narrative. In our view, protest allowed a discursive resource for the client to defy the "victim position", and to take her distance from it. It was also clear that the prior emergence of action i-moments to ensure her safety and the urge to think about violence and solutions (i.e. reflection i-moments) helped to clarify the "victim position" and its effects on her life. These involved, as the previous example illustrates, the refusal to return to the partner and perpetuate the abusive situation. So, action and reflection i-moments seemed linked to a latter emergence of protest, as these results suggested. Susan asserted that she did not believe or trust him anymore (different from before, where Susan in the "victim position" would believe and trust him), and consequently she will no longer be in this relationship (protest i-moment). After session four, in the middle phase, a court sentence established that the abusive partner had to immediately leave the house and could not come near her.

Protest i-moments in the middle of the therapeutic process seemed to mean that Susan was engaged in an active repositioning. As fear was treated as an entity in therapy (externalized), Susan started to be actively engaged in defying it. This allowed her to separate herself from the problem domination, starting a new relation with it. The following illustration shows how she began to stand outside the problematic story

dominated by fear. Susan made a clear distinction between features that characterized her life dominated by fear and her new position of not letting fear to be dominant again.

> *Fifth session*
>
> **Therapist:** *So, you are trying to have control over the fear. But you'd like to have more control over the fear of your husband harming your child and harming you physically. However, fear tries to interfere but it can't...*
>
> **Client:** ***No. I will not let it interfere. It is a question of stubbornness now… it interfered so many times, and for so long, that it's enough now… I have to put a stop to it, don't I?*** [Protest i-moment]

When protest became the most salient i-moment (from session five to eight), re-conceptualization i-moments began to be narrated (after session four). Re-conceptualization seemed to be constructed from the protest i-moment, since, as we said before, protest already created a re-positioning. It was this re-positioning that gave protest i-moments its status of a bridge that the quantitative analysis also suggested. Thus, the re-positioning that emerged in protest i-moments, allowing the client to get out of the victim position, seemed to be a developmental precursor of re-conceptualization. This i-moment fully integrated the previous self's features, competences, experiences and the process between them and the present situation, acknowledging the transformation involved. In the next example she stated how she felt "now" as a result of a process of "*thinking and rethinking the situation".*

> *Eight session*
>
> **Therapist**: *Especially at this stage... it's time to receive, isn't it? Not to search...*
>
> **Client**: ***That's exactly how I feel, I need to receive… I came to the conclusion that… sometimes I've told people that the last months have been very bad, the last months with John, I mean, but lately, with all this thinking and rethinking of the situation, I see that***

they were not. In fact bad were the four years of emotional repression and lack of affection.

Therapist: *It's another interesting perspective…*

Client: ***I really thought mainly about the last months, but now I don't, I've started to realize that it comes from years ago…*** [Re-conceptualization i-moment]

This i-moment seemed to appear in order to reframe violent experience, meaning that she looked to past experiences and saw how they affected her, how she came to new solutions and how she dealt with them at that time. At this stage, the experience of violence began to be integrated in a new manner in the story of the self. After active positioning towards her husband (protest) she saw how specific behaviors were related to the escalation of violence, how her responses helped to maintain the violence, and how manipulative her husband still was, namely with their daughter, and what kind of different reactions she started to have at that time.

It is rather clear at this stage (see figures II - 3 and II - 4) that, as re-conceptualization was being narrated and also amplified, action and reflection became less salient. Protest, however, increased its salience as re-conceptualizations first appeared, and then decreased, due to the integration of former positions, made possible by re-conceptualization.

At the middle stage, though with a higher salience than in earlier sessions, protest was still oriented towards others, namely her ex-husband's family, and their efforts to persuade her to give up the criminal charges. Reflection and action i-moments began to decrease as therapy evolved, but were still present. These i-moments seemed to be current signs congruent with the developing self narrative.

Eight session:

Client: *(talking to the husband's brother)* <u>***I don't have any guilt, because there weren't any provocations, absolutely none. So don't think that I'm going to assume this kind of thing, let him take his responsibility, he never did it until now, let him start doing it now, to see if he grows up!***</u> [Protest i-moment]

Therapist: *If we anticipated a possible meeting, the first thing you'd do is to call the police?*

Client: ***The first thing I'd do is to say "stay away!"*** [Action Protest i-moment]

Therapist: *In those moments, was there any situation in which you would take responsibility for it?*

Client: ***He is completely responsible for his actions; he just has to think about it.*** [Reflection i-moment]

As suggested by the theoretical model previewed and also by the quantitative findings, new experiences emerged after re-conceptualization started being narrated in the final sessions. From session nine to follow-up, new experiences became the most salient i-moment, focusing on investments in new relationships and projects, and generalization of progress made during the psychotherapeutic process. It is important to notice the time spent on elaborating about new relationships of friendship and intimacy. In this specific case, engagement in new relations was a very important achievement. Susan stated that she was able to clarify the relationship boundaries, unlike the abusive one. This learning seemed to be based on the meta-position made possible by re-conceptualization, from which Susan gained a new understanding of the abusive relationship and from where she was able to further plan new relations.

Last session:

Therapist: *It is becoming an intimate relationship…*

Client: ***It is a relationship with all the essential features defined, that is, no commitment - "I don't want to marry you or even think about it" - we are here to spend some time together… with honesty above all…***

Therapist: *Honesty…*

Client: ***Above all I want truth and honesty. "I'm here for whatever you need", this is reciprocal, and I fortunately attested that… is unconditional within our space. There are no accusations… those boring situations. And that's what's happening.***

Therapist: *This is the relationship you've wished for at this moment…*

Client: ***Yes. We are in permanent contact with each other, we laugh, we joke…***

Therapist: *Relationally, this is a position….?*

Client: ***Much more conscious… and far more critical…*** [New experience i-moment]

(...)

Therapist: *...To have space to be ourselves as the protagonists of our lives.*

Client: ***Exactly. I think that is the most important. It has to be us to take charge of our life and not fears or other people or whatever. It must be us. We know what we are, what we like, what we want or we do not want and we have to lead our lives according to that***. [Reflection i-moment]

Therapist: *... It's us that construct our history…*

Client: ***I found that... that it was removed from me for a long time for some time, it disappeared completely. More... at the personal level, I find that there are more things. It has to do with things that I also liked to do, or to write or to play... there are things that I recovered, things that I am doing again and that I will never again give up doing***. [New experience i-moment]

Re-conceptualization was an i-moment also highly elaborated in the final sessions, in what regarded reframing the violent experience and elaborating on new or improved versions of the self. In the next clinical illustration, Susan indicated how changes in her own facets and life roles occurred through the process, and characterized them. She clearly applied the resource of a meta-position when she stated that she started to *"make new readings keeping my distance from situations"*. Protest, action and reflection were scarcely narrated in this final phase.

Ninth session

Therapist: *That has to do with the ability to make new readings of situations…*

Client: ***Exactly. And to make new readings, while keeping distance from situations…***

Therapist: *This ability was always there and somehow lost ground, or is it a new one?*

Client: ***I think that it is not completely new, but there is much that is new in this ability. I start to feel a new ability to analyze situations. I used to do a superficial analysis of situations, I wouldn't look for real motivations… if there was an easy explanation, I took it, the faster, and not always the right one. But not now, now I can see through, I also keep my distance, try to look for motivations, not only mine, but others' as well. I've always been an observer, but I didn't use this skill enough…***

Therapist: *Why was this skill invisible for so long?*

Client: ***I felt trapped. Now I admire my freedom of thought, movement and expression. During marriage they weren't there… his abuse prevented me for having those…***

Therapist: *Maybe the position as a crime victim prevented you from having the observing skill…*

Client: ***That's what I think…***

Therapist: *There were other positions that demanded more space than this one…*

Client: ***I think I centered myself on fear… fear was what most prevented me in all this. I came to a point when there was fear of having an opinion, of expressing myself… so, sometimes, it was better not to think about situations…***

Therapist: *Observing that it was useless when living with a person like that …*

Client: ***Exactly. But not now!*** *[Re-conceptualization i-moment]*

5. DISCUSSION

The effort of conducting a mixed method of quantitative and qualitative analysis in this case seemed to highlight an i-moments' profile congruent with our theoretical model presented in the introduction section of this paper.

About the type of i-moments that emerged in this case, we believe that i-moments of action and reflection in initial sessions are novelties that may still occur in the context of the former narrative. In fact, they seemed to derive directly from the effects of the problem – Susan performed new actions and thoughts about different solutions in early sessions in therapy. These might have been trivialized in Susan's story, as White and Epston (1990) suggested. Therapy was an opportunity to talk about them in a new context and get them noticed and amplified. In this sense, they seemed to be the departure point from which a network of i-moments developed.

Susan then began to enact a defiant position (present in protest i-moments) against her husband, and others that supported violence and "fear", amplifying this feature in the middle sessions. Our findings suggested that the protest i-moment acted as a linking i-moment between the first sessions (action and reflection i-moments) and the subsequent ones, where re-conceptualization emerged. So, the protest i-moment could be involved in defiance of the problem and its effects in its first emergence, but as its salience increased, a new self position became noticed and clearly differentiated from the earlier one (associated with the condition of victim). We can discuss the developmental role of protest i-moments based on possible connections between i-moment evolution and sequential stages of APES, from the perspective of the assimilation model (Stiles, 2006), as i-moments of action and reflection were more salient in the first sessions and seemed to be related to the early stages (0 to 2) of APES This case study contributed, in our view, to draw attention to the importance of protest i-moments in the creation of a new narrative, which we link to stage 3, *problem statement/clarification* of APES. At this stage the problematic voice is clearly stated, and it is expected that opposing voices of the self are distinguished and are able to talk about each other. Protest i-moments in Susan's case seemed to be used as a way of distinguishing her from the previous victim position and of asserting herself. This assertive positioning was directed not only to her husband, but also to her husband's family and the community voices that could somehow legitimate violence. So, as

protest i-moments' salience progressed, it seemed more likely for re-conceptualization to emerge, as our findings suggested.

Subsequently, re-conceptualization i-moments, which were closer to protest in the middle sessions, emerged and evolved toward an increasing salience. A reframing of the experience of violence was elaborated in order to promote a redefinition of aggressors' role and to enact new and preferred versions of self. Concerning the APES stages, the movement toward the next stage 4, *understanding/insight*, means that the problematic voice began to be understood, due to the *meaning bridge* that was created between that voice and the community of voices. This assimilation process entails a common understanding between these voices. We believe that re-conceptualization could be the narration of the meaning bridge, as we considered two important aspects to code it – the contrast between former and present position of self, and the process of change. Susan described this process of new meaning creation by bringing previously opposing voices into an integrated story of the self. She mostly referred to the experience of violence, her relationship with John, and new versions of herself.

According to Angus and Hardtke (2006), insight emerges from the reflexive narrative mode and allows a new awareness of the stories a person tells and the world of feelings that inhabit them. So, this insight provides the story with a narrative coherence, due to the achievement of new understanding in therapy sessions. In a case study, the same authors reported the account of a client's awareness of past experiences and feelings in a coherent narrative within the establishment of a temporal order. Insight, therefore, provided an explanation for the depressive story, the development of new skills and appreciation of the client's agency, which enabled her to commit herself to make changes in the future. In a similar manner, re-conceptualization i-moments provided new understanding of past (story dominated by fear) and present episodes (new skills and self agency), within a temporal framework that organizes and structures the self narrative. This coherent narrative of the self made possible the authorship of future life scripts.

Brinegar, Salvi, Stiles & Greenberg (2006) associated insight with an important stage in a developmental path that leads to positive improvement, since it is a turning point where feelings change to take on a positive valence. We could also associate the emergence of re-conceptualization with a considerable decrease in psychological

distress levels, measured by GSI at session eight. We also believe that re-conceptualization is a point from where new accomplishments may be performed by clients, not only other i-moments, which become coherent with the new story, but also new experience i-moments.

The emergence of meaning bridges allowed the movement to stage 5, *application/working through* of APES, where previous understanding is used to work on a specific problem. This is similar to one of our definitions for new experiences, the generalizing of gains to other life dimensions. In the final phase, new experiences emerged and were highly elaborated as a result of the meta-position created by re-conceptualization that, by accessing former and emergent narratives, allowed Susan to envision and plan the future. As she was achieving new versions of the self, these new performances were a clear result of the process of change. This meant that a reframing of the former position as the victim, and all its consequences, provided an inner change that set the stage for interpersonal changes too, as happened with Susan. As she understood the features of her relationship with John from dating to marriage, she found it necessary to set some rules on new relationships. This does not mean that she prevented herself from having satisfying relations, but used the acquired knowledge as a resource to be able to enjoy intimacy. So, the insight of a problematic voice turned it into a resource in the new narrative as it was fully assimilated, and was no longer a problematic and distressful experience. This was a clear contrast with the positions Susan brought to initial sessions, when she said that she had severe difficulties in remembering violent episodes, and when she did, details were missing. She always associated it with a personality feature of "putting it all behind".

Even though none of the i-moments correspond with the distinction of a landscape of action and consciousness, or identity as White (2007, following Bruner, 1986) states, our results seemed to depict these two areas through the process. It is possible that the urge to solve the problem of abuse, with her life at stake, lead Susan to engage in specific actions, shown in the action i-moments prevalence in the first sessions. Reflection, protest and re-conceptualization then seemed to occupy the middle sessions, where mainly new self versions were talked through, elaborated and amplified. New thoughts, new positioning and new understanding seemed to inhabit this representational area. Then, in the final sessions, when these new self features had been

internalized, a new range of actions were narrated (new experiences i-moments). This pattern followed a general therapeutic movement from the action landscape to the identity landscape (where meaning is attributed to prior experiences in order to influence the following ones), and back to action.

> «These identity conclusions determine what significance is given to specific events of people's lives, and they are further developed through reflection on these events and on the themes that these events are part of. All of these conclusions, including those of the internal state categories, significantly influence people's actions; they are shaping of life» (White, 2007, p. 107).

6. CONCLUSION

This good outcome case allowed a quantitative overview of i-moment evolution and further illustrates their developmental characteristics. As we knew that re-conceptualization and new experiences were associated with successful therapy outcomes, this intensive analysis seems to underline the developmental character of i-moments in the construction of new narrative and to account for the role of protest i-moments. These i-moments seem to be important for the emergence of re-conceptualization, and therefore new experiences.

This analysis could be improved with the inclusion of a contrasting poor outcome case. In previous empirical research, action, reflection and protest i-moment were found to be salient in early phases of poor outcome cases, as happens in the good outcome group. It would be necessary to study a poor outcome case to understand if there are differences in these i-moments that can account for the two different pathways: the further development of re-conceptualization and new experiences, or the maintenance of the same i-moments as the most salient ones through the process. However, it was our purpose to specifically address successful therapy features, in order to fully explore them in the present work.

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CHAPTER III

INNOVATIVE MOMENTS AND THERAPEUTIC FAILURE IN NARRATIVE THERAPY

CHAPTER III
INNOVATIVE MOMENTS AND THERAPEUTIC FAILURE IN NARRATIVE THERAPY[4]

1. ABSTRACT

Innovative moments (i-moments) are the narrative details that occur in psychotherapeutic conversations that are outside the influence of the problematic narrative (M. Gonçalves, Matos, & Santos, in press). The *Innovative Moments Coding System: version 1* (IMCS; *Sistema de Codificação dos Momentos de Inovação: versão 1*; M. Gonçalves, Matos, & Santos, 2006) is a method for tracking these moments in the therapeutic conversation. This research method identifies the emergence of five types of i-moments throughout the process, namely action, reflection, protest, re-conceptualization and new experiences. In this study, we analyze a poor outcome case of narrative therapy, using the IMCS. In this case, reflection and protest i-moments were the most common ones. Contrarily to the good outcome cases, these i-moments profile did not give place to an increased narrative elaboration as therapy evolves, and from the middle to the end of therapy there is no emergence of re-conceptualization and new experiences. Protest and reflection i-moments also show signs of recurrent return to the problem position, in a process of *mutual in-feeding* (Valsiner, 2002), creating a feed-back loop between innovation and the problem, making difficult the escape from this dichotomy.

2. INTRODUCTION

This case study follows what Stiles entitled as *theory building case study* (Stiles, 2003, 2007). Case study research has been argued to be particularly relevant in psychotherapeutic process research (e.g., Gedo, 1999; Hilliard, 1993; Kazdin, 1981; Kiesler, 1981; Molenaar & Valsiner, 2005; Morgan & Morgan, 2001). Stiles (2003) suggested that "case studies, as well as statistical hypothesis-testing research, can permeate scientific theory and contribute to quality control" (p. 7).

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In this sense, data from a case study were analyzed in relation to the theory, having the possibility to improve or refine it. Theoretical assumptions are modified through and also built up by a large number of observations of a specific individuals (Stiles, 2003). These unique features of each case are needed to inform theory not only about commonalities, but also about different aspects that theory needs to take into account (Stiles, 2007).

2.1. Innovative moments

Previous research (M. Gonçalves, Santos, Matos, Mendes, & Martins, 2008; Matos, Santos & M. Gonçalves, in press) suggested that *Innovative Moments* (i-moments), drawn from the term *unique outcomes* (White & Epston, 1990), have an important role in therapeutic change. I-moments are exceptions to the problematic story that clients and therapist are able to identify, elaborate and expand through the conversation, creating by this way alternatives to the problematic narrative plot. An i-moment occurs when a client narrates episodes that are different or novel from the perspective of the "rule" that a problematic story has somehow created for the life of the person. They are narrative details, which can emerge as thoughts, behaviors, projects, intentions, desires, and so on, occurring often in psychotherapy and contributing to the process of self narrative change.

Let us take as an example a client that has as a main problematic theme in her self-narrative: the respect of the others' aims, always sacrificing her own. This is strongly associated with a depressive mood and a sense of lack of entitlement that emerges in several important relationships in her life (with her partner, with her children, in her job). An i-moment in this context would be an episode in which this "rule" ("I should always sacrifice myself") was somehow disobeyed, for instance, a situation in which the woman was assertive and affirmed her own agenda.

In several previously researches with different clients (e.g., depressive, victims of partner abuse) and diverse therapeutic models (narrative, emotional focused therapy, constructivist) we systematically found (M. Gonçalves, Mendes, Ribeiro, Angus & Greenberg, 2008; M. Gonçalves, Santos, Matos, Mendes & Martins, 2008; Matos, 2006; Matos et al, in press; Ribeiro, 2008) five different types of i-moments: (1) action, (2)

reflection, (3) protest, (4) re-conceptualization and (5) new experiences. We will offer some examples from the previous clinical situation to illustrate these different types.

(1) Action i-moments refer to specific actions that are not predicted by the problem-saturated story.

Example: The client describes in the session a situation in which she did something differently, for example, she went for a walk instead of going to her mother's house as she thought she must do in order to be a "good" daughter.

(2) Reflection i-moments are all the moments in which the person thinks differently than what one could expect from the problematic story, or when one understands something new, that contradicts or does not support the problematic story.

Example: The person started wondering why is it that her wishes are always felt as wrong while others' wishes are always felt as right.

(3) Protest i-moments reflect an opposition towards the problematic narrative and its consequences. They can be an action (like in action i-moments) or a thought (like in reflection i-moments), but they are more than mere actions or thoughts, due to their proactive positioning. They seem to involve a creation of a metaphorical space between the person and the problem or between the client and the persons that support the problem. They allow the person to protest against the problem, separating the problem from him/her self. In this sense, they not only imply resistance but also a re-appreciation of the client's position in relation to the problem. They are active ways of showing the self and others that people want something very different in their life. Sometimes protest may emerge as a form of resistance towards the problematic story.

Example: The client strongly asserted in the session that she will no longer tolerate her needs being ignored by the important people in her life.

(4) Re-conceptualization i-moments are more complex than the previous ones. These i-moments involve two components: the contrast between the past self (problematic narrative) and the present self, and the description of the processes that allowed self's transformation from the past to the present. Thus, the client not only understands something new, but he or she can also establish a distinction from a previous condition. These i-moments involve a reflexive position toward the change process, or to use a distinction made by Sarbin (1986), the person is not only an *actor* of that process (since she was involved in the transformation), but also its *author* (she did

it intentionally and understands how the transformation occurred). This implies a meta-level from which the person can see the difference between the old plot and the (anticipated) new one and from this position construct the development of the new story.

Example: “I learned since I was young to ignore what I want and focus on others’ wishes. But now I found that this was a way of treating myself as a non-person, making me feel a kind of emptiness that was difficult to live with. Reflecting about my life, and discovering how this way of dealing with others and myself made sense to me in the past, but not anymore, I decided to assert my wishes and this transformed my relationships and also the way I felt inside…”

(5) New experiences are i-moments in which new projects, activities or experiences, that were impossible before given the constraints of the problematic narrative, start taking place. These i-moments represent the expansion of the story into the future.

Example: The client decided that her husband could take care of himself and prepare his own dinner, while she goes to night school to complete her education.

These i-moments were studied in a narrative psychotherapy sample in a previous research (M. Gonçalves, Santos, Matos, Mendes & Martins, 2008; Matos et al., in press), in which two contrasting groups were compared. Our results suggested that, although i-moments emerged in both good and poor outcome groups, the time clients spend elaborating them (salience index) and their type were different. Therefore, i-moments showed a significantly higher salience in good outcome group and two specific i-moments, which were re-conceptualization and new experiences, significantly differentiated both groups. Moreover, the poor outcome group was characterized by the emergence throughout the process by mainly action, reflection and protest i-moments. There were no significant differences between groups concerning these i-moments. However, these i-moments also characterize early sessions of successful therapy. Thus, an important question is how action, reflection and protest i-moments in early phases developed differently towards therapeutic success or failure. Following, we will suggest a possible explanation for the failure of these i-moments to create change in poor outcome cases. We will first suggest a hypothetical explanation and then check if it adjusts to the poor outcome case that is the target of this study.

2.2. Therapeutic failure

Our main argument is that action, reflection and protest i-moments seem to have the potential to transform narratives when they interact with re-conceptualization i-moments, as in successful therapy, but also that they could have the effect of supporting the problematic narrative when re-conceptualization is absent. We have suggested that without the creation of re-conceptualization from which the person can expand and explore the meanings of action, reflection and protest i-moments, these last forms of i-moments can only free temporarily the person from the problem, but they also facilitate the return to it. This is possible given the lack of further elaboration outside the domain of the problem that these i-moments sometimes represent (like actions, thoughts or resistance toward the problem), meaning that these i-moments seem to be constructed by the client as a mere negation of the problem. It is our hypothesis, that re-conceptualization, by its nature (see the three components involved in it), cannot be a mere negation of the problem as it necessarily creates meaning outside the influence of the problematic narrative.

Therefore, as suggested before (M. Gonçalves et al., in press), i-moments of action, reflection and protest may act as a mere opposition to the problem narrative, not allowing the development of new meanings outside the semiotic duality problematic narrative – negation of the problematic narrative. If this happens, the problem is present even when it is absent, since the meaning of the i-moments seem to require and are strongly related to the meaning of the "problem", as we will further discuss. Given that "a central need for dialogical self is to maintain dynamic stability within self" (Valsiner, 2002), these i-moments could be associated with conditions (the regulation of the opposite meanings) that represent a failure to change, or to develop new meaning complexes. So, poor outcome cases can involve, in fact, a situation of *mutual in-feeding* (Valsiner, 2002). Mutual in-feeding means that different voices (different parts of the self) establish relations between them that tend to «feed into each other» (Valsiner, 2002, p.258). In this poor outcome case, we suggest that the relation between problem saturated narrative and i-moments' emergence can result in a circular dynamic loop that maintain stability throughout time. The emergence of i-moments seems to create narrative diversity within the self but does not lead to further development as it entails a cyclical relation that cannot be overcome within this form itself.

Clinical vignette

Client: ***I can't stand this situation anymore. My husband was supposed to stand by me. I'm tired of criticisms and being ignored… I have my needs and wishes! I want them to be acknowledged!*** [Protest i-moment] *But it's so difficult for me to say these things to him. I just can't do it! I can't find the courage. It's not worth it.*

From a dialogical point of view, client performs a cyclical movement between a voice and a counter-voice (underlined in the previous clinical vignette) that does not allow the development of the system of meanings throughout therapy. This leads to an irresolvable dilemma and makes change difficult to achieve. In this situation, the problematic narrative is dominated by a double voice that expresses i-moments, in which this second voice works as a shadow of the first. Gustaffson (1992; see also Omer, 1994) suggested a similar process responsible for the maintenance of these stories in which the only alternative to the main story is a shadow story: "these stories seem inescapable because what is viewed as the only alternative (the *shadow* story) turns out to be a loop that reintroduces the main line" (p. 47).

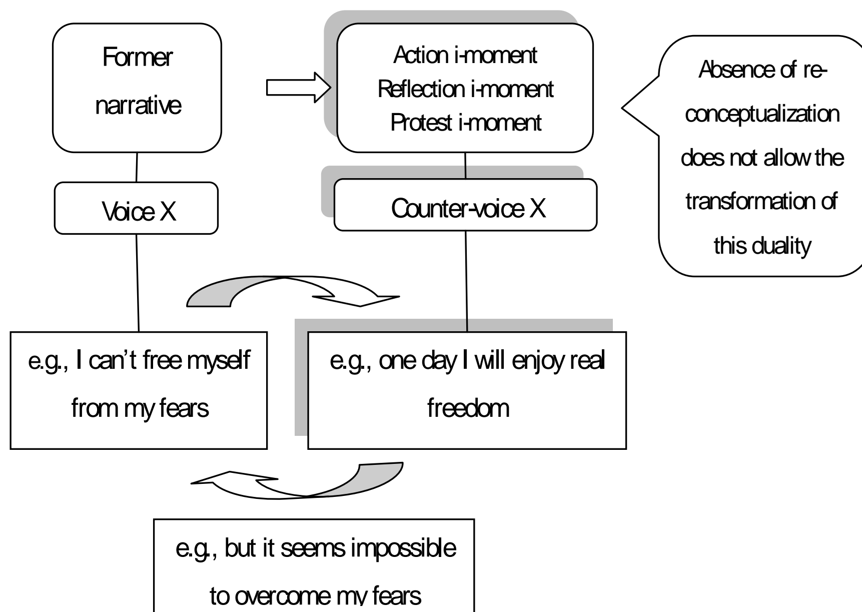

Figure III - 1. Action, reflection and protest i-moments and mutual in-feeding. Adapted from M. Gonçalves et al. (in press).

A dialectical interpretation of mutual in-feeding (Valsiner, 2002) is an important resource to further understand this process in psychotherapy. Josephs and colleagues (Josephs & Valsiner, 1998; Josephs, Valsiner & Surgan, 1999) conceptualized meaning-making processes in terms of a dialectic perspective, which is inherent to any transformation process as in therapeutic change. For these authors, the construction of meaning entails the regulation of dialogical relations between meaning complexes which are composed of united dual fields. So, when the meaning of {A} is identified, a whole range of its opposite field is also defined by {non A}, as in {A} as foreground and {non A} as background. These dual fields emerge together, being {non A} the countersign of {A}. The field {A} can be a word or a sentence with a specific meaning, which can have related synonyms. On the other hand, {non A} emerges together with the previous one and includes its opposites, although in a unstructured or fuzzy way. This {non A} field has also the potential of involving a «yet-to-be differentiated field of meanings-to-be» (Josephs et al., 1999, p. 265), having the prerogative of linking the present meaning with a future one. These dual fields are related to each other by opposition that can be harmonious or tensional. When both opposites co-occur with no

tension at all, they tend to close the meaning complex. On the contrary, if tension occurs it enables the complex to transform, as it allows the establishment of dialogical relations with other meaning complexes. Meaning transformation can occur through growth (progressive differentiation of the {A} field), or constructive elaboration (the {non A} field develops towards a separation of {A} changing its nature). So, to change one meaning complex {A}, the field {non A} needs to be somehow elaborated so that another meaning complex {B} emerges and substitutes the first one. In this case scenario, {non B} will entail features of the meaning complex {A<>non A}.

Circumvention strategies (Josephs & Valsiner, 1998; Josephs at al., 1999) can be used with the purpose of regulating the dialogical relations between meaning complexes. They are semiotic tools that can either strengthen a given meaning or overcome it in the task of organizing the flow of everyday experience.

We believe that the problematic narrative that a client brings to therapy can be understood through the concept of macro organizer of self's meaning system (Josephs & Valsiner, 1998). So, a macro organizer is composed of a set of laws for the organization of the person's experiences that guarantee stability and expectedness in meaning making efforts. They tend to be resistant to change and to constrain the generation of new meaning complexes, or the modification of present ones. In sum, they seem to maintain the prevailing meanings system. In this sense, they tend to compose a dominant and monological voice that suppresses the other possible ones to emerge and makes «the negotiation of meaning a very difficult task» (M. Gonçalves & Guilfoyle, 2006, p. 253). We can easily point out the analogy between this monological narrative and the problem saturated narrative proposed by White. For this author, clients bring to therapy "problem-saturated accounts of their lives" (White, 2007, p. 39) that "have shaped their negative conclusions about their life and their identity" (White, 2007, p. 27).

Relating to the i-moments emergence, we can consider the {A} the meaning expressed by the problematic narrative and {non A} as the whole range of oppositions related to the problem as non problem. In therapeutic conversation, if the client chooses to elaborate on the field {non A}, either by his/her intention or by the therapist's suggestion, it is most likely to lead to the development of a novelty, or to an i-moments, as some version of {non A} is identified with {B}, originating the meaning complex

{B<>non B}. We propose that stability and therapeutic failure are related to the emergence of these meaning complexes (i-moments) that are different from the macro-organizer narrative, but are the target of circumvention strategies that produces decay in the innovation movement. These circumvention strategies produces a movement back to {A}, avoiding the elaboration of {non B} into {C}, producing novelty cycles. Rather, the problem ({A<>non A} and the i-moments ({B<>non B}) meaning complexes were related in a way that feed each other throughout the process, in a mutual in-feeding situation. In the following clinical vignette, the client was a victim of partner abuse and said in early therapeutic sessions that she needs "*to find a solution*" for her marriage, as it was becoming unbearable for her. Immediately after narrating the I-moment, she circumvents the meaning of it by the introduction of a symbolic helper, "God's will", that makes all her efforts to change fruitless and useless, as she "*can't do anything about it*".

> *Clinical vignette*
>
> **Client:** ***I´ve been thinking that I really have to find a solution for my marriage… It has been so difficult to live with him and his mood…*** [Reflection i-moment] But it is God's will, isn't it? We can't do anything about it!

We will now present a poor outcome case study based on a qualitative analysis of i-moments' emergence. Following Stiles suggestion (2003, 2007) we aimed to see if observations from this case match our model that accounts for therapeutic failure. So, we intend to first identify what types of i-moments appear in this particular case and how they progress throughout therapy, and then to explore the processes of mutual in-feeding and what particular i-moments are related to them.

3. Method

3.1. Client

Maria is a retired industrial worker, with forty seven years old and married twenty years ago. She has two sons, one is sixteen and the other is ten years old. Her husband, David, who is physically handicapped, has been sexually and psychologically

violent toward her since the first year of marriage. Maria was recommended for therapy after she sought for help in an institution for crime victims. When she came to psychotherapy she had severe symptoms of depression (e.g., sadness, hopelessness, social withdraw, isolation). She is from a very poor family. Her mother died when she was 6 years old and she had a bad relationship with her father, whom was also physically violent toward her during her childhood. Her husband's condition has been an obstacle towards her wishes to leave the relationship, because she pities him. This resulted in being submissive to her husband and his family. She also has relational problems with her oldest son, as she blames herself of not being a "good mother". Her intent was to leave home with her youngest child to a temporary crime victims' shelter. Her main obstacles were lack of financial independence and the impossibility to take her oldest son with her.

The following protocol was applied to assess the therapeutic outcomes of this clinical case: specific instruments were used in the first, fourth, eight, twelve, fifteen (last) and follow-up sessions (six months after the last session). The outcome measures were: the Brief Symptom Inventory (BSI; Derogatis, 1982; Portuguese version adapted by Canavarro, 1999) for the assessment of clinical symptoms, specifically the Global Severity Index (GSI); a regular clinical registration concerning the violence received by the partner: abusive actions received (physical, psychological and/or sexual), their frequency and severity assessed in a qualitative scale (low, medium, high); the Working Alliance Inventory (WAI; Horvath, 1982; Portuguese version adapted by Machado and Horvath, 1999) was used for the assessment of therapeutic alliance quality; and the Scale of Beliefs about Partner Violence (Escala de Crenças sobre Violência Conjugal - ECVC; Matos, Machado & M. Gonçalves, 2000) was applied to evaluate the client's beliefs regarding violence.

Maria's case was selected from a sample of female victims of partner intimate violence gathered in a previous research (M. Gonçalves, Santos, Matos, Mendes & Martins, 2008; Matos et al., in press). She signed a written consent after being informed of the research objectives, and treatment was provided with no charge. She underwent individual narrative therapy (White & Epston, 1990) in a Portuguese university clinic.

This case evolved through fifteen sessions[5] (initially four weekly sessions and then twice a month) plus one follow-up (after six months). After evaluating therapeutic outcomes, Maria's case was included in the poor outcome group due to an evolution throughout therapeutic process that maintained psychological distress condition assessed by BSI (similar to the Portuguese population with complaints) and a continued victimization condition. The therapeutic alliance scores were high, showing an increasing tendency towards the process end. She also showed low tolerance regarding violence (cf. table III – 1). This case was selected for this study as it was the poor outcome case that showed the highest value for GSI at the last follow-up session of the sample of female victims of an abusive partner. At the same time, this case also presented the lowest values for i-moments' salience.

Table III - 1. Outcome measures evolution in the case of Maria.

	Sessions					
	1	4	7	12	Last	Follow-up
BSI	2.66	1.35	1.2	1.41	0.62	1.64
Victimization received	Physical and psychological				Maintenance of psychological	
WAI	-	5.71	6.41	6.12	6.55	6.63
ECVC	31	-	-	-	30	31

3.2. Therapist and therapy

The therapist whom attended the case had a master degree on Psychology when the research was developed, and five years of experience in psychotherapy with battered women. Psychotherapy was supervised regarding adherence of therapist to narrative therapy.

Narrative therapy (White & Epston, 1990) is a therapeutic approach suitable for women victims of partner violence (cf. Matos & M. Gonçalves, 2004). These women usually present a self-narrative highly saturated by the problem (the effects of

[5] Sessions 8 and 9 were not rated due to technical problems with video recording procedures.

victimization), characterized by, for instances, self-blame, shame, puzzlement, skepticism and hesitation towards the possibility of change (Martin et al., 2000; Matos, 2006). The clinical practice of externalizing the problem allows these women to differentiate themselves from problems' demands and their personal wishes. This distinction creates a space for personal agency and breaks the fusion between the problem and the self (e.g., "the battering is my fault", "if I was a better woman he wouldn't beat me"). Finally, social discourses (e.g., of gender, of male power) seem to support partner violence and make these victims personal change difficult (Madigan & Law, 1998). Therefore, the deconstruction of social and cultural discourses allows women to reposition themselves toward these dominant discourses, discovering in this movement new practices and values (e.g., tolerance, equality).

3.3. The Innovative Moments Coding System

The *Innovative Moments Coding System: version1* (IMCS; Sistema de Codificação dos Momentos de Inovação: versão 1, M. Gonçalves et al., 2006) was used to analyze processes of change throughout cases. As mentioned earlier, it is composed by five specific types: (1) Action i-moments; (2) Reflection i-moments; (3) Protest i-moments; (4) Re-conceptualization i-moments; and (5) New experiences i-moments.

Table III - 2. Types of i-moments and examples. From the Innovative Moments Coding System: version1 (IMCS; Sistema de Codificação dos Momentos de Inovação: versão 1, M. Gonçalves et al., 2006).

Types of i-moments	Examples
Action i-moments: Specific actions or behaviours that defy the problem.	▪ New coping behaviours facing obstacles; ▪ Effective resolution of unsolved problems; ▪ Active exploration of solutions; ▪ Restoring autonomy; ▪ Searching for information about the problem.
Reflection i-moments: Thinking processes that indicate the understanding of something new that makes the problem illegitimate (e.g., thoughts, intentions, interrogations, doubts)	▪ New problem formulations and/or re-formulation of its effects; ▪ Reconsidering problems causes (e.g., severity, intensity, intentionality, aetiology); ▪ Consideration of life dilemmas; ▪ Considering cognitive and affective dilemmas; ▪ Reflecting about cultural, social and religious demands; ▪ References of self worth (e.g., strength to fight, positive thinking, positive feelings, well-being references…); ▪ Self instructions (e.g., "you have to fight"); ▪ Reflecting about the intention to fight problems demands (e.g., shame).
Protest i-moments: Resistance, defiance or protest that can be planned or concretized behaviours, thoughts, or/and feelings.	▪ Defiance position toward the problem and problems allies; ▪ Assertive attitudes towards others; ▪ Public repositioning towards culturally dominant values.
Re-conceptualization i-moments: Process description, at a meta-cognitive level (the client not only manifests thoughts and behaviours out of the problem dominated story, but also understands the processes that are involved in it)	▪ References to new/emergent identity versions; ▪ Re-evaluation of relationships; ▪ Re-evaluation of experiences within problem development frame (e.g. aetiology, interference, costs…).
New experiences i-moments: References to new projects, activities or investments planned or underway, as a consequence of change.	▪ Generalization into the future and other life dimensions of therapeutic gains; ▪ Problematic experience as a resource to new situations; ▪ Investment in new projects and personal image in private and public spaces; ▪ Investment in new relationships.

3.4. Coding procedures

Coding of i-moments was conducted by viewing each session in video and recording the type and the time duration of each i-moment as it appeared in the session. Duration was assessed by recording the beginning and the end of each i-moment, to the nearest second. The sessions were coded in a sequential order (session one, two ... and so forth). For each session, we computed an index of salience, which is the percentage of time in the session occupied by each type of i-moment. We also computed an index of overall salience of i-moments by session as the sum of the saliencies' of the five i-moments.

3.5. Reliability

Session recordings were coded by two trained judges. Judge A was the author of this work and judge B was a team made by the therapist and another judge, a Ph.D. student. Judge A, who was unaware of the outcomes, coded all the sessions, while judge B coded only the sessions in which the outcome assessment instruments were applied (sessions one, four, seven, twelve, last and follow-up). Reliability indexes were computed on these sessions (30% of the sessions). Both judges coded the sessions after the entire sample was collected. Judges discussed, before the independent coding procedures, their understanding of the main problem of the client (the "rule" or the problematic narrative) in order to code the i-moments (the exceptions to the "rule"). In this case the problem's externalization (see White & Epston, 2000; White, 2007) made the problem clearer, since client and therapist discussed them in a personified or objectified form (see Results section).

The percentage of agreement on overall i-moments salience was of 80%. Interjudge agreement on overall salience was calculated as the time identified by both judges divided by the time identified by either judge (or, equivalently, twice the time spent on agreed i-moments divided by the sum of i-moment times independently identified by the two judges). Reliability of distinguishing i-moments' categories, assessed by Cohen's kappa, was of .81. Because of the high interjudge reliability, we based our analyses on judge's A coding.

3.6. Data analysis

I-moments were qualitatively analyzed, following Stiles (2007) suggestion, according to their relevance to our theory of therapeutic failure, grounded in session's transcripts.

In order to explore the process of mutual in-feeding, i-moments were analyzed with the semiotic tools of dialectical structure of meaning making (Josephs & Valsiner, 1998; Josephs et al., 1999). Our analysis identified the problem expressed by the {A<>non A} meaning complex and i-moments the {B<>non B} meaning complex, and the regulation of their relations through the circumvention strategies. These can be (1) circumvention of meaning by focusing on a competing goal (client bypasses the meaning as she highlights a motivational goal that rivals with the previous meaning; e.g., *"it's so difficult for me to say these things to him. I just can't do it!");* (2) circumvention of meaning by the introduction of symbolic helpers (client uses symbolic statements, that are somehow decontextualized, to distance herself from the previous new meaning; e.g., "*it's God's will*"); circumvention of meaning by challenging one macro organizer by a competing macro organizer (client uses absolutist and determinist expressions, for instance "I will" to express i-moments, that are followed by "I can't" sentences that neutralizes the former organizer).

4. Results

4.1. IMs emergence and salience

Results from Maria's case showed that i-moments were scarcely elaborated as process progressed (see Santos, M. Gonçalves, Matos & Salvatore, 2008, for a comparison with a good outcome case). Symptoms index began with high value (above cutoff point), and actually had some oscillation, ending also high in follow-up session (see figure III - 2).

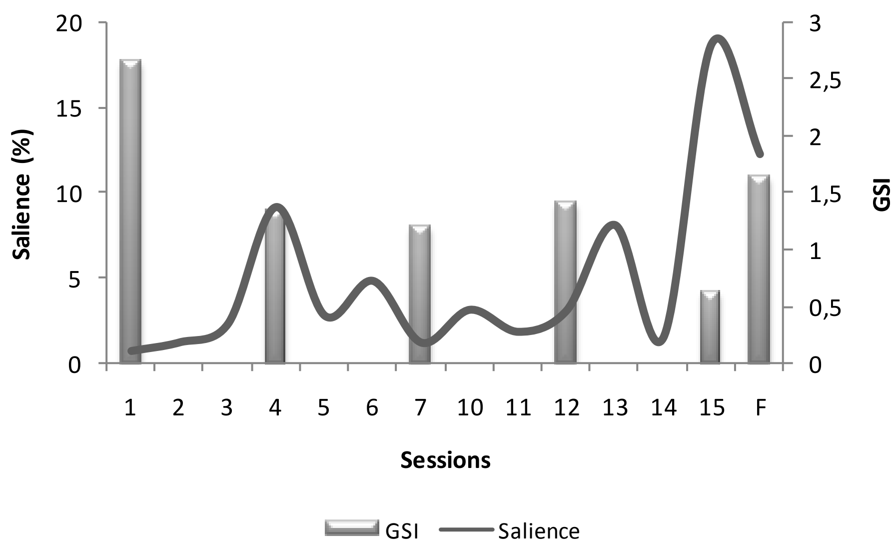

Figure III - 2. Salience (%) of i-moments through therapeutic process and GSI scores for poor outcome case.

An overview of i-moments' salience showed that protest and reflection (figure III - 3) were the i-moments with higher salience (2.9% and 1.7% of mean salience, respectively). They were the only i-moments present since the first session and had an increasing tendency. Maria spent less time narrating re-conceptualization (0.21% of mean salience) which emerged in session thirteenth and follow-up. Action (0.14% of mean salience) emerged at the fifth session and new experiences (0.11% of mean salience) i-moments emerged in follow-up session only.

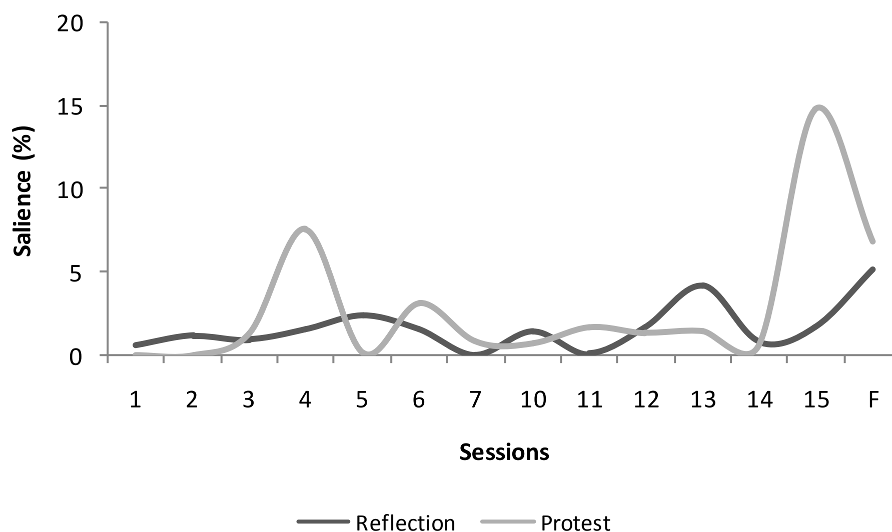

Figure III - 3. Evolution of reflection and protest i-moments salience (%) throughout the process.

As suggested before (M. Gonçalves, Santos, Matos, Mendes & Martins, 2008; Matos et al., in press) poor outcome seemed to be related to the emergence of mainly i-moments of action, reflection and protest. This case findings' show that reflection and protest are actually the i-moments present along all the process. So, their emergence and evolution will be analyzed further on. Action, re-conceptualization and new experiences results will not be object of analysis since they do not characterize the therapeutic process due to their almost absence.

4.2. IMs emergence and the problematic narrative

Coding i-moments in therapeutic processes involves a prior definition of the client's problems or problematic relations (see Reliability section). This is achieved as coders get familiar with the case and consensually agreed on what should be the problem, and by contrast, what could constitute an i-moment. We will further illustrate with a therapy excerpt from the firts session what was considered the problem by the client and the therapist, concerning its nature and effects. Maria identified the "wave" as the externalized problem (see White & Epston, 1990), which compiles the negative effects of twenty years of partner abuse, mainly depressive symptoms, lack of

entitlement, helplessness and hopelessness. I-moments were then considered every moment or episode that were not regulated or ruled by the "wave". The next excerpt is from the first session of Maria's case, when client and therapist are elaborating on the "wave" and its' effects on her life (underlined).

1st session

Client: *(...)* and when my husband started to say all those things, it all came down to me… it looked like a giant wave, when there are hurricanes or earth quakes, that are extremely high, and that wave came and drew me…

Therapist: *Is this a wave of "I'm not worthy"?*

Client: Of I'm not worthy…

Therapist: *So, let's call it the wave…*

Client: She came and destroyed me, hate me, because there were things from the past that… I don't know…

Therapist: *In symbolic terms, can we use the wave to refer to this flood of difficulties, the notion of not being worthy, of not having value, of not being interested to change?*

Client: Yes.

(...)

Therapist: *So, Maria, what has been happening is that you have been letting yourself be convinced by the wave…*

Client: Yes.

Therapist: *If this wave controls your life forever what would be its goal? Where does the wave want you in your life?*

Client: Everything that is negative… Everything that is negative, that's what I can say…

Therapist: *What are the aims of the wave for your life?*

Client: I don't know what the answer is… the aim of not to protect myself, not to face anything, not to have any illusions…

Therapist: *So, the wave has…*

Client: *Sometimes it has the positive effect of protecting me, of not seeing situations in a positive way that "they are not so good because they are not like this".*

Therapist: *Does it protect you? Make you feel good?*

Client: *There are moments that it says "why do you have to see positive sides in situations? Why do you have to have illusions about your life?"*

Therapist: *It makes you feel good in the sense that it makes you not do anything.*

Client: *Yes.*

Therapist: *It is easier this way?*

Client: *Yes, yes…*

Therapist: *To let it be… to resign…*

Client: *To resign!*

(…)

Therapist: *Let me ask you something, as we are almost finishing our time… how is it for you to have the wave in your life? What did it take away from you? You've said before that you paid a high price for the wave…*

Client: *The joy, the joy is gone… I like joking, saying foolish things… unless with my husband's family…*

Therapist: *Besides joy, what else did the wave take away from you?*

Client: *That's it. It toke the joy, the will to do lots of things, to see things in a new light… although I was never an optimistic person… I've never been that, but to see things in a new light…*

Therapist: *In a realistic way?*

Client: *Yes, more…*

Therapist: *Not so much optimistic but fifty-fifty…*

Client: *Yes.*

Therapist: *We can have on one side optimism, on the other pessimism, and realism on the middle…*

Client: *And I think the wave also destroyed me towards my children, I could have taken more care of them, and I didn't.*

Therapist: *As a mother, you think that the wave…*

Client: *It destroyed me completely!*

4.3. I-moments emergence and mutual in-feeding

4.3.1. Reflection i-moments

Reflection i-moments were present since the first sessions. Maria questioned herself about the experience of violence (for instance, reasons for her husband's behavior and possible explanations for not being able to change the continuing abusive situation) and also formulated wishes to overcome the problem. This first illustration shows how Maria was willing to change, despite the presence of the "wave voice".

First session

Therapist: *That position has a voice that states: "You have to convince yourself that you are not worth a thing, you have no value at all, there is no use to fight, it's no use to start doing new things… don't go that way because you won't have any results". Is it this kind of voice?*

Client: *Yes, partly it is. It's thinking that "it's no use going that way because you won't have any results".*

Therapist: *You said that "partly" there's a voice that says there's no use making any effort because you would never get anywhere. But is there another voice? [elaboration on {non A}]*

Client: ***Yes, there's another part that seems that I can do everything!*** *[Reflection i-moment {B}] But suddenly, it falls down! Like a cards' castle that we build and then suddenly falls apart! [return to the problem {A}]*

The voice "*you would never get anywhere*" was brought by Maria since the beginning of the therapeutic process. This voice was clearly related to (or even expressed by) the problem narrative and constituted a macro organizer meaning

complex (Josephs & Valsiner, 1998). The employment of the words "*never*" and "*anywhere*" show how definite and determinist this organizer had been in Maria's life. She also said that this was true "partly", leading to the therapist's question directed to the possibility of another voice emergence. So, in terms of dialectical meaning complexes, being {A} the macro organizer, therapist questioned directly to the elaboration of the field {non A} through *"But is there another voice?"*. Client answered with an i-moment that expresses "*seems that I can do everything*" as the result of the elaboration of the field {non A}. So, Maria stated the existence of these oppositional voices (meaning complexes), but after narrating the i-moment, the word "*but*" indicated the re-emergence of the previous and opposite voice by saying *"But suddenly, it falls down! Like a cards' castle that we build and then suddenly falls apart!"* (underlined in the previous example). By doing so, she prevented the meaning complexes to create tension by circumventing the meaning expressed of the i-moment. She used a symbolic helper, a "*cards' castle"*, in order to express that i-moments' meaning was not structured enough and it could be easily destroyed (also noted by the word "*seem*"), then creating a distance from it and reinforcing the voice "*you would never get anywhere*". According to Josephs and Valsiner (1998), the use of macro organizers ("*you would never get anywhere*") tend to rigidify the meanings system and to maintain the monological voice dominance. Attempts to create exceptions are possible, as in the question from the therapist, but they can be easily understood as attacks to the macro organizer's meaning, leading to a circular movement strengthening its rigidity.

We believe that the previous example involves a mutual in-feeding situation. Although a new voice ("*seems that I can do everything*") was brought to therapeutic conversation as an i-moment, its potential meaning development was immediately bypassed. In this sense, Maria actually returned to and strengthened the meaning of the problem voice, despite the emergence of the i-moment.

Not all of the i-moments narrated have these features of returning to the problem as the previous one. In the following example Maria states the coexistence of two oppositional voices: the submissive voice that has been dominant during the marriage, which has been causing emotional distress (expressed by "*lost cause*" and "*rage*"), and a reflection one (i-moment) that questions herself about why she kept "*giving up*" and accepting her husband's demands over the years.

Third session

Therapist: *Your relationship with your husband originated this effect that the wave has on your life. We should conceive the wave as an effect of living with him for 19 years...*

Client: *I know it's a lost cause. Sometimes I feel this huge rage… **but why do I have to give up on everything, and why can't I say no, but always give up? When he asks "did you like it?" I answer "Yes, I did", he asks "is it ok?" I answer "it's fine", he asks "have you done that?" I answer "yes". But why do I keep giving up?*** [Reflection i-moment]

In this illustration, the emergence of i-moments seemed to be a voice that coexists with the problem, also contributing to the mutual in-feeding situation. Maria did not express tension or open conflict between these voices, which could lead to some kind of resolution. One possibility could be that she decided to not give up on her needs anymore. If that was the case, a new i-moment would be developed and narrative elaboration would be improved. In this specific example, the "*lost cause*" and "*rage*" are ingredients of a submissive voice, congruent with the macro organizer complex {A}. Maria enacts another voice, composed of questioning herself about the reasons that kept her in the submissive position. We understand the questioning about the effects of the violent situation important in victims of intimate violence as they may allow a new comprehension of the experience and may lead to new self positioning, others then the victimized ones. Maria actually realizes that she has been acting in a submissive way, by the reflection i-moment, the {B} meaning complex. However, this new meaning {B - *"but why do I have to give up on everything, and why can't I say no, but always give up?"* } involves description of situations that belong to the {non B} field (*When he asks "did you like it?" I answer "Yes, I did", he asks "is it ok?" I answer "it's fine", he asks "have you done that?" I answer "yes".*). This field is conceptualized as being rather close to the {A - problem} meaning complex (Josephs et al., 1999). So, in a sense, problem is still pretty much present in this i-moment.

At the middle stage of Maria's therapeutic process, reflection i-moments are oriented to her dilemmas, focusing on leaving home and going with her youngest son to

a shelter, and also about an increasing sense of self capacity to achieve change. As we can see below, Maria continues to state wishes of change, different from the ideas that the “wave” demands for her.

> *Fifth session:*
>
> **Therapist:** *Besides that, are there other ideas that the "wave" tries to convince you?*
>
> **Client:** *I don’t know if they are nonsense... But this week I found that, I thought* ***“I need time for me, where am I going to get that time to organize my ideas, to find a little of peace? Where? What can I do? …” These ideas come to my mind …*** [Reflection i-moment] *I’m very confused, I’m so confused... I can’t ... I’m confused...*

Therapist is, in this excerpt, working upon the effects of the wave in Maria’s life, or in the {A<> non A} complex of meaning. Maria enacts an i-moment by the statement “*I need*” which could mean that Maria starts identifying a competing personal goal as an alternative to the problem’s organization of meanings. She says she needs time “*to organize my ideas*” and also a space away from the problematic situation, the {B <> non B} complex. However, the field {B - “*I need*” } is followed by questions and hesitations which are an expression of the {non B field}, with characteristics easily identified with {A}. She did not express any kind of strategies to make her needs fulfilled (what could end up increasing narrative elaboration, therefore a salience enhancement). On the contrary, she soon returns to the problem voice when she communicates a state of confusion and the impossibility to perform the i-moment by the absolutist statement “*I can’t*” statement. This is a circumvention strategy for taking over the “*I need*” statement, expressing the prevailing macro organizer of meaning (“I can’t”).

This excerpt also enabled us to see a repetitive pattern in reflection i-moments. They were often composed of a sterile questioning, which without considering specific strategies that could be catalytic of change, made the return to the problem also predictable.

In final sessions Maria actually decided that she would not leave home, as she was considering initially, mainly because she could not take her oldest son to the

shelter. Reflection i-moments had an increasing salience as process progressed and were focused mainly on considerations about self capacity to achieve change. Curiously enough, this content is the exact opposite of what she defined as the "wave's" rule, that is the idea that whatever the efforts that she would be engaged in she would never achieve positive results, and that she was not worthy.

We can see in the next excerpt a sequence of a reflection, a protest and a reflection i-moment.

> *Twelfth Session:*
>
> **Therapist:** *Definitely, I think these moments are victories towards the wave. If the wave had a total influence on you, probably Maria wouldn't be here for some time ago…*
>
> **Client:** *Yes, the wave tried to dominate me, many times, in the half way here, I considered... to go back, to give up…*
>
> **Therapist:** *What prevented you from doing it?*
>
> **Client:** ***If I told you that there are moments that I think "I will say to the therapist: let's go forward, it doesn't matter, let's not think of anything else, and don't look back"*** [Reflection i-moment] <u>*but later suddenly, immediately, it's finished. The point was erased. I can't do it, I can't decide myself really: I am very puzzled about all this…*</u>
>
> **Therapist:** *As you are saying, at this moment your priority is not leaving home. We consider already that you have no conditions to do it now, but do you still have the intention to struggle against the wave when it prevents you from doing what you really want?*
>
> **Client:** ***Yes, I think so, yes…*** *[Protest i-moment]*
>
> **Therapist:** *Shall we continue this trajectory? But if you think it is going to be difficult, what are you expectations?*
>
> **Client:** ***Deeply inside, I keep thinking that I'll release myself from all of this. I continue to think that I will be free of everything. I always have that in my mind: I'll release myself and I'm going away from here.*** [Reflection i-moment]

Therapist elaborates on the idea that going to the sessions are "victories", exceptional moments when Maria seemed to defy the wave despite its influence *"to go back, to give up*" ({A}). As she asks what prevents her to obey the wave, opening the discussion to the field {non A}, Maria narrates a reflection i-moment, stating her wish to change in a new meaning complex {B}. It is expressed through a competing goal ("*I will*" and self instructions), a circumvention strategy that could be employed to *takeover* (or destroy) the meaning of {A}. However, that meaning complex was again instantly counterpointed by the dominant macro-organizer ("I can't"). This prevented the i-moment further elaboration and somehow "normalized" it through the help of some kind of symbolism *("The point was erased")* as a circumvention strategy to disregard the i-moment meaning. Maria regulated this opposition by taking over the provocative meaning of the I-moment and its possible potential of being amplified. Afterwards, therapist summarizes Marias' latest decisions and asks about her intentions to have moments of non compliance with the problem, in an attempt to value other exceptional moments. It enabled the emergence of a protest and a reflection i-moment which meaning was not bypassed, although they seemed to maintain a relation with the problem. The Protest i-moment, as the {B} field, was composed of a confirmation of therapist words, and client's words "*I think so*" could indicate a glimpse of the field {non B}. The reflection i-moment that follows is also related to a recurrent statement of magical wishes.

4.3.2. Protest i-moments

Maria also started narrating episodes of protest since early sessions, specifically she defied her husband's power position in a new way and also the problem voice. In the following excerpt, Maria said she wanted to end with the "wave" completely.

> *Fourth session*
>
> **Therapist:** *What do you want to do to this "wave" (externalized label for depressive symptoms)? Today you've defied it ...*
>
> **Client:** ***End with it completely,*** [Protest i-moment] <u>*but it seems very difficult to me…*</u>
>
> **Therapist:** *End with it…! You´re ambitious!*

One of narrative therapy goals is to change the client's relation with the problem to a more viable one. As the therapist identified an exceptional moment of defiance, highlighting the {non A} field of the {A<> non A} complex. Instead of a change in that relation, Maria stated the wish of eliminating the problem ({B}). This magical or non realistic objective, stated in absolute terms like "*completely*", was immediately counterpointed with the difficulty of this task and its' meaning was circumvented by a self oriented competing goal (the difficulty of the task), allowing the problematic voice to takeover the i-moment once again. This protest i-moment was pretty much centered on defying the problem, but no strategies or further elaboration were narrated in order to change this relation. It made the gap between her wish and her perceived competence on that moment so high that she looped to into the problem voice as the task seemed overwhelming for her.

The following excerpt is an example of a protest I-moment that is not involved in mutual in-feeding. It seemed to us that therapist intervention was important to the development of a reflection i-moment subsequently.

> *Fourth session*
>
> **Client:** *Last week, he was sick, having troubles breathing, and I stood by him, trying to help. A couple of days later he told me "you're kind to me again".* ***And I told him "that's because I felt pity for you, that's all"*** [Protest i-moment]*, but then I thought…*
>
> **Therapist:** *Why were you surprised?*
>
> **Client:** *Because I wasn´t expecting to say that.*
>
> **Therapist:** *In what sense?*
>
> **Client:** ***How could I do that? … Every time he was sick I helped and supported him, knowing that in that same day he can despise me. But it's this feeling… it's not love, it's a caring feeling, pity, compassion, that mix together and makes me be there for him in these situations.*** [Reflection i-moment]

The husband's report *"you're kind to me again"* was part of the macro organizer complex {A <> non A}. Maria then enacted a protest i-moment as she told him that the

only reason she took care of him was for pity, not for a caring feeling, as he wanted her to say. This i-moment ({B}) is a clear contrast with the problematic voice. She never said that before, as she began to realize this aspect early in psychotherapy, so it's a protest i-moment. Immediately after the i-moment, the sentence "*but then I thought…*" could indicate that she would open the {non B} field and state an opposite meaning if not interrupted by the therapist question. This question was directed to the i-moment exploration, specifically the feeling of surprise of having that assertiveness towards her husband. Further elaboration by therapist ("*In what sense?")* gives origin to a new reflective i-moment. Maria acknowledges that she usually feels pity for him and that's why she continues to take care of him. This makes her feel bad about herself because her caring is not reciprocal and she knows that he can be violent upon her afterward. Again, reflection i-moment was related to the problematic situation and involves some sort of self questioning, but it also seemed to derive from the previous protest. In this sense we observed a growth in the {B} field into {B'}, as it becomes differentiated, but always related to previous {B} (Josephs et al., 1999).

Another picture of the problem's dominance in Maria's life narratives and her difficulty to elaborate on the meaning of the i-moment is given by the following example.

> *Ninth session*
>
> **Therapist: If** *the wave was so big and oppressive, you would have never come to our sessions! And you haven't missed one session!*
>
> **Client:** ***No, I didn't. On the way here, to the clinic, I kept thinking "I'm not going", but then "no, I'm going!". I was fighting on the way here…*** [Protest i-moment] *But I can't fight all the time…. It's very complex…*

Therapist presented the "wave" as being "*oppressive*" but, even so, she stressed that Maria was able to never miss one session. The field {A} as the problem was noticed, and then the field {non A} as the exception was highlighted by therapist. This actually could be a window of opportunity for the development of new exceptional episodes of self empowerment as in good outcome cases. Maria elaborated from the {non A} and narrated a protest i-moment ({B}), in which she showed how she defied

the problem as she was walking to the clinic, establishing a dialogue with it. However, this voice was not fully elaborated but rather restrained as she emphasized that she could not perform these exceptions "*all the time*". She used the resources of the macro-organizer ("*I can't*") to transform the potential meaning of actually being able to defy the problem.

In final sessions, protest i-moments showed an increasing salience and became oriented to different directions like the partner, the problem and her husband's family. Until final sessions, we could still find evidence of strategies that circumvented the meaning of i-moments and maintained mutual in-feeding. Protest i-moment continued to show this ambivalence as we can see in the following example.

> *Fourteenth session:*
>
> **Client:** *No, I did not change. I didn't. Because, for instance… he is quieter now, he doesn't fight as much, as long as things are all right. It's always like this.* ***But I always have in my mind that everything that I've been through I can still go through it again. All the insults, the abuse, that total, absolute and complete dominance… I would say that I needed to ask permission to breath.***
>
> **Therapist:** *That's it.*
>
> **Client:** ***It is not so much, of course, but … I almost had to ask: "Do you give me permission to breath?"*** [Reflection i-moment]
>
> **Therapist:** *Yes.*
>
> **Client:** *The dominance was so, so…*
>
> (…)
>
> **Therapist:** *Yes, he keeps…*
>
> **Client:** *Dominating me all the time!*
>
> **Therapist:** *Wanting that you think like that. Let's use that metaphor…*
>
> **Client:** *Yes.*
>
> **Therapist:** *Do you ask less often permission to breathe now?*
>
> **Client:** ***Yes, I ask less permission, yes. I say "I do not agree, I don't want, I don't think like you, I don't want to live here all my life"*** [Protest i-moment] <u>*but sometimes I think these things but I*</u>

can't say them, because when we live with a person who is not willing to understand, when we want to say it, we know that there's going to be a huge conflict and I avoid it.

In the beginning of this excerpt Maria states that she did not change and the reason why there are not so many fights is that he is quieter, as the meaning complex {A<>non A}. Despite this acknowledgment she states that she keeps in mind what she went through these last years ({B}), and she recognizes her husband's dominance until current days. This i-moment seemed to coexist with the problem. As client acknowledged that she almost had to ask "permission to breathe", therapist elaborated on it and it seemed to occur a growth of the {B} meaning complex, as client answered that she asked her husband "*less*" often "*permission to breathe*".

Maria showed in the Protest i-moment how she was able to state her position towards her husband more often ({B}), however sometimes she chooses not to do it (return to the complex {A<>non A}), ruled by the "*I can't*" organizer, just to avoid conflict. In this example it seems that these two ways of being coexist (submissive vs. assertive) but she does not make a commitment with the assertive position. Once again, she strengthened the belief that it was not worth trying to change, making this change dependent from the husband responses to her, as she "would never get anywhere", a rule present since the beginning of therapy.

In final sessions data suggest a movement not only toward diversity of i-moments, but a slight change in their quality. We can see a glimpse of empowerment in protest IMs and new self versions in reflection i-moments in the next excerpt. These are i-moments' subtypes usually related to successful therapy, but emerging in early phases (Santos et al., 2008).

Last session

Therapist: *Does it happen only with your husband, or with other people?*

Client: With other people too. It happens with my mother-in-law. If I have to say I won't do it, I'm not going, if she asks something that I don't want to do, I don't do it. I feel that I don't fear her or my husband anymore. I'm capable of saying "I'm not doing it and

I'm not going". [Protest i-moment] ***I've been thinking a lot… I've forgiven a lot until now… I've never had respect for myself, and it's time to have respect for myself.*** [Reflection i-moment]

This might mean that the client actually achieved some change, as we see from the movements within i-moments. It seemed that some new meanings were achieved out of the vicious cycle of mutual in-feeding. These voices suffer some proliferation, showing dynamism. However, they did not configure an actual movement for the self's system development.

5. DISCUSSION

One of the first conclusions we can draw upon the emergence of i-moments in Maria's case is that she was able to narrate exceptional features of her life and elaborate around them (salience) in therapeutic conversation, despite the severe symptoms. However, the types of i-moments enacted – mainly reflection and protest - did not give place to the narrative elaboration (through an increasing salience) and to the emergence of re-conceptualization and new experiences. This was predicted by our model for therapeutic failure and is congruent with our theoretical assumptions.

One can argue that the maintenance of protest and reflection i-moments could constitute a viable alternative narrative, from the client's point of view. Maria was seen in psychotherapy in order to improve from depressive symptoms, and also to plan and perform her decision of leaving home. However, she decided she could not leave home without her oldest son, and therapeutic work focused on developing viable ways of relating to her husband. This last issue is clear in protest i-moments and the attention to this issue explains their increasing salience in last sessions. At the last session there was actually an improvement in distress. Results even show that slight changes in these i-moments' content occurred in final sessions.

We believe that these changes (confirmed by i-moments emergence throughout the process) occurred in a context of dynamism. Valsiner proposed that «If the number of parts in a multivoiced self-system is conceptually allowed to increase […], the self-system is dynamic, but not developmental» (2002, p.260). In fact, we also found that the system of meanings stood stable and did not evolve since the types of i-moments enacted maintained the same self-narrative and they were involved in a circular

feedback loop. Relations between them and the problem were regulated in a way that originated mutual in-feeding, sustained along the therapeutic process. From a dialectical point of view, being the problem expressed by the {A<>non A} meaning complex and i-moments the {B<>non B} meaning complex, one can say that these two complex were related in a way that feed each other throughout the process. I-moments seemed to emerge from some sort of growth in the {non A} field. Then {B} emerged as a new meaning complex. Being {non B} everything that was opposite to {B}, it could entailed something about previous {A} field. So, circumvention strategies seemed to act upon this {non B} and bypassed the meaning of {B}, promoting a returning to {A} field, the problem. As the i-moments emerged, they were constructed in ways that lead to the use of circumvention strategies that bypassed their meaning and facilitate the return to the problem. Thus, a recurrent feedback loop happened between the problem and i-moments (see figure III – 4).

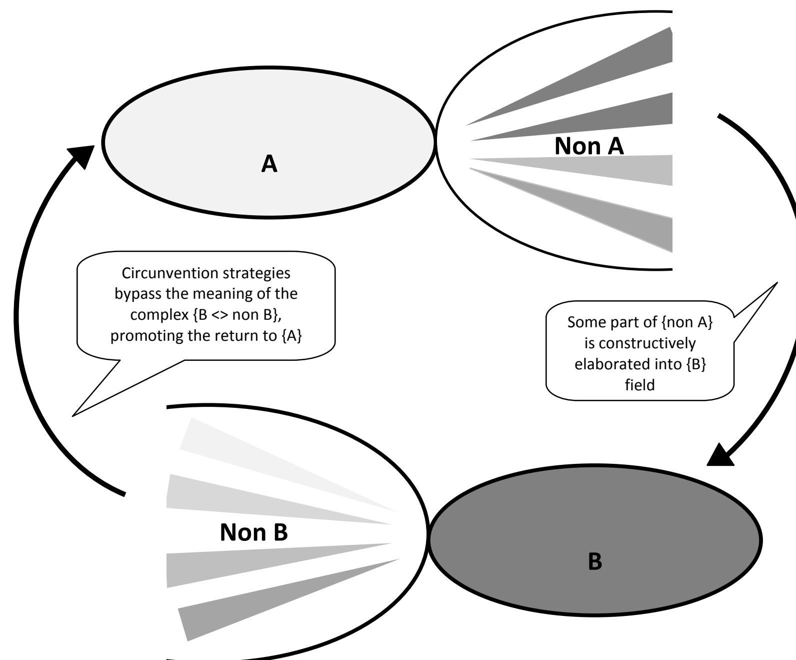

Figure III - 4. Mutual in feeding: a dialectical perspective over meaning maintenance. Adapted from Josephs et al. (1999).

The next illustration (figure III – 5) presents the same depiction of the process of returning to the problem following the first example of the results section.

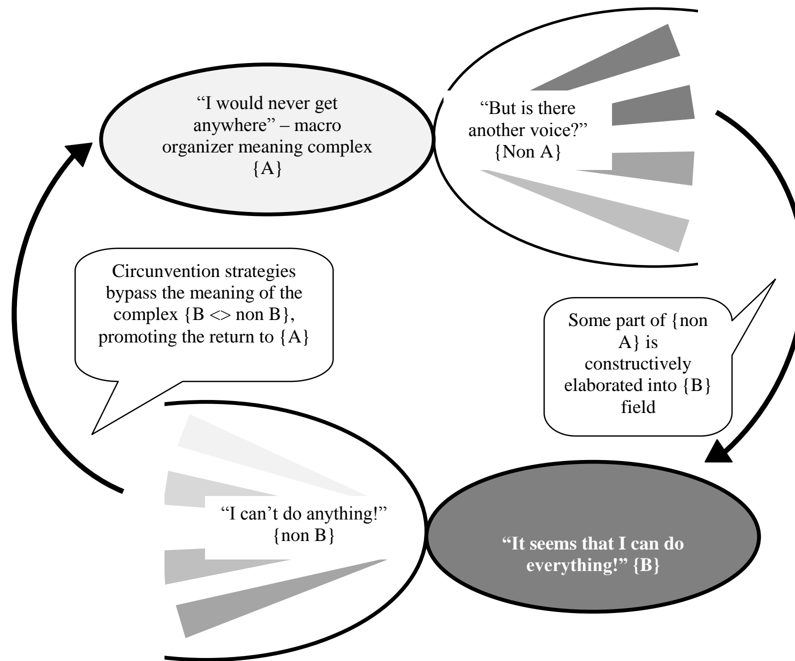

Figure III - 5. Mutual in feeding: a dialectical perspective over meaning maintenance with a case example.

It was also possible to point out how these i-moments did not develop into other types of i-moments, neither allowed salience progression, as happened in successful cases. The meanings expressed by i-moments were frequently followed and consequently restrained by the problem voice. This voice was usually introduced by an oppositional word (*but*) and made possible the return to the meanings ruled by the macro-organizer. It seemed that i-moments were systematically trivialized, neglected or simply taken over by the immediate emergence of the problem voice. So, dialogical relations of opposition and rivalry between the problem's voice and the I-moment were

"solved" by an immediate return to the problem. In this sense, i-moments did not evolve to the construction of other possible voices, but they seem to work as shadow voices of the problem, allowing its perpetuation. This restricted a further elaboration and new meaning complexes did not emerge (see figure III - 6), as they were absorbed into the vicious cycle. This process ended up strengthening the problem voice and maintaining its dominance not only because it was still present, but because it prevented other possible voices to develop. So, these two prevailing voices have dialogical relations of feedback loop between them that ended up in a feedforward loop of mutual in-feeding. This was actually a dynamic and also dialogical process, although promoting a stable cyclical movement of return to the problem along therapy. So, these two voices feed each other and preserve monologization and thus the unsuccessful therapy, as «not only monologization but also an extreme dialogicality could be involved in maintenance of the problematic dimensions of our lives» (Cunha, 2007, p.135).

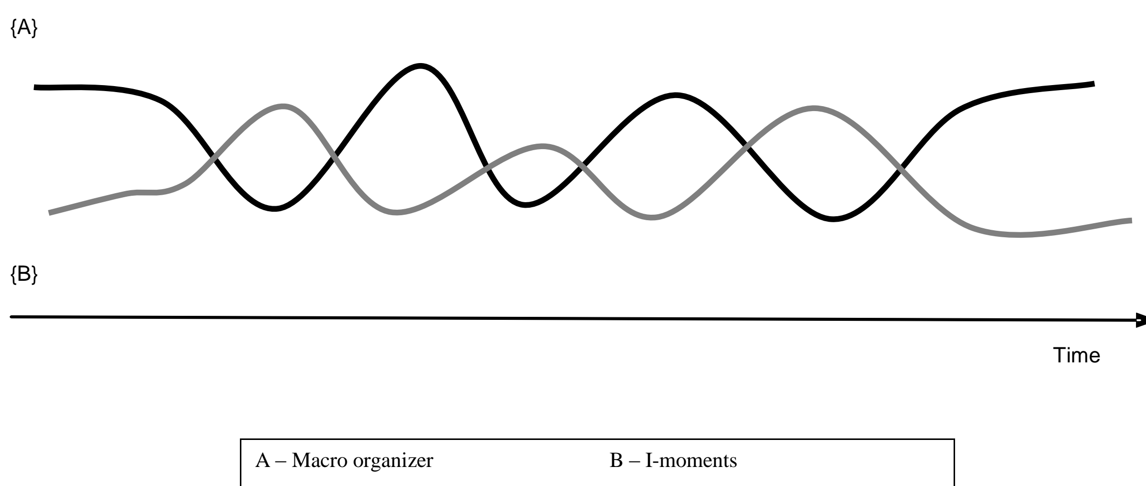

Figure III - 6. Mutual in-feeding throughout therapeutic process. Adapted from M. Gonçalves, Santos, Matos, Mendes, Ribeiro et al. (2008).

Not all of the i-moments of reflection and protest showed an immediate return to the problem voice. Mutual in-feeding can also be sustained by the content of the i-moments. So, since early sessions it is clear that general i-moments reported are mainly related to the aggressor and the experience of abuse. The prevalence of protest i-moments towards the aggressor can be perceived as the performance of exceptional moments inside the intimate sphere. They have no audience, meaning that others cannot

validate that change was occurring. Reflection i-moments were also related mainly to the problem, like unproductive questioning about abuse and victim condition, and also whishes that she would be capable of changing. We do not mean that these types of reflection i-moments are not important or useful at some part of therapeutic process. It means that these exceptions, since they are always related to the problem, somehow maintain its presence as they are recurrent across the entire process, as they are monothematic and recurrent. We have seen in good outcome cases that reflection and protest i-moments become, as process progresses, also directed to self change processes and self empowerment, respectively. This deflection from the problem and emphasis on the person set the stage for the development of re-conceptualization that emerge and increase in good outcome cases from the middle to the end of therapy.

As we can observe in figure III - 4, the emergence of a meaning complex directly from another one, entails features of the former in itself. Another path for development would be that {B<>non B} could lead to the development of other meanings, that would be, in its nature, differentiated from {A<>non A} (see figure III - 7). We believe that one possible process that could favor the development of differentiated i-moments (as {C<>non C}) could be the emergence of some forms of protest that state self empowerment towards self's facets and others (than the aggressor). After this differentiation, a development toward change would involve the emergence of meta-position to evaluate both voices and explain the process that origin new meanings. So, the emergence of re-conceptualization would involve more than both opposite voices present in Maria's case, since the regulation of these meaning complexes would lead to an integration of both, that would be narratively elaborated (through an increased salience) and could lead to the authorship of a new narrative. The absence of re-conceptualization i-moments lead to a failure to organize and relate the problematic voice and the i-moments (action, reflection and protest) and to constitute a new macro-organizer of meaning. This would set up the characteristics of the new self narrative.

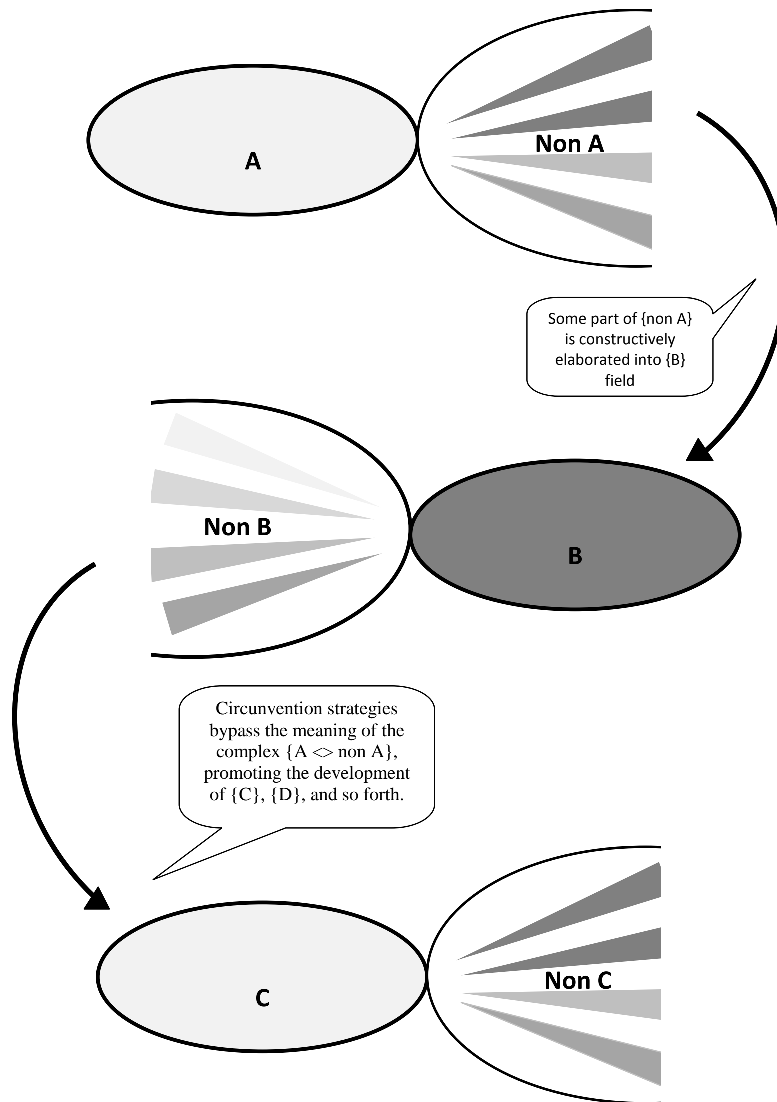

Figure III - 7. I-moments development: A dialectical perspective over meaning construction. Adapted from Josephs et al. (1999).

As process progressed, we saw that Maria's possible self positions were constantly reduced to the one of the problem, resulting in the prevalence and maintenance of a monological «interaction» as «one position or voice is admitted as the only possible position» (M. Gonçalves & Guilfoyle, 2006, p.253). The therapist frequently tried to open the conversation to dialogicality, in the sense that she tried to

promote and make possible the appearance of new perspectives through the elaboration of i-moments (or emphasizing the opposition within {A<>non A} complex). The recurrent effort of therapist in order to open the conversation to dialogicality, or to new possibilities can be argued as becoming, at some point, a part of the feedback cycle. Therapist's proposal seemed to be often accepted but also immediately refused by the client, as part of the return to the problem and maintenance of the *status quo*. It is important to notice that the client always came to therapy despite the "wave's" demands and, thus, one can argue that one possible form of breaking this cycle could be a drop-out from the client.

M. Gonçalves and Guilfoyle (2006) pointed out that a therapeutic interaction can indeed develop in a monological pole, as we could see in Maria's refusal of therapist invitation for authorship of «different positions from the problematic ones» (p.256). One belief that could be in the origin for the sustained monologism of Maria's case could be that «small changes are no changes at all» (M. Gonçalves & Guilfoyle, 2006, p.264). What makes small changes unnoticeable is the frequent reference to the desired change as an unachievable objective or magical wish. Then, small exceptions tend to be despised, as well as the amount of effort that is necessary to achieve the goal that seems overwhelming. Maria often states that she is not capable of undergoing with the development of exceptional episodes because this task seems too difficult for her. She actually acts by the rule "you would never go anywhere" (see results section) that ends up confirmed. So, «change becomes a dangerous utopia, which allows the status quo to keep itself unchangeable» (M. Gonçalves & Guilfoyle, 2006, p.264) as client seem to position herself in a monological narrative where i-moments do not challenge the pre-organized patterns.

We can address other possible explanations for therapeutic failure. It can be associated with the severe depressive symptoms that she suffered at the beginning of therapy, and that actually increased at the follow-up. This could indicate that more therapeutic sessions were needed to prevent relapse. Other specific conditions were present that prevented Maria leaving home and going to a temporary shelter for victims. On one hand, it was impossible to take her oldest son with her, according to the shelter's rules. She would have to leave him alone with his father, who had been

negligent to his sons during marriage. On the other hand, she was not able to cope with her feelings of pity towards her husband and his physical disability. Leaving home meant leaving a person with some special needs alone, what seemed unfair to her at the time. Of course, her story of abuse by her father could be another reason to keep her in this abusive relationship. Above all, isolation and lack of social support present throughout the marriage lead to a reduced net of social relationships, which could have been very helpful in the decision making and problem resolution processes.

This study has the obvious limitation of relying in one poor outcome case. We do not know if the same pattern would be found in other poor outcome cases in narrative therapy, or in another treatment approach. It also seems interesting to find out if successful therapeutic cases can, at any stage, present mutual in-feeding situations and how the dynamic stability evolves toward development. We believe that this change could happen through re-conceptualization, but we do not have data to confirm it until now.

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CHAPTER IV

INNOVATIVE MOMENTS AND CHANGE PROCESSES IN PSYCHOTHERAPY: AN EXERCISE IN NEW METHODOLOGY

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INNOVATIVE MOMENTS AND CHANGE PROCESSES IN PSYCHOTHERAPY: AN EXERCISE IN NEW METHODOLOGY[6]

1. Abstract

Psychotherapy is a field where development of dynamic methodologies is a conceptual imperative. In this chapter we present an analysis of the *Innovative Moments* (i-moments) emergence in psychotherapeutic process, through a dialogical lens. I-moments are the novel ways of thinking, interacting, and behaving that the client narrates in the therapeutic conversation, which is different from the rule he/she usually applies to his/her life. This rule is composed of general meanings over the world that guides their behaviors and understandings about it. Using Josephs' and colleagues dialectical framework (Josephs & Valsiner, 1998; Josephs, Valsiner & Surgan, 1999) we can conceive this rule as a macro-organizer of meaning. So, i-moments are considered new emergent meanings that are the promoters of change in psychotherapy. We explain how i-moments develop from the macro organizer of self's meanings and their dialectical nature. We shall then analyze the processes of meaning maintenance in therapeutic failure, as i-moments emerge and are recurrently integrated into the macro organizer of meaning. We also explore how i-moments meanings develop in order to achieve therapeutic change, namely into higher levels of meaning hierarchy, expressed by re-conceptualization and new experiences i-moments.

2. Narrating in psychotherapy

According to the narrative metaphor, people make sense of themselves through the construction of narrative structures (Bruner, 1986; McAdams, 1993; Ó. Gonçalves, 2000; Polkinghorne, 2004; Sarbin, 1986). When these self-narratives become mono-thematic (Hermans & Hermans-Jansen, 1995), monological (M. Gonçalves, Matos, & Santos, in press), dominant (Neimeyer, Herrero, & Botella, 2006) or saturated by the problem (White, 2007), they cease to have the flexibility of organizing the flow of

[6] This chapter will appear in the *Handbook of Dynamic Process Methodology in the Social and Developmental Sciences* in co-authorship with Anita Santos & Miguel M. Gonçalves.

experiences of daily life. These dominant narratives become a strict rule of acting, feeling and thinking (e.g., depressive self-narrative) and all the episodes outside this rule tend to be trivialized or ignored, making the emergence of novelties very difficult to occur. An *Innovative Moment* (i-moment) refers to the emergence of a feeling, a thought, an episode or even a project that is different from the ways people usually make sense of their lives. Thus, i-moments constitute opportunities in therapy (and in everyday life) to challenge the dominant self-narrative (see Gonçalves et al., in press).

I-moments have been studied in the context of narrative (M. Gonçalves, Santos, Matos, Mendes, & Martins, 2008; Matos, 2006; Matos, Santos, M. Gonçalves, & Martins, in press), emotion-focused (M. Gonçalves, Mendes, Ribeiro, Angus, & Greenberg, 2008), and constructivist psychotherapy (Ribeiro, 2008) and also in daily life changes (Cruz, 2008; Meira, 2008). We hypothesize that i-moments are process variables that allow depicting developmental patterns in self change processes. In this work we will apply the dialogical-dialectical approach (Josephs & Valsiner, 1998, Josephs et al., 1999) of meaning making to understand how i-moments emerge and develop, based on findings from a sample of narrative therapy (Matos et al., in press).

We start by describing the processes involved in the maintenance of the problematic narrative (the rule) and also how the novelty (the exception) emerges, and then we focus on their dialectical nature, from a dialogical perspective. Within this framework, we explain the processes involved in the meaning maintenance and change in narrative psychotherapy.

3. Innovative moments in narrative therapy

Signs, or meanings, are the mediators of psychological processes involved in development, as in psychotherapeutic change and either at an intra or interpersonal realm. They regulate the ongoing and fluid everyday experiences with the persons' meanings about them, organized in a narrative structure (Bruner, 1986; McAdams, 1993; Ó. Gonçalves, 2000; Polkinghorne, 1988; Sarbin, 1986; Valsiner, 2005). The developmental focus of this work follows Valsiner's (2001) definition of «*present-to-future*» developmental models, in which researchers «*focus on the processes of emergence – or construction – of novelty*» (p.86). A semiotic approach enables the

study of the meanings emergence online, as they are happening and as future oriented. Consider the following statements:

"I want to change"

and

"*I guess* I want to change"

These statements not only entail a present self condition of wanting to change, with some contrast with the past, but also different future potential orientations. The first statement may allow the engagement in the change process, whereas the second may prevent this active engagement, as the client used "*I guess*". The second statement seems to entail an ambivalent feature of self-uncertainty and bypass the power of self oriented goals expressed in "I want to change". Ultimately, "I *guess*" can lead to further reflections about wanting to change, actually not engaging in real efforts in order to do so. On the other hand, "I *want* to change" can promote a self state that combines reflective and active attempts to achieve a given transformation. However, the same example "I *guess* I want to change", depending on the context, can involve the source of ambiguity or tension that is needed for further development to happen. The expressed uncertainty also entails a flexible structure needed for the emergence of other meanings. In this sense, "I want to change" can be seen as a way to escape ambivalence and promote stability, but at the same time, almost paradoxically, preventing development.

The self system of meanings is hierarchical, constantly involved in auto-regulation processes that either maintain stability, or generate flexibility that can lead to transformation. Regulation allows the abstraction of personal experiences into subjective and generalized meanings, which can later be applied in different contexts. Signs are interdependent, since they regulate each other in different levels of the hierarchy. The example "I want to change" may be situated at a lower level before the client entered therapy, but may also constitute a high level organizer that rules the person's actions and thoughts in the future. Signs at the lower levels can thus be developed into the higher ones through an abstraction process (*abstractive generalization,* Valsiner, 2001). The reverse process is also valid, since meanings of higher levels are able to regulate particular contexts (*contextualizing specification*, Valsiner, 2001).

The client brings to the therapeutic encounter a current understanding or meaning about a specific problem that is expressed through a problematic narrative, or narratives, which seem to be composed by several rules or laws constituting the main framework for his/her understanding of life experiences. In this sense, they seem to work as macro organizers of self's meanings (Josephs & Valsiner, 1998). There are other clinical situations in which there is hardly an organized structure of meanings and signs may be rather dispersed and not at all organized (see Dimaggio, 2006). This applies to some psychotic states (e.g. Lysaker & Lysaker, 2006) and also to some personality disorders (e.g. Dimaggio & Semerari, 2004). In this chapter we will however deal with situations in which clearly a macro organizer – or several - creates strong restraints to meaning making processes (this is akin, as we wrote, to monological narratives (M. Gonçalves et al., in press).

Macro organizers of meanings are higher order meanings that work at an abstractive level, providing the person with specific rules of action and worldviews. In this sense, they seem to be also an evaluator of the person's experiences and provider of morality judgment over them by statements like "I should" or "I should not". These macro-organizers emerge in the client's narratives, usually by the emphasis in a main theme that can be a specific problem or a problematic situation, or even a set of recurrent themes, due to their «rigid generative processes» (Josephs & Valsiner, 1998, p.73). So, they originate applications of general rules (such as avoidance of "danger" in anxiety, for instance) to the daily life context, becoming dominating and restrictive of clients' experiences in the extent that micro or daily narratives that clients narrate are contaminated by it.

The established macro-organizer of meaning is at the foreground and whenever new potential meanings emerge they tend to decay and no innovation develops. The use of this generalized meaning organizer has the consequence of stabilizing or even restraining the person meaning-making efforts, as «the application of only a few basic rules would generate homogeneity within a closed system» (Josephs & Valsiner, 1998, p.73). A macro organizer can be challenged by the occurrence of exceptions to its rule, by the self or others suggestion (as the therapist), but they can easily lead «only to circular protest or defense ("one should not do that because one should not do that") and often to a further strengthening of rigidity» (Josephs & Valsiner, 1998, p.73).

For instance, a female client that describes panic symptoms and episodes of agoraphobia as her major problem will probably narrate life situations highly contaminated by intense anxiety and fear. Somatic complaints, progressive isolation and social withdraw would also be ingredients in her narratives. Her feelings would be dominated by the fear of losing control and avoidance actions would be recurrently used and therefore maintained.

> **Client:** *"I spend a lot of time at home… watching TV, most of all. I can´t find anything to do that pleases me. I really avoid getting out. Every time I need to go shopping it seems real torture to me. I must think about the best time to go: when I will not find so many people at the supermarket or when there will be less traffic on the road because I'm not able to drive in highways, it gets me confused and wondering where I could park the car...*
>
> *I avoid going to the mall... I feel like I can´t breathe and I have to get out. Even in church, I have to stay by the door. All of this is too much to bear… I can't tell anyone about it. I won't allow anyone to think I'm being weak…"*

In this previous case, the words "*I can't, I avoid, I won't allow*" are clearly associated with a macro organizer of meanings that demands and establishes rules for her life. The macro organizer meaning condenses all the client's usual ways of acting and reasoning. An exception to this meaning organization would be, for instance, going out to the supermarket to buy something, even out of rush hours. Another example can be thinking, at some point, that the consequences of the progressive isolation will be dramatic for her life, or that she simply needs to change. These constructions were named *unique outcomes* in the re-authoring therapeutic model of White and Epston (1990). Therapeutic conversation invites

> …people to continue to develop and tell stories about their lives, but they also help people to include some of the more neglected but potentially significant events and experiences that are "out of phase" with their dominant storylines. These events and experiences can be considered "unique outcomes" or "exceptions" (White, 2007, p.61).

In this model, unique outcomes are especially important as they are the departure point for change to happen. According to White and Epston (1990) «alternative stories can be generated or regenerated through a performance of meaning around unique outcomes» (p. 32). As clients become able to notice these exceptions and they are expanded in therapeutic conversation, they will further constitute a new self-narrative or a new self macro organizer of meanings. The therapist will help the client to identify or co-construct these exceptional moments by means of therapeutic conversation. From this point onwards they become noticeable more often and then they are expanded into new life areas or situations. These exceptional moments seem to be the roots that provide a basis for the narrative construction of novelty, in narrative therapy. They also feed the new self-narrative, since they seem to attract other exceptions throughout therapy, in a process of novelty escalation that is the construction of a new macro organizer of meaning. If we believe that the problem dictates the rule for the person's life, then any exception to it would be an unique outcome. As Watzlawick, Weakland and Fish (1974) pointed out «ordinarily, the promoter of change (even in certain aspects of growth and development) is deviance from some norm» (p. 31).

In the next example "*I did it two or three times*" would be considered an unique outcome, as well as "*I guess one of those times I wasn't so nervous*". However, it is also clear that client integrated this episode in the macro organizer, since she immediately said "*I will not try to do it anytime soon!*".

> **Client**: *"Facing a crowd?* ***I did it two or three times*** *and I will not try to do it anytime soon! I will certainly not! It's such an awkward feeling, my heart beat so fast, I was nervous and disoriented. My only goal was to get home quickly.* ***I guess one of those times I wasn't so nervous****."*

A network of exceptions could be elaborated from the construction of meaningful connections between them, and turn into a new self macro-organizer narrative. Progressively, as successful therapy evolves, what was the exception will become the new rule for the client's life.

Unique outcomes seem to be occurring before therapy started. Krause et al. (2007) suggested that change starts occurring before the client enters in therapy, being the «acceptance of one's own limits and the awareness of the need for help» (p. 674) the first efforts that lead to the actual search for help. Therefore, one of the first noticeable unique outcomes could be seeking for help and attending therapy.

3.1. Innovative moments (i-moments)

From the notion that narrative change is achieved by the elaboration of exceptions, a method for tracking these moments was developed. As research in narrative therapy developed, the notion of unique outcomes was found to be misleading. As they seemed to have an important role in therapeutic change (Matos et al., in press), the concept of innovative moments (i-moments) was adopted because they were found to be frequent and of a diverse nature (innovative, not unique), emerging throughout therapy. Besides, they are processes and not simply outcomes.

According to the *Innovative Moments Coding System: version 7* (IMCS; M. Gonçalves, Matos, & Santos, 2008) (Appendix II), i-moments are tracked from the macro organizer of meanings that the client brings to therapeutic conversation. This is often composed by a set of meanings about the clients' problems or problematic relationships and also the relevant symptoms. Once the macro organizer of meanings for a specific client is identified, i-moments are depicted since they are everything that is different or innovative from the usual way person experiences, acts, reasons and feels (see table IV - 1).

Table IV - 1. I-moments types and examples. From Innovative Moments Coding System: version 7 (M. Gonçalve, Matos & Santos, 2008).

Types of i-moments	Subtypes	Examples
Action i-moment: Actions or specific behaviours against the problem.	(i) Reactive	▪ New coping behaviours facing anticipated or existent obstacles
	(ii) Proactive	▪ Effective resolution of unsolved problems ▪ Active exploration of solutions ▪ Restoring autonomy and self-control ▪ Searching for information about the problem
Reflection i-moment: Thinking processes that indicate the understanding of something new that makes the problem unacceptable (e.g., thoughts, intentions, interrogations, doubts).	(i) Creating distance from the problems	▪ Comprehension – Reconsidering problems' causes and/or awareness of its effects ▪ New problem formulations ▪ Adaptive self instructions and thoughts and/or ▪ Intention to fight problems' demands ▪ Considering cognitive and affective dilemmas
	(ii) Centered on the change	▪ Therapeutic Process – Reflecting about the therapeutic process ▪ Change Process – Considering the process and strategies implemented to overcome the problem ▪ New positions – emergence of new positions regarding problem's prescriptions ▪ Statements of self-worth and/or feelings of well-being
Protest i-moment: Moments of attitudinal defiance, that involve some kind of confrontation (directed at others or facets of oneself); it could be planned or concretized behaviours, thoughts, or/and feelings.	(i) Problem-oriented position	▪ Position of confrontation and critique in relation to the problem and those who support it.
	(ii) Emergence of new positions	▪ Positions of assertiveness and empowerment.
Re-conceptualization i-moment: Process description, at a meta-cognitive level (the client not only manifests thoughts and behaviours out of the problem dominated story, but also understands the processes that are involved in it).		▪ References to new/emergent identity positions; ▪ Re-evaluation of relationships; ▪ Reframing of previous problems; ▪ Redefinition of others.
New experiences i-moments: References to new aims, experiences, activities or projects, anticipated or in action, as consequence of change.		▪ Generalization into the future and other life dimensions of good outcomes; ▪ Problematic experience as a resource to new situations; ▪ Investment in new projects as a result of the process of change; ▪ Investment in new relationships as a result of the process of change.

The nature of i-moments is diverse, since it can be of different types, relating to their content and the processes involved. Consider, for instance, the problem presented above in the example and the following clinical illustration:

> **Client:** *"Yesterday, I managed to get out for half an hour and go to the supermarket because I barely had food at home."*

This is considered an i-moment, as it refers to a specific action that was not predicted by the macro organizer that demands her to stay home and not to defy the fear. So, in what concerns the type, this is an action i-moment. It was actually the first time that the client engaged herself in this active behavior in order to face her fears and isolation. Action i-moments can be of two subtypes: *reaction* and *pro-action*. The former action i-moment (going to the supermarket) was of the subtype *reaction*, since it was conditioned by the necessity to eat. *Pro-action* subtypes are signs of some autonomy or regained self control.

In the next example, the action of taking an elevator was not a result of a given constraining situation. She was actually in control of the situation, acting in advance, rather than waiting to react to fear and anxiety situations.

> **Client:** *"Yesterday I made an experiment – I had a medical consultation in the first floor of a building and I took the elevator!"*

Another type of i-moment is reflection. This can be any moment in which the person thinks differently than what one could expect from the dominant macro-organizer point of view, or when he/she understands something new that contradicts the former. The following example relates to a self instruction with the intention of defying the macro organizer demands. This example is subtype I - *creating distance from the problems*.

> **Client:** *"I woke up this morning with this thought: I must do something, something outside the house, maybe go for a walk."*

If the client enacts a reflection subtype II, some features have to be related with a perceived change, or new achievements. Stating the difference between a prior and a present self position could be a reflection *centered on change*.

> **Client:** *"I have been realizing that I'm able now to think about situations and about what happened, how I reacted and how I should do different next time."*

The following type, the protest i-moments can be either composed of an action (like action i-moments) or a thought (like reflection i-momets), but they add to these actions or thoughts an attitude of active defiance or non-compliance with the rules proposed by the macro organizer and its specifications. So, we can see, either explicitly or implicitly, two positions: one that supports the problematic narrative (a person, a community), and another that defies and contradicts the former (the client). The subtype I refers to a *problem-oriented position*, which entails confrontation in relation to the macro organizer meanings and those persons that seem to support it. In the next example, client expresses a new attitude facing fear, also acknowledging that she have been "feeding" it, with her compliance to it.

> **Client**: *"I will try to fight my fears! I can't stand living like this anymore!"*

A different version of protest is the emergence of new positions of *assertiveness and also empowerment*. These protests are characterized by self confidence utterances with a firm voice tone, and they are not exclusively directed to the problematic meanings.

> **Client**: *"I am m my own top priority now! I will move forward with my life!"*

The next excerpt accounts for a more complex type of i-moment: re-conceptualization.

Client: *"I know I react to situations in a different way from before and that some time ago I couldn't even do this distinction or this kind of evaluation. Just to exemplify, some days ago I parked my car near a column. When I got there, there was a car in front and I thought I couldn't get mine out. But I took a deep breath, I calmed myself, and I managed to get it out without a single scratch. Not too long ago, I would wait for the other car to leave, regardless how long that would take. I know this is just a small example, but it is also the result of an everyday effort of practicing (driving in rush hours and in more than two road lanes, parking, etc.), and not letting my negative thoughts take advantage over my actions. If I hadn't done so, I could not have succeeded. I'd better be prepared than staying in the shadow of what I could have done. I believe that I have possibilities and positive answers to my fears. "*

Re-conceptualization i-moments involve two main components: the contrast between the past self (the prevailing macro organizer narrative at therapy beginning) and the present self, and the description of the processes that allowed self's transformation from the past to the present. In this case, now she reacts *"to situations in a different way from before*", contrasting with *"some time ago, I would wait for the other car to leave, as long as it took"*. The *"everyday effort of practicing and not letting my negative thoughts to take advantage over my actions"* and the notion that it is *"better be prepared"* were part of the process that allowed change to occur. Thus, as in reflection i-moments, the client achieves new understandings, but he or she also describes the change process involved. These i-moments are characterized by the achievement of a meta-level position, as we can see in "*some time ago I couldn't do this distinction or this kind of evaluation",* from which the person can see the difference between the old plot and the new one and from where the new story can be developed.

New experiences are the i-moments related to future projects, activities or experiences as they are described as being the performance of the change process. This expansion to the future was impossible before, given the constraints of the macro-organizer narrative. It prevented the person to engage into future novel experiences, as

the meanings stood stable. New experiences is also the consequence of the establishment of a new higher order meaning organization that enables a new range of actions and thoughts accordingly. In the next example, as she achieved self-confidence due to recent achievements, she thought that talking about the change process with a friend would benefit her. This means a new engagement in social activities, which she had not done in recent years.

> **Client**: *"Now that I feel more confident, I feel that I have to improve my self-confidence. I think I need to talk about this with a friend. I have a friend that always helped me facing situations, she showed she trusted me, I think it's time for me to trust her also."*

3.2. I-moments and psychotherapeutic outcome in narrative therapy

The i-moments research findings (M. Gonçalves, Santos, Matos, Mendes, & Martins, 2008; Matos et al., in press) indicated that poor outcome cases from a narrative sample were characterized mainly through the emergence of action, reflection and protest i-moments since the beginning of therapy and their maintenance throughout the process. In good outcome cases all types of i-moments were present (from action to new experiences). However, they were characterized mainly by the emergence of re-conceptualization and new experiences i-moments, after the middle phase of therapy. At the same time, the i-moments salience[7], which is a measure of the percentage of time that client spent narrating the i-moment in each session, was found to be significantly higher in good outcome group, with an increasing profile. In poor outcome group salience was found to be rather stable throughout process phases.

Having these results in mind, we hypothesized about what kind of processes were involved in the elaboration of i-moments that prevented the network of i-moments to develop, as in good outcome cases, namely the increasing of the salience and the emergence of re-conceptualization and new experiences (M. Gonçalves et al., in press).

We hypothesize that, in poor outcome cases, the narrative macro organizer and i-moments were two opposite meanings, with a feedback loop relation, as they end up feeding into each other in a cyclical movement. Given that circular dynamic loop,

[7] Salience is a percentage index, computed from the time the client spent narrating an i-moments in seconds divided by the total time of the session, in seconds.

stability was maintained along the time and thus represented a failure to change or to develop new meaning complexes. The recurrent emergence of i-moments seemed to create narrative diversity within the self, although no further development was achieved. We believe that i-moments emergence throughout the poor outcome process occurred in a context of dynamism, where innovation was allowed to emerge in contrast to the macro organizer, but nevertheless without further development into different i-moments. As «a central need for dialogical self is to maintain dynamic stability within self» (Valsiner, 2002, p. 258), clients seemed to be engaged in a cyclical movement between a voice and a counter-voice that lead to an irresolvable dilemma and made change difficult to achieve. This process is described as mutual in-feeding, meaning that different meaning complexes establish relations between themselves that tend to feed into each other» throughout time (Valsiner, 2002, p.258).

A process of development would involve the emergence of novelty with a continuous, an irreversible and a future-oriented way (Valsiner, 1991), as different parts of the self can relate to each other in order to the emergence of new relations and also new meanings. This seemed to happen in good outcome cases, as clients seemed to have found a way to engage in i-moments development through the emergence of differentiated meanings.

There is a sequential order in psychotherapy, in terms of i-moments development. In the early stages action and reflection are the most narrated i-moments, as narrative details that accounted for the first signs of the ongoing change process. Then, protest i-moments begin to emerge and they become more often narrated as process evolved to middle sessions. At a middle stage, re-conceptualization emerged and increased its salience, leading finally to new experiences. As these two i-moments were narrated and expanded (clients spent more time talking about them), the other i-moments types declined in their salience, although they were still present in the final stages (see Figure IV - 1).

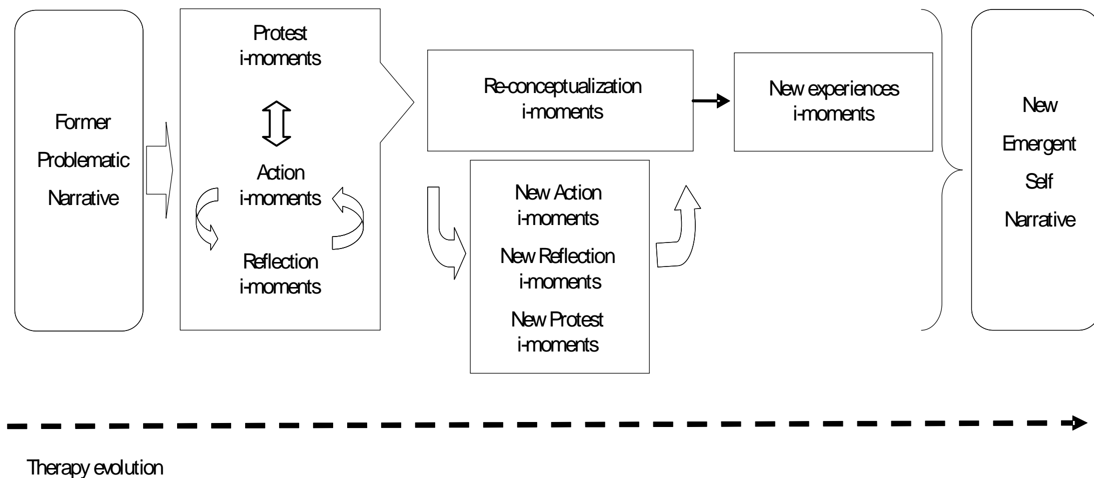

Figure IV - 1. Model for therapeutic change (adapted from M. Gonçalves et al., in press).

4. DIALECTICAL APPROACH TO I-MOMENTS

According to Valsiner (2005), meanings are synonymous of signs, the semiotic devices that people use in order to give sense to their experience. They correspond to present effort to, grounded on previous past knowledge, anticipate or move towards a future meaning or toward self development. All the range of this possible future conditions is guided by semiotic mediators that seem to occur in parallel at different levels of abstraction, from highly generalized fields (like values or beliefs) to verbally accessible mediators (self´s narratives emerging in therapeutic conversation). At this point, we will focus on this lower level of self narratives in psychotherapy, highlighting a microgenetic perspective of i-moments emergence.

4.1. The emergence of i-moments

We have described essentially two possible and contrary meaning complexes in self's narratives – the macro organizer of problematic meanings and i-moments as alternative meanings. We have also argued that the macro organizer of problematic meanings seem to be in a high level and i-moments at a lower level of meaning organization, at least when the therapy starts. The emergence of i-moments has, at the same time, the potential to change the macro organizer of problematic meanings.

Josephs et al. (1999) proposed a method to study the meaning making processes at a microgenetic[8] level, with the aim to explain (not to understand) them further.

According to Josephs and Valsiner (1998), meaning is transformed through dialogical relations between meaning complexes. Meaning complexes are composed «of signs (meanings *per se*) that present some aspects of the world, their implied opposites, and their qualifiers» (Josephs & Valsiner, 1998, p.70). By these signs, people act upon meanings in a given present context but also oriented to the future, by means of «meanacting (acting toward creating meaning)» (Josephs and Valsiner, 1998, p.258). The person transforms the present meaning complexes into futures ones in an autodialogical process of negotiation of the tension or disequilibrium created between them.

Meaning complexes are composed of dual fields, the field {A} and {non A}. These dual fields emerge together (explicitly or implicitly), being {A} the sign and {non A} the countersign of {A}, as in {A} the foreground and {non A} the background. Being "I feel fear" the field {A}, it is associated also with a whole range of its opposites, defined by the field {non A}, composing both the meaning complex {fear and non-fear}. We can only understand the feeling of fear taking all possible opposites feelings into account.

The field {A} is composed of a sign or signs with a specific meaning, to which we can relate synonyms and various versions by using semantic qualifiers (cf. Josephs & Valsiner, 1998). Qualifiers usually modify the meaning of the field, either opening it to transformation or closing it. So, the meaning of the field {A} could be open up for transformation by the use of qualifiers, that are signs that limit or modify the meaning of the field, such as *sometimes* or *all the time*. For instance, "*Sometimes* I feel fear of going out" is different from "I feel fear of going out *all the time*". The latter could be conceived as a macro-organizer of the meaning system, since it entails a sense of totality of the person life and actually closes the meaning complex to transformation.

The {non A} field emerges together with the previous {A} and includes its opposites, although in an unstructured or fuzzy way. It is contrasted with field {A} that is clearly defined. So, non-fear can include fearless, intrepid, brave, unafraid,

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

courageous, or even calm, cool or relaxing. This {non A} field has also the potential of involving a «yet-to-be differentiated field of meanings-to-be» (Josephs et al., 1999, p. 265), as it links the present meaning with a future one. So, {A} and {non A}, that can be thought as *as-is* and *as-if-could-be*, are related to each other by an opposition that «is the basis for its change» (Josephs et al., 1999, p. 261), which can be either harmonious or tensional. When both opposites co-occur with no tension at all, they tend to close the meaning complex. On the contrary, if tension occurs it enables the complex to transform, as it allows the establishment of dialogical relations with other meaning complexes.

Meaning transformation can occur through a process of growth of the {A} field. It can become progressive differentiated into {A'}, {A''} or {A'''}. In these transformations, the similarity with the {A} field is maintained. In this sense, the {A – "*Sometimes* I feel fear of going out"} field can grow into an opposition like {A' - "I *only* feel fear *when* I need to go to the supermarket"}. It can also integrate the previous one and grow into {A'' - "I feel fear *every time* I need to go out"}, or even perform a takeover of previous fields by {A''' - "I feel fear *all the time*"}. The qualifiers *sometimes*, *only*, *every time* and *all the time* modify the meaning of the field {A} opening it to possible transformations. For instance, *only* and *when* open the complex to the {non A} field, a still unstructured one, that can assume a various range of meaning. On the other hand, *every time* and *all the time* protect the meaning to evolve, stabilizing it and assuring its determinacy.

On the other hand, the constructive elaboration of the field {non A} develops towards a separation of {A} by changing its nature, constituting an innovation from it. So, to change one meaning complex {A - "I feel fear of going out"}, there has to be tension between the fields (like, for instance, in the previous example "*Sometimes* I feel fear of going out"), and the field {non A} needs to be somehow elaborated so that another meaning complex emerges and substitutes the first one. For instance, the field {B} could be "But yesterday I managed to go out". We also assume that the field {B}, once formed, has a dialectical relation with a field {non B}, which could entail features of the field {A}. Meaning-making entails the regulation of dialogical relations between meaning complexes, {A} and {B}. They can have dialogical relations of two different natures: harmonious or tensional. In harmonious coexistence, A and B can coexist

without rivalry: "*I feel fear of going out* [{A}] *but when I go out its ok* [{B}]*"*. The coexistence is clear when {A} is a determined statement and {B} does not imply any sort of tension. When tension is present some kind of resolution is needed. For instance, "*I sometimes feel fear of going out* [{A}] *but yesterday I managed to go out*, *and it was ok* [{B}]". The use of the qualifier sometimes can open up the meaning to transformation, since that statement is valid for a specific moment, then a new meaning is elaborated by the action of "going out yesterday". We can assume that {B- going out} took over {A - fear} as "*it was ok"* was applied to ensure that fear did not interfere. However, a meaning complex can protect itself from a takeover. In this sense, {A} can changes into {A'} (feelings of *caution* or *alert* instead of *fear*).

Summing up, we can consider the field {A} the meaning complex that expresses the macro organizer [9] and {non A} as the whole range of oppositions related to the problem as {non problem}. In therapeutic conversation, if the client chooses to elaborate on the field {non A}, either by his/her intention or by therapist suggestion, it is most likely to conduct to the development of a novelty, or to an i-moment, as some version of {non A}. The elaboration of the field {non A} can lead to another meaning field {B}, originating the meaning complex {B<>non B}.

According to i-moments coding procedures, when facing materials (e.g., therapeutic sessions) coders must firstly agree upon the macro organizer of meaning that entails a problem or problematic situation, in which client is involved in. We can assume that this is akin to the field {A<>non A}. Then, they must be aware to every meaning that is different or novel from the meaning of {A<>non A}. In other words, it is this difference at the meaning level that allows coders to mark a given excerpt as an i-moment. It is to say that we need to compare each segment of conversation with the problem and decide whether it belongs to the {A} or whether it is something different, a {B} meaning complex. In this sense, i-moments are a counter-meaning of the problem.

Meanings develop or are maintained through the establishment of dialogical relations between meaning complexes. These relations enable them to put together a hierarchy of meanings. A macro organizer is then a higher level meaning, and its relation to other meanings can be of integration or even takeover (destroying the

[9] For clarification purposes we adopt the meaning complex {A<>non A} to refer to the macro organizer of problematic meanings in every following examples in this work. We consider that clients can bring more than one problem, so more than one macro-organizer. However, this analysis should be undertaken in intensive case analyses, which is not the purpose of this paper.

previous meaning complex). However, its meaning can be defied by other meaning complexes, and other kinds of relations can be established. The insertion of i-moments, for instance, is an example of the emergence of low level meaning complexes. Their meaning can be simply bypassed by the macro organizer, and the novelty will decay.

The meaning of an i-moment can nonetheless establish some sort of relation with the macro organizer enabling its transformation. Circumvention strategies regulate the relations between meanings complexes (Josephs & Valsiner, 1998; Josephs et al., 1999). They are semiotic tools used by people instantly in the task of organizing the flow of everyday experience. They can strengthen a given meaning or overcome it, making new meanings. Their role is to give meanings a marginal or central importance, originating their maintenance or change. They lie on the goals and preferences of the person, so they act upon in an idiosyncratic context.

Circumvention strategies can lead to a wide range of possible outcomes, such as promotion or restrain of meaning construction. They are semiotic regulators that allow focusing on higher level meanings attending to the person's preferences, choices, and emphasis. The regulation processes between meaning complexes can result, as we said before, in a takeover that means an overcoming of meaning, but complexes can also have a harmonious or rival coexistence.

Circumvention strategies of meaning can act by focusing on or emphasizing specific features of the meaning complexes. So, focusing on a competing goal can mean that the client bypasses the meaning as she highlights a motivational goal that rivals with the previous meaning; e.g., "I will face fear, because *I have to* find a job, which means that *I have to* go out and *I have to* talk with other people!" Circumventing a meaning via highlighting personal preferences can happen when the client makes a stand as he/she will do what he/she likes ("I like") and what he/she wants ("I want, I need, I must") in that particular situation or even for his/her life.[10] Another form can be the circumvention of meaning through the introduction of symbolic helpers (the client uses symbolic statements, that are somehow decontextualized, in order to distance herself from the previous new meaning; e.g., "it's God's will"). Another circumvention strategy that seems to appear often, and in parallel with the previous ones, is by means of focusing on semantic qualifiers. So, expressions that somehow emphasize an

[10] These two types of circumvention strategies are difficult to distinguish, so we will apply them as being the same strategy by focusing on stronger goals and personal preferences in the following examples.

absolutist and determinist fashion in i-moments, such as “I will *no longer* accept this” can be used, but other that seem to promote some instability in meaning can also be used, like “*Sometimes* I feel fear”, which can open to meaning to further elaboration.

4.2. Therapeutic failure and dynamic stability of meaning-making

Stability and therapeutic failure were analyzed by means of the relations between the macro-organizer meaning ({A<>non A}) and the i-moments ({B<>non B}). These relations were regulated by the circumvention strategies that acted upon i-moments, bypassing their meaning and making the innovation movement decay. We will now illustrate our assumptions with examples from a previous case study (Santos, M. Gonçalves, & Matos, 2008) of a woman victim of partner violence. This case had a poor therapeutic outcome and we will analyze it through the lens of dialectical meaning transformation.

Maria had been married for twenty years and her husband, David, had been sexually and psychologically violent toward her since the first year of marriage. When she came to psychotherapy she had severe symptoms of depression (e.g., sadness, hopelessness, social withdraw, isolation) that were externalized[11] and labeled as “the wave”. The next illustration shows how Maria was willing to change, despite the presence of the “wave voice”.

> *First session*
>
> **Therapist**: *That position has a voice that states: “You have to convince yourself that you are not worth a thing, you have no value at all, there is no use to fight, it’s no use to start doing new things… don’t go that way because you won’t have any results”. Is it this kind of voice?*
>
> **Client**: *Yes, partly it is. It’s thinking that “it’s no use going that way because you won’t have any results”.*

[11] Externalization of the problem is a narrative practice that invites clients to analyze the problem as an external “entity” (White and Epston, 1990; White, 2007). In the case of victims of partner violence, the externalized problem is, for instance, fear, sadness or personal characteristics that support the violence, but not the abuse.

Therapist: *You said that "partly" there's a voice that says there's no use making any effort because you would never get anywhere. But is there another voice?* [elaboration on {non A}]
Client: ***Yes, there's another part that seems that I can do everything!*** [Reflection i-moment {B}] <u>But suddenly, it falls down! Like a cards' castle that we build and then suddenly falls apart!</u> [return to the problem {A}]

The voice "*you would never get anywhere*" was brought by Maria as belonging to the macro-organizer of problematic meaning. The employment of the words "*never*" and "*anywhere*" shows how definite and determinist this organizer had been in Maria's life. She also said that this was "partly" true, leading the therapist to question the presence of another voice. So, in terms of dialectical meaning complexes, being {A} the macro-organizer, therapist questioned directly to the elaboration of the field {non A} through *"But is there another voice?".* The client answered with an i-moment that expresses "*seems that I can do everything*" as the result of the elaboration of the field {non A}. Therefore, Maria stated the existence of these oppositional voices (meaning complexes), but after narrating the i-moment, the word "*but*" indicated the re-emergence of the previous and opposite voice by saying *"But suddenly, it falls down! Like a cards' castle that we build and then suddenly falls apart!".* By doing so, she prevented the meaning complexes to create tension by circumventing the meaning expressed in the i-moment. She used a symbolic helper, a "*cards' castle"*, in order to express that i-moments' meaning was not structured enough and it could be easily destroyed (also noted by the word "*seem*"), then creating a distance from it and reinforcing the voice "*you would never get anywhere*". Attempts to create exceptions are possible, as in the question from the therapist, but they can be easily understood as attacks to the macro-organizer's meaning, leading to a circular movement that strength its rigidity. The i-moment ("*seems that I can do everything*") was immediately bypassed. In this sense, Maria actually returned to and strengthened the meaning of the problem voice, despite the emergence of the i-moment (see figure IV - 2).

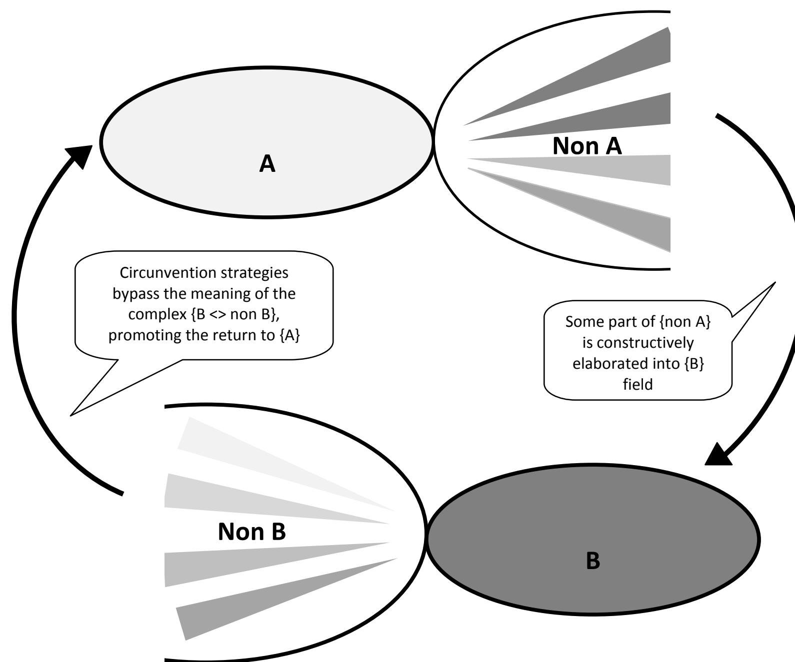

Figure IV - 2. Mutual in-feeding: a dialectical perspective over meaning maintenance. Adapted from Josephs et al. (1999).

As we detected in the previous analysis, the i-moment - {B} field - emerged from the development of {non A}. Then, immediately after, a circumvention strategy was applied to bypass the i-moment and promote the movement back to the {A} field, the macro organizer. I-moments seemed to emerge from the constructive elaboration of the {non A} field. Then {B} emerged as a new meaning complex. Being {non B} everything that was opposite to {B}, it entailed something about previous {A} field. So, circumvention strategies seemed to act upon this {non B} and bypassed the meaning of {B}, promoting a returning to {A} field, the problem. As i-moments emerged, they were constructed in ways that lead to the use of circumvention strategies that bypassed their meaning and facilitate the return to the problem. Thus, a recurrent feedback loop happened between the problem and i-moments.

In another example, relating to protest i-moment, Maria said she wanted to end with the “wave” completely.

Fourth session

Therapist: *What do you want to do to this "wave" (externalized label for depressive symptoms)? Today you've defied it …* [elaboration on {non A}]

Client: ***End with it completely,*** [Protest i-moment {B}] *but it seems very difficult to me…* [return to the problem {A}]

Therapist: *End with it…! You're ambitious!*

As the therapist identified an exceptional moment of defiance, highlighting the {non A} field of the {A<> non A} complex, Maria enacted a protest i-moment. Instead of a change in her relation to the problem, Maria stated the wish of eliminating the problem ({B}). This magical or non realistic aim stated in absolute terms like "*completely*", was immediately counterpointed with the difficulty of this task and its meaning was circumvented by a self oriented competing goal (the difficulty of the task), allowing the problematic voice to takeover the i-moment once again. This protest i-moment was pretty much centered on defying the problem, but no strategies or further elaboration were narrated in order to change this relation. It made the gap between her wish and her perceived competence on that moment so high that she returned to the problem voice as the task seemed overwhelming for her.

In the analyzed excerpts, the meanings expressed by i-moments were frequently followed and consequently restrained by the problem voice that made the return to the meanings ruled by the macro-organizer possible. It seemed that i-moments were systematically trivialized, neglected or simply taken over by the immediate emergence of the problem voice. So, dialogical relations of opposition and rivalry between the macro-organizer and the i-moment were "solved" by an immediate return to the problem. In this sense, i-moments did not evolve to the construction of other possible voices, but they seemed to work as shadow voices of the problem, allowing its perpetuation and closing the meanings system. This restricted a further elaboration and new meaning complexes did not emerge (see Figure IV - 3), as they were absorbed into the vicious cycle. This process ended up strengthening the problem voice and maintaining its dominance not only because it was still present, but because it prevented other possible voices from developing.

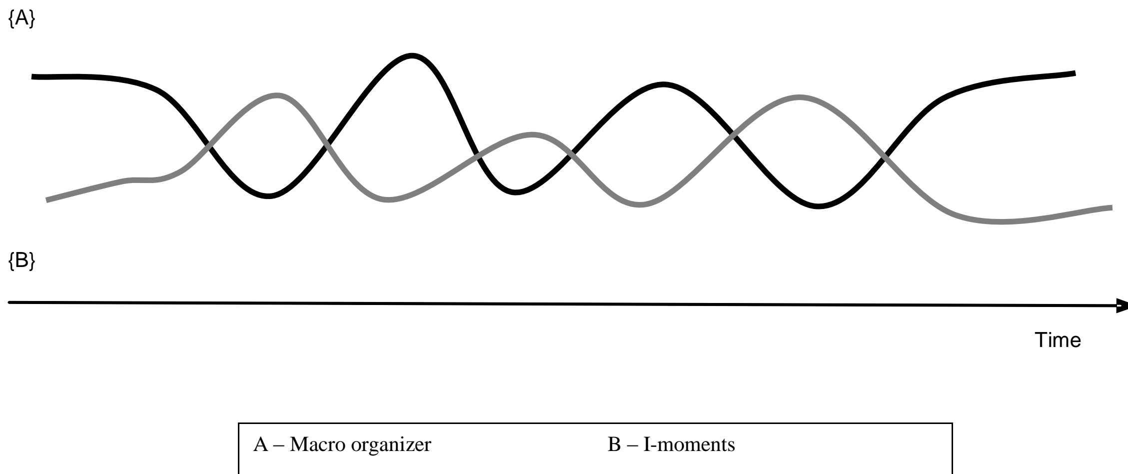

Figure IV - 3. Mutual in-feeding along therapeutic process. Adapted from M. Gonçalves, Santos, Matos, Mendes, Ribeiro et al. (2008).

In mutual in-feeding the field {non B} is somehow prompt to return to {A}, because it entails features of that same field. So, circumvention strategies are easily used to perform the task of bypass the i-moments meaning {B}. Mutual in-feeding seemed to be also related to the content of the i-moments. So, the overall reported i-moments were mainly related to the aggressor and the experience of abuse. The prevalence of protest i-moments of subtype I - problem oriented - showed a performance of innovations inside the intimate sphere. They have no audience, meaning that others cannot validate that change was occurring. Reflection i-moments were also related mainly to the distancing from the problem (subtype I), like the questioning about abuse and victim condition, whishes that she would be capable of changing and also magical wishes of problem elimination. We do not mean that these subtypes of i-moments are not important or useful at some point of the therapeutic process. It means that these exceptions, since they are always related to the macro organizer, somehow maintain the presence of the problem, by innovating simple by contradicting the problem (cf. M. Gonçalves et al., in press).

In this sense, the {B} field seemed to be able to grow into B', B'', B''' as different i-moments, but always of the same subtype/content. Taking reflection as an example, different forms of expressing the need for change can be used, always related to the first main idea. The i-moment "*then I thought I have to free myself from this fear,*

I need to change" can suffer a growth process into other forms, that are still related to {A}, such as*" there are moments when I think "I will say to the therapist: let's go forward, it doesn't matter, let's not think of anything else, and don't look back"*, or even "*I always have that in my mind: I'll free myself and I'm going away from here."*

Another path that could explain the stability of meaning is when {A} and {B} suffer a growth process into mutual escalating (Valsiner, 2002). Instead of feeding each other, entailing dialogical relations between them, both A and B grow into over generalizing each meanings, entering in a cross-fire situation but maintaining the relation stable. An example of escalating could be "*I think I need to change*", that develops into "*I really want to change*", and later into "*I will definitely change*". However, this is not a form of development either, since the escalating keeps the meaning complexes apart, with no dialogical relations between them, ending up in a monological outcome. This process of growing of the meaning complexes does not allow development, because it also maintains the meaning stability (Valsiner, 2002).

So, i-moments of action, reflection and protest may act as a mere opposition to the problem narrative, not allowing the development of new meanings outside the semiotic duality problematic narrative – negation of the problematic narrative (see also Gonçalves et al., in press). What seemed to be clear with the dialectical approach is that the problem is present even when it is absent, since the meaning of the i-moments seem to require a definition by opposition of the "problem". The consequent emergence of {anti B}, and its containing features of {A} field, brings the possibility of a return to the problem at anytime.

5. From Dynamism to Development

After explaining how the process of stability of i-moments seemed to be established and maintained in poor therapeutic outcome, we will present some possible explanations for the development of i-moments in good therapeutic outcome processes. It is important to notice that these are theoretical elaborations grounded on clinical vignettes of narrative clinical cases and they correspond to an effort of developing this method in order to explain the innovation emergence.

A study of mutual in-feeding through the identification of return to the problem markers (M. Gonçalves, Santos, Matos, Mendes, Ribeiro et al., in press) showed that

mutual in-feeding is a rare situation in good outcome cases, and that only happens in early sessions. Moreover, in these cases this process only occurs in action, reflection and protest i-moments. Findings showed that the resolution of mutual in-feeding seemed to occur in initial phases and parallel with the emergence of re-conceptualization in middle stages. On the other hand, in these cases most of the i-moments narrated in the beginning of the process are free from mutual in-feeding, enabling a development to other types and to an increasing salience, since they are not "trapped" in a circular feedback movement. For development to occur it seems necessary that clients are able not only to narrate i-moments, but also to avoid the mutual in-feeding situation, or to be able to find a way out of it when it happens.

These findings made us curious about the possible dialectical processes that allowed emergence of development. We are now trying to give a glimpse of these possible processes, as no research was intensively carried out with this method in good outcome therapy. We start by giving some clues about the resolution processes of mutual in-feeding. Then we will see how i-moments can develop in a progressive and a differentiated way, constructing the network of exceptions that will give place to a new rule, or narrative. Re-conceptualization i-moment, the most complex one, will be analyzed according to the notion of synthesis.

5.1. Resolving mutual in-feeding processes through takeover

One of the first processes that seem evident to occur in good outcome cases in therapy is the progressive development of i-moments. So, from the macro organizer, first exceptions are identified, which lead to their elaboration and from here to new i-moments emergence. We saw before that an i-moment {B} occurred from the constructive elaboration on {non A}. The following excerpt is from a victim of partner violence, Susan, who narrated fear as the most dominant problem in her life.

> *Third session*
>
> **Client**: *[...] I'm becoming aggressive, I started to… most of the times he beat me* [problem {A}] ***I tried not to answer, to be quiet,*** [action i-moment {B}]. *But there were situations when, mostly with verbal violence, that... it happened today, I lost my head and I said*

> *awful things to him, some of them I remember, others I don't.* [Return to the problem {A}] *And that…*
>
> **Therapist**: *It seems to cause you distress.* [Stresses the negative feelings associated with the problem {A}]
>
> **Client**: *Yes, a lot.* ***That made me turn around and start thinking "no, I can't go on like this because someday I'll be just like him, and I don't want that!".*** [Reflection i-moment {C}]

In the previous illustration we found that Susan mostly did not react to the violence upon her, as an action of self-protection. Then, she immediately stated that sometimes she reacted to verbal provocations being verbally aggressive towards him, which was considered a return to the problem. The aggressive behavior not only could lead to a violence escalade toward higher severity, but it also does not solve the situation, rather maintains it. The therapist highlighted the negative emotional state associated with the return to the problem ({A}), creating a state of clear tension between opposites. The client then elaborated on {non A – all possible non distressful situations} and narrated a new i-moment, stating a turning point and a self instruction. Return to the problem was circumvented by focusing on self preferences "*I don't want it*" with some powerful signs of self determination "*I can't go on like this*", creating a higher order organizer. {A} meaning seemed to be destroyed by a takeover, and thus restrained the possibility of returning to the problem (see Figure IV - 4).

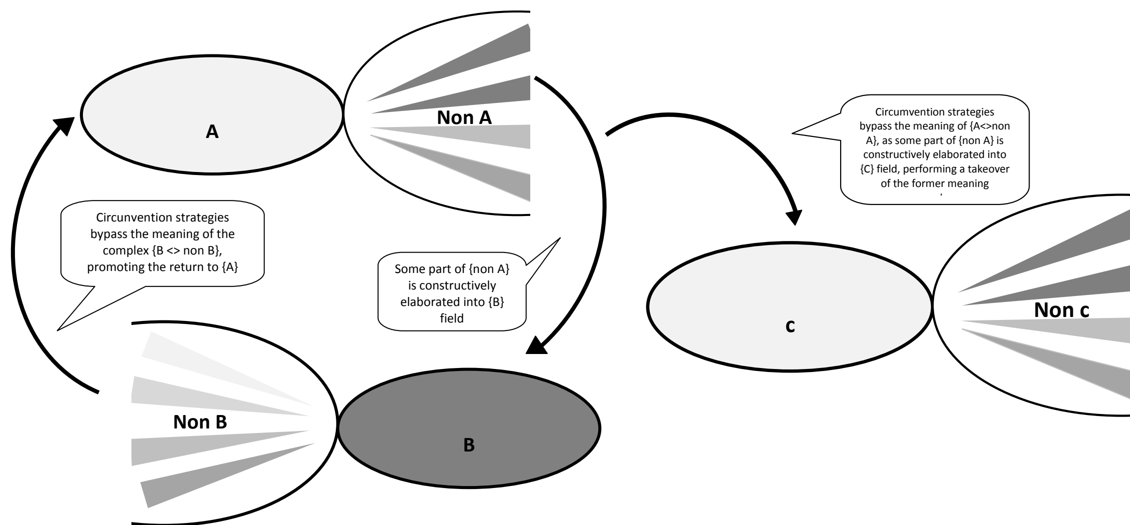

Figure IV - 4. Resolving mutual in-feeding.

To summarize, circumvention strategies seem to play a significant role not only in meaning maintenance, but also in the creation of higher level signs, or new i-moments meanings. New qualifiers can also be used in order to do it, such some deterministic expressions, like *must* and *ought to*, for instance, which would compete with the ones used in the macro organizer. The possibility of returning to the problem is, in this sense, reduced, because fields {B}, {C} or {D} no longer use qualifiers that imply ambiguity (*I think*, *sometimes*), but of determinacy.

5.2. Resolving mutual in-feeding processes by focusing on social validation

Resolving mutual in-feeding can also be enacted by therapist focus on social validation of changes. Joan, a victim of partner violence, living with her husband and two children, reported that her major difficulty was to "control" herself, meaning that she was not able to cope with the effects of the violent relation and had episodes of impulsiveness (with co-workers and her children, being often unfair to them), and also symptoms of depression and anxiety. This was a poor outcome case of the therapy (the excerpt is from a session from the final therapeutic phase):

Tenth session

Therapist: *What are those abilities?*

Client: ***Self-control. I never thought I could control myself!*** [reflection i-moment {B}] ***but I don't know if it is enough…*** [return to the problem {A}]

[...]

Therapist: *In a scale from 1 to 10, you are at point 8. In what are you different from before?*

Client: ***I'm more confident of myself, and have self-control.***

Therapist: *And other abilities, as a woman?*

Client: ***Self-control. And ready to help others***.

Therapist: *As a wife?*

Client: ***Self-control, when I'm with him and with my children***...

Therapist: *As a mother?*

Client: ***Less boring, for instance.***

Therapist: *As a professional?*

Client: ***I have self-confidence,*** *[reflection i-moment {B}] but that's somehow complicated... [return to the problem {A}]*

In the previous excerpt the reflection i-moment that client elicited is a new meaning complex {B – self control}, that was being amplified by the therapist questioning. An interesting feature is that client repeats the content of the i-moment as an answer to almost all the questions and does not elaborate on the new abilities, as she kept positioning herself in the macro organizer. The recurrence of the return to the problem seemed to prevent the elaboration of this ability, although the therapist's questioning around the generalization of this i-moment to other personal roles (from woman to wife, mother and professional). The same example continues as follows:

Therapist: *And to the society, how do others look at you at this moment, contrasting with before?*

Client: *Everyone sees me as a strong woman. Because sometimes they say: "If it were me, I wouldn't be able to handle it..."*

Therapist: *So they value you?*

Client: *Yes.*

Therapist: *"Strong", how? Like resistant?*

Client: ***Yes, resistant.***

(…)

Therapist: *They value you for...?*

Client: ***For moving forward and accomplish…***

Therapist: *What?*

Client: ***For being here, talking with you, to be able to face the situation, to talk about it, for instance.***

Therapist: *And to able to perform some changes in your life, too?*

Client: ***Yes. For trying to get it right.*** *[Reflection i-moment {C}]*

It seemed that when questioning stops focusing on herself and is directed to the others position over her accomplishments (elaboration on {non A}), contrasting with the former macro-organizer *("at this moment, contrasting with before?").* Joan seemed to be able to not just amplify the features of the previous i-moment, but to identify a set of new self features {C}, that are not limited to control vs. non control. Bringing to therapy the dialogical interactions with others, besides the therapist, seemed an important step in the resolution of mutual in-feeding in this situation. Therapist seemed to introduce a catalytic resource in order to promote novelty. The emergence of {C} made a takeover of the macro organizer of meaning, surpassing the mutual in-feeding process, opening the opportunity to the emergence of new self meanings, like {D}, that are not, in their nature, close to the {A} meaning (see Figure IV - 5).

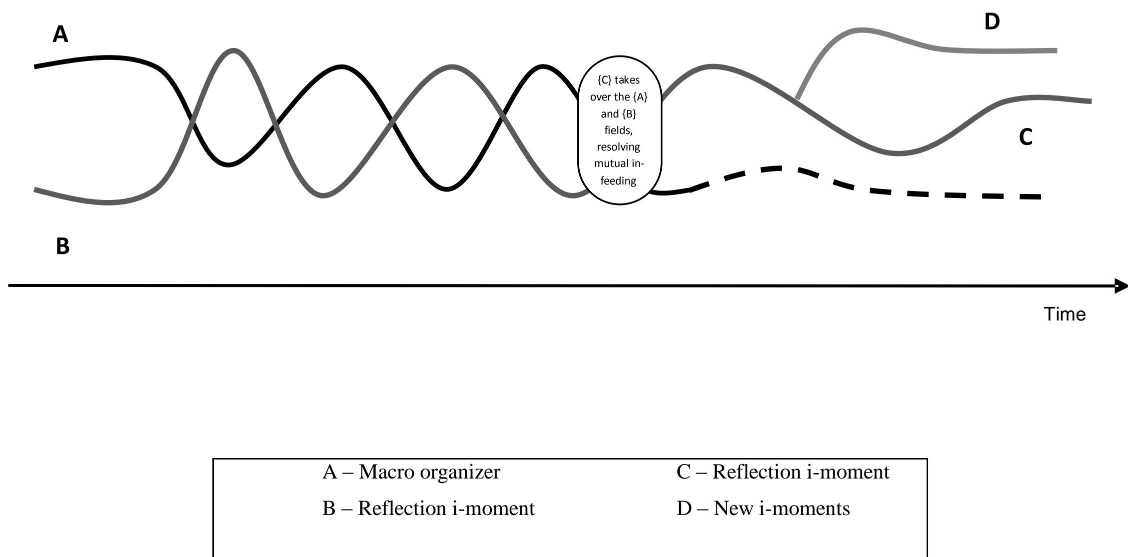

Figure IV - 5. Resolving mutual in-feeding through a takeover process.

6. The emergence of I-moments and the development of a new self-narrative

I-moments can develop in a continuous way, without any struggle between innovation and the macro organizer. This way is actually the one that promotes -- from early sessions of therapy onwards -- a clear distance from the macro organizer meanings. In other words, the constructive elaboration of the {non A} field can lead to new meanings {B}, {C}, {D}, and so on. This progressive construction will differentiate the new meanings from the macro organizer {A<> non A}. In this section we illustrate several forms of i-moments development: (1) through constructive elaboration; (2) by content development; and (3) by means of circumvention strategies of meaning.

6.1. I-moments development through constructive elaboration

In the following illustration Susan was narrating an episode of violence. At some point, she needed to get out of home, in order to protect herself and her daughter. Due to this situation, she engaged in thoughts about possible solutions, such as getting separated. This action i-moment lead to the emergence of the meaning *"I have to get separated, I have to do something".*

> *First session:*
>
> **Therapist**: *So, you left home…* [elaboration on non A]
>
> **Client**: ***I went out with my daughter on a bike and I ended up in a medical centre, I phoned… phoned… some friends*** [Action i-moment, {B}] *because* ***I started thinking "I have to get separated, I have to do something"***. [Reflection i-moment, {C}]

As we can see, the {non A} leads to the development of novelty as the need for actions of self-protection {B}. The implicit emergence of {non B}, as not taking actions to self protection, is immediately perceived as a self damage situation, leading to the emergence of a novel understanding, implied on {C}, as possible ways of resolving the violence situation (see figure IV - 6). Note the use of "*I have to*" to emphasize a personal need and also to takeover the {A<>non A} meaning. Both i-moments are related to subtypes I, congruent with therapy beginning.

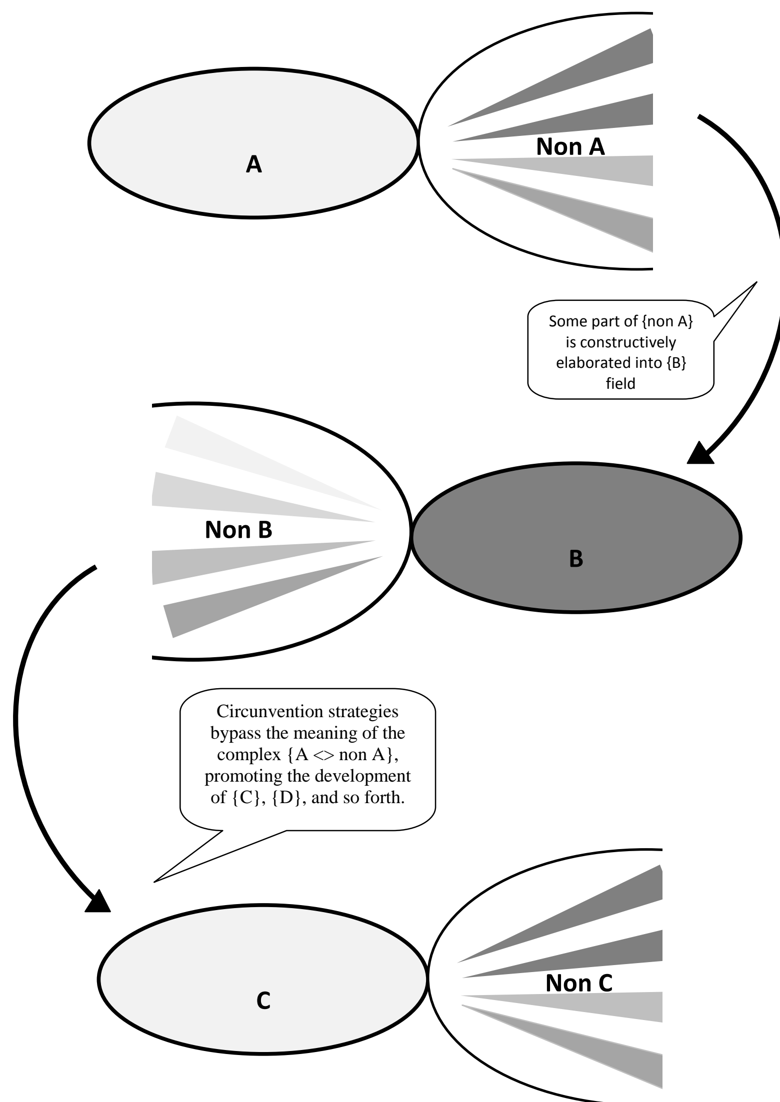

Figure IV - 6. Development of i-moments.

6.2. I-moments content development

Another possible form of i-moments development is when the subtypes of action, reflection or protest i-moments evolve into new meanings inside the same i-moment, but from subtypes I to subtypes II. Thus, reflection i-moments may evolve from the *creation of distance from the problem* to *centering the innovation on change*; protest from *problem-oriented position* to the *emergence of new positions*; and action from subtype *reaction* to subtype *proaction*. In fact, the meaning of the i-moments of

subtype I seem to be important, as they are the exceptions closer to the macro-organizer, and thus they act in the *zone of proximal development* (Leiman & Stiles, 2001) of the macro-organizer, defying it at the same time. As the change model presented before suggested, they are proofs that change is being accomplished, and they are the basis for further i-moments identification and amplification in therapeutic conversation. Assuming that the first subtypes are closer to the problem, and then more prompt to return to the problem, the path to their maintenance (and not deflection) could be by circumventing the problem by the use of strategies that highlight personal preferences and intentions, and therefore promote the development of new meanings that are no longer mere oppositions to the problem, leading to i-moments type II.

> *Second session*
>
> **Therapist**: *You were telling me that you want to do some changes in your life, qualitative changes…* [elaboration on non A]
>
> **Client**: ***I do. I do want to change. I've been realizing that I've been silencing and annihilating myself*** [reflection i-moment – {B} type I], *… I used to read, to have friends with whom I talked a lot. Since I married things began to change…*
>
> **Therapist**: *[...] There has been some kind of disinvestment in yourself...*
>
> **Client**: ***Yes, completely. But now… some time ago I started to look for myself, to take care of myself.*** [reflection i-moment – {B} type II]

The previous example refers to two i-moments, of the same type, however with different subtypes. The therapist question is related to the elaboration of {non A} field, about the changes client wants to achieve in the therapeutic process. Client enacts a reflection i-moment of subtype I. This {B} field refers to the acknowledgment that she wanted to change, due to a progressive understanding that she has been *"silencing and annihilating"* herself since her marriage began. The macro organizer was circumvented by a personal goal "*I do want to change*". Note also the inexistence of fuzzy qualifiers in this field, making the meaning clear and determined. The therapist actually summarizes this understanding by adding the sense of disinvestment, focusing on the

{non B – not wanting to change} field. As this field is very close to the macro-organizer, the contrast seemed to be highlighted and tension was created. Then client said "*Yes, completely.*" This statement seemed to enact and make clear to her that she had been not investing in herself, as a past condition, from where she enacted a reflection i-moment of subtype II ("But now…"), as she stated an actual change of starting to take care of herself[12]. We can see here a development from a reflection i-moment of distancing from the problem {B} to one centered on change {C}, by focusing on personal goals.

This last process could be involved in the i-moments development into more salient (more time narrated in session) and differentiated (more types and subtypes emerge). The circumvention strategies seemed to facilitate not only the emergence of these new meanings but their maintenance and ability to create other meanings.

6.3. Development of i-moments by circumvention strategies of meaning

As we argued before, the more distant one sets from the problem meaning complex, the easier it is to avoid the return to the old macro organizer. In fact, i-moments seem to suffer an escalade in good outcome cases. This can be promoted by the use of circumvention strategies that enhance the positive meaning of an i-moment, highlighting, for instance, the personal goals of the client. So, these meaning mediators seem to promote the development of i-moments, since they are elaborated in a way that makes unlikely the return to the macro organizer and, therefore, promote the emergence of other i-moments.

In the next excerpt, Susan narrates an episode with her husband, when she had an assertive attitude.

> *Third session*
>
> ***Therapist**: I was suggesting that you spend the least time possible with him at this stage… being separated … try to spend the least time possible with him, not be with him in the same space during the day…*[elaboration on {non A}]

[12] This i-moment could easily be coded as an action i-moment. From our point of view, the client did not relate any specific action and, given the context of the session, to "take care" of her meant to firstly have some space and time to think about the situation.

> ***Client****: Last week it was ok. But then he kept saying "give me one more chance"* [{A}]. ***And there was a time when I said "I gave four years of chances, I don't have any more to give you". "I know you don't believe me, but", "I'm sorry, I don't believe you nor do I trust you, and you had four years to… well, I gave you four years of chances, I don't have any more to give you".*** [Protest i-moment, {B}]

The repetition of "*I don't have any more (chances) to give you"* is a strategy to focus on a personal goal and reinforces the meaning of her assertiveness in this protest i-moment. In this example the i-moment is still very close to the macro organizer meaning {A – giving one more chance}, but the use of the repetition and the negative "I don't" focused the meaning in her present goals {B – not giving more chances}, taking over the {A} macro organizer, and opening the meaning system to development.

In the subsequent example Susan made a clear distinction between features that characterized her life dominated by fear ({A}) and her new position of not letting fear to be dominant again ({B}). "*I will not let it interfere"* shows a personal intentionality, with the strengthening of this position with the contrast with the past "*it interfered so many times, and for so long"* that emphasizes the clear gap between the past and present, strengthening the present position as "*that it's enough now…"*.

> *Fifth session*
>
> **Therapist**: *So, you are trying to have control over fear. But you'd like to have more control over the fear of your husband harming your child and harming you physically. However, fear tries to interfere but it can't…* [meaning complex {A}]
>
> **Client: *No. I will not let it interfere. It is a question of stubbornness now… it interfered so many times and for so long, that it's enough now… I have to put a stop to it, don't I?*** [Protest i-moment meaning complex {B}]

The development of i-moments has a lot to do with therapist intervention. It is not our aim to fully explore the range of therapist interventions and techniques in this

work, but to draw attention to some important features of therapist's action from a dialogical point of view. So, in this sense, therapist intervention can play an important role by separating i-moments from the past macro organizer emphasizing the existing gap between them. Consequently, this contrast creates tension between both meaning complexes and can promote the move towards i-moments elaboration. This movement is obviously idiographic, in the sense that it is congruent with the client's goals and preferences, and also promoted by her/his engagement with the alternative exceptions and refusal of following the past rules (macro organizer). In the following illustration Sophia was narrating the history of violence and the reasons that lead her to therapy. She had been separated from her partner several times before (macro organizer) and she is again separated from him, after being victim of a car accident provoked by him when she was pregnant.

> *First session:*
> **Therapist**: *What is the meaning of this situation for you? You have separated from him before, what is different this time?* [Elaboration on {non A}]
> **Client**: ***It's very different. Because I value me and my son's life, that is also his and he couldn't give that value. That's the most important for me, because a son is above us. My other daughter is also above everything and everyone.*** [Reflection i-moment, {B}]
> **Therapist**: *You made this decision because you put yourself first and you are thinking about the future…* [Elaboration on {B}]
> **Client**: ***And I want the best for my children. He couldn't value his son nor his wife, that's what really gets me. It's very different now.*** [Reflection i-moment, {B}]

In this previous excerpt, it seemed that the meaning of the macro organizer (emphasis on the return to her partner as she did before) was circumvented. This seemed to be promoted by the use of the strategy of abstraction. So, client focused on the assumption that her children are "*above everything and everyone*". These moral stances are defined as being of higher level and somehow even seem to be «immune to counterfactual evidence» (Josephs & Valsiner, 1998, p.79). In fact, the several times she

returned to her partner seem now insignificant, as a new rule has been created for future actions.

7. RE-CONCEPTUALIZATION OF THE EMERGENCE OF I-MOMENT THROUGH THE NOTION OF SYNTHESIS

According to the change model proposed before, after the emergence of action, reflection and protest i-moments, re-conceptualization emerges and has an increasing salience in good outcome groups. The emergence of re-conceptualization i-moments seemed to be a result of a synthesis process (see Cunha, Ribeiro & Cavadas, 2008). By definition, this i-moment entails not only features of the past and the present, but also the transformation process. A meta-position had been achieved by the client that enables to see what had been happening and make meaningful connections between events. One can say that they are now able to see their story and to write their life script, from an authorship position (M. Gonçalves et al., in press).

We believe that, for re-conceptualization to occur, it is important that the client had already achieved a position of separation from the problem, or a new relation to it. Previous findings (M. Gonçalves, Mendes, et al., 2008; Santos, M. Gonçalves, Matos, & Salvatore, 2008) suggested that protest i-moments seemed to promote this differentiation, as we saw in previous examples. Re-conceptualization i-moment seemed to be developed also after the other i-moments forms are present in psychotherapy in early stages. For instance, reflection could act as a precursor of re-conceptualization i-moment by making the first attempts to achieve new understandings and to depict self transformations.

An example of constructive elaboration, leading to a re-conceptualization i-moment, in a successful case is given in the next excerpt of Susan's case. In this excerpt, divided in two parts, she had been recently separated from her husband, and her therapist was elaborating on the contrast between her vision of partner's violence before she sought for help (judicial and psychological).

Fourth session

Therapist: *Do you think that being separated from your husband, that taking gradual steps towards a resolution, helps you to have a different image of the problem?* [Elaboration on {non A}]

Client: ***I lost the tendency of forgiving him, still not all of it, the tendency to relativism and I'm starting to see things in a new light.*** [{B} Reflection]

Therapist: *That's curious, because you have persons that are trying to convince you otherwise…* [Elaboration on {non B}]

Client: ***I'm also verifying something else: the more people try to convince me otherwise, the more I convince myself that I'm right, there is no way around.*** [Protest {C}]

Therapist: *What do you think that helped you resist towards the discourse of unaccountability (of your husband) that others tried to convince you of?* [elaboration on {non A}]

Client: ***It's beginning to realize that things were really worse than I imagined.*** [Reflection {B'}]

Therapist: *Hum*

Client: *And watching my son and thinking that there's no use for him to go through this. He's suffering the consequences, especially of being with his father… but my parents support is important, having them around.*

Therapist: *[…] You are telling me that you see the situation of living with violence in a new and more responsible perspective.*

Client: *I keep remembering lots of things, memories that come to my mind, that if… I think I have to write them down.*

Therapist: *And what…*

Client: *There are lots of things that came to my mind and then disappeared. I want to remember them again and I can't.*

***Therapist**: What helped you to have a clear picture of the problem?*
[Elaboration on {non A}]

Client: I think that I was starting to talk openly with others... Starting to talk helped me to start remembering fights with him that didn't come to mind. [Action {B''}]

In the previous excerpt, the therapist asked about "a different image of the problem*",* enabling an elaboration of the {non A} field. The client answered with a reflection i-moment, the {B} field, as she *"lost the tendency of forgiving him".* In this i-moment we can still see features of the {A} field *"still not all of it*". After this, the therapist made the counter-point {non B}, once again bringing the gap between both voices into light. The client stated that she was right, she is entitled to be right, as she has been the victim, and he must be responsible for his actions. Then, she will not drop the charges against him, as his family asked her to do. This protest i-moment {C} takes over the problem using the circumvention strategy of personal preferences "*I convince myself*" and also a powerful qualifier "*there is no way around".* This actually takes over the meaning of "*people try to convince me otherwise*" that belongs to the problematic narrative. For this reason, we consider this protest a meaning of higher level from the previous reflection. It seems to state a new starting point for her life. We begin to notice that the rules of the problem are becoming less followed. The therapist's next question seems to aim to consolidate this clear opposition to the problem narrative ("*discourse of unaccountability that others tried to convince*") expressed in the "*resistance*" – {non A}. The client stated new understandings in the sequence of the former ones, using qualifiers "*things were <u>really</u> worse than I imagined*" in {B} field. So, the main new comprehensions were not to forgive his violent actions upon her and realize that these were actually worse than she thought they were, mainly due to her tendency to relativism in the past (problematic narrative). Then, the therapist asks again about the {non A} field, the "*clear picture of the problem*". The client elaborates on this field and enacts an action i-moment saying that she started talking about the victimization with other people, enabling her to begin to remember things that she did not remember before [{B''} action]. This field is very closely related to the previous reflection.

Fourth session (continuation)

Therapist: *At this moment you recognize what you have gone through.* [Elaboration on {non B''}]

Client: ***In a clearer way, yes. I think that there are things that are beginning to hurt me, because I'm letting them come forward. I used to postpone before, not thinking, because if I thought about it I felt down and my son suffered. Now my parents are helping me. I'm starting to have a space for myself. I'm starting to have time to think and to let memories come.*** [{D} re-conceptualization]

Therapist: *I'm realizing that the anesthesia is going away.*

Client: ***Yes, it is. I've never cried before, I've never talked about some situations… but now I cry, this is beginning to happen to me.*** [{D} continuation of the re-conceptualization]

Therapist: *But that is…*

Client: *I still control myself a lot because my daughter is always present and I control myself because my parents are present… and they have been through a lot lately… I can't imagine what they have been through…*

Therapist: *[…] In fact, the anesthesia and bad feelings are going away… however, even if you want to tranquilize important people in your life, it is also important to have moments when you can release yourself from that tension. This is one of those spaces, but maybe you'll have to look for others…*

Client: ***From now on I'll try to find other spaces. I'll try to find others.*** [New experiences {E}]

The therapist stressed the negative emotion associated with the problem, when she hides her situation from others because of fear. So, the client developed recognition of what she went through with the violence experience and a new comprehension that she had not had while she was living with him. The process that allowed this understanding was the achievement of the former i-moments, to think about it and let her memories come to her, as she did not remember violence episodes when she came to

therapy. Also, a new emotional expression is involved (crying) as a result of this change. In other words, re-conceptualization forms a new meaning complex {D} that is of higher level than the previous ones, resulting from a synthesis process not only of i-moments but also of the problem that is integrated or assimilated into this new comprehension (see figure IV - 7) The client enacts another meaning complex {E} as she said she needed to find new spaces (other social contexts) where she could be able to express her feelings and have relaxing moments. These movements towards well-being could only be narrated due to the new comprehension expressed before in re-conceptualization i-moment.

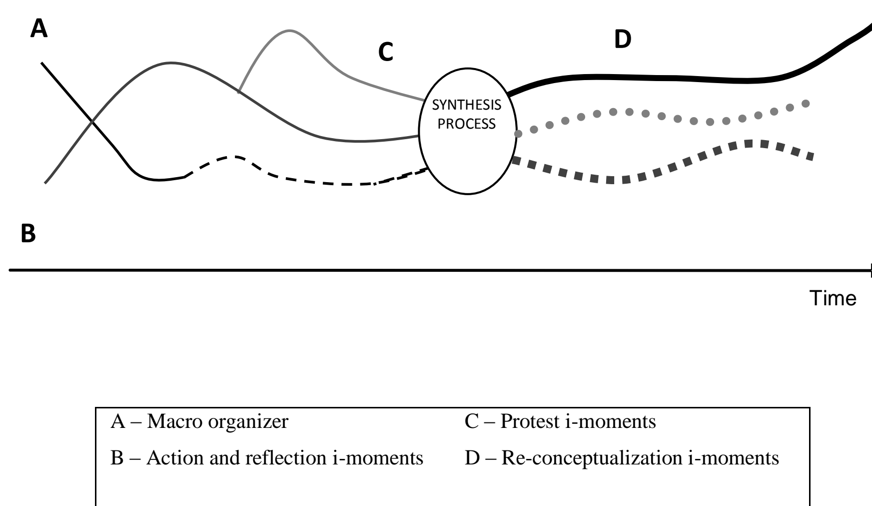

Figure IV - 7. Synthesis process and the emergence of re-conceptualization (D).

The therapist's intervention bringing forward the distinction between the former and the new self frequently elicits re-conceptualization i-moments. In narrative therapy, re-conceptualization can be triggered by the establishment of an opposition to the previous macro-organizer as we can see in the next illustration. In the next example the therapist compares the present ("time to receive") and the past ("time to search for") in terms of affective relationships. This meaning complex is again a re-conceptualization, fruit of previous achievements, as she stated in the process of "*thinking and rethinking the situation"*.

Eight session

Therapist: *Especially at this stage… it's time to receive, isn't it? Not to search…* [elaboration on {non A}]

Client: ***That's exactly how I feel, I need to receive… I came to the conclusion that… sometimes I've told people that the last months have been very bad, the last months with John, I mean, but lately, with all this thinking and rethinking of the situation, I see that they were not. In fact bad were the four years of emotional repression and lack of affection.***

Therapist: *It's another interesting perspective…*

Client: ***I really thought mainly about the last months, but now I don't, I've started to realize that it comes from years ago…*** [Re-conceptualization i-moment {D}[13]]

Therapist: *We can also talk about future contexts…* [elaboration on {non D}]

Client: *I really love to be with other people, I need to have people around me, I like to have friends and quality relations, essentially. I've always been an affectionate person…* ***and I'm recovering that well being that I used to have with other people, that I always had, I'm being able to recover it.*** [New experiences i-moment {E}]

This i-moment seemed to appear in order to reframe violent experience, meaning that she looked to past experiences and saw how they affected her, how she came to new solutions and how she dealt with them at that time. At this stage, the experience of violence began to be integrated into a new manner in the story of the self. This re-conceptualization was not preceded by a series of other i-moments, like in the previous example. Rather, at this stage of therapy, Susan enacted several re-conceptualizations i-moments as a form of synthesis from the i-moments that had been emerging in previous sessions. If we decompose this i-moment, it seemed made of several small achievements that taken together compose this new rule for Susan's life.

[13] Re-conceptualization is associated with field {D} for clarity purposes and also to highlight the higher order nature of this i-moment. It would be necessary to analyze the entire case to identify the meanings that promoted this re-conceptualization emergence that is the A, B and C complexes.

Lyra (1999, 2007) described the process of abbreviation as the way of emerging novelty in mother-infant relations, as some old features of the interchange become abbreviated allowing to explore new relational features (e.g., when caregiver and child are playing with an object). So re-conceptualization emergence could be the result of an abbreviation process, as it implies the integration of past conditions that are now regulated in an integrated manner. The former behaviors are no longer needed, since their meaning is abstracted and assimilated by the re-conceptualization, which means that it is available for further mediations.

The emergence of re-conceptualization can be understood as the achievement of a new macro-organizer of self's meanings. As we create meaning ahead from our needs in daily life, this new framework, or meaning organizer, is a very important developmental tool for the client. This synthesis of former i-moments, as a pattern formation, provides the client with a narrative framework to understand not only present and past experiences {D}, but also futures ones. In fact, a new experiences i-moment emerged, from the therapist elaboration about future contexts {non D}. Accordingly to the re-conceptualization meaning that stated lack of affection with her partner since they were married and her need to receive now, new experiences developed from its contrast, the self feature of being an affective person that seemed to be vanished in the relation with her husband and that she seemed to be able to recover {E}.

The study of re-conceptualization would benefit from a deep analysis following either personal themes or voices throughout therapeutic process. It may be possible that some self positions may not achieve re-conceptualization along the process. It would be also interesting to demonstrate the weight of each of the three i-moments (action, reflection and protest) in re-conceptualization's development.

8. Conclusion

The dialectical analysis allowed a deep understanding of the meaning construction in therapy through i-moments. Moreover, it allowed explaining its emergence in a developmental framework. The dialectical nature of i-moments points to its inherent dialogicality. They seem to emerge from a dialogical relationship of contrast with the macro-organizer. Thus, the kinds of dialogical relationship between the macro-organizer and new meaning complexes will allow the maintenance of the first or the

development of new macro-organizers. In psychotherapy, i-moments are, by the action of the therapist, questioned, contrasted, emphasized or even trivialized in therapeutic conversation. Besides the therapist effort in inviting the client to dialogue, this intervention will depend «on the way the client gives meaning to it» (M. Gonçalves & Guilfoyle, 2006, p. 253). Congruently, Leiman and Stiles propose the application of the zone of proximal development to therapy interchanges as an «intersubjective field» (Leiman & Stiles, 2001, p.316), where the developmental stage of the client will influence his/her ability to make sense out of therapeutic interventions.

The meanings that clients bring to therapy seem to be organized in a way that a macro organizer is constraining the meanings system. By constrain we mean that it is a higher meaning that influence the lower ones, and often these lower levels are being continuously integrated into the previous organization. These relations between levels of meaning are stable, in the sense that do not allow the «permanent impermanence of signs» (Valsiner, 2001, p.89).

The macro organizer meaning acts like a rule for the person's life. In therapy, it is from this rule that transformation and change may occur, since it is the main meaning available for co-constructing change. The exceptions to this rule, or i-moments, seem to be the departure point for meaning transformation. However, i-moments can also become a part of the meaning maintenance, as in the process of mutual in-feeding, deeply explored in previous works (M. Gonçalves et al., in press; Santos, M. Gonçalves & Matos, 2008).

The resolution of mutual in-feeding seems to be promoted by a progressive defiance of the macro organizer of problematic meaning by i-moments meanings, establishing a different relation between them. The contrast that i-moments meanings created is used in order to takeover the macro organizer, to reinforce person's goals, and, therefore, to elaborate on these exceptions. As i-moments meanings become differentiated from the macro organizer, they act like attractors to the development of further exceptions. So, i-moments suffer a differentiation in their type and content, and also an escalation as they become more elaborated in therapy. Consequently they achieve higher order levels in self's meaning system, progressively replacing previous organizers.

The i-moments escalation and progressive differentiation seems also to be the process involved in the re-conceptualization emergence. Moreover, this type of i-moment also involves the assimilation of the problem in an abstracted and generalized meaning, as a product of a synthesis process. Re-conceptualization progressive salience seemed to reduce the probability of the mutual in-feeding occurrence, since opposition was not a possibility anymore. So, the emergence of re-conceptualization would involve more than an opposition of meaning complexes, as it lead to an integration of both, that would be narratively elaborated (through an increased salience) into a new macro-organizer of meaning. These new meanings became a source of flexibility in self's meanings system, being also the departure point for new innovative cycles (that is, the emergence of more i-moments).

Re-conceptualization could be considered a promoter sign, or meaning mediator, because it seems to support development with «a feed-forward function» (Valsiner, 2005, p.2002). It also seemed to be internalized in good outcome cases and set up conditions for future experiences, where the knowledge achieved can be transferred into other contexts (new experiences i-moments). Subsequent i-moments are ruled by re-conceptualization framework, meaning that in the same contexts of life, people's actions and thoughts follow a new macro organizer that allows new meanings. This is also possible due to the temporal framework that it implies, connecting the past to the present and anticipating the future, and the formation of a new higher order stability, or a new *gestalt*.

One can argue that this process may be, once again, the establishment of a monological narrative. However, a sense of stability is needed in self's system of meanings in order to develop and be able to integrate new meanings. So, in successful therapy, this new macro-organizer would not entail monological relations between parts of the self, but dialogical ones. It would enable them to negotiate new meanings and achieve new higher order semiotic mediators, allowing not only the macro organizer to orient persons' experiences, but also that novelty can be developed and transform the higher levels meanings. In this sense, it will become also more flexible.

In this approach, as in other developmental ones, the role of tension or desiquilibrium is a central feature for change to happen (Josephs et al., 1999; Lewis, 2002). We would argue that it is essential for novelty to unfold within auto-regulatory

self systems, since introduces a discontinuity or even a state of disorder that the person needs to resolve. This resolution may lead to the maintenance of the old patterns, as we saw in mutual in-feeding situation, but it can also lead to the rupture of those patterns, allowing an opportunity to transform and change them.

9. FINAL REMARKS

In this work we analyze the developmental and dialogical framework in which i-moments emerge in therapy. Therapeutic change is considered a developmental process that is promoted by the emergence of i-moments. Meanings are understood as complexes that entail dialogical relations between them. Therefore, the evolution of the clinical process into failure or success seems dependent on the regulation of these dialogical interchanges. The macro organizer of meanings, brought by the client to therapy, can relate with i-moments' meanings in a process of mutual in-feeding, preventing new i-moments to develop, namely re-conceptualization. The dialectical approach allowed us to deeply understand this process and to propose some ways to resolve it by, for instance, a takeover of the macro organizer by means of the circumvention strategies. The semiotic tools are thus important in promoting stability but also in enhancing development. As i-moments develop into new ones, and become distant from the previous macro-organizer, the more complex and narrative structured i-moment, re-conceptualization, seemed to emerge by a process of synthesis. It seems to allow the development of a new macro organizer of meanings, regulating and mediating not only clients' experiences, but also their past and novel meanings. Future analysis of this process will be helpful for practice, in the sense that the therapist can be involved in promoting actively the emergence of re-conceptualization i-moments.

The analysis of therapeutic change as a developmental process, allows revealing what processes take place at a microgenetic level that promote ontogenic change. The dialectical approach is a useful tool to study the rapid flow of micro-processes that are involved in i-moments emergence, maintenance and transformation into self's narratives throughout therapeutic process. It also enables researchers to account for the dynamics of the change processes that seemed to be built upon tension generation. The dialogical processes that allow resolving tensional states can have many possible forms that are still needed to be studied, not only in therapy but in everyday life self transformations.

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CONCLUSÃO

“Eu não sou eu nem sou o outro,
Sou qualquer coisa de intermédio:
Pilar da ponte de tédio
Que vai de mim para o Outro. “

Mário de Sá-Carneiro

CONCLUSÃO

Apresentados os estudos que compõem este trabalho, importa, a título conclusivo, tecer algumas considerações e analisar as suas implicações.

A organização desta dissertação em quatro estudos foi um factor fundamental que permitiu imprimir um carácter progressivo e evolutivo na investigação realizada. Possibilitou, deste modo, poupar esforços relacionados com a elaboração de uma única compilação dos estudos realizados e redireccioná-los para a própria investigação, que, devido à sua vertente de qualitativa, se revelou morosa e consumidora de tempo.

Deste trabalho resultaram, além da consolidação dos dados empíricos acerca dos Momentos de Inovação (MIs), o desenvolvimento do Sistema de Codificação dos Momentos de Inovação. Esta é uma forma padronizada de desenvolver investigação com os MIs, aplicável a materiais qualitativos e com objectivos de investigação acerca da mudança. Assim, ao longo da realização deste trabalho, foi possível acompanhar a evolução do sistema de codificação dos MIs, desde a versão 1 (utilizada nos trabalhos empíricos, nos capítulos I, II e III) até à versão 7 que foi explorada no trabalho teórico (capítulo IV).

No campo da análise de dados, foram utilizadas várias metodologias que abarcaram diferentes níveis de análise, revelando-se complementares. No primeiro capítulo, a utilização de análises estatísticas paramétricas no sentido de diferenciar grupos contrastantes permitiu uma abordagem genérica dos padrões de mudança. Esta foi uma etapa importante pois constituiu-se como ponto de partida para as subsequentes pesquisas. Além disso, os resultados obtidos foram de encontro aos dados apresentados anteriormente (Matos, 2006). Este facto permitiu-nos concluir que a utilização do Sistema de Codificação dos Momentos de Inovação é uma ferramenta metodológica consistente.

Consequentemente, tendo por base as diferenças encontradas ao nível da saliência dos MIs, nomeadamente na reconceptualização e nas novas experiências, tornou-se pertinente analisar os diferentes processos que resultam em sucesso ou em insucesso terapêutico como a etapa seguinte da nossa investigação. Relativamente ao caso de sucesso, destaca-se o facto de que os padrões obtidos pela análise quantitativa realizada se mostrarem congruentes com o modelo de mudança proposto. Por outro

lado, a análise qualitativa contribuiu para fundamentar os mesmos resultados, salientando-se o papel dos MIs de protesto no desenvolvimento da reconceptualização, um dado que tem vindo a ser demonstrado noutras investigações (M. Gonçalves, Mendes, et al., 2008). Salientamos ainda neste estudo de caso de sucesso, a análise multidimensional e de *clusters*, que se revelou uma forma interessante de analisar os MIs ao longo do processo terapêutico a partir da forma como eles emergem. Esta pode ser uma forma interessante de analisar futuros resultados, cujos padrões sejam díspares do modelo aqui apresentado, no sentido de perceber que outros padrões de organização dos MIs podem também contribuir para a mudança.

Em relação ao papel preponderante da reconceptualização e das novas experiências no nosso modelo de mudança, salienta-se o facto da terapia de re-autoria promover a reconstrução (após a desconstrução do problema), através do questionamento dirigido à promoção de novos significados e também da expansão das narrativas para o futuro que podem, de algum modo, promover a sua saliência nos casos de sucesso terapêutico. No entanto, consideramos que os objectivos de promover uma ampliação da significação que possa sustentar movimentos orientados para o futuro não são exclusivamente narrativos. Pelo contrário, parecem até ser mais ou menos transversais às diversas orientações terapêuticas, tal como temos observado na terapia focada nas emoções (M. Gonçalves, Mendes, et al., 2008) e na construtivista (cf. Ribeiro, 2008).

O estudo de caso de insucesso segue uma abordagem qualitativa e microgenética de análise dos MIs, que surgiu a partir da conceptualização teórica dos processos de *alimentação mútua* (*mutual in-feeding*, Valsiner, 2002) envolvidos no insucesso. A adopção do modelo dialéctico possibilitou-nos a adopção de ferramentas de micro-análise importantes e, segundo a nossa perspectiva, adequadas ao processo evolutivo adjacente. Permitiu-nos perceber de que forma a emergência dos MIs se concertava com o macro organizador de significados já existente, respondendo à nossa curiosidade inicial relativa ao porquê de os MIs não evoluírem no sentido da mudança nestes casos terapêuticos.

É também digno de nota o facto de optarmos por dois estudos de caso. Com efeito, esta parece-nos uma metodologia que privilegia a análise em profundidade da emergência dos MIs nos casos terapêuticos, facilitando a contextualização de todos os

aspectos relativos aos processos de mudança em análise e, desde logo, permitindo analisar a complexidade e especificidade inerentes aos mesmos. Deste modo, contribuiu decisivamente para a expansão e sofisticação do modelo de mudança proposto.

No estudo final, de carácter teórico, as ferramentas dialécticas foram exploradas e ilustradas a partir de casos clínicos, no sentido de se constituírem como um método de análise do desenvolvimento da mudança. Foram avançadas propostas de resolução dos processos de alimentação mútua envolvidos no insucesso, e formas de desenvolvimento dos MIs no sucesso. Do nosso ponto de vista, este trabalho foi essencial para um progressivo reenquadramento das raízes narrativas dos MIs numa abordagem de carácter desenvolvimental e dialógica, que vinha a ser desenhado desde os estudos anteriores.

A mudança narrativa é, assim, encarada como um processo desenvolvimental. A análise dos MIs através da metodologia semiótica e dialéctica que permitiu perceber a emergência da mudança *online*, ou seja, à medida que emerge no processo terapêutico. Neste contexto, faz-nos sentido entender os MIs enquanto significados veiculados por detalhes narrativos que são captados pelo investigador na conversação terapêutica, a partir do seu contraste em relação ao macro organizador de significados. Este veicula regras internalizadas que permitem ao cliente fazer sentido da sua experiência que se revelam através das suas narrativas.

O macro organizador de significados é referido como sinónimo de narrativa dominante e monológica nos primeiros trabalhos. Parece-nos que a adopção deste conceito permite abarcar a noção de dinamismo de auto-regulação face à emergência de novidade, patentes, por exemplo, na análise do caso de insucesso. Ou seja, perceber como o indivíduo se auto regula face à emergência de novos significados de uma forma dinâmica e dialógica, mantendo os mesmos significados ou desenvolvendo-os. Os MIs são, então, significados emergentes da conversação terapêutica, identificados pelas suas características de novidade e inovação em relação ao macro organizador de significados.

A narrativa dominante, que parece ser frequentemente saturada pelos sintomas e pelo problema, pode ser apenas uma expressão do macro organizador dos significados que "povoam" a identidade do indivíduo. Frequentemente os clientes pedem ajuda em psicoterapia sem sintomatologia clinicamente significativa, de acordo com as medidas de resultado terapêutico, nem configuram um diagnóstico específico. O macro

organizador de significados engloba uma teia de significados veiculados por diferentes expressões narrativas, não se restringindo a um só tema, argumento ou personagens.

Dada a transversalidade da emergência dos MIs em várias orientações terapêuticas (Batista, 2008; M. Gonçalves, Mendes, et al., 2008; Ribeiro, 2008) e também na mudança não terapêutica (Cruz, 2008: Meira, 2008), importa reflectir acerca das implicações da investigação acerca dos momentos de inovação para a prática psicoterapêutica. Ressalva-se, no entanto, a ainda escassez de dados acerca dos processos envolvidos na emergência dos MIs noutras abordagens de intervenção.

Parece-nos importante enfatizar o dinamismo envolvido no processo de alimentação mútua na psicoterapia e na sua manutenção. O objectivo terapêutico na orientação narrativa seria o de criar distanciamento em relação às vozes problemáticas para posteriormente serem assimiladas, ou para serem estabelecidas novas relações entre estas e as alternativas. No caso de insucesso analisado, este distanciamento parece não ter sido criado, uma vez que a cliente fala a partir da voz do problema e integra a inovação novamente no sistema organizador de significados. As questões do terapeuta acerca das inovações podem, assim, ser facilmente integradas na manutenção das vozes opostas e divergentes. Além das formas propostas para resolver este dilema, a identificação e clarificação do contraste entre as excepções e a regra parece ser um caminho interessante, uma vez que o foco passa a ser a diferença entre as vozes, e não a preferência por uma ou por outra. Esta última opção pode, de facto, resultar na percepção por parte do cliente de que os seus significados centrais estão a ser ameaçados, impulsionando-o para a mudança.

Os MIs podem também ser utilizados para monitorizar o progresso, enquanto medidas de processo terapêutico. O clínico pode, deste modo, utilizar os materiais do seu cliente para fazer investigação acerca da sua mudança. Assim, a utilização de registos diários, tarefas para casa ou mesmo de diários do cliente podem ser analisados de acordo com os MIs. Espera-se aqui uma progressão idêntica à proposta pelo modelo de mudança à medida que o tratamento progride. Desta análise podem surgir indicadores importantes relativamente à forma como os significados se transformam ou não, dando pistas terapêuticas importantes para a promoção da mudança.

Apenas uma referência final em relação à problemática abordada neste trabalho – a vitimação na intimidade. O facto de os problemas psicológicos advirem dos efeitos

da violência que estava a ser exercida sobre as mulheres permite uma conceptualização do macro organizador dos significados em torno desses mesmos efeitos. Este facto permitiu, ao nível da investigação, uma clara identificação dos momentos excepcionais. Noutro tipo de população, os problemas podem ter uma natureza dispersa e relacionada com uma grande variedade de efeitos ou mesmo de contextos (e.g. familiares, relacionais, profissionais), o que poderá dificultar a identificação da "regra" e, por consequência, das "excepções". Por outro lado, esta amostra encerra problemáticas específicas que se constituem como desafios à intervenção psicoterapêutica, como por exemplo, a "adaptação" à situação de violência, o dilema relativo à separação, os constrangimentos sociais, os contornos judiciais do crime que sobre elas é perpetrado, entre outros. Consideramos que este trabalho pode fornecer detalhes importantes acerca dos processos envolvidos na psicoterapia com mulheres vítimas de violência na intimidade. A análise dos processos dialógicos envolvidos no sucesso e no insucesso terapêutico poderá influenciar a forma como os terapeutas forenses conceptualizam não só a intervenção terapêutica individual junto desta população, mas também num âmbito mais alargado, ao nível, por exemplo, da intervenção junto dos grupos de auto-ajuda com vítimas e até mesmo ao nível da prevenção.

As implicações ao nível de futuras investigações foram oportunamente abordadas nos estudos apresentados e também ao longo desta conclusão. Acreditamos que a sua divulgação foi importante para a recente proliferação dos dados e do debate em torno dos MIs em dissertações, comunicações em congressos e publicações (cf. Cruz, 2008; Batista, 2008; M. Gonçalves, Santos, Matos, Mendes, & Martins, 2008; M. Gonçalves, Mendes, Ribeiro, Angus, & Greenberg, 2008; Meira, 2008; Ribeiro, 2008). Foi também nosso intuito, ao longo deste trabalho, explorar e explicitar possibilidades de investigação dos MIs que possam ser utilizados por outros investigadores cativados, tal como nós, pelo estudo da mudança terapêutica.

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ANEXOS

ANEXO I

SISTEMA DE CODIFICAÇÃO DOS MOMENTOS DE INOVAÇÃO: VERSÃO 1

Sistema de Codificação dos Momentos de Inovação
Versão 1

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Universidade do Minho, Dezembro de 2006

O Sistema de Codificação dos Momentos de Inovação (SCMI) é um procedimento de análise de dados qualitativo, na medida em que utiliza dados qualitativos e a análise obedece ao princípio da inferência da inclusão nas categorias a partir dos dados. Assim, a análise do conteúdo processa-se a partir de categorias dos momentos de inovação, sendo uma categorização não finalizada, aberta a novas sistematizações com a introdução de novos dados.

1. Definição de Momentos de Inovação

Momento de Inovação (MI) refere-se à emergência de algo fora da história saturada pelo problema, diferente daquilo que é, geralmente, narrado pelo cliente (White & Epson, 1990). Pode ser um sentimento, um pensamento, um episódio ou um projecto não previsível/legitimado pela história saturada pelo problema.

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1.1 Pressupostos

De acordo com a terapia narrativa, a construção de narrativas novas e alternativas é o resultado da elaboração dos resultados únicos; estes são considerados como aberturas às novas histórias, ou oportunidades para que a mudança terapêutica possa ocorrer. Estes surgem frequentemente na conversação terapêutica, embora sejam trivializados e ignorados quando as histórias saturadas pelo problema são dominantes (diferente da noção de "único").

A noção de resultado único parece enfatizar um produto, ao invés de um processo de mudança. Assim, a noção de Momentos de Inovação descende directamente da de resultado único, de acordo com a conceptualização da terapia narrativa de re-autoria (White & Epston, 1990). Assim, os MIs encerram uma natureza dinâmica, processual e múltipla, e viabilizam mudanças pequenas mas significativas, que se constituem como marcadores do desenvolvimento narrativo da novidade (Gonçalves, Matos, & Santos, 2006).

2. Âmbito de aplicação

O Sistema de Codificação dos Momentos de Inovação tem como objectivo central o de permitir perceber os processos de mudança subjacentes às situações em estudo (mudança terapêutica, mudança espontânea, transições de vida, adaptação a

novas condições de saúde, …). Aplica-se em investigações com dados qualitativos, nomeadamente discurso e/ou conversação, mais concretamente sessões terapêuticas, entrevistas qualitativas, biografias, preferencialmente em suporte vídeo.

3. Dimensões de análise:

3.1 Tipologia: Acção, Reflexão, Protesto, Reconceptualização e Novas Experiências, de acordo com a Grelha de MIs.

3.1.1. Tabela 1. Grelha dos Momentos de Inovação

Tipos de MI	Exemplos
MIs de Acção: Acções ou comportamentos específicos de desafio ao problema.	▪ Novos desempenhos face à antecipada ou efectiva reinstalação de um obstáculo; ▪ Resolução de problemas não-resolvidos; ▪ Exploração activa de soluções específicas (e.g., recurso a técnicos ou instituições, procura de apoio efectivo); ▪ Restauração da autonomia (e.g., não interferência do problema no domínio profissional, financeiro) e do auto-controlo (e.g., separar domínio profissional e pessoal); ▪ Procura de informação sobre o problema.
MIs de Reflexão: Excepções de carácter cognitivo ou produtos cognitivos (ex. pensamentos, intenções, interrogações, dúvidas) que indiciam a compreensão de algo novo e que não legitimam o problema.	▪ Novas formulações do problema e consciência dos seus efeitos; ▪ Reconsiderações acerca das causas do problema (ex. gravidade, intensidade, reiteração, intencionalidade, etiologia); ▪ Articulação de dilemas cognitivos e afectivos; ▪ Reflexão face às prescrições culturais/sociais/religiosas; ▪ Referências a crenças de auto-valorização (e.g., força para lutar, pensamentos positivos); ▪ Auto-instruções (e.g., "tens que lutar"); ▪ Reflexão sobre a intenção de combater prescrições do problema (e.g., vergonha).
MIs de Protesto: Momentos de dissidência atitudinal, concretizados, planeados ou projectados.	▪ Posição de crítica/confronto face às prescrições do problema ou dos aliados do problema; ▪ Manifestações assertivas genéricas face a outros; ▪ Reposicionamento face às prescrições culturais, sociais, religiosas, e educacionais.
MIs de Reconceptualização: Descrição processual, a nível metacognitivo (i.e., não só surgem pensamentos e/ou desempenhos fora da lógica do problema, como emerge também o processo subjacente).	▪ Redefinição das versões de si (e.g., evidência de renovação pessoal; bem-estar a vários níveis; libertar-se da versão vítima; preservação de capacidades); ▪ Releitura da sua relação com os outros; ▪ Reapropriação de experiências na base do desenvolvimento do problema (e.g., reflexão sobre etiologia, escala, interferência/ custos, aprender a desvincular-se); ▪ Redefinição da versão acerca dos outros (e.g., enquanto aliados da mudança ou do problema no processo de mudança).
MIs de Novas Experiências: Referências a novas projectos, actividades ou investimentos, em curso ou antecipados, como consequências da mudança.	▪ Generalização no futuro de ganhos para outras dimensões da vida; ▪ Reutilização da experiência problemática para novas situações (e.g., problema como recurso ou aprendizagem; renovação de significados – transversalidade do problema); ▪ Reinvestimentos em novos projectos, posturas, imagem pessoal no espaço público e privado (e.g., profissionais, lazer); ▪ Reinvestimentos relacionais (e.g., íntimo, colegas).

3.1.2 Diferenciação entre MIs

MI de Acção – Envolvem acções ou comportamentos específicos de desafio ao problema.

MI de Reflexão – Emergência de novas compreensões de carácter cognitivo que não legitimam o problema. Não implica confronto (cf. MI de Protesto).

MI de Protesto – Momentos de dissidência/divergência ao nível atitudinal, que podem envolver comportamentos, pensamentos e sentimentos, projectados ou concretizados.

Pressupõe a existência de duas posições: uma que legitima ou suporta o problema (veiculada por uma pessoa concretamente, ou num nível mais abstracto, a sociedade, ou uma determinada cultura), e outra posição que desafia ou confronta a primeira. Envolve uma postura do/a cliente de proacção e de agência pessoal

Os MIs reflexivos e de protesto distinguem-se pelo facto dos primeiros relatarem uma posição mais interna, de consideração de outras perspectivas acerca de algo (e.g., "*penso que encontrei uma solução*"), de questionamento ou meditação (e.g., "*será que algo justifica esta ...?*"), enquanto que os MIs de protesto, apesar de também poderem ser pensamentos (ou sentimentos), são mais proactivos, categóricos, afirmativos e/ou assertivos (e.g., "*acho que nada pode justificar um acto destes; decidi não me condicionar mais pelo medo*"). Envolvem uma forma de se posicionar face ao problema e aos seus efeitos, e aos outros (e.g., "*disse à minha mãe que não aceito a ideia dela de que eu tenho que aguentar isto*!").

MI de Reconceptualização – Implica a descrição processual da mudança a partir de um nível metacognitivo. Esta posição permite aceder ao *self* antigo/anterior (antes da mudança) e ao self emergente/em desenvolvimento, a partir de uma 3ª posição, do exterior (uma posição de reflexão). O/a cliente não só descreve pensamentos e desempenhos fora da lógica do problema/história saturada, como percebe o processo subjacente.

Os MIs reflexivos diferenciam-se dos de Reconceptualização, na medida em que os primeiros estão associados a pensamentos de excepção (associados ao passado, ao presente ou ao futuro) e os segundos a momentos de elaboração narrativa em que a participante descreve, através de um processo metacognitivo, uma determinada mudança alcançada. É narrada a percepção de uma determinada transformação, o processo envolvido na sua emergência e a distinção entre aquele momento e a condição anterior àquela transformação.

MI de Novas Experiências – Envolve a antecipação ou planeamento de novas experiências, projectos ou actividades a um nível pessoal, profissional e relacional. Descreve as consequências do processo de mudança, por exemplo em termos de retirar ilações para o futuro ou de se assumir como perito experiencial, referindo concretamente que os novos desempenhos advêm do facto de ter passado pela situação problemática. Reflecte também a *performance* da Reconceptualização, ou o desempenho de novas competências em conformidade com a narrativa emergente.

3.2 Marcador discursivo: indicadores de conteúdo do MI.

3.3 Saliência: percentagem de tempo dispendido por cada MI na sessão, por referência ao tempo total da sessão.

3.4 Emergência: o MI é trazido para a conversação pelo/a terapeuta ou pelo/a cliente para a sessão.

4. Procedimento de cotação

A codificação processa-se através da visualização em vídeo das sessões. A sessão é analisada sequencialmente, com as paragens necessárias para reflexões.

5. Regras de codificação

1. Quando o/a cliente concorda com a suscitação pela terapeuta de um MI, codifica-se MI quando a novidade surge pela primeira vez na consulta (narração relativa

ao presente, ou passado recente) e não no passado. Os MIs identificados pelo terapeuta e outros (por exemplo, leitura de uma carta de alguém que identifica novos desempenhos do/a cliente), com os quais o/a cliente concorda são cotados por defeito, ou seja, num nível inferior (assumindo a ordem acção – reflexão – protesto - reconceptualização – novas experiências).

Exemplo:

1. Terapeuta: reconceptualização

Cliente: reflexão (excepto se houver evidencia clara/explicita que o RC está a ocorrer no presente)

2. Cliente: (lê uma carta escrita pela irmã a pedido da terapeuta) *[...] "Que imagem projecta a C. ?" [...] "A C. projecta a imagem de alguém que está novamente bem com a vida",* ***é verdade****, "voltou a ter um sorriso alegre e aberto",* ***também é verdade.*** *"Voltou a procurar os velhos amigos que haverá esquecido. As preocupações com a sua imagem com a sua imagem deixaram de estar postas de lado",* ***também é verdade…*** – a concordância da cliente com as afirmações da irmã (que corresponderiam ao MI de reconceptualização) é codificada ao nível do MI de reflexão. Porém, se esta mera conformidade fosse, de algum modo elaborada no sentido de um MI de reconceptualização, este seria codificado.

2. Os marcadores discursivos não são mutuamente exclusivos (codifica-se o mais saliente).

3. A emergência de MIs numa sequência temporal, dentro do mesmo marcador discursivo, codifica-se como sendo um só, mesmo que interrompido pelo terapeuta.

Exemplo: múltiplas acções de protecções pessoal (mudar a fechadura, tirar fotocópias de documentos) que configuram MI de acção num caso de violência conjugal.

T : *Fez muito bem. Então os aspectos que tínhamos combinado em relação à sua segurança?*

C: Já mudei as fechaduras, tenho os números de telefone dos vários...

T: *Instituições de urgência.*

C: Instituições de urgência. Tenho tudo. Mas pronto, documentos e isso já não me preocupa porque tenho os meus pais comigo neste momento, felizmente.

T: *Não, repare, e a Luísa teve o sistema do seu lado, o que nem sempre acontece, mas teve, porque podia não poder voltar para casa até hoje.*

C: Eu sei.

T: *Podia não ter podido voltar para casa.*

C: Felizmente.

T: *Como acontece na maioria dos casos. Por isso a questão dos documentos teria sido [ ] não foi importante porque [ ]*

C: Eu já os tinha na mala do carro, junto ao pneu suplente. Naquele mesmo dia tirei fotocópias na escola porque eu tenho[ ] A escola tem sempre fotocópias de todos os documentos.

T: *Para além de ter mudado as fechaduras, de ter conseguido ter os documentos originais consigo activou mais alguma daquelas estratégias, outras estratégias? Outra estratégia foi de não ter regressado a casa sozinha.*

C: Exacto.

T: *Fez muito bem, hum hum.*

C: Até porque não era capaz e até para voltar, eu por volta das 9h tinha ligado à minha vizinha, a uma senhora que mora lá, a perguntar se via luz ou qualquer coisa e ela disse-me que não e que não viu.

4. Podemos definir os MI como a emergência de novidades, mesmo quando a pessoa afirma esta novidade como uma característica estável.

Exemplo: “eu sou o tipo de pessoa que não se deixa influenciar pelo medo.” – A cliente foi inúmeras vezes antes influenciada pelo medo.

5. Protesto pode envolver acção ou reflexão, sendo que se codifica sempre protesto quando esta situação se verifica.

6. Quando há sobreposição de MI na codificação assume-se a hierarquia acção – reflexão – protesto - reconceptualização e codifica-se o mais abrangente.

7. Codificar somente os MI quando eles emergem e não codificar retroactivamente (quando são identificados posteriormente pela cliente).

8. Separação dos MI: Quando um MI é entrecortado por outro, a segunda parte conta-se como parte da primeira.

6. Validade

Critérios de validade: exaustividade e exclusão mútua na codificação dos MIs.

7. Fidelidade

A codificação realiza-se com recurso a 2 juízes, que visualizam as sessões em simultâneo e efectuam a codificação por consenso. Um 3º juiz, mais experiente, procede à codificação de forma independente de cerca de 30% da amostra, para a qual se calcula a percentagem de acordo e o índice de fidelidade entre juízes (através do procedimento estatístico *Kappa de Cohen*). Se o acordo for superior a 80%, considera-se que os dados obtidos pela codificação consensual são fidedignos e não são dependentes do investigador.

8. Referências

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ANEXO II

INNOVATIVE MOMENTS CODING SYSTEM: VERSION 7

INNOVATIVE MOMENTS CODING SYSTEM

VERSION 7

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University of Minho, July, 2008

Innovative Moments Coding System (IMCS) is a procedure of qualitative analysis. Data must be of qualitative type and the analysis procedure obeys the inferential principle of categories inclusion. Therefore, content analysis of data is performed by Innovative Moments (i-moments) categories. The System is open ended, allowing new conceptualizations derived from data analysis.

1. Innovative Moments definition

An Innovative Moment (i-moment) refers to the emergence of something outside the problem saturated story, different from what is usually narrated by the client (White & Epston, 1990). This can be a feeling, a thought, an episode or even a project not predicted by the problem saturated story. Consequently, an i-moment is, necessarily, a narrative novelty.

1.1 Principles

I-moments notion emerges from the re-authoring model proposed by White and Epston (1990), and refers to what these authors assigned as “unique outcome”. According to narrative therapy (White & Epston, 1990), the constructions of new and alternative narratives are the result of the elaboration of unique outcomes; these are considered openings to new narratives, or opportunities so that therapeutic change can happen. They emerge during therapeutic conversation, although being trivialized or unacknowledged when problem saturated stories are dominant.

The denomination of “unique” does not refer to a judgemental frequency (e.g., in the sense that appears only once), but to the contrast with the problem (“unique” from the point of view of the problem). The term outcome also does not refer to a therapeutic outcome, but an emphasis is placed on process dimensions of change. Innovative Moments entail a dynamic, process and a multiple nature. They enable small but significant changes that constitute markers of narrative development of novelty (Gonçalves, Matos & Santos, in press). Thus, in our coding system, we choose to refer to unique outcomes as i-moments.

2. Applicability

IMCS aims to allow the understanding of change processes beneath different life situations that are under study (therapeutic change, non therapeutic change, life transitions, new health situation adaptation…). IMCS applies to qualitative data, namely discourse or conversation, as therapeutic sessions, qualitative/in depth interviews, biographies, predominantly in video systems or transcripts.

3. Dimensions of analysis:

3.1 Types of i-moments: Action, Reflection, Protest, Re-conceptualization and New Experiences (see table 1).

3.1.1 Table 1 - Innovative Moments Grid

Types of i-moments	Subtypes	Examples
Action i-moment: Actions or specific behaviours against the problem.	(i) Reactive	▪ New coping behaviours facing anticipated or existent obstacles
	(ii) Proactive	▪ Effective resolution of unsolved problems ▪ Active exploration of solutions ▪ Restoring autonomy and self-control ▪ Searching for information about the problem
Reflection i-moment: Thinking processes that indicate the understanding of something new that makes the problem unacceptable (e.g., thoughts, intentions, interrogations, doubts).	(i) Creating distance from the problems	▪ Comprehension – Reconsidering problems' causes and/or awareness of its effects ▪ New problem formulations ▪ Adaptive self instructions and thoughts and/or ▪ Intention to fight problems' demands ▪ Considering cognitive and affective dilemmas
	(ii) Centered on the change	▪ Therapeutic Process – Reflecting about the therapeutic process ▪ Change Process – Considering the process and strategies implemented to overcome the problem ▪ New positions – emergence of new positions regarding problem's prescriptions ▪ Statements of self-worth and/or feelings of well-being
Protest i-moment: Moments of attitudinal defiance, that involve some kind of confrontation (directed at others or facets of oneself); it could be planned or concretized behaviours, thoughts, or/and feelings.	(i) Problem-oriented position	▪ Position of confrontation and critique in relation to the problem and those who support it.
	(ii) Emergence of new positions	▪ Positions of assertiveness and empowerment.
Re-conceptualization i-moment: Process description, at a meta-cognitive level (the client not only manifests thoughts and behaviours out of the problem dominated story, but also understands the processes that are involved in it).		▪ References to new/emergent identity positions; ▪ Re-evaluation of relationships; ▪ Reframing of previous problems; ▪ Redefinition of others.
New experiences i-moments: References to new aims, experiences, activities or projects, anticipated or in action, as consequence of change.		▪ Generalization into the future and other life dimensions of good outcomes; ▪ Problematic experience as a resource to new situations; ▪ Investment in new projects as a result of the process of change; ▪ Investment in new relationships as a result of the process of change.

3.1.2 Differentiating i-moments

Action i-moments – Actions or specific behaviours against the problematic story. They should not be the result or a direct consequence of the problem, but they should lead to the potential creation of new meanings. Thus, for instance, to protect myself instinctively from an aggression is not an i-moment. But, to protect myself in a more intentional way, is considered an i-moment (e.g., leaving home or asking for help).

Clinical vignette[14]

T (therapist): Was it difficult for you to take this step (not accepting the rules of "fear" and going out)?

C (client): Yes, it was a huge step. For the last several months I barely got out. Even coming to therapy was a major challenge. I felt really powerless going out. I have to prepare myself really well to be able to do this.

Reflection i-moments – Emergence of new understandings or thoughts that do not legitimate the problem or are not congruent with the dominant plot. According to Bruner (1986), a good story implies the landscape of action and consciousness. I-moments of Reflection relates to the landscape of consciousness, to the way a person feels, knows and thinks. On the other hand, the landscape of action includes the setting, the actors and the actions (usually present in action and protest i-moment). Reflection i-moment does not imply defiance by the individual towards someone or to the community/society, which represents/entails a position that supports the problem, like it happens in the protest i-moment.

Note: Whenever possible, Action and Reflection i-moments should be coded separately (e.g. "I left home for the first time [Action i-moment] and I felt good. [Reflection i-moment]"). When the client/interviewee is reflecting about specific actions, we should code Reflection (e.g. "Leaving home for the first time made me feel great!")

[14] The clinical vignettes were published in Gonçalves, Matos & Santos (in press)

Clinical vignette

C: I'm starting to wonder about what my life will be like if I keep feeding my depression.

T: It's becoming clear that depression had a hidden agenda for your life?

C: Yes, sure.

T: What is it that depression wants from you?

C: It wants to rule my whole life and in the end it wants to steal my life from me.

Protest i-moments – moments of protest**,** defiance or attitudinal divergence, which can involve actions, thoughts and feelings, projected or accomplished.

Assumes the presence of two positions: one that legitimates or supports the problem (entailed by a person or by a given society or culture), and another one that defies or confronts the first one. It involves proactivity and personal agency by the client.

I-moments of reflection and protest differentiate themselves by the internal positioning of the first ones, of considering alternatives (e.g., "*I believe I found a solution*"), of questioning (e.g., "*I'm wondering if something can justify that …?*"). However, protest i-moment can also involve thoughts or feelings, but it is a way of repositioning the self through a proactive, categorical, affirmative or assertive process (e.g., "*I think that nothing can justify this; I decided that I won't allow fear to interfere in my life any more*"). They involve a repositioning towards the problem and its effects, as well as to the others that eventually legitimate the problem (e.g., *"I told my mother that I won't accept her ideas about my marriage!").*

Clinical vignette

C: I talked about it just to demonstrate what I've been doing until now, fighting for it…

T: Fighting against the idea that you should do what your parents thought was good for you?

C: I was trying to change myself all the time, to please them. But now I'm getting tired, I am realising that it doesn't make any sense to make this effort.

T: That effort keeps you in a position of changing yourself all the time, the way you feel and think…

C: Yes, sure. And I'm really tired of that, I can't stand it anymore. After all, parents are supposed to love their children and not judge them all the time.

Re-conceptualization i-moments – implies a kind of meta-reflection level, from where the person not only understands what is different in her/him, but is also able to describe the processes involved in the transformation.

This meta-position enables to access the self in the past (problematic narrative), the emerging self, as well as the description of the processes that allowed the transformation from the past to the present. While reflection i-moments are related to novelty in terms of a thinking *episode* or *moment* (related to the past, present or future) that is outside the prescription of the dominant story, re-conceptualization i-moments are associated with the narration of a meta-reflection *process* involved in change. The perception of some transformation is narrated, making clear (1) the process involved in its emergence and (2) the distinction between that moment and the former condition. These two elements must be distinct. Thus, as an example, when the client says "now I'm more responsible", this is not by itself a re-conceptualization i-moment. To do so, another element has to be present, like "now I'm more responsible and that allows me X or Z" (X or Z not being a mere description of responsibility). Therefore, the element associated to the process of change cannot be exactly the same as the transformation (e.g., "more patient" and I've learned to be more patient). Nevertheless, this contrast between past self and emerging/changing self can appear implicitly [e.g. "I am more mature now (than in the past)"], as long as this is clearly distinct from the transformation process.

Note: In case of doubt between a Re-conceptualization i-moment and a Reflection II i-moment, we should be more conservative and code Reflection II.

Clinical vignette (victim of partner abuse)

C: I think I started enjoying myself again. I had a time… I think I've stopped in time. I've always been a person that liked me. There was a time… maybe because of my attitude, because of all that was happening, I think there was a time that I was not

respecting myself… despite the effort to show that I wasn't feeling… so well with myself… I couldn't feel that joy of living, that I recovered now… and now I keep thinking "you have to move on and get your life back".

T: This position of "you have to move on" has been decisive?

C: That was important. I felt so weak at the beginning! I hated feeling like that…. Today I think "I'm not weak". In fact, maybe I am very strong, because of all that has happened to me, I can still see the good side of people and I don't think I'm being naïve… Now, when I look at myself, I think "no, you can really make a difference, and you have value as a person". For a while I couldn't have this dialogue with myself, I couldn't say "you can do it" nor even think "I am good at this or that"…

New Experiences i-moments – these refer to the anticipation or planning of new experiences, projects or activities at personal, professional and relational levels. They describe the consequences of the change process, for instance acquire new understandings that are useful for the future or assuming him/herself as an experiential expert, referring which new skills are acquired after overcoming the problematic experience. They also can reflect the performance of change or new skills that are akin to the emergent narrative (e.g., new projects that derive from a new self version).

Clinical vignette

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

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

3.2 Subtype (see table 1)**:** regarding i-moments of action, reflection and protest. These subcategories are based on the research conducted with the IMCS. After qualitative analysis, the researchers identified these subtypes in a consensual way.

3.3 Salience: percentage of time consumed by each i-moment in the session, related to total amount of time of the session (with transcripts the salience could be measured by the quantity of text occupied by each i-moment, in reference to the full text).

3.4 Emergence: indicates if the i-moment is brought to the conversation by therapist/interviewer or the client/interviewed. Basically, there are three possibilities: (1) the i-moment is produced by the therapist and accepted by the client; (2) the i-moment results from a therapist's question which clearly facilitates its emergence (e.g., T: What can you learn from this experience?; C: I learned that… [a specific i-moment]); (3) The i-moment is spontaneously produced by the client, not being triggered by any question made by the therapist. This topic should be coded after the codification of the i-moments.

4. Coding procedures

Coding is done, preferentially, through video visualization of data, using the scoring sheet (attached) or the coding can be done using software that allows video to be coded. Each session can be analyzed and reviewed; however when having several sessions they must be coded sequentially (only code the next one when the previous is completed).

5. Coding rules

1. It is recommended that coders read throughout the entire data (e.g., one entire session) to get acquainted with the material. In following readings coders should start coding the material, spending as much time as they think necessary. The initially coded i-moment could be revised in subsequent readings.

2. I-moments can be coded whether in past, present and/or future time.

3. After an initial analysis of the sessions/interviews, raters must discuss about their comprehension of client's/ interviewee's problems. Thus, the innovative moments

are identified based on this consensual definition of the problems. Subsequently, each rater identifies, throughout the sessions/interviews, all the problems mentioned by the client/participant. The definition of the problems must be linked with the verbal material, i.e., close to client's/ interviewee's narrative, allowing the identification of the i-moments in relation to it. Hence, the i-moments are coded with reference to a previous problem. For instance, the act of "*running away from the problem"* can be codified as an action i-moment if the problem is intimate abuse, even though an equivalent act can be part of the problem if we are talking about an anxiety disorder.

4. Throughout sessions/interviews problems brought by the client/interviewee are identified. This definition should stay close to the original material. This is important since it will allow identifying the i-moment within a specific problem frame. The i-moments should be coded *related* to a previous problem. For example, the act of *escaping* could be coded with an action i-moment if the problem is being a victim of partner's abuse, but in a case of anxiety, it could be part of the problem.

5. I-moments emerge within a sequence that can be interrupted by the therapist. It is coded as the same i-moment, if within the same theme.

Example: multiple actions of personal protection (changing locks, coping documents) are Action i-moment in cases of partner abuse.

T: *You've done well. What about our arrangement about your safety?*

C: I've changed the locks, I've the phone numbers of…

T: *Emergency institutions*

C: *Emergency institutions**. I have it all. Documents… that doesn't worry me because I've my parents with me now, fortunately.***

T: *As you can see, you've had the system on your side, what doesn't always happen, but you had. You couldn't even return home today…*

C: I know

T: *As it happens in most cases. So documents would have been […] it wasn't important because […]*

C: I have them in the car. In that same day I have done copies at school because… school always has copies of all personal documents

T: *Besides changing locks, having your original documents, have you applied any other strategies? Another strategy was not returning home alone…*

C: That's right!

T:*You've done well.*

C: Even because I couldn't do it. I've called a neighbour to ask if she had seen anything and she told me that she hadn't seen anything.

6. I-moments are defined as the emergence of something that is somehow new, even if the person states this novelty as a personal stable trait.

Example: "I'm not the kind of person that is influenced by fear"– the client has been influenced by fear many times before.

7. Protest can involve action or reflection, being coded protest whenever this situation applies.

8. After coding an excerpt where several i-moments appear sequentially, the coder should re-read them to see if it is possible and adequate to aggregate them, evaluating if they are all part of a more complex i-moment.

Example:

C: ***You know… when I was there at the museum, I thought to myself: you really are different… A year ago you wouldn't be able to go to the supermarket! Ever since I started going out, I started feeling less depressed… it is also related to our conversations and changing jobs…*** [At first sight – Re-conceptualization i-moment]

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

C: ***I called my dad and told him: we're going out today!*** [at first sight – Action i-moment]

T: This is new, isn't it?

C: Yes, it's like I tell you… I sense that I'm different… [at first sight – Reflection i-moment]

The coding should go like this:

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

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

C: I called my dad and told him: we're going out today!

T: This is new, isn't it?

C: Yes, it's like I tell you… I sense that I'm different…

[Re-conceptualization i-moment]

9. When an overlapping of i-moments occurs in the process of codification (in the same sentence or paragraph), we accept the following hierarchy (from the more basic to the more complex): 1. [action – reflection] – 2. [protest] – 3. [reconceptualization – new experiences], and consequently we code the most inclusive i-moment, that is the one considered hierarchically superior. So, when action and reflection are both present they are coded separately. When reconceptualization (RC) and new experiences (NE) occur overlapped we code the overlap coding RC/NE. For purposes of salience we can consider this mixture of RC and NE as RC (unless of course we have good reason to keep the code separated from "pure" RC)

Special considerations for salience measures

10. Beginning of an i-moment: i-moments should be coded from the beginning of the grammatical sentence where the innovation content is appearing explicitly. (e.g. "Yesterday I went to the beach with my boyfriend and, / **for the first time in a long time I didn't feel depressed**. [Reflection i-moment]" – the slash signals a different thought.)

11. When an i-moment is questioned by the therapist, this question is not included when measuring salience; however, the therapist interventions are taken into account during the elaboration of an i-moment.

Example:

T: How did you feel this week?

*C: **I looked like someone else… everybody noticed that I was happier…***

T: ***And your happiness was reflected in what?***

C: ***Well… in everything… at work, at home…***

T: ***What, in your opinion, helped you feel that way?***

*C: **I think the most important thing was the conversation I had with my husband.*** [Reflection i-moment]

12. Likewise, when an i-moment is elaborated by the client, the first utterance of the therapist should be excluded, while the in-between turn-takings are included.

Example:

T: Susan, you look very different! It's shown in your posture... you look much more relaxed.

C: ***Yeah, absolutely.***

T: ***You're also much more at ease.***

C: ***Yes, I feel that also.*** [Reflection i-moment]

13. Length/Duration of an i-moment: If the client, while elaborating an i-moment, drifts away and changes the theme (e.g. making some commentaries about other things), this part of his speech is not included in the i-moment.

Example:

*C: **This week went very well… I went to the gym, also the theatre…** since it has been restored, they have been having different shows every week... I already knew that the director is not the same anymore. He's an old friend of my mother. My mother was born in X [place] and went to Y school, they were colleagues at school... I mean, then they drift away because of some quarrel – you know how that is like... friends are friends, but business apart. **Anyway, I had a great time, I could keep my mind away from the usual problems…*** [Do not code the underlined part]

Special cases for coding procedures in therapy

14. Regarding the empty chair task in psychotherapeutic processes:

i) I-moments are only coded when client is talking in his/her own position, and not in someone else's position (father, mother …);

ii) I-moments are coded when they refer to the critical self and experiential positions.

15. Usually, changes in relationships are coded as new experiences i-moments (e.g., "we are getting closer"; "I'm giving more value to friendship", etc.).

16. The reframing of difficult live events is, most of the time, coded as re-conceptualization.

17. Negative changes are not identified as i-moments.

6. Validity

Criterions of validity: exhaustively and mutual exclusion in i-moments coding procedures.

7. Reliability

The coding requires a skilled rater, appropriately trained (who is expected to code the entire sample). Besides this, a second independent rater should be also called upon to code at least 30% of the sample, on the basis of which the percentage of agreement and the kappa of Cohen. Throughout this process, the pair of judges will meet regularly to conduct the reliability procedures specified before and to note differences in their perspectives of the problem and in their i-moments coding (e.g. every 2 or 3 sessions coded). If these are detected, they are resolved through consensual discussion/coding.

If Cohen's Kappa is lower than 0.75, the sample needs to be reviewed by an external and more experienced auditor. This auditor will look at disagreements that

appeared in the material rated by the first pair of judges and review their differences, arriving at a final coding.

8. References

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