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Innovative moments and change in narrative therapy

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Abstract

Narrative therapy suggests that change happens by paying close attention in therapy to “unique outcomes”, which are narrative details outside the main story (White and Epston, 1990). In this exploratory study, “unique outcomes” were analysed in five good outcome and five poor outcome psychotherapy cases using the Innovative Moments Coding System (IMCS 7.0, Gonçalves, Matos & Santos, 2008). Across 127 sessions, innovative moments (i-moments) were coded in terms of salience and type. In accordance with the theory, results suggest that i-moments are important to therapeutic change. Poor and good outcome groups have a global difference in the salience of the IMs. In addition, results suggest that two particular types of IMs are needed in narrative therapy for therapeutic change to take place: re-conceptualization and new experience. Implications for future research using this model of analysis are discussed.

Key- words: Unique outcomes, Innovative moments, Narrative therapy.

Narrative therapy, in its re-authoring version was suggested in the late 1980s and early 1990s by White and Epston (1990). It has developed into a variety of treatment applications in psychotherapy and has turned into one of the most influential models in the narrative therapies (see Freedman & Combs, 1996; Monk, Winslade, Crocket, & Epston, 1997; Smith & Nylund, 1996; Winslade & Monk, 1999; White, 2004, 2007; Zimmerman & Dickerson, 1996). From the perspective of this model, as well as other discursive therapies (e.g., Angus & McLeod, 2004, Hoyt, 1998; Neimeyer & Raskin, 2000; Omer & Alon, 1997) clients correct dysfunctional psychological processes by the construction of new narratives of life. In the re-authoring model (White & Epston, 1990) it is proposed that the identification and elaboration of “unique outcomes” (UOs) is one of the main processes through which therapy allows the construction of new life-narratives. Unique outcomes are narrative details outside of what White (2004; 2007; White & Epston, 1990) called the dominant or problem-saturated story, which is a narrative reduced to a single theme (e.g., depression, anxiety). According to this theory, despite the redundancy of the dominant story, even very disturbed clients experience unique outcomes. However, these do not contribute to the emergence of an alternative story because the dominant or problem-saturated narrative is so central that leads the person to devalue and refuse alternative accounts of the events. The problem-saturated narrative blinds clients to alternative ways of acting, feeling, thinking or relating, and they often trivialise, ignore or forget these unique outcomes. This process has some similarities with what cognitive therapists call cognitive distortions (e.g., minimization, abstractive selection).

Describing this therapeutic process, Freedman and Combs (1996), following White and Epston’s original work, suggested that in the psychotherapeutic construction of a new plot the therapist should emphasize the conversation around UOs. This can happen in the landscape of action or in the landscape of consciousness (using a distinction made by Bruner, 1986). For Bruner (1986) a good story is made in this dual landscape, the landscape of action, that includes the setting, the actors and the actions, and the landscape of consciousness, which refers to how actors feel,

know and think. While the UOs in the landscape of action are events involving actions, the meanings concerning these UOs constitute the landscape of consciousness (intentions, desires, values or beliefs). Narrative therapists (see Freedman and Combs, 1996; White, 2007) have proposed a therapeutic structure in which the therapist promotes the consolidation of a new story by highlighting UOs, for example, by questioning and making connections between UO elements in the landscape of action (e.g., therapists would ask questions like “How this novelty occur?” or “How did you prepare for this?”) and elements in the landscape of consciousness (e.g., “What characteristic of yourself this new event highlights? What values you cherish are made visible by this?”). They may also suggest connections between past, present and future UOs (e.g., “How this new event relates to X – [being X a past UO]?”), to increase the temporal plausibility of the emergent new story. This narrative elaboration allows the client to construct from heterogeneous unique outcomes a new gestalt that can be transformed into a new narrative of life. The construction of this gestalt allows the client to feel, think and act differently from the feelings, thoughts and actions framed by the problem-saturated story.

From our perspective, narrative therapy is appropriate for women victim of intimate violence, the population we focus in this study, for several reasons (cf. Matos & Gonçalves, 2004). First, partner violence is an experience that produces several detrimental effects shaping a self-narrative saturated by the problem, usually dominated by self-blame, shame, puzzlement, scepticism and hesitation towards the possibility of change (Martin, Berenson, Griffing, Sage, Madry, Bingham & Primm, 2000). Second, these difficulties are fed by a fusion between the problem and the self (e.g., “the battering is my fault”, “if I was a better woman he won’t beat me”) and the practices of externalizing the problem allows to precisely create a distinction between what the problem “wants” for one’s life and what the person prefers, developing a new space for agency. Third, this therapeutic proposal focuses on the deconstruction of social and cultural discourses, and this is a domain where the social discourses (e.g., of gender, of male power) clearly support partner violence and usually make personal change difficult. To make these social practices and values explicit allow

the clients to reposition themselves toward these dominant discourses, discovering in this movement new practices and values (e.g., tolerance, equality).

Based on the narrative therapy literature and on a previous empirical research (Matos & Gonçalves, 2004), we constructed a coding system of unique outcomes – the Innovative Moments Coding System (Gonçalves, Matos & Santos, 2008) – to discriminate between different types of unique outcomes. We discussed previously (Gonçalves, Matos & Santos, in press) why we prefer the designation of innovative moments (or simply i-moments) instead of unique outcomes. First, there is nothing unique in the unique outcomes and, as the theory suggests and the clinical practice makes evident, they occur often in psychotherapy (see de Shazer, 1991, for a similar critique). Second, the idea of an outcome seems to contradict our emphasis on the process of these moments. These occurrences are not outcomes in the sense normally used in psychotherapy research but are part of the process of constructing a new narrative.

In previous research (Matos & Gonçalves, 2004; Gonçalves, Matos & Santos, in press) we distinguished five different types of i-moments (IMs): (1) action, (2) reflection, (3) protest, (4) re-conceptualization and (5) new experiences. (1) Action IMs refer to specific actions that are not predicted by the problem-saturated story. (2) Reflection IMs are all the moments in which the person thinks differently than what one could expect from the problematic story, or when the person understands something new that contradicts the problematic story. (3) Protest IMs can be an action (like action IMs) or a thought (like reflection IMs), but they are more than mere actions or thoughts, reflecting a protest against the problem-saturated story and its specifications. (4) re-conceptualization IMs are more complex than the previous ones. They involve a meta-cognitive level, meaning that the person not only understands what is different about him or herself, but is also able to describe the processes involved in this transformation. Thus re-conceptualization IMs involve three components: the self in the past (problematic narrative), the self in the present, and some description of the processes that allowed the transformation from the past to the present. The client not only understands something new but can also express a distinction from a previous

condition; (5) New experiences are IMs in which new projects, activities or experiences, that were impossible before, given the constraints of the problem-saturated narrative, start taking place.

In this article, we present the first study from a program of research that aims to analyse the role of IMs in psychotherapeutic change. We present an exploratory research that studies (1) if, as predicted by the theory, IMs are important for psychotherapy success, that is, if more IMs emerge in good than in poor outcome cases, (2) if different types of IMs (e.g., action, reflection) emerge differently in good and poor psychotherapy outcome cases, and (3) if different IMs appear in different phases of the therapeutic process (e.g., beginning vs. end of therapy).

Method

1. Participants

The clients were ten women with current experience of multidimensional partner abuse who were involved in individual narrative therapy (White & Epston, 1990).

1.1. Clients

Clients attended psychotherapy in a Portuguese university clinic. Clients provided written consent after being informed of the research objectives (“to study the therapeutic process with women victims of partner’s abuse”). Treatment was provided with no charge.

Client’s age varied from 22 to 57 years old. Four of them had no children and the rest had from one to four children. Their levels of education varied from basic to post-graduate education, and their occupations varied from rather unskilled workers (e.g., needle-woman, factory worker) to highly qualified ones (e.g., teacher, radiology technician).

The abusive relationship, in which these women were involved, had lasted from one to twenty years. Four women were victimized for a long period of time (more than five years) and for the rest

the violence experience was briefer (less than five years). Psychological violence was present in all the cases. Simultaneously, five clients were victims of physical and sexual aggression. Seven of them had needed, at least once, medical treatment for the injuries. Seven of them were medicated with antidepressants and anxiolytics. Six clients felt, at least once, that their lives were in danger due to partner violence. Besides seeking psychotherapy, four clients asked for help from the criminal justice system.

Five clients were recommended to psychotherapy by other psychologists, two were sent from justice institutions (police and courts), one came by her own initiative and the other two were recommended by professionals that support crime victims.

Seven of the clients were married; one of them cohabitated with the partner, and the other two were dating (without cohabitation). By the end of psychotherapy, four clients had ended the relationship.

Four of the clients' partners also attended psychotherapy (with another psychotherapist). Two of them ended with good therapeutic outcome, one turned to be a drop-out and the other one was still in psychotherapy when this study finished.

1.2. Therapist

All cases were treated by the same therapist (the first author), who had a master degree in Psychology at the time of the study and five years of experience in psychotherapy with battered women. The psychotherapy sessions were supervised by the third author with respect to adherence to narrative therapy principles. The model of therapy was developed from the narrative model of White and Epston (1990, see also White, 2007) and involved the (1) externalization of problems (a narrative practice of deconstruction that invites client to see the problem as an external "entity"), other than the abuse (e.g., fear, sadness, personal characteristics that support the abuse), (2) identification of the cultural and social assumptions that support women's abuse (e.g., patriarchal power, critical view toward women that leave their partners), (3) identification of unique outcomes

(or, as we prefer, i-moments), (4) therapeutic questioning around these unique outcomes, trying to create a new plot alternative to the one that was externalized, (5) consolidation of the changes through social validation (e.g., rituals of change, writings letters to women in similar situations), trying to make more visible the way change happened. The supervision done by the third author supported the adherence of the therapist to the narrative model.

Measures

To assess the therapeutic outcomes throughout the processes, instruments were applied following a planned protocol: administration of specific instruments in the first, fourth, eighth, twelfth, sixteenth and follow-up session (six months after the last session). This assessment aimed to assess the clinical symptoms, the victimization received by the partner, the therapeutic alliance and the beliefs regarding partner violence. Results of this assessment protocol were used to form contrasting groups within the sample (good and poor psychotherapy outcome cases), as we will further explain in the procedures. The measures involved were:

Clinically relevant symptoms: the Brief Symptom Inventory (B.S.I., L. Derogatis, 1982; Portuguese version adapted by Canavarro, 1999) was used in the assessment of clinical symptoms. The measure used in this research was the Global Severity Index (G.S.I.). This questionnaire was applied in every fourth sessions, starting at the first one.

Severity of the abuse: in order to assess this dimension, there was a regular clinical monitoring concerning the violence received by the client. Clients were asked about abusive actions received (physical, psychological and/or sexual), their frequency and severity in every occasion of assessment. Victimization was assessed by the therapist and recorded on a three point scale (low, medium, high).

Therapeutic alliance: the Working Alliance Inventory (WAI, Horvath, 1982; Portuguese version adapted by Machado and Horvath, 1999) was used to assess therapeutic alliance quality.

Versions for client and observers (two independent observers applied the instrument to videos of the sessions) were applied. This scale was applied every fourth sessions, starting at the fourth one.

Client's beliefs towards violence: the Scale of Beliefs about Partner Violence (Escala de Crenças sobre Violência Conjugal - E.C.V.C., Matos, Machado & Gonçalves, 2000) was applied to evaluate client's beliefs regarding partner violence. This scale is composed of 25 items, which are statements concerning partner's violence legitimization. Clients answer on a 5-point Likert scale, anchored from "totally disagree" to "totally agree". Total score was used on three evaluation occasions (first, last and follow-up session). This scale has a good reliability (Cronbach α of 0.9) and prior studies have shown a strong positive association between aggressive acts toward the partner and the global scores in the scale (Machado, Matos & Gonçalves, 2004).

To study the process of change, all the cases were coded, using for that the **Manual for the Innovative Moments Coding System** (Gonçalves, Matos & Santos, 2008). Examples of the five different types of IMs found within these participants' experiences are presented, as they were described earlier in this article.

(1) Action IMs

The following example illustrates an episode of violence, in which the client performed some actions trying to prevent her husband to continue the violence escalation and she also sought for help after the incident (IMs are underlined).

***Client:** So, in August he started talking about my single life, in front of our two year's old child! I kept not answering him. And my son was there... I was putting in order some clothes in the closet and he was slapping and pushing me, kicking me and some other things I don't remember. "Why have you done that? You have to explain me that!" I kept not answering him. I just told him "take him (the child) away from here. Take him somewhere else". But I kept not answering. Meanwhile I went to the kitchen and he assaulted me and slapped me in the face. I get a huge hematoma 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 registered what happened and took a picture of me. Then we talked about it. (Action IM)

(2) Reflection IMs

Below is an example of an Action IM followed by Reflection. Client explains to the therapist how she usually tries to prevent and escape from violent episodes. She decided to leave home with her child, also preventing him to assist to the family violence, and ended up in health center. This situation made her think about what was happening and triggered the urge to make some decision that could end with this problem.

Therapist: When you answer, how do you answer?

Client: Initially I start to answer calmly, asking him to be calm "let's seat and talk". (Action IM)

Therapist: Trying to regain control...

Client: I always try to establish a relation "let's seat, look at me, calm down"... but it was impossible. He can't talk and look at me, in any situation. So I took my child and left home, because he was seeing all that... (Action IM)

Therapist: You left the house...

Client: I left with the child. I ended up in health center. I phoned to my friends and... (Action IM) Meanwhile I started thinking "I have to get separated, I have to do something" (Reflection IM)

(3) Protest IMs

In the following example, a woman tells the aggressor that she will no longer accept a relationship with these abusive features. It also shows her understanding that his excuses are part of a cycle that perpetuates violence.

Client: Last week it was ok. But then he kept saying "give me one more chance". And then I said "I gave you four years of chances; I don't have any more to give to you. I'm sorry, I don't believe you and I don't trust you, and you had four years to change." (Protest IM).

In the previous example the protest IM is also an action, but an action that reveals self-assertion, which leads us to code for protest. Protest IM can also occur in the form of thoughts, but to code protest (instead of reflection) these thoughts must be more assertive than simply discovering something new or thinking something new. Below is an example that illustrates this.

Therapist: *What's your position about it?*

Client: *I think my position is getting tough, I feel I'm getting much tougher, because I see he keeps trying to...*

Therapist: *Tougher? In what sense?*

Client: *In the sense that showing him I'm no longer willing to accept his interferences concerning our child. Because he actually disturbs him! I won't put this up anymore, that's it! (Protest IM)*

(4) Re-conceptualization IMs

To code these IMs 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 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. Know, I stand up and speak; I don't let anyone to go over me, which I actually did. (Re-conceptualization IM)*

(5) New experiences:

The client describes how she may apply the new learned skills to new experiences and situations.

Therapist: *It seems we are in an ascending line... change is gradual; it will be punctuated by some ups and downs, as inherent to the whole process. In this session we discussed all the emergent changes that you have accomplished, in a high-speed rhythm...*

Client: *I was looking forward for this change, although I've never thought it could happen this way... and now there's a strong will of... there's many things that I wished to accomplish, even at a personal level, things that I want to change, a lot of*

things really. One of them is... I'm a very disorganized person, and it's been my plan for a while to try to start to change, to become organized.

Therapist: You're now in a position to change that...

Client: That's one thing I want to start doing. (New Experiences IM)

Insert table 1.

Procedures

IM coding was based on the **Manual for the Innovative Moments Coding System** (Gonçalves, Santos & Matos, 2008). The coding procedures took place after the end of all psychotherapeutic processes, to avoid creating any bias in the therapy.

Coding of IMs was conducted by viewing each session in video (with a clock) and recording the type and the time duration (salience) of each IM as it appeared in the session. Duration was assessed by recording the beginning and the end of each IM, 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 (the percentage of time in the session devoted to that IM) for each of the five IMs. We also computed an index of overall salience of IMs as the total percentage of time in the session devoted to any of the five IMs (i.e., the sum of the saliences' of the five IMs).

We distinguished a good outcome group and a poor outcome group based on two criteria: Good outcome was said to have occurred when 1) there was a reduced level of symptoms as assessed by B.S.I. (similar to the Portuguese population without complaints) and 2) victimization by the partner ended or showed a very significant change from the beginning to the end of therapy. This last criterion involved a significant change in victimization pattern, though they might still experience relatively minor forms of violence (e.g., insulting, shouting), and also a modification of episode frequency - from a continuous frequency to an occasional one.

The good outcome group included five participants who evolved towards a no relevant symptom condition and, simultaneously, victimization ceased (three cases), or violence changed significantly (two cases). Poor outcome group had five clients. Two of them presented, at the end of therapy, continued psychological suffering, and the others showed no significant change in violence pattern and prevalence. In this group, three drop-outs were also included.

There were no significant differences between groups regarding age ($U = 7.50, p = .29$), relationship duration ($U = 8.00, p = .28$) and victimization duration ($U = 7.50, p = .22$). Regarding education level, there was a marginally significant difference between groups ($U = 4.00, p = .07$), having the good outcome group a higher education.

On the total, 127 sessions in videotape format were coded. The good outcome group had a mean of 15 sessions per case, whereas the poor outcome group had 11 (Table 2). The good outcome group has a marginally higher number of sessions ($U=4.50, p=.085$) which resulted in part from including 3 drop-outs cases in the poor-outcome group.

Insert table 2.

Coding Procedures and Reliability

Session recordings were coded by two trained judges. Judge A was the second author; 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 4, 8, 12, 16 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 procedure of IMs, what were their understanding of the main problem of each client (the “rule” or the problematic narrative) in order to code the IMs (the exceptions to the “rule”). This discussion allowed a consensual definition of the main problems of the clients. In these cases the problematic

narrative was defined in all the cases as the abuse and its diverse effects (e.g., fear, sadness, culpability, helplessness). The clinical practice of externalization the problems (see White & Epston, 2000; White, 2007) also made it easier to identify the problems along the therapeutic processes, given that clients and therapists discussed the problems in a personified form.

Overall salience was calculated as the proportion of the total time in sessions that was devoted to any IM 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 IM times independently identified by the two judges). The percentage of agreement on overall IMs salience was of 86% (85% and 87%, respectively good outcome group and poor outcome group).

Time devoted to each IM was divided into thought units, defined as continuous passages devoted to the same IM classification. Reliability of distinguishing IM categories, assessed by Cohen's kappa, was .89 based on N=547. Because of the high interjudge reliability, we based our analyses on judge's A coding.

Results

The number of participants on each group (N=5) in our sample point to the use of non-parametric tests. However, we used the strategy of computing both parametric and their equivalent non-parametric tests as advised by Fife-Schaw (2006). Given that the conclusions drawn from both set of tests were the same in all cases, we opted for presenting the parametric tests' results, as these are more robust and allow us to use multivariate analyses, reducing the number of tests carried out and, therefore, the probability of the Type I error.

Outcome measures for good and poor outcome groups

At treatment intake, there were no differences between the good and poor outcome groups on the Global Severity Index (G.S.I. – measured by B.S.I., L. Derogatis, 1982; Portuguese version adapted by Canavarro, 1999) ($t(8) = -.78, p=.46$).

The E.C.V.C. (Scale of Beliefs about Partner Violence, Machado, Matos & Gonçalves, 2004) results showed that all the clients revealed, across the three evaluation occasions, a tendency toward reduced tolerance of partner violence. The attitudes towards partner violence were not significantly different across groups ($U = 5.50, p = .14$).

Finally, the WAI (Horvath, 1982; Portuguese version adapted by Machado and Horvath, 1999) results showed that the therapeutic alliance was high in both groups and all the sessions evaluated (between 182 and 252). At the fourth session, there were significant differences between good and poor outcome group only in the perspective of one observer ($U=0,000; p=0,009$), according to whom the therapeutic alliance was better in the good outcome. There were no significant differences in the perspective of the other observer ($U = 5,000; p = 0,117$) or the clients ($U = 8,500; p = 0,402$).

The emergence of IMs in good and poor outcome groups

Salience of i-moments aggregated across therapy. To test the statistical significance of the differences between the two outcome groups in terms of the overall salience of i-moments (cf. Figure 1), a one-way analysis of covariance (ANCOVA) was carried out using the number of coded sessions as the covariate. The good outcome group ($EMM = 153.05, SE = 23.46$) had a significantly higher salience of i-moments, $F(1,7) = 7.08, p = .032, \eta^2=.50$, than the poor outcome group ($EMM = 56.99, SE = 23.46$).

Insert Figure 1.

Profiles of i-moments in good and poor outcome group

Salience of different types of i-moments aggregated across therapy. A multivariate analysis of covariance (MANCOVA) was computed to test for differences between groups in the salience of different types of i-moments, using the number of sessions as a covariate (Table 3).

Insert Table 3

No significant multivariate differences between the two outcome groups were found (Wilks' Lambda = .20, $F(5,3) = 2.47$, $p = .24$), but the good outcome group exhibited a significantly higher salience of re-conceptualization ($EMM_{\text{good}} = 49.51$, $EMM_{\text{poor}} = 3.75$, $SE = 10.96$, $F(1,7) = 7.37$, $p = .03$, $\eta^2 = .51$) and new experiences type of i-moments ($EMM_{\text{good}} = 30.19$, $EMM_{\text{poor}} = -1.48$, $SE = 8.15$, $F(1,7) = 6.37$, $p = .04$, $\eta^2 = .48$) than the poor outcome group.

Salience of re-conceptualization and new experiences IMs across psychotherapy phases and symptom evolution

Given the observed significant differences, we examined the evolution of the salience of the Re-conceptualization and New Experiences IMs (figures 1 and 2) in both groups.

The figures show data regarding re-conceptualization and new experiences IMs' salience as well as scores of G.S.I., in sessions where the assessment protocol was applied. Salience is presented in terms of the mean value of each group for re-conceptualization and new experiences IMs in those particular sessions. The evolution of these IMs in good outcome group was clearly different from the poor outcome one. In the majority of good outcome cases, re-conceptualization and new experiences emerge in the middle phase of therapy, maintaining and increasing their salience along the sessions. Data suggest that the reducing tendency of GSI scores throughout the sessions was parallel to the ascending tendency of re-conceptualization and new experiences.

Insert figure 2.

In poor outcome cases, re-conceptualization and new experiences IMs were much more discrete and sometimes almost or completely absent. GSI scores showed a reduction in session 4, when those IMs emerged, but increased in session 8, when those IMs were absent.

Insert figure 3.

Discussion

Our results suggest that the therapeutic elaboration of i-moments may be an important dimension of effective narrative psychotherapy. The poor and good outcome groups differed significantly in IM salience. This index is a measure closely related to the narrative elaboration of the IM. Presumably, salience partially reflects the questions the therapist asks and the details that lead to a particular IM being narratively elaborated. An IM poorly narrated is translated in our coding system into a reduced salience.

Re-conceptualization and new experience IMs were very rare in poor outcome cases, and their salience was very low (see figure 1). The difference in the global salience of IMs between groups could be explained by the differences in re-conceptualization and new experiences IMs.

Regarding the evolution of IMs our data suggest that there were differences in the way the IMs developed across therapy in poor and good outcome cases. In the majority of good outcome cases, re-conceptualization and new experiences emerged in the middle of the therapy and increased through the final phase, whereas they were almost absent throughout the entire process in poor outcome cases. In what follows, we offer an attempt to interpret these preliminary data, though we emphasize that further research is needed, using different methods (e.g., microgenetic analysis of the development trajectories that is taken in each case, cf. Siegler & Crowley, 1991)

The relevance of re-conceptualization and new experiences IMs in the change process

Whereas the narrative model proposes that the elaboration of i-moments is enough to create change, our results suggested that only two particular types of IMs are associated with therapeutic change. We have previously suggested (Gonçalves, Matos & Santos, 2008) that re-conceptualization IMs allow the person not only to be an actor of his or her self-narrative, but more importantly an author (following the distinction proposed by Sarbin, 1986). Thus, re-conceptualization IMs involve a reflexive orientation toward the change process itself, allowing the person to affect the process of change. Re-conceptualization IMs are the most complex ones, given the involvement of a meta-position over change, creating a decentring from the client and an ability to see what is becoming different from the old plot and what new paths may occur in the new narrative. So, these IMs are very proactive and creative, denoting a clear preference that the person has for the new story. It is in, our view, these ingredients that allow an authorship position regarding change.

It is also relevant that these IMs do not appear at the early phases of therapy. We speculate that the other IMs are important, being markers that something new is under development (e.g., new actions, new thoughts, new experiences), but it is re-conceptualization IMs that allow the expansion of these elementary novelties to a new and consolidated self-narrative. Of course, this hypothesis needs to be researched in other studies, but this may explain why there are no differences in action, reflection and protest IMs between good and poor outcome cases. In both groups something new is under way, as it is reflected by those IMs, but it is only in good outcome cases that re-conceptualization IMs occur in a relevant salience, allowing the transformation of the previous IMs into a new narrative. In this sense, re-conceptualization IMs act as a gravity field connecting the other IMs (action, reflection, protest) and giving them a narrative meaning and structure, due to the meta-position they allow over the change process and the connection between an “old” and a “new” story. Without these dimensions, hardly any IMs can transform themselves into a new story, given the absence of narrative coherence and complexity. Actions, thoughts or protests against a life

dominated by the problem can easily be forgotten, allowing the novelty to be lost. It is our proposal that re-conceptualization IMs make this novelty decay much harder.

Other researchers and scholars have also studying what we call re-conceptualization from different angles. For instance, in the research done by Angus and colleagues with the Narrative Process Model (Angus, Lewin, Bouffard, Rotondi-Trevisan, 2004) the authors conclude that “the reflexive decentring from and then reengagement with distressing life experiences ... facilitates the articulation of new understandings about the self in relation to others” (Angus, Lewin, Bouffard & Rotondi-Trevisan, 2004, p. 90). The main difference between reflexive mode and re-conceptualization IMs is that in the former, all the reflexive positions from the client are coded, while in the latter we only coded moments of novelty (that is, i-moments).

It may also be noted that re-conceptualization IMs seem to converge (a) with the concept of insight in psychodynamic approaches, (b) with the concept of understanding/insight in the assimilation of problematic experiences sequence, which has similarly been differentially associated with favourable outcomes on standard assessment instruments (Detert et al., 2006; Stiles, 2006), and with the cognitive changes that Tang and Derubeis (1999) and others have observed to be associated with sudden gains, dramatic improvements in symptom intensity from one session to the next.

The assimilation link suggests the possibility that the differential association of the different IMs with GSI outcomes reflects a developmental phenomenon. That is, the activity, reflection, and protest IMs may reflect progress reaching a level of assimilation the precedes the dramatic drop in distress associated with the transition between the APES stages of vague understanding/emergence of the problem to understanding/insight (Brinegar et al., 2006; Detert et al., 2006).

From a different perspective, Hermans (2003) suggested that a very important dialogical process occurs in successful psychotherapy: the emergence of a meta-position, a position from where the other I-positions can be seen and evaluated (see also Dimaggio, Salvatore, Azzara & Catania, 2003; Leiman & Stiles, 2001). In fact, in order to code this IM, as we referred before, two

positions need to be present, the former self and the emergent self, which means that somehow a meta-position is needed.

The coherence and structure that re-conceptualization IMs reflects is certainly related to the emergence of new experience IMs. Notice that new experiences are almost absent from poor outcome cases. New experience IMs represents the expansion of the emerged new narrative into the future. One needs to be able to imagine future selves in order for the movement into the future to take place (see for instances Markus & Nurius, 1986). As Valsiner (2004) proposed «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 our view, for the story to be expanded into the future, a meta-position like the one that re-conceptualization allows is needed, to imagine a future with other possibilities outside the problematic narrative.

In summary, we suggest that change as tracked by IMs could happen in a cyclical way, which could start with action, reflection and/or protest IMs, as relevant signs for the person and for significant others that something different is happening (e.g., “I won’t take abuse anymore”, a protest IM). The next movement in the cycle could be re-conceptualization allowing the person to create a meta-position, which allows him or her to see how he/she is changing as well as the differences between the “old” and the “emergent” self-narrative. Perhaps, several movements from action, reflection and protest through re-conceptualization, and back again to action, reflection and protest (that is, new signs that change is really happening), could be needed to validate change, before the person is able to project him/herself into the future with a secure narrative.

Limitations

This study contains several threats to internal validity that obviously impose limits on the interpretations made from the data. Some obvious ones are the research design and the small sample

size, the absence of independence between the therapists and the researchers, the fact that only one therapist collect data, and the insertion of the drop-outs cases in the poor outcome group. The insertion of drop-out cases created an unbalance between the groups in terms of the number of sessions, the good-outcome groups having more sessions than the poor-outcome group. Obviously, this difference (although only marginally significant) is a possible alternative explanation for the differences found between groups. Other interpretations are also possible, for instance, the involvement of clients in the narration of the i-moments in the good-outcome group may have prevented the drop-out of these clients. Or, alternatively, the poor-outcome cases could be lately classified as good-outcome if they stay more time in therapy. At this stage it is not possible to choose one of these (or other) interpretations. Future studies may need to balance the samples with more caution.

Another obvious limitation is the marginally significant difference between groups (good and poor outcomes) concerning education level and the observer rating of the therapeutic alliance. Thus, the main differences between the groups may be partially explained by these differences instead of the differences found in the IMs. On the other hand, it may also be that education or intellectual capacity enhances individuals' ability to make use of verbal psychotherapy. Also, given the small sample size and the focus in victims of partner violence, conclusions are necessarily limited and the ability to generalize the findings about psychotherapeutic change is restricted. However, because of the intense process of coding, the interjudges reliability and the significant results obtained with a small sample, we can have a modest confidence in the findings.

It is also important to state that, even though we conclude that i-moments can indicate therapeutic change, surely other conditions may have also facilitated or interfered with the course of psychotherapy (e.g., hesitation towards change, lack of social validation of the i-moments, role of the audiences). Although a follow-up of six months was made, it would be useful to reassess the cases (e.g., one year after the therapy cessed) in order to corroborate the psychotherapy outcomes.

The fact that the therapeutic process was conducted by one single psychotherapist is of course another important limitation, although conversely, this provides some assurance that differences were not due to therapist effects. We were cautious to avoid creating bias in the coding process (e.g., by using blind coding, coding at the end of all psychotherapies). The coding system has still another problem that we were unable to solve until now. The system has no formal way of coding the problematic narrative (the rule) before the i-moments (the exception to the rule) are coded. We have acceptable interjudge agreement which suggest that coders are addressing the same phenomenon, and before starting identifying i-moments the coders have to consensually agree upon what is the problematic narrative. Future studies can, however, be improved if a method to track the problematic narrative was created.

One final limitation is the possibility that IMs are not predictors of the change process, but intermediate outcomes variables. With this research design we cannot be sure that IMs are process or mediating variables (see Kendall, Holmbeck & Verduin, 2004) and both interpretations are possible. Of course, if IMs are intermediate variables our results will be almost tautological (good outcome intermediate variables are associated with final outcome variables). This is a very critical limitation that we need to address in future studies. Therapists that operate in the narrative field strongly believe that emphasising the narrative details outside the dominant problematic plot is a form of creating further novelties and change, but this need to be proved by research designs that clearly address this question. Our coding system can be a way to start the study of these processes by which the attention to narrative details outside the problematic narrative can create stable therapeutic change, but to achieve this aim other research designs are needed. However, one can still argue that even if i-moments are outcome intermediate measures they can be a powerful way to study how psychotherapy conducted with this model develops in good and poor-outcome clients.

Implications

This exploratory study was pioneering in analysing psychotherapeutic change through a new methodology – the Innovative Moments Coding System. With this framework we were able to reliably identify narrative features that moved outside the main story and to find differences between good and poor psychotherapy outcome groups.

We are currently conducting further studies, replicating this methodology with different psychotherapeutic models (e.g., cognitive, experiential) and different populations (e.g., patients with depression), to see if the patterns observed in this study can be replicated and also to identify other profiles of change construction in psychotherapy. We are also developing ways of using the IM system in a more qualitative fashion, by intensively studying single cases-studies. These studies will also give a glimpse of how therapists elicit and sustain i-moments in psychotherapy and what could be the processes behind the elaboration of re-conceptualization i-moments.

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Table 1

Types of IMs and Their Discursive Markers, from Innovative Moments Coding System – Version 6.2

(reference to be inserted after revision).

TYPES	DISCURSIVE MARKERS	EXAMPLES
ACTION Specific actions that defy the problem	A – new coping behaviours facing re-victimization B – effective resolution of unsolved problems C – active exploration of solutions towards violence	- security plans - getting a job - getting a lawyer
REFLECTION Thinking processes that indicate the understanding of something new that makes the problem illegitimate (e.g., thoughts, intentions, interrogations, doubts)	A – new problem formulations and/or re-formulation of its effects B – violence is re-examined C – consideration of life dilemmas ...	- “I realize that’s worse than I ever imagined...” - “I know now that nothing I did could justify his attitudes” - “I keep wondering if it isn’t better to leave this relationship...”
PROTEST Resistance or protest towards other or self’s facets	A – defiance of partner prescriptions B – resistance towards problems prescription C – public repositioning towards culturally dominant values	- to “disobey” - to defy resignation - assertiveness facing cultural myths about marriage
RE-CONCEPTUALIZATION 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)	A – references to new/emergent identity versions B – re-evaluation of marriage or intimate relationship C – re-evaluation of violence	- “I re-conquered myself...” - “I realized that this relationship can have an end...” - “The interference of violence in my life is more circumscribed...”
NEW EXPERIENCES References to new intentions, projects, activities or investments planned or in course	A – involvement in other life dimensions B – victimization as a resource for the future C – investment in new projects	- political positioning - victimization as a learning experience - new relationships

Table 2

Number of Sessions in Good and Poor Outcome Groups

Good outcome group		Poor outcome group	
Cases	Number of sessions	Cases	Number of sessions
1	14	6	11
2	16	7	6
3	12	8	7
4	16	9	16
5	16	10	13

Table 3

Salience of Different Types of Innovative Moments Aggregated Across Therapy

	Good Outcome Group (N=5)	Poor Outcome Group (N=5)		
	EMM (SE)	EMM (SE)	F (1,7)	η^2
Action	14.83 (4.49)	5.23 (4.49)	1.92	.22
Reflection	19.20 (4.68)	19.12 (4.68)	.001	.00
Protest	39.33 (6.75)	30.38 (6.75)	.74	.10
Re-conceptualization	49.51 (10.96)	3.75 (10.96)	7.37*	.51
New experiences	30.19 (8.15)	-1.48 (8.15)	6.37*	.48

* p<.05

Figure 1. Overall Saliency of Innovative Moments' types in good outcome and poor outcome group.

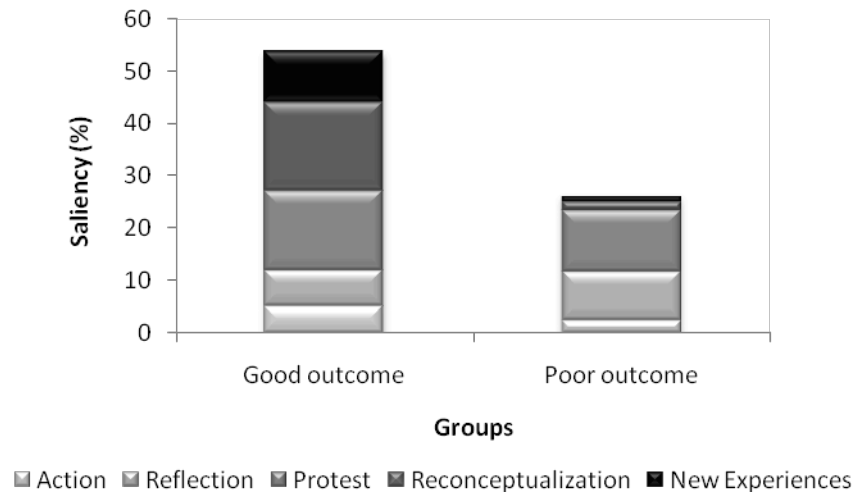


Figure 2. Salience of Re-conceptualization and New Experiences IMs and Global Severity Index (G.S.I.) in good outcome group, regarding assessment sessions.

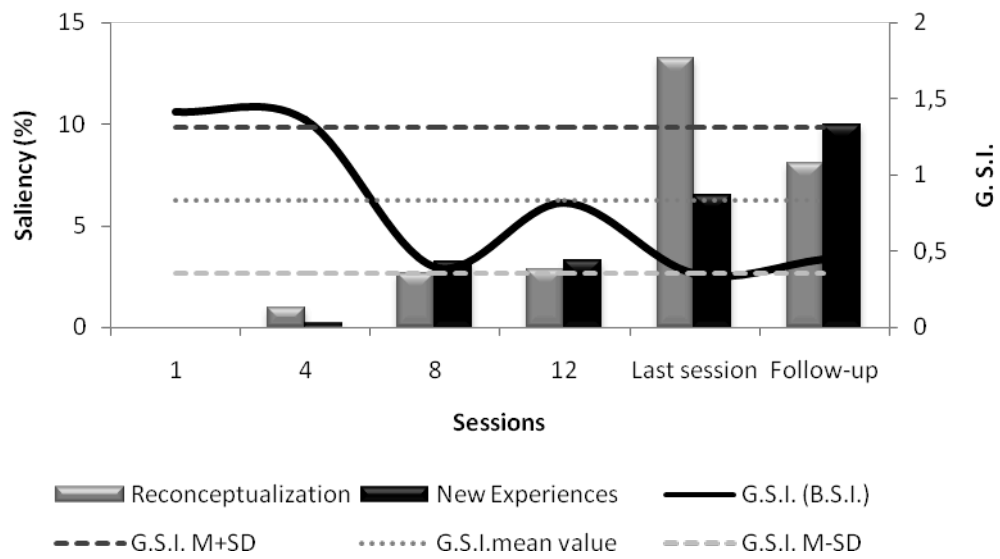


Figure 3. Salience of Re-conceptualization and New Experiences IMs and Global Severity Index (G.S.I.) in poor outcome group, regarding assessment sessions.

