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Gonçalves, M. M., Ribeiro, A. P., **Mendes, I.**, Matos, M., & Santos, A. (2011). Tracking novelties in psychotherapy process research: The Innovative Moments Coding System. *Psychotherapy Research, 21*, 497-509. DOI:10.1080/10503307.2011.560207

<http://www.tandfonline.com/doi/abs/10.1080/10503307.2011.560207>

Abstract

This article presents a method for the assessment of *innovative moments* which are novelties that emerge in contrast to a client's problematic self-narrative as expressed in therapy, the *innovative moments coding system* (IMCS). The authors discuss the theoretical background of the IMCS as well as its coding procedures. Results from several studies suggest that the IMCS is a reliable and valid coding system that can be applied to several modalities of psychotherapy. Finally, future research implications are discussed.

Tracking Novelties in Psychotherapy Process Research: The Innovative Moments Coding System

In this paper we present a coding system that allows researchers to track changes or novelties throughout the psychotherapeutic process. Moreover, we present data that supports the validity and reliability of this coding system. Psychotherapy, when effective, produces significant changes in clients' lives and these changes are anticipated, reflected, stimulated and discussed during psychotherapeutic sessions. The coding system presented in this article – the *innovative moments coding system* (IMCS; Gonçalves, Matos, & Santos, 2009a) – offers researchers a tool that transcends particular theoretical orientations and allows for in-session changes (see Orlinsky, Rønnestad, & Willutzki, 2004) to be detected from the transcripts or audio/video recordings.

IMCS allows identification of *innovative moments* (IMs) in contrast to the previous problematic pattern that brought the client to therapy. For example, if depressive functioning was identified as a previous problematic pattern and was the target of the therapist's and client's efforts to produce change, whenever this pattern is disrupted or challenged and a new pattern emerges it is treated as an IM. More specifically, if the previous pattern of functioning is characterized by devaluation of own needs and privileging others' wishes (e.g., “there's a lot that makes me feel like I'm a bad person. And I've just got to keep on trying, just accept him (husband) the way he is and just shut up.”), an IM would include all the times the person values his or her own needs, emerging in the form of thoughts, actions or feelings (e.g., “I don't want to live like that anymore, I want to be able to enjoy life, to let out my feelings and thoughts... I deserve that.”). Thus, an IM occurs every time the problematic pattern is challenged and a new way of feeling, thinking, and/or acting emerges that is different from one might expect given the previous functioning.

IMCS allows the tracking of IMs which emerge during therapeutic sessions; for instance, as insight is being developed (in psychodynamic therapy) or as a new pattern of emotional processing is being elaborated (as with chair work in emotion-focused therapy). It also allows the tracking of IMs that have occurred outside the therapeutic session, as when novelties that have taken place

between sessions are discussed and reflected upon in the therapeutic session. Either way the IMs are identified in the therapeutic discourse, including both client's and therapist's conversations, on the assumption that they are co-constructed in the therapeutic interaction (Angus, Levitt & Hardtke, 1999). The emergence of novelties occurs in the therapeutic dialog, so the contribution of both therapist and client must be acknowledged, although the degree of involvement of each participant varies in different therapeutic modalities and at different moments of the same therapeutic process. IMs can result indirectly from a statement of the therapist (e.g., a question, an interpretation), as long as the client accepts it; they can result directly from the therapist's invitation to elaborate a novelty; or they can even be elicited directly by the client without any therapist's intervention. The main point here is that both therapist and client are active contributors to the emergence of novelties. The therapist makes efforts to produce change, but the client is also an active partner, often producing IMs without therapist interventions (Bohart & Tallman, 2010).

This idea of identifying IMs by contrast with a previous problematic pattern has its point of origin in narrative therapy (White & Epston, 1990; see also Gonçalves, Matos, & Santos, 2009b). According to narrative therapy, when clients start psychotherapy they are under the influence of a problematic self-narrative that constrains the way in which meaning is constructed. This is a pattern which is present at the onset of therapy and is responsible for the suffering and the lack of adaptation the client exhibits at that point. Problematic self-narratives can be conceived as a set of redundant rules of behaving, feeling and thinking (as, for instance, in depression) and IMs are all the times when these rules are challenged and exceptions occur.¹ This proposal is congruent with the perspective of Frank and Frank (1991), which suggests that humans have an intrinsic need for making sense of the world and for that purpose an assumptive system is constructed. Sometimes, however, this assumptive system becomes maladaptive, leading to demoralization. Frank and Frank go further by suggesting that "Effective psychotherapies combat demoralization by persuading patients to transform these pathogenic meanings to ones that rekindle hope, enhance mastery,

heighten self-esteem, and reintegrate patients with their group” (p. 52). When this transformation is successful, new assumptions emerge which are identified as IMs by IMCS.

The notion of problematic self-narrative, in the narrative perspective, or maladaptive assumptive system, in Frank and Frank’s proposal, bears resemblances to analogous concepts in other therapeutic models. For instance, problematic self-narratives have similarities with the concept of the cognitive schema in cognitive therapy (Beck, 1976), defined as a “cognitive structure for screening, coding, and evaluating the stimuli that impinge on the organism” (Beck, 1976, p. 233). In emotion-focused therapy the problematic self-narrative is akin to what Goldman and Greenberg (1997) designate by affective problem markers, like unfinished business or a conflict split. From a psychodynamic perspective what Luborsky (1997) refers to as a core conflictual relationship theme (CCRT) also has similarities with the notion of problematic self-narrative. As Luborsky suggests, the method for extracting a CCRT “is based on the principle that *redundancy* across relationship narratives is a good basis for assessing the central relationship pattern” (p. 59, italics added). Finally, in constructivist therapies, core constructs are defined as abstract and frequently universalized meanings which have critical organizing roles as regards the entirety of our construct systems, ultimately embodying our most basic values and sense of self (Kelly, 1955; Mahoney, 1991).

These concepts, independently of their huge theoretical differences, have two commonalities with the concept of problematic self-narrative. First, they all refer to a pattern which manifests itself in several areas of the client’s life, from thoughts, actions, and feelings to significant relationships. Second, this pattern has some redundancy, in the sense that it keeps repeating itself (see the quote from Luborsky, 1997, above), producing suffering and dysfunctionality. Thus, therapists use strategies to disrupt these patterns, trying to create alternatives of feeling, thinking, acting, and relating. Every time an alternative takes place the IMCS captures it as an IM.

As we explain below, we identify the dimensions of the problematic self-narrative as a list of problems, very close to the client's discourse. This makes the IMCS flexible enough to be adapted and used in a wide variety of individual psychotherapies, since the definition of the problematic pattern and the contrasting novelties are inferred from what therapists and clients discuss in therapy and are not inferred from the theoretical perspective of the researcher. In the rest of the article we use the terms problematic self-narrative and problematic pattern interchangeably.

IMCS is useful not only for studying patterns of change across different models of psychotherapy (more on this below) but also because it offers a reliable tool for identifying novelties' emergence, allowing this emergence to be studied and compared with other processes. For instance, studying how novelties are constructed and negotiated in the therapeutic interaction, or how they are associated with therapeutic alliance, or even the associations between novelty emergence and symptoms' evolution, could explain important dimensions of psychotherapy process research.

Types of IMs

Five possible categories of IMs were previously identified inductively, based on the analysis of psychotherapy sessions of women who were victims of domestic violence, followed in narrative therapy (Matos, Santos, Gonçalves, & Martins, 2009). From this original study, the IMCS was applied to depressive clients followed in narrative therapy (Gonçalves & Ribeiro, 2010), emotion-focused therapy (Gonçalves, Mendes, Ribeiro, Angus, & Greenberg, 2010; Mendes et al. in press) and client-centered therapy (Gonçalves et al., 2010). The system has been changed in several ways, but the five types are still those which emerged in the original sample. Below, a definition of each IM is provided, along with a clinical vignette to illustrate them (see also table 1). For the purpose of clarity, all vignettes are from a hypothetical client diagnosed with major depression accompanied by severe social isolation.

Action IMs

Action IMs are actions or specific behaviors that counter the problem or which are not congruent with the problematic pattern (or problematic self-narrative). These actions have the potential to create new meanings.

Clinical vignette

Client (C): *Yesterday, I went to the cinema for the first time in months!*

This action is perceived by the client as a new action, differently from what happens when the problematic pattern is dominant. It is important to note that we code IMs every time a novelty emerges and is perceived by the client as such. Even if the same novelty keeps repeating itself (e.g., client keeps going to cinema) it is still coded as an IM, if the client perceives it as bringing further change. If the client does not perceive the repetition as bringing change the occurrence is not coded as an IM.

Reflection IMs

Reflection IMs consist of the emergence of new understandings or thoughts that do not support the problem or are not congruent with the problematic pattern. There are two types of reflection. Subtype I are IMs in which the problem is challenged and the client thinks about it in a different, new way. Subtype II are IMs centered on the change process. They could describe a contrast between the past (problematic) and the present (non-problematic) or be centered on the processes that facilitate the transformations that have been occurring (see Appendix I for further description of reflection subtypes).

Clinical vignette

C: *I realize that the more I isolate myself, the more depression gets overwhelming...* (Subtype I)

This new way of thinking is different from the previous pattern of functioning in which the client saw the isolation as a protection from others and the only way to cope with depression.

C: *I believe that our talks, our sessions, have proven fruitful, I felt like going back a bit to old times, it was good, I felt good, I felt it was worth it.* (Subtype II)

In this example the client elaborates upon how he is feeling now, as change starts to develop, creating a contrast between now and “old times” (without depression).

Protest IMs

Protest IMs are moments of confrontation and defiance toward the problematic pattern, which can involve actions, thoughts, and feelings. They imply the presence of two positions: one that supports the problem (entailed by other persons and/or an internalized position of oneself), which can be implicit; and another one that defies or confronts the first one. They involve proactivity and personal agency on the part of the client, assuming a strong attitudinal position of rejection of the former problematic pattern.

Like reflection IMs, protest IMs can also involve thoughts or feelings, but they represent a way of repositioning the self through a proactive, 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 longer”). They involve a repositioning towards the problem and its effects, as well as towards others who might be somehow supporting the problematic pattern (e.g., “I told my mother that I won’t accept her ideas about my marriage!”). As the previous example illustrates they might also involve actions, but again there is a strong attitudinal element in them, involving an explicit rejection of the previous problematic pattern. The presence of the rejection toward the previous way of functioning is the key element that allows distinguishing protest from action and from reflection.

There are two subtypes of protest IMs. Subtype I represents a critique of a position that supports the problem (e.g., “It isn’t fair that people are expecting me to be X,” X being a component of the previous problematic pattern). Subtype II is centered on the needs of the self that result from the rejection of the problem (e.g., “As I reject being X, it is becoming clearer to me what I deserve in my life”) (see Appendix I for further description of protest subtypes).

Clinical vignette

C: My fear of others’ judgments was keeping me in a world apart. This was somehow safer but it was making me worse as time went by. I won’t let my fear of others destroy my life. (Subtype I)

This example involves a new way of thinking, like reflection IMs, but the strong emotional rejection of the previous problematic pattern turns it into a protest IM, in which the client clearly rejects how it functioned before.

C: I'm feeling stronger now, and won't let depression rule my life anymore! I want to experience life, I want to grow and it feels good to be in charge of my own life again. (Subtype II)

The second protest subtype also involves rejection of the previous problematic pattern, but more than rejection emerges and the client elaborates on his or her needs ("I want to be in charge of my life"), which were hidden by the previous functioning.

Reconceptualization IMs

Reconceptualization IMs imply a kind of meta-reflection level, from where the person not only understands what is different in him or herself, but is also able to describe the processes involved in the transformation.

This meta-position enables access to the self in the past (problematic self-narrative), the emerging self, as well as the description of the processes which allowed for the transformation from the past to the present. In reconceptualization IMs the perception of a transformation is narrated, clarifying (1) the process involved in its emergence and (2) the contrast between that moment and a former problematic condition. The contrast between past self and emerging/changing self can appear implicitly (e.g., "I am more responsible now [than in the past]"). Moreover, the elements involved in the contrast and in the process must be distinct. Thus, for example, when the client says "now I'm more responsible", this is not by itself a reconceptualization IM. To be coded as such, another element has to be present, which suggests some knowledge of the process through which the transformation took place (e.g., "I am more responsible now [than in the past], because I started to appreciate more the relationship with my son and being irresponsible was killing all the ties I have with him"). Therefore, the element associated with the process of change cannot be exactly the same as the contrast.

Clinical vignette

C: *You know... when I was there at the museum, I was thinking to myself: “you are really a different person... A year ago you wouldn’t even be able to go to the supermarket”!* [Contrast]

T: *How do you think you were able to change this?*

C: *I think the first important step was starting going out and also not expecting that things would be just wonderful and without any difficulties. Now I know how to tolerate my life difficulties without feeling overwhelmed. Life is life, not a paradise, but also not the hell I thought it was.* [Process]

Performing change

Performing change IMs refer to the anticipation or planning of new experiences, projects, or activities at the personal, professional, and relational level. They can also reflect the performance of change or new skills that are akin to the emergent new pattern (e.g., new projects that derive from a new self version). They describe the consequences of the change process developed so far such as, for instance, acquiring new understandings which are viewed as useful for the future or new skills that were developed after overcoming the problematic experience. The coding of performing change implies the presence of a marker of change, that is, the client has to narrate the perception of some meaningful transformation.

Clinical vignette

C: *I want to do all the things that were impossible for me to do while I was dominated by depression. 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.*

In this example the client states several projects that he has for the future, as he is changing and revising the previous problematic pattern. The first sentence indicates that he sees the change process as already having occurred or being in the process of occurring. Performing change is the projection into the future of the changes achieved so far.

In order to systematize the procedures of IMs coding, the IMCS (version 7.2; Gonçalves et al., 2009a) was developed. The IMCS is a qualitative method of data analysis which was developed for studying psychotherapy change. It can also be applied, however, to understanding life change processes, such as change in specific life transitions, daily change, or adaptation to a new health situation (see Meira, Gonçalves, Salgado, and Cunha (2009) for application to personal change outside psychotherapy). It can be applied to qualitative data, namely discourse or conversation, such as therapeutic sessions, qualitative or in-depth interviews, and biographies, predominantly in video/audio systems or transcript support.

Methodological Procedures

The coding procedure requires data analysis by two judges unaware of the outcome status of the cases under analysis (e.g., belonging to a good outcome group). Five steps are carried out in the process of coding IMs (additional steps for coding IMs are provided in Appendix II): (1) training, (2) consensual definition of the problems by the two judges, (3) identification of IMs, defining their onset and offset, for purposes of tracking the *salience* (that is, the proportion of the session occupied by each IM), (4) categorization of previously identified IMs in terms of type, and (5) categorization of previously identified IMs in terms of emergence.

Training

In order to develop our research program, we have developed an IM coding training protocol comprising different phases. First, the IMCS manual (Gonçalves et al., 2009a) is provided to judges so they can familiarize themselves with the theoretical assumptions and the procedures of the system. The judges then have to code two training workbooks, where for every given excerpt they have to code the type of IM. Afterwards, they code transcripts from two therapy sessions where they have to identify IMs and categorize them. These two coding steps are followed by a discussion with the group of judges in training and/or with a skilled judge. Ratings are then compared with

those of expert judges. Finally, a new workbook with examples of IMs is used to establish the reliability of the coder.

Consensual Definition of the Problems by the Two Judges

The first step of the process of coding consists of reading the transcript, watching the videos, or listening to the records of the data. Following this initial procedure, judges independently list the clients' problems (or themes of the problematic self-narrative) and then meet to discuss their comprehension of clients' problematic self-narratives. After this discussion, the problems are consensually defined (as closely as possible to the client's discourse).

This procedure sets the stage for IM identification, since IMs consist of every moment in which the participant engages in novel or different actions, thoughts, or emotions from the identified problem(s). For instance, the act of "walking away from the problematic situation" can be coded as an action IM if the problem is domestic violence, even though an equivalent act can be part of the problem if an anxiety disorder is involved. The process of identifying IMs by contrast with the problematic previous pattern demands that coders code entire cases, and not samples of sessions from one case, unless the coders become familiar with the entire case before they start the coding of particular sessions.

Identification of IMs: Defining their Onset and Offset in the Transcripts for Purposes of Tracking the Salience

In order to allow judges to track IMs within the client discourse, the sessions are independently coded in the order in which they occurred. Judges code IMs from the video, audio or transcript, when either the therapist or client started to talk about any content which constituted an exception to the client's problematic pattern, identifying each IM's onset and offset. IMs contain both client and therapist turn-taking. Thus, the IMs can result from questions or tasks suggested by the therapist, but they are only coded as IMs if the client accepts the therapist's formulation and elaborates on them. For instance, if the therapist poses a question which contains an IM and the client rejects it or does not elaborate on it in some way it is not coded.

We then compute the *saliency* as the proportion of session occupied by each IM. This measure refers to the percentage of words of each IM in the session when we are coding from transcript (*textual saliency*), or, instead, to the percentage of time, when we are coding from audio or video (*temporal saliency*). We compute the saliency of the five types of IMs for each session, as well as the mean saliency of each type throughout all sessions of the therapeutic process. We also compute the overall saliency of IMs as the total percentage of words or time in the session occupied by all IMs. Inter-judge agreement on saliency is calculated as the overlapping of the saliency identified by both judges divided by the total saliency identified by either judge (or, equivalently, twice the agreed saliency spent on IMs divided by the sum of IMs saliency independently identified by the two judges).

To make the procedure of coding clearer we will use as an example the case of Lisa, a well-known EFT client from the York I Depression Study sample (“The Case of Lisa,” 2008; Gonçalves et al., 2010). One of Lisa’s problematic self-narrative themes was “Resentment and difficulty in expressing her own feelings”:

L: ... *maybe that's why I don't tell him [husband] how I really feel inside (sniff) ... yeah, there's, or, um, even though I express it, it's just kind of laughed at... **but then my feelings are my feelings and I'm entitled to them.***

The bold sentence would be coded as an IM, since this would by definition be an exception to Lisa’s problematic pattern. Therefore, the onset is marked when the client starts elaborating the IM and the offset when the clients stops this elaboration.

Categorization of Previously Identified IMs in Terms of Type

After identifying IMs and their saliency, the judges have to identify, independently, which types of IMs are present (e.g., action, reflection). It is important to note that the five categories of IMs are mutually exclusive. Sometimes, however, more complex IMs (e.g., reconceptualization) could contain a more elementary one (e.g., action). When this is the case, the more complex IM is coded. Thus, we consider at the first level action and reflection, at the second level protest, at the

third level performing change and, finally, at the higher level, reconceptualization. These decisions are based on previous studies that suggest that action, reflection, and protest occur in both good and poor outcome cases, and from the beginning to the end of therapy; reconceptualization and performing change occur more in good outcome cases and from the middle to the end of therapy (Gonçalves et al., 2010; Matos et al., 2009; Mendes et al., in press).

Categorization of Previously Identified IMs in Terms of Emergence

Finally, judges have to categorize previously identified IMs in terms of their emergence; that is, indicate whether the IM is brought to the conversation by the therapist or the client. There are essentially three possibilities: (1) the IM is produced by the therapist and accepted by the client; (2) the IM results from a therapist's question or statement which clearly facilitates its emergence (e.g., "T: What can you learn from this experience?; C: I learned that... [a specific IM]"); (3) the IM is spontaneously produced by the client, not triggered by any question asked by the therapist.

It is important to note that the pair of judges meets after coding each session to conduct the reliability procedure (i.e., inter-judge percentage of agreement and Cohen's Kappa) and to note the differences in their perspectives on the problems and in their IM coding. Whenever these are detected, they are resolved through consensual discussion/coding. During these meetings, the judges discuss the procedures and criteria they used. Through this interactive procedure, the judges are able to integrate the strengths of each other's approach, and thereby facilitate consensus (cf. Brinegar et al., 2006). As we privilege false-negative over false-positive results, IMs on which the investigators could not reach an agreement are eliminated (Krause et al., 2007). The analysis is then based on the consensus between the two judges. It is important to note that, throughout this training, coders are made familiar with the data collection and participants, but are neither aware of the hypothesis being studied in that particular study, nor of the outcome of the cases.

Reliability and validity of IMCS

In this section results obtained so far with the IMCS are summarized in two different topics: (1) reliability of single cases and samples studied so far and (2) findings on criterion, convergent and divergent validity.

Inter-judge Reliability

Studies using IMCS showed a good reliability of the coding system across therapeutic models and diagnoses (or problems) The average percentage of agreement ranged from 84% to 94% and the average Cohen's Kappa ranged from 0.80 to 0.97, showing a strong agreement between judges (Hill & Lambert, 2004). Table 2 summarizes these findings.

Validity

Criterion validity

Studies developed with the IMCS were performed with small samples (Gonçalves & Ribeiro, 2010; Gonçalves et al., 2010; Matos et al., 2009; Mendes et al., 2010) contrasting good and poor outcome cases, and intensive single-case studies (Pinheiro, Gonçalves, & Caro-Gabalda, 2009; Ribeiro, Gonçalves, & Ribeiro, 2009; Rodrigues, Mendes, Gonçalves, & Neimeyer, 2010; Santos, Gonçalves, & Matos, 2010; Santos, Gonçalves, Matos, & Salvatore, 2009). Despite the small number of cases, 543 sessions of psychotherapy from different therapeutic models were studied (see Table 2).

The samples studied so far include women who were victims of domestic violence, treated with narrative therapy (Matos et al., 2009), and major depression, treated with emotion-focused therapy (Mendes et al., 2010), and with client-centered therapy (Gonçalves et al., 2010). The commonalities between these studies support the criterion validity of IMCS. First, in both good and poor outcome cases IMs emerge, which suggests that independently of the success of the therapy IMs appear. As can be seen in Table 3, however, despite the emergence in both good and poor outcome cases the salience is very different in these cases, being significantly higher in the study with narrative therapy (Matos et al., 2009) and in the sample of emotion-focused therapy (Mendes et al., in press). This suggests that good outcome cases tend to elaborate more IMs than poor

outcome cases (the exception being the study with client-centered therapy, Gonçalves et al., 2010). Moreover, in all three samples there are differences between good and poor outcome cases in two types of IMs: reconceptualization and performing change IMs appear with higher salience in good outcome cases and hardly emerge at all in poor outcome cases, or have a residual presence. These differences are statistically significant in the three studies. These differences are the only ones that distinguish good from poor outcome cases, which suggests that the differences obtained in the narrative therapy and in the emotion-focused samples in the global IMs are owed to higher salience in these two specific IMs. Finally, reconceptualization and performing change tend to appear in all studies in the middle of the treatment and increase salience at the end of it in good outcome cases. From these common results, most of which were also replicated in several case studies conducted with the IMCS, we have devised a model of IMs development and change in brief psychotherapy that assigns a central role to reconceptualization and performing change IMs (Gonçalves et al., 2009).

Convergent validity

Two studies support the convergent validity of IMCS, one that compared the IMCS with the *assimilation of problematic experiences* (APES; Stiles et al., 1990; Stiles, 2002)) and another that compared the IMCS with the Generic Change Indicators (Krause et al., 2007). In the first study Pinheiro, Gonçalves and Caro-Gabalda (2009) compared the coding done with APES with the coding from IMCS in one case of Linguistic Therapy of Evaluation (Caro, 1996). The coding with IMCS was done without any knowledge of the previous coding with APES. The assimilation model (Honos-Webb & Stiles, 1998; Stiles, 1999, 2002; Stiles et al., 1990) construes the self as a community of internal voices. The model suggests that disconnection of problematic voices from the community underlies many forms of psychopathology. Change occurs as problematic voices are assimilated through psychotherapeutic dialog by building *meaning bridges*, which are signs (e.g., words, images, gestures, narratives) that, to some extent, have the same or similar meaning to the problematic voices and the community. APES comprises a progression as a series of eight

stages, numbered from zero to seven, that describe the kind of dialog that occurs between the problematic voices and the community, from the warded-off stage (in which the client is unaware of the problem, the problematic voice being warded off from the community of voices that constitutes the self), to a mastery stage (in which the previously problematic voice is fully assimilated by the self and constitutes a resource to deal with life situations). According to the results obtained so far with the IMCS we would expect that action, reflection and protest IMs would be associated with lower levels of APES, whereas reconceptualization and performing change would be associated with higher stages. This prediction is based on the findings reported above that suggest that reconceptualization and performing change occur later in successful treatment and that these IMs are almost absent in poor outcome cases. Moreover, a study done with APES (Detert, Llewelyn, Hardy, Barkham, & Stiles, 2006) shows that stage 4 is reached in good outcome cases, but not in poor outcome cases. Thus, for APES the level 4 is a marker of success, while in the IMCS the marker of success is the emergence and development of reconceptualization and performing change IMs. Consistently with what was expected, action, reflection, and protest IMs were more associated with levels 2 and 3 of APES, whereas reconceptualization and performing change were more associated with levels 4 to 6 of APES. These findings support the idea that reconceptualization and performing change are more developed or complex IMs.

The second study compared the coding of IMCS with that of the Generic Change Indicators model (Krause et al., 2007) that describes an ideal sequence of successive changes, in which level of complexity increases progressively and that begins with the “Acceptance of the existence of a problem” and ends with the “Construction of a biographically grounded subjective theory of self and of his or her relationship with surroundings” (p.677). Martínez, Mendes, Krause, and Gonçalves (2009) compared the coding done by the two systems in a case of psychodynamic long-term therapy. The coding of the generic change indicators (Krause et al., 2007) had already been done and 70 episodes of change were identified with this system. In 48 of the 70 there was at least one type of IM, which means that a statistically significant association exists between both. Moreover,

results also show a connection between the more elaborated IMs and the generic change episodes that correspond to a higher level of complexity (mainly level II) according to the Generic Change Indicators.

Divergent validity

Martínez et al. (2009), in the case reported above, also studied episodes of alliance rupture, that were coded according to Eubanks-Carter, Muran, Safran, and Mitchell (2008). The episodes of rupture on the therapeutic alliance are a disruption in the process of intersubjective negotiation, where both participants distance themselves from or confront each other, creating a moment of failure in the communication between them, preventing therapeutic change from occurring (Safran & Muran, 2000). Of the 26 episodes of rupture that were identified, IMs only appear in two of them. This finding suggests that a negative association exists between the emergence of IMs and the presence of alliance ruptures, that is, alliance ruptures, as expected, are not moments in which novelties could be elaborated.

Final Remarks

IMCS has proved its flexibility up to now insofar as it has been applied to different models of therapy and different samples, such as clients diagnosed with major depression or victims of domestic violence. At the onset of its use one important question was if it could be applied to models of therapy which did not entail a narrative framework, given that the concept of IM was clearly rooted in narrative therapy. The possibility of using it with different models of therapy, in which the therapist uses different techniques from the ones prescribed by narrative therapy, is a major asset of this system. In fact, this flexibility is not so unexpected, given that, independently of the theory that organizes the therapist's behavior, all therapists wish to create and sustain novelties in clients' lives.

One interesting finding from the research using IMCS is the common pattern of results obtained in different samples. As stated before, regardless of minor differences between the samples

studied, the major findings are similar, regardless of the type of therapy and even the diagnosis. This suggests that, although therapists use different therapeutic techniques, IMCS allows the identification of a common path of change in brief therapy. These commonalities between therapies support the perspective of common factors (Norcross & Goldfried, 2005; Wampold, 2001) or common principles (Castonguay & Beutler, 2006) in psychotherapy, which asserts that factors or principles shared by all psychotherapies are the main processes through which change takes place. The samples studied are very small and these findings should be regarded with caution, but simultaneously the congruency of findings in several samples and case studies gives cause for some confidence in these results.

So far, IMCS has mainly been used with brief individual therapy and we do not know if this system is applicable to long psychotherapies and to couple (see Jussila, 2009 for a pilot study with couple therapy), family or group therapy. Other exploratory studies could target these possible domains of application in the future. Also, so far, we do not have any studies with patients with disturbances of axes II (DSM-IV, APA, 2000) or highly disturbed patients (e.g., psychotic, eating disorders). Future studies should also address other forms of validity, like construct validity, through exploratory and confirmatory factor analysis, to improve the robustness of IMCS. Another line of research could address the causal relations between IMs and other changes in psychotherapy. So far the research design has been correlational (comparing good with poor outcome cases), but it is important to discover if IMs predict symptom changes, self-narrative changes (e.g., differences in autobiographical narrations from the beginning to the end of therapy), or both.

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Footnotes

¹ In narrative therapy (White & Epston, 1990; White, 2007) these occurrences are labeled as *unique outcomes*. See Gonçalves et al. (2009b) on why we prefer the term innovative moment.

Appendix I: Subtypes of Reflection and Protest IMs

After in-depth qualitative analysis, we identified two subtypes of reflection and protest (see below).

When coding reflections and protest IMs, both judges should also identify the subtype. In order to insure reliability, Cohen’s Kappa is calculated regarding the subtype.

Reflection	Content (examples)
Subtype I Creating distance from the problem(s)	<ol style="list-style-type: none"> 1. Understanding – Reconsidering problem(s) causes and/or awareness of their effects C: I realize that the reason my husband doesn’t help me is because I, over the years... I have this image of myself as super, you know, superwoman. 2. New problem(s) formulations C: I realize that what I was doing was just not humanly possible because I was pushing myself and I never allowed myself any free time, uh, to myself ... and it's more natural and more healthy to let some of these extra activities go... 3. Adaptive self-instructions and thoughts C: I do want to get out of here! I want to improve! 4. Intention to fight problem(s) demands C: I will try to fight my fears! 5. References of self-worth and/or feelings of well-being C: I’ve imposed goals on myself all my life and do my utmost to achieve them, always with a lot of hard work, but I always managed to get there somehow...

Subtype II
Centered on the
change

1. Therapeutic Process – Reflecting about the therapeutic process

C: I believe that our talks, our sessions, have proven fruitful, I felt like going back a bit to old times, it was good, I felt good, I felt it was worth it.

2. Change Process – Considering the process and strategies implemented to overcome the problem(s)

C: This week I managed to study (...) I felt really interested about studying and I found it very useful to study in the library, instead of studying at home. This week I felt a bit more, well, a bit more loose...

3. References of self-worth and/or feelings of well-being (as consequences of change)

C: I feel like I've sort of made a lot of progress and I'm gonna go on from here. I continue to make progress!

4. New positions – references to new/emergent identity versions in face of the problem(s)

C: I'm feeling stronger, I feel more in control! I feel like I do feel better about myself.

Protest

Subtype I
Criticizing the
problem(s)

Content (examples)

1. Position of critique in relation to the problem(s) or/and the others who support it

C: I hope you are somewhere writhing in remorse for your actions because you deserve it! I've told you, you were stupid, just being your son has been nothing but hurt the whole of my life! It wasn't fair to be brought up that way. I think you're very selfish!

T: Say that again.

C: I think you're very selfish! (in a empty chair dialog with the father)

*The other could be an internalized other or a side of oneself:

C: What am I becoming after all? Is this where I'll be getting to? Am I going to stagnate here!?

Note that this is not the same as self-criticism or guilt, which would not be considered protest: ²

C: The truth is that I don't know how to express what I'm feeling! Suddenly there's like a big frustration and a deception, self-deception of having such a difficult personality because I consider myself a difficult person that is difficult to approach, to deal with!

² This general rule should not be assumed in an absolutist manner since “guilt” or even “self-criticism” can constitute an IM regarding specific situations in which their absence supports the problem’s maintenance, for instance in narcissistic, anti-social, and/or aggressive functioning.

Subtype II
Emergence of
new positions

1. Positions of assertiveness and empowerment

C: I am an adult and I am responsible for my life, and, and, I want to acknowledge these feelings and I'm going to let them out! I want to experience life, I want to grow and it feels good to be in charge of my own life.

2. Repositioning oneself towards the problem(s)

C: I had to live up to my father's expectations all my life. I don't want to do it anymore, it's too hard! I want to get off of it, I don't want to do it anymore, it's hard!

(...)

C: I know it's important for you to see me all settled but maybe this is just not what I want, maybe like I am happy like the things I have right now, like I don't really have the urge to do the same thing you have done, like I don't, maybe who knows like maybe one day I do have a house but right now it's not really one of my goals like to have this house and it's not my goal like to have this big car like I'm just not into these status symbols, like I just, I'm, yes I am able to make a living it is not that secure it is not that much money but I'm having a very good time and I'm fine!

Appendix II: Coding Tips

Bold sentences are IMs.

IMs' salience	
<p>1. Beginning of an IM: IMs should be coded from the beginning of the grammatical sentence where the innovation content is appearing explicitly.</p>	<p>1. Example: C: Yesterday I went to the beach with my boyfriend and / for the first time in a long time I didn't feel depressed. [Reflection IM] (the slash signals a different thought.)</p>
<p>2. When an IM is questioned by the therapist, the question that prompted the IM is not included when salience is measured; however, all the other therapist's interventions are taken into account during the elaboration of an IM.</p>	<p>2. 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 IM]</p>
<p>3. When an IM is elaborated by the client, the first utterance of the therapist should be excluded, while the in-between turn-takings are included.</p>	<p>3. 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 IM]</p>
<p>4. If the client, while elaborating an IM, drifts away and changes the theme (e.g., making comments about other things), this part of his/her speech is not included in the IM.</p>	<p>4. Example: C: <i>This week I went to the gym, also the theater...[Action IM] <u>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</u> Anyway, I had a great time, I could keep my mind away from the usual problems...</i>[Reflection IM] [Do not code the underlined part]</p>

IM Types

1. After coding an **excerpt where several IMs appear sequentially (or overlap)**, 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 IM.

We accept the following **hierarchy** (from the more basic to the more complex): 1. [action – reflection] 2. [protest] – 3. [performing change] – 4. [reconceptualization] and consequently we code the most inclusive IM. Thus we use the following decision-making process:

- (a) When action and reflection are both present they are coded separately;
- (b) When action or reflection (or both) and protest overlap, we code the overlap as protest.
- (c) When action or reflection (or both) and performing change overlap, we code the overlap as performing change;
- (d) When protest and performing change overlap, we code the overlap as performing change;
- (e) When reconceptualization and performing change overlap, we code the overlap as reconceptualization.

2. Differentiating reflections from actions:

2.1. Whenever possible, **Action and Reflection IMs should be coded separately.**

2.2. When the client/ interviewee is **reflecting**

1. 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 –

Reconceptualization IM]

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 IM]

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 IM]

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... [Reconceptualization IM].

2. Examples:

2.1. **I left home for the first time** [Action IM] **and I felt good** [Reflection IM].

2.2. **Leaving home for the first time made me feel**

about specific actions, we should code Reflection. **great!** [Reflection IM].

3. Coding performing change IMs:

3.1. Implies the presence of an implicit or explicit marker of change, i.e., the client narrates the perception of some transformation. If the client narrates a vague desire to change, it should be coded as a reflection, even if we are able to recognize that this goal is a clear consequence of the change process.

3.2. Nevertheless, the contrast between past self and emerging/changing self can also be stated by the therapist and accepted by the client.

3. Examples:

3.1.

C: **“There is so many thing that I still want to change in my life!”** [Reflection IM].

Versus

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 [marker of change]. 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** [Performing Change IM]

3.2.

T: **I believe Maria is much closer to what you would like than in the beginning...**

C: **Yes, no doubt about it!** [marker of change]

T: **What is it that is still missing? New targets?**

C: **I want to get solid... in these last times, I’ve really made up my mind to achieve targets: the relationship with my boyfriend, the relationship with my father...** [Performing Change IM]

3.3. Performing change IMs can be a performance of change or new skills that are akin to the emergent narrative. This kind of IM implies not only a reflection about the change, but also the narration of a specific episode (performance) which mirrors it.

3.3.

- Marker of change without a new performance episode:

C: **Now I'm more assertive than I was in the past!**

[[Reflection IM]

- Marker of change with a new performance episode:

C: **I was able to actually bring up the subject and talk to my husband about it,** [new performance

episode] *as before in the past , I was afraid to say something because he'd take it the wrong*

way...[Marker of change] [Performing Change IM].

Table 1

Innovative Moments Grid (Version 7.2)

Types of IMs	Subtypes	Contents
<p>Action Actions or specific behaviors against the problem(s).</p>		<p>New coping behaviors facing obstacles Effective resolution of unsolved problem(s) Active exploration of solutions Strategies implemented to overcome the problem</p>
<p>Reflection Thinking processes that indicate the understanding of something new that creates a change in the problematic pattern (e.g., thoughts, intentions, interrogations, doubts).</p>	<p>(i) Creating distance from the problem(s) (ii) Centered on the change</p>	<p>Comprehension – reconsidering causes of problems and/or awareness of their effects New problem(s) formulations Adaptive self-instructions and thoughts, Intention to fight problem(s)' demands, references of self-worth and/or feelings of well-being Therapeutic process – reflecting about the therapeutic process Change process – considering the process to overcome the problem(s); references of self-worth and/or feelings of well-being (as consequences of change). New positions – references to new/emergent identity versions in the face of the problem(s).</p>
<p>Protest Moments of critique, which involve some kind of confrontation (directed at others or versions of oneself); it could be planned or actual behaviors, thoughts, or/and feelings.</p>	<p>(i) Criticizing the problem(s) (ii) Emergence of new positions</p>	<p>Position of critique in relation to the problem(s) or/and the others who support it. The other could be an internalized other or facet of oneself. Positions of assertiveness and empowerment Repositioning oneself towards the problem(s).</p>
<p>Reconceptualization Process description, at a meta-cognitive level (the client not only manifests thoughts and behaviors outside the problematic narrative, but also understands the processes that are involved in it).</p>		<p>Reconceptualization always involves two dimensions: A. Description of the shift between two positions (past and present). B. The process underlying this transformation.</p>
<p>Performing Change References to new aims, experiences, activities, or projects, anticipated or in action, as consequence of change.</p>		<p>Generalization to the future and other life dimensions of good outcomes Problematic experience as a resource for 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 New skills unrelated to the problem Re-emergence of neglected or forgotten self-versions</p>

Table 2

Reliability across studies

Reference	Therapeutic Model	Problem	N	Number of sessions	Percentage of the case(s) coded by both judges	Average Percentage of agreement	Average K
Gonçalves, Mendes, Cruz, et al., 2010	Client-Centered Therapy	Major Depression	6	93	30%	85.88%	.97
Mendes et al., 2010	Emotion-Focused Therapy	Major Depression	6	105	50%	88.70%	.86
Gonçalves & Ribeiro, 2010	Narrative Therapy	Major Depression	10	188	100%	89.2%	.91
Matos et al., 2009	Narrative therapy	Victims of intimate violence	10	127	30%	86%	.89
Pinheiro et al., 2009	Cognitive Therapy	Generalized Anxiety	1	14	40%	94%	.85
Ribeiro et al., 2009	Constructivist Therapy	Adaptation Disorder	1	10	100%	84.05%	.90

Rodrigues et al., 2010	Constructivist Therapy	Complicated Grief	1	6	100%	89%	.80
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Table 3

IMs' salience mean across studies

Therapeutic Model	IMs' Salience (%) Mean	
	Good-outcome Group	Poor-Outcome Group
NT (Matos et., al, 2009)	10,76 (4.84)	5,38 (1.79)
EFT (Mendes et al., in press)	30,31(4.02)	8,90 (5.97)
CCT (Gonçalves et al., 2010)	10,84(5.50)	5,82(3.74)