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NARRATIVE MEASURES IN PSYCHOTHERAPHY

Three narrative-based coding systems: Innovative moments, ambivalence and ambivalence resolution

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Abstract
Narrative and dialogical perspectives suggest that personal meaning systems' flexibility is an important resource for change in psychotherapy. Drawn from these theoretical backgrounds, a research program focused on the identification of Innovative Moments (IMs)—exceptions to the inflexible meaning systems present in psychopathological suffering—has been carried out. For this purpose, three process-oriented coding systems were developed: The IMs Coding System, the Ambivalence Coding System, and the Ambivalence Resolution Coding System. They allow, respectively, for the study of change, ambivalence, and ambivalence resolution in therapy. This paper presents these coding systems, the main findings that resulted from their application to different samples and therapeutic models, the main current and future lines of research, as well as the clinical applications of this research program.

Keywords: narrative measures; innovative moments; ambivalence; ambivalence resolution; process research

This paper presents three narrative-based interrelated coding systems and the main findings that result from their application to different clinical samples (Alves et al., 2014, 2016; Gonçalves et al., 2012; Gonçalves, Ribeiro, Silva, Mendes, & Sousa, 2016; Gonçalves, Ribeiro, Stiles, et al., 2011; Matos, Santos, Gonçalves, & Martins, 2009; Mendes et al., 2010; Ribeiro et al., 2014). This research line started over a decade ago with a study conducted by Matos and Gonçalves (2004) that aimed to find different types of *unique outcomes* that emerged throughout narrative therapy (NT) with victims of intimate violence. White and Epston (1990) proposed this concept to describe exceptions to problem-saturated narratives. More specifically, they suggest that

> although life is rich in lived experience, we give meaning to very little of this experience […] Many of these experiences are 'out of phase' with the plots or themes of the dominant stories of our lives […] However these 'out of phase' experiences can be potentially significant and […] can provide a point of entry for the development of alternative storylines of people's lives. (White, 2007, p. 219)

These out of phase experiences correspond to what the authors refer to as *unique outcomes*, that is, exceptions to the maladaptive patterns (or problem-saturated narratives, using White and Epston's term) that brought clients to therapy. In our research, we termed these exceptions innovative moments (IMs), an empirical operationalization of unique outcomes.

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The dialogical self theory proposed by Hermans and Kempen (1993) has been another important reference in the elaboration of our theoretical model. Dialogical theories propose that the self is multivocal—that is, composed of multiple positions that may have a voice in the self—and that the construction of meaning derives from the dialogical interchange (e.g., agreement, disagreement, opposition, and coalition) between different positions of the self. Thus, the consistency of our personal meaning system is the result of the dialogue between different positions and the temporary dominance of one position over the others, in a given moment in time. Furthermore, as Hermans (2004) proposed, positions can be internal (e.g., *me as researcher*), or external (e.g., *my mother*), as well as specific (e.g., a specific position, *me as psychologist*) or more abstract and generalized (e.g., *the community of readers that hopefully will read this article*). Positions of the self are manifested as voices, and this concept is very similar to the way Stiles used the term in the Assimilation Model (Stiles, 2002; Stiles, Meshot, Anderson, & Sloan, 1992; Stiles et al., 1991).

The assimilation model is probably the most well-known dialogical theory of change in psychotherapy and shares important links with our perspective. According to this model, in successful therapy, a client may assimilate avoided, distressing, or difficult voices so that they can become available resources (Stiles, 2002). This process follows a sequence that is summarized in the eight stages of the Assimilation of Problematic Experiences Scale (APES; Stiles, 2001, 2005; Stiles et al., 1991, 1992). The APES stages, numbered 0–7, anchor a continuum of assimilation that describes the changing relation of the non-dominant voice to the dominant community of voices (that is, the self): (0) Warded off/dissociated, (1) unwanted thoughts/active avoidance, (2) vague awareness/emergence, (3) problem statement/clarification, (4) understanding/insight, (5) application/working through, (6) resourcefulness/problem solution, and (7) integration/mastery. One typical form of psychological suffering (e.g., clear in depression or anxiety disorders) is characterized by inflexibility, as the same meanings emerge over and over again (see also the special section on narrative dysfunctions from Dimaggio, 2006). Dialogically, the same dominant positions are emerging (i.e., are being voiced in the self) and constraining the development of alternative ones that are being constantly silenced (Stiles, 2011).

A study by Osatuke, Stiles, Barkham, Hardy, and Shapiro (2011; see also Osatuke et al., 2007) found a common dialogical pattern in depressive clients: A conflict between a dominant interpersonally submissive voice (e.g., "the others are right, I am wrong"), which organizes the majority of experiences (being the dominant narrator), and an assertive voice (e.g., "I have the right to think or feel this way") that is suppressed by the community of voices that constitute the self. For such depressive patients, the process of rejecting and silencing other voices maintains a dominant maladaptive pattern characterized by rigidity. Such dominant self-narratives comprise strict implicit rules, such as "always privilege the wishes of others and ignore your own." The voices suggesting otherwise might attempt to emerge, but they tend to be suppressed or avoided, producing tension. Thus, for instance, when the person faces a conflict with others and is unable to be assertive, a tension is created because the non-dominant (but assertive) voices are suppressed and fight to be heard. In this line of reasoning, an IM occurs every time the assertive position is voiced in the self, regardless of whether this emerges as a thought, an action, a wish, or a feeling. As a non-dominant voice is assimilated in the course of successful therapy, it becomes more accessible and less dissociated from the community of voices, and the rigidity of the dominant self-narrative decreases. Take the following example from *Lisa* (see Gonçalves, Mendes, Ribeiro, Angus, & Greenberg, 2010), who at the beginning of therapy presented a maladaptive pattern of resentment and difficulty expressing her own feelings: "That is why I don't tell my husband what I feel inside … and even if I did, he would probably laugh." At some point in therapy, an alternative voice emerged when she stated "but my feelings are my feelings and I'm entitled to them." This was clearly an example of an IM, and from the assimilation model perspective it constitutes the expression of a non-dominant voice.

The IMs model and the assimilation model offer related ways to understand and measure the process of therapeutic change. Tentatively, the problematic self-narrative holds the dominant community of voices together and excludes the unassimilated voices. Because unassimilated voices are expressions of important elements of our self, even when silenced, they do not disappear. Thus, whenever unassimilated voices express themselves, IMs occur. Change occurs as clients move from a problematic to a more functional self-narrative, one that incorporates the previously excluded voices. This process occurs through the emergence, accumulation, and articulation of IMs. When non-dominant voices express themselves, through the occurrence of an IM, the dominance of the current community of voices is disrupted, and an opportunity for the development of a meaning bridge emerges. The meaning bridge promotes the negotiation between the dominant voice and the intruding (previously silenced) one. That is,

one step towards the integration of these theories is to propose that the IMs model focuses on the binding and the assimilation model focuses on what is bound (Ribeiro, Stiles, & Gonçalves, 2016). A recent case study (Gonçalves et al., 2014) compared these two methods and found that more elementary IMs were associated with APES's stages below 4, and more developed IMs were identified at higher APES stages (at or above APES's stage 4). Thus, the notion of clients' movement towards higher stages, operationalized through the eight levels of APES, is coincident with the IMs' model, as more developed IMs (i.e., high-level IMs, see below) are conceptualized as more centered on the elaboration of the change processes and have been more frequently identified as therapy unfolds.

The Narrative-Emotion Process Coding System (Boritz, Bryntwick, Angus, Greenberg, & Constantino, 2014) is another coding system that has connections with the concept of IMs. This coding system, described in detail by Angus et al. (2016), has three types of general categories: Problem markers, transition markers, and change markers. Each of these categories is then divided into subcategories. There are clear similarities between change markers and IMs, and transition markers and what we describe below as ambivalence markers.

In the next section we describe the IMs Coding System (IMCS; Gonçalves, Ribeiro, Mendes, Matos, & Santos, 2011) and summarize the main results of the research conducted so far. After describing the IMCS, we will describe the Ambivalence Coding System (ACS)[1] and the Ambivalence Resolution Coding System (ARCS) and summarize the main findings from the research conducted with each one of these methodologies. The main samples used for these studies are presented in Table I (more extended characterization of these samples can be found in the original articles). Table I also contains the publication reference, the studied therapeutic model, the problem or diagnosis, as well as other relevant information on the samples. All samples consisted of an equal number of recovered and unchanged cases, which were selected from larger samples for the specific studies. We used Jacobson and Truax (1991) criteria to define recovered and unchanged cases. In the remaining pages of this article these samples will be referred to with the acronym defined in Table I.

Innovative Moments Coding System (IMCS; Gonçalves, Ribeiro, Mendes, et al., 2011)

This coding system was inspired by the concept of unique outcome from NT (White & Epston, 1990), but it is not restricted to NT research. Moreover, we should note that unlike other methods (e.g., Core Conflictual Relationship Theme [CCRT]; Luborsky, Barber, & Diguer, 1992) the system does not track narratives as units of analysis, rather it analyzes the client's entire discourse.

To illustrate the three coding systems throughout this paper, we will use clinical vignettes from a complicated grief case of a 63-year-old woman (that we will further refer to as "Laura," a fictional name) who lost her 30-year-old daughter to cancer two years before starting therapy (this case was included in a grief sample presented in Alves et al., 2014, 2016). After her daughter's death, Laura showed a significant incapacity to reconnect with her world (e.g., playing with her grandchildren, working at her family store, driving her car) and to find meaning to the death of her "young and generous" daughter. At the beginning of therapy, Laura told the therapist that

> it's been really hard because I did so many sacrifices to have my two kids and now … losing my 30 years old daughter, losing her like this, it's a brutal thing that has no explanation and we don't know what to do with our lives now. (session 1)

This sentence depicts how her personal world was tragically shattered and lost coherence, creating a scenario of "no explanation," that is, of no meaning. As therapy progressed and the construction of a healthier bond with her deceased daughter emerged, Laura started finding a more adaptive and peaceful meaning to her daughter's death, in connection with her spiritual beliefs:

> If eternity exists … I think she was so good that she may be in a really good place now. (…) I think she is with Jesus and she is better there than she was here because if I wanted her here I would be selfish as she was suffering so much (referring to the cancer). (session 5).

The Diversity of IMs

In our initial studies we identified five different types of IMs (see Gonçalves, Ribeiro, Mendes, et al., 2011): Action, reflection, protest, reconceptualization, and performing change (the latter was recently termed action 2). An IM study examining emotion-focused therapy (EFT) sessions (Mendes et al., 2011) helped us to identify and discriminate two levels of reflection and two levels of protest IMs, resulting in the current system, with seven types of IMs (see Table II): Action 1 and 2, reflection 1 and 2, protest 1 and 2, and reconceptualization. Thus, we have two groups of IMs: Low-level IMs (action

Table I. Summary of the samples coded with IMCS.

Reference	Therapeutic model	Problem	*N*	No. of Sessions	Average of sessions	Average % of agreement	Average of *K*
Gonçalves et al. (2012)	Client-centered therapy (CCT)	Major depression	6	93	16.83 (*SD* = .98)	85.9%	.97
Mendes et al. (2010)	Emotion-focused therapy (EFT)	Major depression	6	105	17.50 (*SD* = 1.87)	88.7%	.86
Gonçalves, Ribeiro, et al. (2016)	Narrative therapy (NT)	Major depression	10	180	18.70 (*SD* = 1.83)	89.9%	.91
Matos et al. (2009)	Narrative therapy (NTIV)	Victims of intimate violence	10	127	12.7 (*SD* = 3.74)	86%	.89
Alves et al. (2014)	Constructivist grief therapy (CGT)	Complicated Grief	6	83	13.83 (*SD* = 0.98)	Pair 1 89.2% Pair 2: 83.7%	Pair 1: .91 Pair 2: .80
Gonçalves, Silva, et al. (in press)	CBT	Major depression	6	111	18.67 (*SD* = 3.27)	90%	.94

Table II. IMs with examples.

Types of IM	Subtypes	Definition	Examples (problematic narrative: depression)
Low-level IMs (creating distance from the problem)	Action I	Performed and intended actions to overcome the problem	C: Yesterday, I went to the cinema for the first time in months!
	Reflection I	New understandings of the problem	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 …
	Protest I	Objecting the problem and its assumptions	C: What am I becoming after all? Is this where I'll be getting to? Am I going to stagnate here?!
High-level IMs (centered on change)	Performing change (Action II)	Generalization into the future and other life dimensions of good outcomes (performed or projected actions)	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 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.
	Reflection II	Contrasting Self (what changed?) OR Self-transformation process (how/why change occurred?)	C: I feel positive and strong. It's okay to ask for these things [her needs], it's a new part of me, so I'm not going to turn it down.
	Protest II	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.
	Re-conceptualization	Meta-reflection where individuals perceive what is changing in themselves (contrast) AND also understands the processes involved in this transformation (process)	C: I feel differently nowadays. I don't worry about what others think about what I'm saying. I discovered that I need to respect my needs and opinions, even if other people disagree with me. I used to be in constant conflict with myself - thinking one thing, saying another - just to prevent any disagreement with others. Why does the disagreement with others need to be worse than this internal fighting?

1, reflection 1, and protest 1) in which exceptions are characterized by the creation of distance from the maladaptive pattern, and high-level IMs (action 2, reflection 2, protest 2, and reconceptualization), centered on the elaboration of the change processes. We must keep in mind that, despite this distinction between low and high levels, IMs are always identified as "out of phase experiences," when compared with the maladaptive/inflexible initial pattern.

Consider two examples that depict Laura's movement from low- to high-level IMs. In the first example, Laura describes her struggle to make sense of her daughter's loss and to be able to reconstruct her sense of self, to reconnect with her world and to overcome the maladaptive grieving response:

> I'm trying everything. I want to be myself again, to be that person always ready for everything (…) We don't know anything, we don't know if she sees or knows or understands what we are living. I don't know anything, anything. But I want her to know that I'm trying really hard to be ok, because she always wanted that, she always did everything to make me feel good. (Reflection 1 IM)

In the next example, she is able to reconnect with her world and to feel her daughter in her life in a more adaptive way: "Now, as I come down to this world again, I feel that I am not alone. I feel that my daughter is with me and that she is never going to leave me" (Reflection 2 IM).

Coding Procedures

The IMCS involves the coding of all psychotherapy sessions (from the first to the last session) by two independent judges to establish inter-coders reliability. So far we have worked only with brief psychotherapy, usually with samples of no more than 20 sessions. Coding IMs involves several tasks: (i) DEFINING the maladaptive pattern: In a sense, the "rule" or dominant problematic narrative that is extracted by coders while reading sessions' transcripts or listening to audio or video recordings. Most of the times this rule is congruent with what was the target of the therapeutic work. "Coders are trained to avoid high levels of inference in this procedure and stay close to what therapist and client discuss in therapy"; (ii) defining moments in which this rule is discontinued or challenged and an exception (an IM) emerges; (iii) identifying the beginning and the end of the IM (in the transcripts or in the recordings), and; (iv) finally, coders have to classify the type of the identified IM. For this last step, depending on the research questions and on the resources available, researchers may use the former system with five types (action, reflection, protest, reconceptualization, and action 2), all the seven types (that is, reflection and protest are discriminated in types 1 and 2), or only two types of IMs (low-level IMs vs. high-level IMs). The first phase (defining the maladaptive pattern) is performed consensually between coders, while the others are done independently. After independently coding two or three sessions, coders meet to calculate reliability and to discuss their understanding of the case. Then they proceed with the independent coding of IMs, and repeat this procedure throughout the coding process.

Two measures are used to study IMs: (i) The proportion of the session taken by each IM, considering the total length of the session, and, (ii) the type of IM (two types, five types, or seven types, as described above). Regarding the first one, when researchers are working with audio or video recordings, proportion can be calculated as the IM's duration in time (compared to the total duration of the session). If they are working with transcripts, the proportion of words can be used (IM length divided by the total length of the session, in number of words).

These procedures allowed establishing the coding's reliability. The data reported previously by Gonçalves, Ribeiro, Mendes, et al. (2011) referred an agreement percentage on IMs of between 84% and 89%, which means that the judges agreed between 84% and 89% of the session on what is the portion containing IMs. Reliability in distinguishing the five IMs types, assessed by Cohen's Kappa, ranged between .80 and .97. Recent studies (Gonçalves, Ribeiro, et al., 2016; Gonçalves, Silva, et al., in press) reported similar values, with an agreement between coders of 89.9% for NT and 90% for CBT and a Cohen's k of .91 for IMs types in NT and .94 in CBT.

IMs and Symptoms' Change

Our first aim was to study the relationship between IMs and symptoms change. Thus, a diversity of studies, summarized below, were conducted. The time-consuming nature of IMs' coding prevented the development of studies with larger samples. Nonetheless, all sessions of the referred samples were coded, which resulted in a considerable amount of studied sessions. We used non-parametric tests and multivariate statistics to test the difference between recovered and unchanged cases in our initial studies. Later on, we used Generalized Linear Models (GLM), in which symptom change was used as a predictor of IMs' progression in therapy (Alves et al., 2014; Gonçalves et al., 2012). Two significant research findings emerged from

these studies: (i) OVERALL IMs (the sum of all proportions of the different types of IMs), and (ii) reconceptualization IMs have a significant higher proportion in recovered than in unchanged cases. Moreover, reconceptualization IMs emerge in the middle of treatment and increase their proportion towards the end.

Multiple samples coded with IMs along the years allowed us to combine samples for further analyses. In a recent study (Gonçalves, Rosa, et al., 2016) we merged six small samples of the previous studies (EFT, Client-centered therapy [CCT], NT, NTIV, CBT, and constructivist grief therapy [CGT]) into a single sample. The combined sample is composed by 44 clients and 729 sessions. A GLM analysis revealed no significant difference between recovered and unchanged cases in the probability of the occurrence of low-level IMs (IMs centered on the problematic pattern) during treatment. On the other hand, the probability of the occurrence of high-level IMs (IMs centered on elaborating change) was significantly different in recovered and unchanged cases right from the first session, and this difference increased until the end of treatment. The fact that these IMs differentiate cases at the first session deserves future studies to confirm IMs' predictive validity. If these results are supported by future studies, identifying IMs in the first session would be particularly relevant as a form of feedback strategy (Lutz, De Jong, & Rubel, 2015), as coding IMs is a very time-consuming task for the entire treatment, but a relatively easy task for only one session.

IMs Predicting the CCRT

In addition to this research in which IMs were related with symptoms' reduction, we also developed studies in which IMs were related with other constructs, thus increasing our confidence in their validity. A recent research conducted by Batista (2016) studied the ability of IMs to predict changes in the CCRT (Luborsky, 1998). The CCRT was one of the first empirical measures of narrative change, widely studied in psychotherapy practice and research (Luborsky & Crits-Christoph, 1998; McCarthy, Gibbons, & Barber, 2008). The CCRT characterizes relational episodes narrated in therapy by identifying three components: The Wishes, needs and intentions (W), the Response of Others (RO), and the Responses of the Self (RS). While the W component refers to the wishes expressed in an interpersonal encounter, the RO describes the perceived reaction of other (or others) interacting with the person, and the RS the way the person perceived his or her response to that interaction. The CCRT method allows for the definition of the rigidity of its components, sharing the assumption proposed above that rigidity is a clear sign of psychological disturbance. One of these measures of flexibility is the Gini dispersion index (see Cierpka et al., 1998), also used in previous studies with the CCRT. According to Cierpka et al. (1998) the higher the Gini dispersion score (range from 0 to 1) the more flexible the interpersonal pattern. Another method is pervasiveness (Crits-Christoph & Luborsky, 1998), which corresponds to the most frequent W, RO or RS.

In Batista's research (2016), the previously referred samples of major depression (EFT, CCT, and NT) were merged to study the relationship between IMs and CCRT components. The results showed that IMs centered on elaborating change (i.e., high-level IMs) were significant predictors of CCRT's increase in flexibility later in treatment, measured by the Gini dispersion index. This does not occur for low-level IMs. Interestingly, this ability to predict an increase in flexibility is congruent with the notion that IMs identify out of phase experiences, as proposed by White (2007), that is, experiences that are associated with less rigidity in interpersonal functioning.

IMs Preceding Symptoms' Change

Until this point all the research findings suggest that IMs are related to the outcome of therapy, but an important question, as these data are correlational, is the nature of this relationship. So, IMs can be conceptualized as process measures (variables that are important to produce change) or outcome variables (variables that represent change). As these designs are observational and we cannot easily experimentally manipulate IMs, one way to approach this question is to analyze the temporal sequence of IMs and symptoms change. Thereby, we developed two studies (Gonçalves, Ribeiro, et al., 2016; Gonçalves, Silva, et al., in press), using Hierarchical Linear Modeling (HLM; Osborne, 2000), in which IMs in one session were used to predict symptom change in the next session (evaluated with the OQ-10.2; Lambert, Finch, Okiishi, & Burlingame, 2005). This design was possible as in both studies outcome measures were available for each session. In previous studies, IMs but not outcome measures were available in all sessions (usually we only had pre- and postmeasures of outcome). The first study (Gonçalves, Ribeiro, et al., 2016) revealed that in NT, IMs were better predictors of symptom decrease in the next session than the reverse (i.e., symptom's change as predictor of IMs in the next session). This occurs for reflection IMs (no differentiation was made here between the two types of reflection), reconceptualization IMs,

and action 2 IMs. These results suggest that IMs in one session have a higher impact on symptoms in the next session than the other way around, which supports the hypothesis that IMs may in fact be a process variable, as narrative therapists have suggested (see the quotation above from White, 2007).

The second study (Gonçalves, Silva, et al., in press) in CBT showed that reflection 2 IMs were able to predict changes in symptoms in the following session (also evaluated with OQ-10.2; Lambert et al., 2005). As in the study with NT, IMs were better predictors of symptoms' change than symptoms' change was a predictor of IMs. Again, this relationship between IMs and symptoms' change supports the idea that IMs could be precursors of change in symptoms. It should be noted that both studies (as well as the former ones) were developed with small samples, a common feature of the majority of process research studies (Crits-Christoph, Gibbons, & Mukherjee, 2013), and these results need to be replicated on larger samples. On the other hand, these studies have an important strong point, as they analyze the impact of possible process variables (i.e., IMs) in the outcome of the following session and, as such, despite not proving causality, they suggest a temporal relationship between these variables. Thus, if replicated and consolidated, they may have important practical implications. For instance, if we devise a way of tracking IMs "online," that is, as treatment is taking place (e.g., using automated methods of coding, see Salvatore, Gennaro, Auletta, Tonti, & Nitti, 2012) this may make it possible to establish feedback strategies for therapists, based on process measures.

The Relevance of Reconceptualization IMs

The different studies referred above emphasize the importance of high-level IMs and, in most of them (CBT sample is the only exception), of reconceptualization IMs. In successful therapy, reconceptualization often becomes one of the most prevalent IMs from the middle of therapy. Reconceptualization is very similar in its definition to the Discovery Storytelling NEPCS category, which was also found as having a high frequency in successful psychotherapy (Angus et al., 2016). We speculate that reconceptualization IMs may be central in achieving narrative change in psychotherapy. Reconceptualization IMs may be conceived as a special form of insight (Castonguay & Hill, 2007) in which a past problematic facet of the client is contrasted with a present more adjusted facet, and the processes that allowed this change are articulated from the client's perspective. From our viewpoint, reconceptualization IMs are more than a description of change, they are also, and perhaps more importantly, an enactment of change. That is, with reconceptualization IMs, clients are revealing and constructing the possible outcome of change to the therapist and to himself or herself. We previously proposed (Gonçalves & Ribeiro, 2012) that the repetition of these IMs allows the client to rehearse how change will evolve. Reconceptualization bridges the past with the present, puts the client into a position of authorship (Sarbin, 1986) of its own narrative, identifies what the preference of the client is (the present, instead of the past), and gives a meaning to the transition the client is trying to accomplish. To illustrate these features, consider this example from Laura's case (session 9), in which she tells the therapist how meaningful it was for her to be able to pick the telephone and to call the widow of her daughter's favorite uncle. She describes this initiative as a symbol of her new strength to cope with other losses and to be available and supportive in some way (not overwhelmed and isolated in her own grief and despair, totally disconnected with others' realities of life and loss, as before):

> C: After making the call I thought to myself 'When could I do something like this in the past?' I couldn't!
>
> T: What did it mean to you to be able to do it now?
>
> C: I feel a different person now. I'm different. Because in the past I would just say 'I also lost a daughter and nobody …' (cared) (…) My anger was constantly there (…)
>
> T: What has changed along this time that enabled you to have this attitude today, to be able to deal with that anger in a different way and to be able to make that phone call?
>
> C: Ah, well, it was slowly … it was something so slow inside of me, it went slowly, slowly until I finally was able to find more peace ah … For example, I lived all my days with my hand here (points to the chest) as if it was a yarn (*symbolizing disorganization*), as if it was a box and what was in that box was bigger than the available space, and it was impossible to expand it more. And now it's much more loose (*flexible, organized*) and without the tears I had before.

We speculate that therapeutic change without reconceptualization IMs is a more superficial, or less consolidated, one. Of course, the important question here is if reconceptualization can occur as an internal process, without the need for the client to make it explicit to the therapist. This may be relevant as some clients are less articulated and verbal than others, or less willing to share details of their lives with others (including the therapist). In a previous study about spontaneous change on daily life, Meira, Salgado, Sousa, Ribeiro, and Gonçalves

(2016) interviewed participants during a four-month period about a specific problem the participants were willing to share and about its evolution along this period. The interviewer used only basic interviewing skills, without any effort to produce change. A measure of change was used at the end of this four-month period, and the results clearly showed a higher proportion of IMs in the interviews of clients who changed more. However, reconceptualization IMs emerged only after being elicited by the interviewer, and only in the group of participants that changed significantly. What is interesting is that spontaneously changed participants did not report reconceptualization IMs, but they seemed to have occurred internally, before being prompted by the interviewer.

Ambivalence Coding System (Gonçalves, Ribeiro, Stiles, et al., 2011)

When IMs emerge, two possibilities may occur: The IM has the potential to challenge the maladaptive pattern and eventually lead to change; or the IM becomes meaningless. Thus, the emergence of an IM may be considered a developmental bifurcation point (Valsiner & Sato, 2006), in which two different paths become available: THE IM is amplified or the IM is attenuated. These ideas were developed after observing sessions in which clients attenuated IMs' change potential, right after their emergence. A simple example could be "I feel less depressed and I was able to take my son to school yesterday (IM); but it is pointless, I'm still a depressed person." The last part of the sentence is an attenuation of the meaning conveyed in the IM. We term such instances of the therapeutic dialogue as Return-to-the-Problem Markers (RPMs; Gonçalves, Ribeiro, Stiles, et al., 2011). Let us consider another example from Laura's case, related to her struggle to survive her daughter's loss and to find some peace afterwards: "I'm trying everything … anything that I see, that may give me some … that I can grab, like a salvation table, I grab it (IM), but this pain is so overwhelming (RPM)." In this sentence we have two components: The IM in the first part, in which she elaborates on her commitment to find alternative and more adaptive ways to grieve, and the RPM in the last one, in which the re-emergence of the dominant painful grief attenuates her attempts to change.

A different possibility occurs when the IM is amplified. This means that the client and the therapist explore and elaborate the meanings of the IM, its implications in the client's life, what the future may bring if this is expanded, and so on. Eventually, a cascade of IMs emerges after the first one and more elaborated IMs also emerge. For instance, a reflection IM could prompt a reconceptualization IM, which in turn would induce more reflection IMs, and so forth. When IMs are attenuated, the maladaptive pattern is reemphasized, when IMs' are amplified the opposite occurs: The client explores alternatives to the maladaptive pattern.

The recurrent emergence of RPMs is a clear sign of ambivalence towards change, and may be an important indicator that progress is compromised. Ambivalence can be understood as an expression of an internal conflict between two opposing tendencies of behaving, thinking, or feeling. One favors change and the other favors the (maladaptive) stability (Engle & Arkowitz, 2006). Clients often recognize the advantages of change but also have concerns about it, such as fear of failure, of responsibility, or of confrontation with the unpredictable or the unknown (Arkowitz & Miller, 2008). When ambivalence is not overcome, the client's problems may persevere and be exacerbated (Miller & Rollnick, 2002), eventually resulting in poor outcomes (Gonçalves, Ribeiro, Stiles, et al., 2011; Ribeiro et al., 2014).

To study the evolution of ambivalence in psychotherapy we developed the ACS (Gonçalves, Ribeiro, Stiles, et al., 2011), which is a system that tracks moments when IMs are attenuated in their change potential with a RPM. We have conducted six studies with ACS so far, with the previously referred samples. In all these studies, ACS has shown very good reliability with Cohen's kappa ranging from .80 (Alves et al., 2016) to .93 (Gonçalves, Ribeiro, Stiles, et al., 2011). The first study (Gonçalves, Ribeiro, Stiles, et al., 2011) used *t*-tests and supported the idea that RPMs occur more in unchanged than in recovered cases. This is particularly relevant as unchanged cases not only presented less IMs (as we have described before), but also revealed a significant proportion of IMs attenuated with RPMs, when compared to recovered cases. In this study, 38.94% of the unchanged group's IMs were attenuated by RPMs, while only 7.84% of the total amount of IMs of the changed group was attenuated by RPMs.

We have conducted three studies using GLM (Alves et al., 2016; Ribeiro, Gonçalves, Silva, Brás, & Sousa, 2015; Ribeiro et al., 2014), and all of them had similar results. Both in EFT and CCT (Ribeiro et al., 2014) no difference was found in global proportions of RPMs in recovered and unchanged cases, but the proportion of RPMs decreased along treatment in recovered cases, when compared to unchanged cases. In the CGT sample (Alves et al., 2016) there was a similar finding: RPMs decreased more in cases with greater symptomatic improvement.

In more recent studies (Ribeiro, Gonçalves, Silva, Sousa, & Brás, 2016), we used HLM to compare the relationship between RPMs and symptoms' improvement in the following session. The findings from two samples—NT and CBT for major depression—suggested that RPMs reduction in a session predicts symptoms improvement (OQ-10.2; Lambert et al., 2005) in the following session, regardless of the outcome group (and the reverse does not happen that is, symptoms' improvement predicting RPMs). Given the results' pattern of these six studies, and the strong reliability of this system, we think that RPMs are an important measure of ambivalence in psychotherapy that allows for the possibility to expand our knowledge on this topic, both clinically and theoretically. Unlike the IMCS (Gonçalves, Ribeiro, Mendes, et al., 2011), this coding system was not published, but can be made available by the authors.

The Ambivalence Resolution Coding System (Braga, Oliveira, Ribeiro, & Gonçalves, 2016)

The ARCS is our most recent tool and only one study has been published with this methodology so far (Braga, Oliveira, et al., 2016). This system was created to study the dialogical processes involved in ambivalence resolution. When ambivalence dominates the self and hinders the therapeutic progress, there are two opposing voices in equilibrium: One voice associated with change—present in IMs—and another one associated with the maladaptive pattern. Let us consider the following example from Laura's third session, in which she's talking to her daughter (through a letter) about the path she's been on since her death, as if she was descending an high and unstable pyramid to come to solid and stable ground: "Since you left me, I really want to get my feet back on the ground again" (an IM). However, just after stating this, Laura continues: " … but I have no strength … there are days when I can 'hold the rope,' but I can't go down, not even one step." (RPM).

As we suggested previously (Gonçalves & Ribeiro, 2012), this tension can be resolved in two different ways. First, the voice associated with the IM can become dominant and the one associated with the maladaptive pattern becomes dominated. Take the following example from Laura's 12th session:

> After my daughter passed away, I even stopped watering the plants, and so they also died. […] But now I do water the plants, I won't let them thirst to death. I water them so they can grow and so I can take them to her, because it makes her so happy. I really believe that, as I believe she is giving me strength so I can finally be at peace, at home. I really believe I am being helped, in every way, through her … I think God finally remembered I exist.

This example represents an inversion of the previous power struggle between these positions or voices: Feeling that her commitment to life would be something that would connect her with her daughter, Laura now strives to take good care of the plants (to "create" life through them, as something she could not do before) so she can "offer them" to her daughter. This is in clear contrast with the problematic position which revealed a significant incapacity to reconnect with her world, namely to take care of herself, of others, and her surroundings, and to find meaning to her daughter's death.

A second possibility is the emergence of a negotiation between these two voices. Consider the next excerpt from Laura's therapy:

> I know she will not come back to me, but now I can see that I cannot sacrifice everyone else around me like my grandchildren or her brother, who are also suffering […] and so I want to let my daughter go a little bit, let her go her way, but always hoping that one day I will meet her again.

In this excerpt, both positions of the self seem to be able to communicate: Laura acknowledges that her daughter will not come back to her in the same existence she had before (which used to be a part of the problematic position), but she does not allow this realization to make her give up on other family members (innovative position) who are also very important to her. In this sense, she expresses her desire to let her daughter go her way, while also hoping she will meet her one day (this is connected with her spiritual beliefs about a post mortem form of life). In this sense, both innovative and maladaptive positions are used as resources for the meaning-making process.

The ARCS (Braga, Oliveira, et al., 2016) describes resolutions as the ones indicated above as *micro-resolutions*, that is, moments when there is an agentic and determined resolution of ambivalence, even if this is a momentary one, and assumes that it is the repetition of these micro-resolutions throughout treatment that will allow for ambivalence to be resolved. The ARCS was constructed, refined, and validated through a systematic analysis of 90 sessions of 6 EFT cases belonging to the York I study (Greenberg & Watson, 1998). The coding involves the successive analysis of each IM (every resolution is, by definition, also an IM; but not all IMs are resolutions). Each IM must be coded as "resolution" or "no resolution" and if a resolution is present, as dominance or negotiation. The

category of no resolution is applied when neither dominance nor negotiation are present or when the IM is immediately followed by a RPM. To assess inter-judge reliability, two judges autonomously coded all the sessions of the six cases used to construct the ARCS. Cohen's Kappa was .89 for the presence vs. absence of resolution and .82 for the dominance vs. the negotiation processes of resolution.

The first study with the ARCS (Braga, Oliveira, et al., 2016) consisted of a case study of a successful case of EFT and it indicated the dominance process of the innovative position as the most frequent process throughout therapy, but also that it tended to decrease as treatment developed. On the other hand, the negotiation between positions seemed to increase from the initial to the final sessions of treatment.

Braga, Ribeiro, and Gonçalves (2016) conducted a new study that includes 22 psychotherapy cases, which resulted from three samples: NT, CBT, and EFT. Preliminary results seem to suggest that this tendency of decreasing dominance and increasing negotiation is typical in successful cases of therapy for depression, independent of the specific model of intervention. In contrast, unsuccessful cases seem to maintain high levels of dominance throughout treatment and reveal little or no negotiation during the process.

These results are congruent with studies suggesting an gradual integration of opposing elements of the self along therapy in sucessful cases. For instance, the assimilation model (Stiles, 2002; Stiles et al., 1990) suggests that, in successful psychotherapy, the problematic position is increasingly integrated in the community of voices through the sequential eight levels of the APES. Studies have found that recovered cases frequently reach level 4 or higher while unchanged cases hardly ever achieve this level (Detert, Llewelyn, Hardy, Barkham, & Stiles, 2006). According to Detert et al. (2006) a meaning bridge between opposing positions emerges only after level 4. A meaning bridge consists of a common language between the problematic and the innovative positions, which allows for the negotiation between them rather than the dominance of one over the other.

There are still several questions we would like to explore, namely if these results would be replicated when studying different problems or clinical diagnoses. Nonetheless, and in what concerns several models of therapy for depression, studies seem to suggest that dominance is a very important and frequent process of ambivalence resolution. However, a shift to a more negotiated relationship between both positions involved in ambivalence is probably a necessary move if ambivalence is to be effectively resolved, and therapy to successfully progress.

Current and Future Research

Centered on the Coding Systems

An important topic being intensively studied is centered on the components of reconceptualization IMs. As presented in Table II, reconceptualization has two components (contrast and process) and when they appear separately, they are usually coded as specific high-level IMs such as reflection 2, protest 2, or action 2. Thus, we are interested in studying whether these isolated components had the same predictive power on symptom's change in the next session as reconceptualization. Interestingly, the isolated components are much more frequent than the occurrence of reconceptualization on its own. However, the analysis of CCT, EFT, NT, and CGT samples suggests that when we consider the predictive value of these variables (i.e., reconceptualization, contrast, and process) in a common GLM model, only reconceptualization has predictive power (Fernández-Navarro, Rosa, et al., 2016). This highlights that reconceptualization may be, in fact, a central dimension of change, as we speculated before (see Gonçalves & Ribeiro, 2012).

Finally, we also initiated a new line of research centered on the study of the processes of change (IMs) and ambivalence in the context of an online intervention for complicated grief. Therefore, we aim to trace how IMs emerge and develop in an online psychotherapeutic sample and to consider what implications might this carry for the further refinement of the IMs Model.

Clinical Applications

So far, it has been a challenge to translate our research into practice and we prefer to further validate these results, and test their implications empirically before we invite therapists to use some of these principles as therapeutic guidelines.

Thus, we have two main projects that will test this applicability. The first project is centered on reconceptualization and the second centered on ambivalence. Regarding reconceptualization, we will continue to study if reconceptualization IMs represent a deeper psychotherapeutic transformation. Thus, we will study if reconceptualization IMs are associated with lower risk of relapse after the end of therapy, and second if introducing questions to elicit the components of reconceptualization (contrast and process) will improve outcomes. Contrasts

may be elicited around the theme "what is better/different than before?" or "what were the main changes in therapy?". Process may be elicited with question(s) on "How did you achieve those changes?" or "What helped you getting to where you are now?". As we referred above, recent research suggests that the articulation of these two elements in the reconceptualization IM is more powerful in predicting change than the presence of either of them in isolation (Fernández-Navarro, Ribeiro, & Gonçalves, 2016). Thus, if this finding gets further support, therapists might be more effective if they ask questions that invite the client to relate a particular contrast ("now I feel that I'm more assertive") with a specific process of change ("I was able to be more assertive, because now I think I should respect myself").

Another application is already being studied, and it is ambivalence progression throughout therapy. The main idea that we are testing is if a feedback system for the therapist (see Lambert, 2015; Lambert, Whipple, Smart, Vermeersch, & Nielsen, 2001) centered on the ambivalence evolution of clients with high rates of ambivalence, improves treatment outcome. For this purpose, we developed a 9-item questionnaire nine items administered to the client in each session to track the evolution of self-reported ambivalence (Oliveira, Ribeiro, & Gonçalves, in press). Moreover, we will triangulate this self-reported ambivalence with ambivalence coded by researchers through the ACS.

In addition to these applications to practice, it will be important to further explore if case formulation using the IMCS or the training of therapists in this model could enhance their clinical performance, regardless of their therapeutic model, as we expect that these processes would be shared by different models of psychotherapy. Thus, our aim for the future is to expand and translate these empirical findings into practice, considering different clinical contexts and therapeutic models.

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Note

[1] Previously referred to as the Return to the Problem Markers Coding System. The decision to change the system's name was based on clarity and theoretical coherence purposes.

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