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EXPLORING INNOVATIVE MOMENTS WITH ADOLESCENTS TREATED FOR DEPRESSION

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Dissertação apresentada no Mestrado Integrado de Psicologia, Faculdade de Psicologia e de Ciências da Educação da Universidade do Porto, orientada pela Professora Doutora ***Margarida Rangel Henriques*** (FPCEUP) e coorientada pelo Professor Doutor ***Miguel Gonçalves*** (EPSIUM).

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Agradecimentos

Gostava de aproveitar estes instantes iniciais para alguma contextualização do percurso e da minha gratidão face a todas as pessoas que assumiram papéis de destaque ao longo desta investigação realizada no âmbito da conclusão do mestrado em psicologia clínica e da saúde. O primeiro momento decisivo deu-se numa tarde solarenga no gabinete da Prof. Margarida, com um convite informal e, como habitualmente, bem-disposto, sensível aos meus anseios e às minhas divagações, mas que gentilmente me obrigou a assumir uma posição, a comprometer-me. Este posicionamento foi pessoalmente muito significativo, sendo que a escolha da temática abordada na presente tese será de situar na busca mais vasta por definição quanto às prioridades para o meu futuro profissional e académico. Uma definição que se impõe, na reta final destes anos de aprendizagem na faculdade de psicologia, e em que a responsabilidade pessoal cresce na exata medida em que decrescem, por um lado o peso por outro a segurança, das expetativas formalmente estruturadas, e um conjunto de escolhas perante os muitos possíveis caminhos por seguir carecem de ser tomadas.

Sabiamente ou não, o projeto de futuro que emerge algures do meu íntimo (e procurar desenlaçar cada ténue cordão que contribui para a robusta corda que sustenta tais intenções será uma tarefa ingrata e porventura até pouco recomendável) almeja o exercício da psicoterapia. Almeja conhecer, compreender e maturar no campo das oceânicas profundezas desta condição que todos partilhamos, e dos processos que permitem soltar as amarras mais íntimas e fazer nascer novos sentidos e propósito em terrenos outrora áridos.

No contexto de algum trabalho conjunto em torno das abordagens terapêuticas narrativas e do contágio com o encanto pelas epistemologias construtivistas e construcionistas aplicadas à psicoterapia que se deu ao longo das UCs lecionadas pela Prof. Margarida, surgiu então a proposta de realizar uma investigação empírica sobre processos de mudança, coorientada pelo Prof. Miguel Gonçalves, que encabeceia a investigação de mudança psicoterapêutica desenvolvida na Universidade do Minho há vários anos. Uma proposta que rapidamente se alicerçou com uma primeira visita à reunião semanal de investigação em Braga e com o início da minha formação nos sistemas utilizados

pela equipa do Prof. Miguel Gonçalves para a codificação de sessões de psicoterapia. Um processo de formação que recordo como cativante, entre numerosas viagens a Braga, momentos de discussão e reflexão no grupo de aprendizagem e inúmeras trocas de email em torno do cálculo dos acordos intercodificador, sendo que quero expressar a minha gratidão face aos formadores Pablo Fernández-Navarro e João Batista, bem como aos colegas de formação, pelas muitas aprendizagens que estas horas me proporcionaram.

Por sua vez, após alguma exploração da possibilidade de integrar uma investigação sobre a mediação dos processos de mudança pela adesão de terapeutas, foi no contexto do Congresso do Self Dialógico, no âmbito do intenso borbulhar de novas ideias que marca estes momentos em que os vários cantos do mundo se encontram, que se definiu que a presente tese iria incidir sobre mudança psicoterapêutica em adolescentes deprimidos acompanhados no âmbito de um ensaio clínico inglês, triangulando-se entre Porto, Braga e Londres, constituindo-se como uma primeira ponte para futuras colaborações e como excursão para latitudes até então desconhecidas, a aplicação dos procedimentos de investigação dos momentos de inovação a processos de psicoterapia com adolescentes. E não tardou, uma vez esclarecidos os procedimentos de articulação institucional e de proteção de dados, e finalizado um treino de codificação adicional para aprofundamento das minhas sensibilidades, o início da extenuante fase de codificação de dados. Dados compostos por entrevistas qualitativas recolhidas antes, após e um ano depois dos acompanhamentos psicoterapêuticos dos jovens participantes, e muito agradeço aos Prof. Sally O'Keefe e Nick Midgley, do Centro Anna Freud em Londres, pela disponibilização dos dados e pelas palavras de ânimo e incentivo.

A codificação dos dados terá ocupado cerca de 80% do tempo total dedicado ao projeto de investigação e foi uma verdadeira odisseia. As inúmeras horas, a codificação e recodificação de casos, o cálculo de acordos, a discussão e negociação, a definição de linhas orientadoras, a adaptação dos procedimentos, o ajustamento de objetivos, a elaboração de bases e mais bases de dados, as contagens, os erros, sua identificação e emenda, as dúvidas pessoais e a frustração, a vontade de desistir, e as forças para persistir. Felizmente pude contar com o João Batista, incansável a solucionar problemas e a apaziguar angústias, e com o Prof. Miguel Gonçalves, que com a sua determinação, humor e extraordinária

prontidão face a qualquer solicitação, soube manter os trabalhos na rota e gerar novas rotas sempre que necessário. Ao mesmo tempo, esta fase foi particularmente enriquecedora para mim pois permitiu um contacto muito íntimo com as histórias dos jovens participantes. Foi um verdadeiro mergulho, que me sensibilizou e conduziu de angústia, até contentamento, passando por abatimento, revolta, compaixão e ternura, e que me proporcionou inúmeros diálogos internos com todas estas pessoas que estiveram tão presentes nos meus dias e muito me marcaram.

Uma vez encerrada a etapa da codificação, em tempo útil mas não sem dias a fio em que abandonei o palco quotidiano habitual e mobilizei esforços hercúleos, a restante elaboração do estudo sucedeu-se com admirável celeridade, talvez estivesse já incubado após os longos meses de codificação. Toda a elaboração das análises, as leituras e a redação do estudo permitiu-me um (re)aprofundamento teórico, um questionamento mais crítico e um esforço acrescido de significação e contextualização do trabalho realizado ao longo dos meses decorridos. Apesar do esforço em manter uma linha redaccional sóbria, penso que em alguns instantes transpareça a ânsia em transcender o âmbito empírico imediato e em aceder às dimensões mais transversais do campo de investigação em que o presente estudo se situa.

Muito haveria para criticar nas formas como procedi, desde detalhes técnicos até à atitude pessoal, mas estou certo de que cresci significativamente ao longo do processo, e a maior fatia da minha gratidão não poderia destinar-se a outrem que não a Prof. Margarida Rangel Henriques. Agora, será impossível de enumerar todas as razões que subjazem a esta gratidão e por isso quero destacar somente uma única: a interminável generosidade que me permitiu habitar estes meses em torno da elaboração da tese de mestrado não meramente como estudante, mas como pessoa.

Por fim, quero também agradecer a todos os membros das equipas de investigação na EPSIUM e na FPCEUP que, como redes de segurança, estiveram sempre presentes, aos meus colegas Ana, Dominique e João, pelo companheirismo ao longo destes anos, à Sofia e aos meus pais, por tudo, que de forma alguma se poderia captar oportunamente nestas linhas.

Resumo

Introdução: Momentos de Inovação (MIs) denotam formas inovadoras e mais ajustadas de pensar, agir, sentir e relacionar-se, que emergem no discurso de clientes de psicoterapia. Contrariamente, marcadores de ambivalência (MAs) são indicadores de resistência contra mudanças. Estudos com adultos encontraram proporções mais elevadas de MIs e decréscimos progressivos de ambivalência em casos recuperados, mas não em casos inalterados. Não existem estudos com adolescentes. **Objetivos:** Explorar associações entre MIs, MAs e melhoria sintomática, e contrastar a produção de MIs e MAs em casos de sucesso vs. insucesso, e em casos tratados com Terapia Cognitivo-comportamental (CBT) vs. Psicoterapia Psicanalítica Breve (STPP), numa amostra de adolescentes deprimidos. **Método:** Entrevistas semiestruturadas pós-intervenção de 24 adolescentes (12-18 anos), participantes de IMPACT-ME (um estudo longitudinal, qualitativo, sobre as vivências de jovens envolvidos num ensaio clínico sobre depressão adolescente), foram codificadas segundo o Sistema de Codificação de Momentos de Inovação. Identificaram-se MIs de nível 2 (significados centrados na mudança), MIs de nível 3 (meta-reflexões que articulam contrastes entre passado e presente com processos de mudança), e MAs. **Resultados:** MIs e MAs emergiram nas entrevistas, as proporções de MIs encontram-se significativamente correlacionadas com melhorias sintomáticas, e foram significativamente superiores nos casos de sucesso do que de insucesso. No grupo de CBT a proporção de MIs de nível 3 foi significativamente superior face ao grupo de STPP. **Conclusão:** Este primeiro estudo de MIs com adolescentes sugere que futura investigação que articule achados empíricos à luz deste modelo poderá aprofundar a compreensão de processos de mudança na psicoterapia com jovens.

Palavras-chave: adolescência, depressão, psicoterapia, processo de mudança, momentos de inovação, marcadores de ambivalência, melhoria sintomatológica.

Abstract

Introduction: Innovative moments (IMs) pinpoint new and more adjusted ways of thinking, acting, feeling, and relating that emerge in clients' discourse during psychotherapy. By contrast, ambivalence markers (AMs) are indicators of resistance to change. Previous studies with adults found high proportions of IMs and a progressive decrease of ambivalence in recovered but not in unchanged cases. Studies with adolescents are absent. **Aims:** To study the associations between IMs, AMs and symptomatic improvement, and contrast the production of IMs and AMs in good vs. poor outcome cases and in cases treated with Cognitive-behavioural Therapy (CBT) vs. Short-term Psychanalytic Psychotherapy (STPP), in a sample of depressed adolescents. **Method:** Semi-structured posttreatment interviews conducted with 24 adolescent (12-18 years) participants of IMPACT-ME (a longitudinal, qualitative study of the experience of adolescents involved in a clinical trial on youth depression), were coded using the Innovative Moments Coding System. Level 2 IMs (meanings centred on changes), level 3 IMs (meta-reflections that articulate contrast between past and present with change processes), and AMs were identified. **Results:** IMs and AMs were found throughout the interviews. The proportions of IMs were significantly correlated to symptomatic improvement and significantly higher in good than in poor outcome cases. In the CBT group the proportions of level 3 IMs were significantly higher than in the STPP group. **Conclusion:** This first study exploring IMs with an adolescent sample suggests that future research targeting at the articulation of empirical findings within this model may foster a deeper understanding of change in psychotherapy with youth.

Keywords: adolescence, depression, psychotherapy, change processes, innovative moments, ambivalence markers, symptomatic improvement.

Article

1. Introduction

1.1. Background

Depressed adolescents show low mood, loss of interest in activities, difficulties with concentration and motivation, changes in appetite and sleep, irritability, physical symptoms, headaches or stomach aches for example, and in some cases thoughts of suicide. Depressive disorders are debilitating and affect psychosocial, family and academic functioning. The diagnostic criteria for depressive disorders (e.g. DSM-5, 2013) are similar for adults and youth, although specific signs and symptoms may differ. Compared with adults, depressed children and adolescents may exhibit higher levels of anxiety and irritability, behavioural problems, social withdrawal, phobias, and exaggerated somatic symptoms (Cox et al., 2012). As pointed out by Midgley et al. (2015), about 2.8% of children under the age of 13, and 5.6% of those between 13 and 18, meet diagnostic criteria for a depressive disorder, and, after the age of 13, depression is twice as common among girls than boys. Children and adolescents suffering from depression are likely to present other difficulties, with comorbidity levels between 50.0 and 80.0%, most commonly some form of anxiety disorder, but also disruptive disorders, substance abuse and emerging personality disorder. The levels of relapse are high, with as many as 70.0% of young people who experience depression having a further episode within five years. In turn, around 80.0% of first episodes of depression occur during the teenage years (Midgley, Ansaldo, & Target, 2014) and long-term consequences are considerable, with an increased risk of self-harm, suicide, depression, physical illness, substance misuse, and interpersonal problems in adulthood. Consequently, the identification of effective treatments for depression early in life must be a public heath priority.

In a review on psychotherapeutic vs. antidepressant medication treatments for youth depression, Cox et al. (2012) point out that several psychological therapies have been trialled. Foremost cognitive-behavioural therapy (CBT) but also interpersonal therapy (IPT), and others. Findings from a network meta-analysis, undertaken by Zhou et al. (2015), to investigate the comparative efficacy of several psychotherapies for depression in youth, found that only IPT and CBT were

significantly more effective than most control conditions at posttreatment and at follow-up, although only IPT retained such superiority at a long-term follow-up. Regarding antidepressant medication, the guidelines recommend a judicious use and a careful monitoring of symptoms and side effects (e.g. NICE, 2005), favouring the selective serotonin reuptake inhibitor fluoxetine, which has most consistently been found to significantly reduce depressive symptoms among depressed youth (Cox et al., 2012).

Goodyer et al. (2011), in the introduction to the IMPACT (Improving Mood with Psychoanalytic and Cognitive Therapies) study protocol, aiming at a comparison between CBT, short-term psychoanalytic psychotherapy (STPP) and a brief psychosocial intervention (SCC), regarding the treatment and relapse prevention of youth depression, summarize that there is now substantial evidence that three psychological treatments (CBT, STPP, IPT) derived from different theoretical perspectives, are efficacious and clinically effective in alleviating depressive symptoms and improving social function in the short-term in at least 50.0% of depressed adolescents. Albeit, there is no evidence that the successful management of acute depression in this age range has longer term benefits, reducing relapse and recurrence. Midgley et al. (2014, p. 129) argue that "despite a considerable investment in studies that have evaluated psychological treatments, there are still major gaps in our understanding of what kind of treatment is most effective for young people, especially in terms of long-term prevention of relapse, and what it is that contributes to a successful (or unsuccessful) outcome".

One of such research efforts, trying to fill the above-mentioned gap, and from whose sample the cases used in this study were retrieved, are the IMPACT (Goodyer et al., 2011) and IMPACT-ME (IMPACT – My Experience, Midgley et al., 2014) studies. Briefly, the IMPACT study is a pragmatic, relapse prevention, superiority randomized controlled trial (RCT), comparing the effectiveness of CBT and STPP with brief psychosocial intervention. In this study, almost 500 participants, aged between 11 and 17 years, that met criteria for moderate to severe depression, were randomized to one of the three treatment conditions, in an effort to identify the most effective treatment to reduce depressive symptoms among adolescents, in the short-term and in the medium/long-term, preventing relapse and recurrence (Midgley et al., 2014).

Regarding these treatments, the STPP treatment selected for the IMPACT trial followed a manual specifically developed for young people with depression and focused on helping young people overcome developmental problems, using both supportive and expressive strategies. The interpretation of unconscious conflicts, and an extensive use of modern attachment theory and internal working models were central. The aim was to increase the coherence of the adolescents' maladaptive mental models of attachment relationships and thereby improve their capacity for affect regulation. Its comprehensive implementation involved parallel work with carers and was delivered weekly for 30 weeks. In turn, the CBT treatment was an active, verbal therapy, based on an individual formulation of current problems and associated antecedents, precipitating and maintaining factors. The emphasis lied on collaborative empiricism, explicit, tangible and shared goals, and clear structured sessions. It included assessment, psychoeducation into the cognitive-behavioural model of depression, the introduction of monitoring methods, behavioural activation and activity scheduling, linking thoughts, feelings and behaviours, identifying and challenging negative automatic thoughts, developing and reinforcing adaptive thoughts and relapse prevention strategies, along with techniques to maintain engagement and optimism for change. Topics introduced within sessions were supported by tasks completed between sessions. The program typically included 12 sessions delivered weekly, followed by eight biweekly sessions, and could be delivered to adolescents alone or to adolescents along with their carers (Goodyer et al., 2011).

The recently published findings indicated that STPP and the brief psychosocial intervention were as effective as CBT, and that all interventions were associated with an average 49.0–52.0% reduction in depression symptoms 12 months after treatment. Consequently, STPP and brief psychosocial intervention appear as additional psychological therapy options for adolescents with moderate to severe depression, as effective as CBT, in the medium-term maintenance of therapeutic gains (Goodyer et al., 2017).

In turn, IMPACT-ME is a qualitative longitudinal study "nested" within IMPACT, targeting to interweave more qualitative data with the traditional quantitative data. The primary aim of IMPACT-ME is to explore the experience of overcoming depression in adolescents who have undergone a course of psychological therapy. The study spread across three time points, involving in-depth

interviews with adolescents and their carers before the start of treatment, at the end of treatment and one year later. The study focused on the way young people understood their difficulties, their hopes and expectations about therapy, the experiences of therapy and change over time, the processes that led to positive or negative treatment outcomes, and broader cultural and contextual factors affecting those outcomes. It intended to go beyond a set of predefined outcome measures to include unexpected social, cultural, and contextual factors and arrive at a more complex reality-based understanding of adolescent depression and change processes, grounded in adolescents' actual experiences (Midgley et al., 2014). And indeed, resorting to the IMPACT-ME sample and applying framework analysis to the pretreatment interviews of 77 adolescents, Midgley et al. (2015), identified five major themes – "misery, despair and tears", "anger and violence towards self and others", "a bleak view of everything", "isolation and cutting-off from the world", and "the impact on education" – that captured in-depth the phenomenology of youth depression.

In line with the above-mentioned efforts to access a more meaningful understanding of personal experiences and processes in depressed adolescents, in the field of psychotherapy research generally, a shift from mere outcome research to the study of processes that promote personal change has been demanded. Kazdin (2009) pointed out that several meta-analyses and reviews have indicated that many forms of psychotherapy lead to therapeutic change, although, the pressing question - "how does psychotherapy work?" – remains largely unanswered. The author argues for research focused on mediators and mechanisms of therapeutic change, in order to provide for evidence-based explanation on how and why interventions produce change. On this topic, one central concern revolves around a new emphasis on theoretical groundings for empirical research, aiming at a meaningful articulation of empirical findings into comprehensive models of therapeutic change. Midgley (2009) argues that empirical research studies focused on the development of measures and the description of clinical processes, and process-outcome research that relies merely on statistical correlations between sets of variables, adding little knowledge about actual mechanisms of change, are only first steps. Indeed, research has moved on to more theoretically informed approaches, based on the belief that progress in studying the therapeutic process needs to be more soundly based on theory about how change is possible to provide

for empirically based, while theoretically meaningful, understandings of underlying processes in psychotherapy.

In this line of thought, the present study seeks to approach adolescent depression, it's idiosyncratic phenomenology and paths to personal change, from the stance of a narrative model of psychotherapeutic change, the Innovative Moments (IMs) model (e.g. Gonçalves, Ribeiro, Silva, Mendes, & Sousa, 2009).

1.2. Innovative Moments: A narrative lens on therapeutic change

The Innovative Moments model (Gonçalves, Matos, & Santos, 2009; amongst others), is anchored in the narrative tradition of White and Epston (1990), and consequently, the contrast between what is known as the dominant/problematic narrative vs. the alternative/preferred narrative is a central tenet on how clients' problems and personal change are understood. Briefly, problematic self-narratives represent identities saturated by the problem and can be thought of as implicit rules of meaning that constrain peoples' lives, strengths and resources, and hinder their personal and relational well-being. Furthermore, drawing upon dialogical self-theory (Hermans & Dimaggio, 2004), the self is understood as the result of the continuous negotiation, tension and (dis)agreement between a multiplicity of voices or I-positions. These voices are formed in a client's relational experiences and cultural contexts, given that meanings essentially stem from the interaction with significant others, and therefore, both intrapersonal meaning-making processes and interpersonal experiences, interact and contribute to the self-narrative. When clients' narratives are dominated by a problem, their multivocality is reduced and many voices are silenced. On the other hand, the transformation of problematic self-narratives involves restoring or developing voices that are better aligned with the clients' preferred identities. In turn, innovation and change in clients' narratives are exceptions to problematic meanings, to the rules imposed by the problematic self-narrative. Accordingly, IMs may be seen as an empirical operationalization of White and Epston's (1990) Unique Outcomes, and refer to instances in which the client's experience does not conform to the rules imposed by the problem, moments in which the client feels, behaves, acts, or thinks in a way that introduces novelties, opposed to or different from what is predicted by the problem. In this sense, innovations in a client's discourse hold the possibility of developing alternative narratives (Montesano, Oliveira, & Gonçalves, 2017).

In order to enable empirical research on the above-detailed model and map the process of change in self-narratives during psychotherapy, the IMs coding system was developed (Gonçalves et al., 2011). This system allows for narrative changes to be tracked throughout a psychotherapeutic process, classifying novelties in client's discourse according to specific categories, initially developed through an inductive methodology. The system assumes an idiographic stance, defining problematic self-narratives and contrasting novelties, or IMs, from each client's discourse. Consequently, this tool is applicable regardless of type of therapeutic approach and has been used with narrative therapy (e.g. Gonçalves, Ribeiro, Silva, Mendes, & Sousa, 2015), client-centred therapy (e.g. Gonçalves et al., 2012), emotion-focused therapy (e.g. Mendes et al., 2010), dilemma-focused therapy (e.g. Montesano, Gonçalves, & Feixas, 2015), and cognitive-behavioural therapy (e.g. Gonçalves et al., 2016). More recently, a couple of complementary coding systems that track ambivalence markers (AMs) and ambivalence resolution processes, were devised. Ambivalence is a process in which the potential of an IM to develop alternatives is diminished and resisted against by the problematic narrative. In other words, when ambivalence dominates the self, there is a balance between two opposing voices, one voice associated with change, corresponding to the IM, and another voice associated with the problematic narrative, that resists against change. Thus, high rates of ambivalence hinder therapeutic progress. Meanwhile, two kinds of processes that allow for ambivalence resolution have been described. On the one hand a process of dominance in which one voice silences the other, and consequently, either the problematic pattern is maintained, or innovation prevails and becomes able to root. On the other hand, a process of negotiation, that allows for an integration and synthesis of both, the problematic and the innovative voice (Gonçalves et al., 2017).

Since its initial development the coding system has gone through several (re)formulations, which may be used depending on the research purposes. Currently, research with the IMCS has mainly focused on the distinction between three levels of IMs. Level 1 IMs, that refer to novelties in the client's narrative focused on creating distance from the problem, and may be intended or performed actions, reflections, or critiques of the problem, that produce some impact in the way the problem is experienced. An example, retrieved from Gonçalves et al. (2017, p. 4), is:

> *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… and it's more natural and more healthy to let some of these extra activities go*.

Level 2 IMs, focused on change, referring to new aims, experiences, activities, projects, all either merely anticipated or already underway, without references to the problem discourse or necessarily related to the problematic experience. An example, retrieved from Gonçalves et al. (2017, p. 4), is:

> *I feel positive and strong. It's okay to ask for these things, it's a new part of me, so I'm not going to turn it down.*

Finally, level 3 IMs, also known as reconceptualization IMs, that encompass the articulation of contrasts between a problematic past self-narrative and an innovative one, with some description of the process by which the change occurred. This type of IM has been described as a meta-positioning, in which clients assume a distance from the problematic experience, recognize changes, and understand, to a certain degree, the processes involved in this transformation. An example, retrieved from Gonçalves et al. (2017, p. 4), is:

> *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.*

The distinction between levels of IMs denotes qualitative differences regarding their influence over the process of change and was made based on empirical findings (Montesano et al., 2017).

As mentioned by Montesano et al. (2017), usually IMs are researched through process-outcome designs, contrasting good outcome (GO) vs. poor outcome (PO) cases and exploring the differential patterns of narrative change in these groups. Generally, in GO cases more IMs arise in a client's discourse as the therapy proceeds. Level 1 IMs emerge from the very beginning, while level 2 and 3 IMs tend to appear at the middle of therapy and continue until the end. In PO cases, the average proportion of IMs tends to be significantly lower, level 1 IMs occur but

without a progressive tendency, and level 2 and 3 IMs may be absent or appear at a very low rate. In sum, whereas level 1 IMs are found in both the GO and the PO cases, successful therapeutic processes imply a greater proportion of IMs, as well as the presence of level 2 and 3 IMs. Thus, the emergence of level 2 and 3 IMs in clients' discourses seems to be the distinctive marker of narrative change. Additionally, level 3 or reconceptualization IMs, appear to be a key change process, as they involve assuming a reflexive position towards the change process and allow the client to bridge past and innovative facets into a coherent meaningful whole (Fernández-Navarro et al., 2018).

Regarding ambivalence (Gonçalves et al., 2017; Gonçalves et al., 2011), when IMs emerge, the client and the therapist either proceed to explore and elaborate an IM, its implications in clients' lives, and consequently challenge the problematic narrative and promote change, or the IM becomes attenuated and the problematic narrative is reemphasized. An example of an AM, retrieved from Gonçalves et al. (2017, p. 8), is:

> *I feel less depressed and I was able to take my son to school yesterday, but it is pointless, I'm still a depressed person [AM].*

The recurrent emergence of AMs is a sign of ambivalence towards change and indicates that therapeutic progress may be compromised. Accordingly, previous studies have shown that AMs occur more often in PO than in GO cases, and that the proportion of AMs decreases along treatment in GO but not in PO cases (Gonçalves et al., 2017).

On the topic of depression, numerous studies with diverse study designs and across different models of therapy have been conducted. For instances, in an exploratory study on IMs in two contrasting cases of depression treated with narrative therapy, Spínola, Cunha, and Gonçalves (2012) found a higher overall proportion of IMs and a higher proportion of performing change and reconceptualization IMs, level 2 and 3 IMs, in the GO contrasted with the PO case.

In turn, in a study on self-narrative reconstruction after dilemma-focused therapy for depression, Montesano et al. (2015) compared GO and PO cases and found that the GO group reported a significantly higher proportion of level 2 and 3 IMs, and that there was a strong correlation between the magnitude of symptom

improvement and the proportion of level 2 and 3 IMs at posttreatment. The authors concluded that clinically significant change and symptomatic improvement are associated with a higher rate of level 2 and 3 IMs in clients' self-narratives.

In another study, Gonçalves et al. (2015) explored the interdependence between narrative change and symptomatic improvement in depressed patients treated with narrative therapy. The results obtained through hierarchical linear modelling showed that narrative innovations were better predictors of symptomatic improvement in the following session than the reverse.

Finally, in a study conducted by Gonçalves et al. (2016), on a sample of depressed patients treated with CBT, findings revealed that level 2 reflection IMs were better predictors of symptomatic reduction in the next session than the reverse, even though the influence was significant in both directions. In this study, no reconceptualization or level 3 IMs (only it's precursors "contrasting past and present" and "reflections on change processes", which are coded as level 2 reflection IMs when occurring separately) were found, perhaps because CBT does not specifically target these instances of narrative innovation in the way therapeutic models from the constructivist tradition do. Nevertheless, these findings reinforced that IMs do occur across different kinds of therapies and may be a necessary element for change, not a mere by-product.

Regarding ambivalence, in a study on emotion-focused therapy for depressed patients, contrasting GO and PO groups, Ribeiro et al. (2014) found that AMs emerged in both groups with similar overall proportions. Albeit, the groups followed different trajectories across treatment. Indeed, whereas the probability of AMs decreased for the GO cases, it remained high throughout therapy for the PO cases.

Albeit considerable evidence underlines the usefulness of the IMs approach (and its accordingly developed research tools) as a theoretical model that allows for a meaningful comprehension of empirical findings in therapeutic process research conducted with adults, amongst others on depression, to date no efforts to explore this approach in the domain of adolescent psychotherapy and change process research have been made.

1.3. The present study

The present study aims to apply the Innovative Moments Coding System (IMCS) and the Ambivalence Coding System (ACS) to posttreatment interviews focused on psychotherapeutic processes and change, collected with a subsample of the adolescent depression patients taking part in the IMPACT-ME study, in order to explore underlying change processes from the stance of the IMs model.

Accordingly, the main research questions and aims of this study are:

1. Do IMs and AMs occur in posttreatment interviews of adolescents that received psychotherapeutic treatment for depression?
2. If they occur, regarding possible associations between IM and AM production patterns and improvements in depressive symptomatology:
    - 2.1. Do IM proportions correlate significantly, and in a negative direction, with the decrease of depressive symptoms? And do AM proportions correlate significantly, and in a positive direction, with the decrease of depressive symptoms?
    - 2.2. Do IM proportions significantly differ between PO vs. GO cases? And AM proportions? More specifically, are IM proportions higher and AM proportions lower in the GO group when compared to the PO group?
3. Moreover, we intend to explore if the age of participants is associated with the proportions of IMs produced, as could be expected from a developmental stance on narrative production. For instances, are the proportions of IMs positively correlated with age?
4. Regarding treatment types, are there any significant differences between IM and AM proportions in the CBT vs. the STPP group?

Additionally, as mentioned before, the IMCS and the ACS have never been applied to an adolescent sample and, consequently, this first exploratory study is also an attempt to clarify whether the IMs model, and its methodological tools, may be a viable and promising option for a theory-based research approach to therapeutic change in adolescence.

2. Method

2.1. Participants

In this study, 24 participants were included. Ages varied between 12 and 18 years (*M* = 16.45, *SD* = 1.74), 13 participants were females and nine were males (data missing for two participants). The final sample comprised 12 participants that met criteria for GO, and 12 participants that were considered PO cases. Concurrently, 12 of the participants belonged to the CBT and 12 to the STPP treatment groups, as detailed in Table 1.

Table 1

Number of participants in the sample's groups and subgroups

		Outcome Status		TOTAL
		Poor	Good	
Treatment	CBT	5	7	12
	STPP	7	5	12
TOTAL		12	12	24

Note. CBT - Cognitive-behavioural Therapy; STPP - Short-term Psychanalytic Psychotherapy.

2.2. Materials

Mood and Feelings Questionnaire

Depressive symptomatology before and after treatment had been assessed in the IMPACT study using the Mood and Feelings Questionnaire (MFQ, Angold, Costello, Pickles, & Winder, 1987), a thirty-three-item, standardized, self-rated questionnaire of depressive symptoms, in which symptomatology related statements regarding feelings and behaviour in the preceding two weeks are rated as NOT TRUE (0 points), SOMETIMES (1 point), or TRUE (2 points), and a score of 28 and above has been used to discriminate adolescents with major depression. Examples of the questionnaire's items are: "I felt miserable or unhappy", "I did everything wrong", among others.

The Expectation of Therapy and the Experience of Therapy Interviews

In the IMPACT-ME study, participants took part in qualitative, semi-structured interviews that were collected across three time points: before the start of treatment (T1), using the *Expectation of Therapy Interview* (Midgley et al., 2011a), and at the

end (T2) and one year after the end of treatment (T3), using the *Experience of Therapy Interview* (Midgley et al., 2011b). The interviews' schedules cover several topics but were used in a flexible way. The pretreatment interview focused on: (a) what brought the adolescents to treatment and how the difficulties had been affecting the lives of the adolescents and those around them; (b) the adolescents' understanding of those difficulties; (c) hopes for change and ideas about what could lead to meaningful change; (d) and ideas and expectations about therapy itself. In turn, in the posttreatment and follow-up interviews (T2 and T3) the topics explored in the pretreatment interview were revisited and an exploration of the adolescents' and their families' experiences of therapy and change over time, with a focus on the processes that led to positive or negative outcomes, as well as the broader cultural and contextual factors affecting those outcomes, and an exploration of the participants' experiences of being involved in the research study, were added.

In the present study, the verbatim transcripts of the pre and posttreatment interviews of the selected participants were used. The pretreatment interviews (T1) were used for the identification and clarification of each participant's difficulties, and the posttreatment interviews (T2), focused on the exploration of changes and change processes, for the codification of IMs and AMs.

The Innovative Moments Coding System

The IMCS (Gonçalves et al., 2017) is a qualitative procedure used to analyse therapy sessions, but also similar materials like interviews, that involves several tasks: (a) defining the problematic narrative of each client; (b) defining moments in which this narrative is discontinued or challenged and an exception, an IM, emerges; (c) identifying the beginnings and endings of the IMs, and; (d) classifying the level of each IM. While the initial definition of the problematic narrative is performed consensually, IM codings are done independently by two coders. These coders meet regularly to calculate reliability and discuss their understanding of the case.

The aim is to identify the proportions of each of the mutually exclusive IM categories, that is, the percentage of words or time involved in each type of IM relative to the total amount of words or time of a therapy session. Under the assumption that change is coconstructed, IM proportions consider the client's as well as the therapist's utterances.

Regarding reliability, previously reported findings referred agreement percentages on IM proportions above 89.9% and Cohen's *kappas* above .91 for the categorization of IM types, using former versions of the coding system (Gonçalves et al., 2017).

The Ambivalence Coding System

The ACS (Gonçalves et al., 2017) is a system that tracks moments in which IMs are attenuated in their change potential with an AM (formerly, return to the problem marker, RPM). The ACS is usually used in combination with the IMCS, as AMs are coded as either present or absent in the discourse that follows each IM of a session. The aim is to identify the proportions of IMs affected by ambivalence in relation to the total number of coded IMs, either globally and/or separately for each category of IMs. Concerning reliability, in previous studies Cohen's *kappas* ranging from .80 to .93 were obtained (Gonçalves et al., 2017).

2.3. Procedures

Sample selection

The cases used in this study were retrieved from a sample of initially 64 participants of the IMPACT-ME study (Midgley et al., 2014), made available by the responsible researchers in accordance with all current standards of data protection and confidentiality. The participants were adolescents taking part in the London arm of the IMPACT trial, diagnosed with unipolar depression, moderate to severe impairment, aged between 11 and 17 years. Exclusion criteria were generalized learning difficulties, pervasive developmental disorder, pregnancy and primary diagnosis of bipolar Type I, schizophrenia and eating disorders.

The sample selection for the present study took into consideration the outcome status, GO vs. PO, and the type of treatment, either CBT, STPP or SCC, in order to allow for comparisons between contrasting groups. The distinction between GO and PO cases was based on the symptomatology scores obtained with the MFQ, and in order to be considered a GO case, as suggested by Midgley et al. (2014), two conditions had to be fulfilled. On the one hand, the posttreatment symptomatology score had to be beneath the cut-off of 27 points, on the other, symptomatic improvement had to be of at least 50.0% (the difference between the pretreatment and the posttreatment scores had to be equal to or greater than half

of the pretreatment score). As an unbiased application of the IMCS and ACS required coders to remain unaware of outcome and treatment type, the case selection was undertaken by the senior researcher not involved in the coding procedures.

Initially, our sample comprised 64 adolescents, 22 cases in the CBT, and 21 cases each in the STPP and in the SCC groups. During the selection procedures it was found that from the 21 participants in the SCC group only two fulfilled the criteria for GO, and this led to the decision to exclude this group entirely. Afterwards, from the remaining 43 participants in the CBT and the STPP groups, 10 were excluded, six from the CBT and four from the STPP group, because they had either not attended or not completed their posttreatment interviews. Three participants were excluded, one in the CBT and two in the STPP group, because their posttreatment symptomatology questionnaires were missing. Three participants were excluded due to early dropout from treatment, two from the CBT and one from the STPP group, and three participants, one from the CBT and two from the STPP group, were excluded due to unclear outcome status, as these participants did fulfil one, but not both, of the two criteria for GO. Finally, as mentioned above, 24 adolescents were selected for the application of the IMCS and ACS coding systems.

Coding procedures

Firstly, the student researcher was trained in the use of the IMCS and the ACS by members of the research team authoring the respective manuals and completed a predefined training protocol involving several weeks of supervised work, either independently or in a small learning group. The training involved attending seminars on theoretical backgrounds, coding procedures, reliability calculations, amongst others, and weekly codings of a transcribed therapy session, with individualized feedback, reflections and discussions in the learning group. At the end of the training, the coding reliability of the student was evaluated and considered adequate.

Finally, in order to deepen coding experience, the student researcher was engaged in the cocodification of a psychotherapeutic case from the sample of an ongoing study, under the supervision of a senior researcher. An estimation of overall dedicated time, including all components of the training, amounts to 50 hours.

In the present study, to assess for coding reliability, the posttreatment interviews of 12 of the 24 cases (50.0% of the total sample) were randomly selected for cocodification by two independent coders (the student researcher and one of the two senior researchers involved in coding), all unaware of outcome and treatment type. The coding process entailed three main steps: (a) the consensual definition of each participant's problematic narrative, operationalized as a list of problems based on the adolescent's complaints and reflections in the pretreatment interview (T1), which were elaborated by the student researcher under supervision of the senior researchers; (b) the identification of IMs in the posttreatment interviews (T2), which required the definition of each IMs beginning and end, as well as its categorization into the respective level; and (c) the identification of AMs, when present, after each coded IM. Coders' reliability was calculated for agreement on IM proportion and categorizations throughout the coding of the 12 selected cases and, whenever significant disagreements occurred, divergent coding options were discussed and coding guidelines established, allowing for a gradual integration of the experienced coders' expertise by the student researcher.

As detailed above, due to inputs from empirical research, the IMs model has undergone continuous reformulations regarding types of IMs (Gonçalves et al., 2017). For the present study, the differentiation between level 1, level 2 and level 3 IMs was used, and during the coding procedures some additional adaptations were found to be necessary. Indeed, after several coding and discussion cycles, we found that the kind of data used, transcripts of retrospective interviews, rather than the usual transcripts of therapy sessions, did not allow for a clear identification of level 1 IMs without considerable intercoder disagreements, doubt and excessive inferences, bringing forth the decision to exclude this category from the coding procedures. In fact, in level 1 IMs, although pinpointing efforts to overcome a client's difficulties, the discursive focus remains on the problematic experiences, not on change. Consequently, the dividing line between mere ruminations and the formulation of new insights and understandings (that would be considered as level 1 IMs) often only becomes apparent throughout the progressive unfolding of change during a psychotherapeutic process, and was found not to be clearly traceable in these retrospective interviews, conducted at a single point in time. Therefore, we chose to only code for level 2 and 3 IMs, which are characterized by a clear discursive focus on change and have shown robust associations to good

psychotherapeutic outcomes (e.g. Gonçalves et al., 2017). In their turn, these IMs could be identified with adequate agreement between coders, in the interviews used in this study.

Finally, reliability calculated for the 12 cocoded cases was found to be adequate, both for the definition of IM proportions, with agreements for individual cases ranging from 80.9 to 100.0%, and for the categorization of IM levels, with a global Cohen's *kappa* of .82. Additionally, with a global Cohen's *kappa* of .94, the agreement on whether AMs were either present or absent after each IM, was also adequate. Subsequently, once adequate reliability had been established, the student researcher went on to code the remaining 12 cases of the sample.

Data analyses

After all coding was completed, data for all cases was compiled into Microsoft Excel® and IBM SPSS® files, containing the total, level 2, and level 3 proportions of IMs, and the proportions of IMs followed by AMs. Additionally, age and gender, type of treatment attended to, the MFQ scores at pre and at posttreatment, the symptomatology variation (T2-T1), and the categorization as a GO or PO case, made available by the researchers of IMPACT-ME, were included.

Statistical analyses focused on descriptive findings, associations between variables, and differences between groups, as detailed in the results section.

3. Results

3.1. Description of findings

The descriptive findings for the overall sample, the GO and PO, and the CBT and the STPP groups, presented in Table 2, answer our first research question. Indeed, significant proportions of the adolescents' discourse throughout the posttreatment interviews were classifiable as IMs. In turn, only some moments of ambivalence were found (some illustrations of the discursive phenomena coded throughout the interviews as problems, level 2 and level 3 IMs, and AMs, can be found in Appendix A).

Table 2

Main descriptive findings

	Age in years	MFQ at T1	MFQ at T2	MFQ variation	Words in T2 interview	Level 2 IM prop. in %	Level 3 IM prop. in %	Total IM prop. in %	Prop. of IMs with AMs, in %
Overall	16.45 (1.74)	48.25 (8.42)	24.67 (15.40)	-23.58 (14.61)	10128 (2963)	5.6 (4.0)	2.3 (3.1)	7.9 (6.4)	7.4 (12.5)
PO	16.75 (1.42)	50.08 (5.84)	38.58 (6.96)	-11.50 (7.09)	10585 (3399)	2.9 (3.1)	0.2 (0.6)	3.1 (3.2)	10.5 (13.9)
GO	16.10 (2.08)	46.42 (10.33)	10.75 (4.99)	-35.67 (8.79)	9672 (2520)	8.3 (2.9)	4.4 (3.2)	12.7 (5.1)	4.3 (10.5)
CBT	16.58 (1.51)	49.00 (8.48)	21.75 (15.12)	-27.25 (16.95)	9138 (2746)	6.6 (4.2)	3.6 (3.6)	10.3 (7.3)	3.3 (9.6)
STPP	16.30 (2.06)	47.50 (8.66)	27.58 (15.77)	-19.92 (11.28)	11118 (2946)	4.5 (3.7)	0.9 (1.9)	5.5 (4.6)	11.6 (13.9)

Note. For all columns: *M* (*SD*); PO – Poor outcome; GO – Good outcome; CBT – Cognitive-behavioural Therapy; STPP – Short-term Psychanalytic Psychotherapy; MFQ – Mood and Feelings Questionnaire; T1 – Pretreatment; T2 – Posttreatment; IM – Innovative moments; AM – Ambivalence markers.

Regarding the statistical testing of associations between variables and the comparisons between contrasting groups, considering that most of the variables of interest were not normally distributed (Shapiro-Wilks tests $p < .05$), and the small number of participants in each group or subgroup (n = 5-12), we opted to resort to non-parametric tests. Therefore, several Spearman correlations and Mann-Whitney U-Tests, to ascertain for comparability and compare groups and subgroups, were conducted. Although these non-parametric tests resort to data ranking, we opted for means (*M*) and standard deviations (*SD*) as descriptive measures (Martins, 2011).

3.2. Correlational analyses

Regarding our second research question, correlational analyses using Spearman's *r* produced evidence for the expected association between the production of IMs and symptomatic improvements. Indeed, statistically significant moderate-to-strong negative correlations were found between the symptomatology scores at posttreatment (T2) and the overall proportions of IMs ($r_s = -.747$, $p < .001$), the proportions of level 2 IMs ($r_s = -.684$, $p < .001$), and the proportions of level 3 IMs ($r_s = -.586$, $p = .003$), as well as for the variation of symptomatology scores from

pre-to-posttreatment (T2-T1) and the overall proportions of IMs (r_s = -.771, $p < .001$), the proportions of level 2 IMs (r_s = -.754, $p < .001$), and the proportions of level 3 IMs (r_s = -.644, $p < .001$). Regarding the expected association between ambivalence and symptom decrease, no significant correlations were found between the proportions of AMs and neither posttreatment symptomatology scores nor symptomatology variation.

Additionally, we explored if age of participants would be significantly associated with any of the IM or AM proportions, but found that none of those correlations were statistically significant (all $p > .05$). Albeit, it should be considered that most of the adolescents (fourteen out of 22), were already 17 or 18 years old, which did not sustain the most suitable conditions for correlational analyses.

3.3. Group comparisons

To assert for comparability between groups and subgroups, several Mann-Whitney U-Tests were conducted. Regarding the comparison between the GO vs. the PO groups, no significant differences were found, neither for age (GO: M = 16.10, SD = 2.08 vs. PO: M = 16.75, SD = 1.42, U = 49.50, p = .473), nor for pretreatment symptomatology scores (GO: M = 46.42, SD = 10.33; ranging 28 to 60 vs. PO: M = 50.08, SD = 5.84; ranging 38 to 58, U = 59.00, p = .452), nor for length of posttreatment interviews in words (GO: M = 9672, SD = 2520 vs. PO: M = 10585, SD = 3399, U = 59.00, p = .453). In turn, regarding treatment types, the CBT vs. the STPP groups, no significant differences were found, neither for age (CBT: M = 16.58, SD = 1.51 vs. STPP: M = 16.30, SD = 2.06, U = 59.00, p = .945), nor for pretreatment symptomatology scores (CBT: M = 49.00, SD = 8.48 vs. STPP: M = 47.50, SD = 8.66, U = 66.00, p = .729), nor for length of posttreatment interviews (CBT: M = 9138, SD = 2746 vs. STPP: M = 11118, SD = 2946, U = 44.00, p = .106). Furthermore, regarding the comparability of the GO vs. the PO subgroups within each treatment type and the comparability between only the GO and only the PO subgroups across treatment types, once more, no significant differences between age, pretreatment symptomatology scores and length of posttreatment interviews, were found (all $p > .05$). Therefore, comparability of groups and subgroups was assured for all intended purposes.

In turn, our expectation that cases from the GO group would show significantly higher proportions of IMs in their posttreatment interviews than cases

from the PO group, was fully confirmed, in fact, we found statistically significant differences for the overall proportion of IMs (GO: $M = 12.7\%$, $SD = 5.1\%$ vs. PO: $M = 3.1\%$, $SD = 3.2\%$, $U = 8.00$, $p < .001$), for the proportion of only level 2 IMs (GO: $M = 8.3\%$, $SD = 2.9\%$ vs. PO: $M = 2.9\%$, $SD = 3.1\%$, $U = 17.00$, $p = .001$) and for the proportion of only level 3 IMs (GO: $M = 4.4\%$, $SD = 3.2\%$ vs. PO: $M = 0.2\%$, $SD = 0.6\%$, $U = 19.50$, $p < .001$).

Regarding our expectation that the proportion of AMs would be significantly higher in PO cases than in GO cases, although higher proportions for overall AMs (GO: $M = 4.3\%$, $SD = 10.5\%$ vs. PO: $M = 10.5\%$, $SD = 13.9\%$) and for AMs following level 2 IMs (GO: $M = 4.6\%$, $SD = 10.7\%$ vs. PO: $M = 10.7\%$, $SD = 13.9\%$) were found in the PO when compared to the GO group, these differences were not statistically significant (all $p > .05$). Regarding level 3 IMs, no single AM was coded in the entire sample, which is congruent with this type of IMs' higher-order role in change processes (Fernández-Navarro et al., 2018).

Furthermore, the comparisons between the CBT and the STPP groups did not reveal statistically significant differences neither for the overall proportion of IMs, nor for the proportion of level 2 IMs, nor for the proportion of AMs (all $p > .05$), but, marginally, for the proportion of level 3 IMs (CBT: $M = 3.6\%$, $SD = 3.6\%$ vs. STPP: $M = 0.9\%$, $SD = 1.9\%$, $U = 40.50$, $p = .042$). The findings for contrasting groups, are further illustrated in Figures 1 and 2.

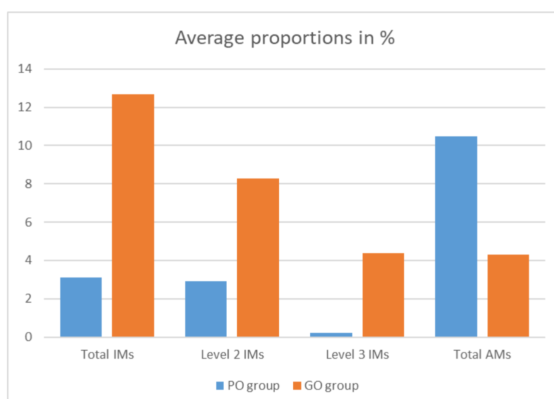

Figure 1. Comparisons PO vs. GO groups.

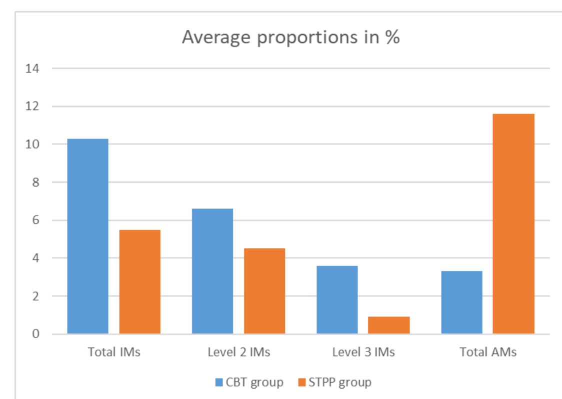

Figure 2. Comparisons CBT vs. STPP groups.

Regarding the sample's subgroups, the results from the comparison of PO and GO cases within each of the treatment types, revealed patterns slightly different from those found in the overall sample. There still were significantly higher proportions of overall IMs in the GO than in the PO subgroups both for CBT ($U =$

2.00, p = .012) and for STPP (U = 2.00, p = .012), although, for the proportion of level 2 IMs the difference was significant only for the STPP cases (U = 4.00, p = .028), but not for the CBT cases (p > .05), while for the proportion of level 3 IMs the difference was significant only for the CBT cases (U < 0.01 p = .003), but not for the STPP cases (p > .05).

Finally, a significant difference was also found while comparing only the GO subgroups, across treatment types. Indeed, once again, the proportion of level 3 IMs was significantly higher in the CBT than in the STPP GO subgroup (CBT: M = 6.2%, SD = 2.1% vs. STPP: M = 1.8%, SD = 2.7%, U = 3.00, p = .018).

4. Discussion

Returning to our original research aims, our findings pointed out that IMs were reliably identifiable in the posttreatment interviews of the adolescents receiving psychotherapeutic treatment for depression used in this study. Indeed, an overall average proportion of 7.9% (SD = 6.4%), 3.1% (SD = 3.2%) for PO cases and 12.7% (SD = 5.1%) for GO cases, of the adolescents' discourse was coded as IMs. For the GO cases this average proportion of 12.7% comes close to the around 15.0% of high-level IMs characteristic for successful therapy cases that Montesano et al. (2017) found in their review on research conducted with the IMCS. Concerning the patterns of IMs in regard to therapeutic outcome, operationalized as a significant decrease of depressive symptoms, generally speaking, it may be stated that the findings of this study were convergent with previous findings in adult samples (e.g. Gonçalves et al., 2017). Indeed, the proportions of IMs – total, level 2, and level 3 – in the overall sample, all revealed significant and moderate-to-strong associations with symptomatic improvement, as much with the posttreatment scores as with the pre-to-posttreatment variations, all in the expected negative direction. Additionally, as revealed by the group comparisons, the proportions of IMs were significantly higher in the GO than in the PO group (for overall IMs: M = 12.7%, SD = 5.1% vs. M = 3.1%, SD = 3.2%). All-in-all, these findings suggest that at least some of the change processes that occurred throughout the treatments of these adolescents may be adequately captured through and understood from the narrative stance of the IMs model. In turn, although occurring in some instances, only very few AMs

were identified throughout the interviews. Yet, this must be understood in regard of the type of data used in the present study, as AMs pinpoint struggles between opposing tendencies towards change within the multivocal self, and therefore may be expected to occur more frequently while a therapeutic process is still ongoing, and considerably less from a retrospective stance, when most of the ambivalence regarding change is expected to have been overcome, at least in GO cases.

In turn, as mentioned before, taking into account the empirical findings of previous research (Fernández-Navarro et al., 2018), the IMs model has placed a growing emphasis on the reconceptualization IM, as its "promotion" to the qualitatively distinct and superior level 3 of processes underlying change, clearly evidences. Concerning the results of this study, we found that, in average, only a proportion of 0.2% (*SD* = 0.6%) of the discourse of the adolescents with PO did correspond to level 3 IMs (in fact, only one level 3 IM was coded in the interviews of the entire PO group), while in the GO group, in average 4.4% (*SD* = 3.2%) of the discourse was coded as level 3 IMs – a 22 times bigger proportion. Besides, still regarding level 3 IMs, the exploratory comparisons between cases that had received CBT vs. STPP, revealed only one significant difference, a higher proportion of level 3 IMs in the overall and in the GO subgroup of the CBT patients. Additionally, while in the overall sample the proportions of level 2 and level 3 IMs were significantly different between GO and PO cases, the comparison of GO and PO subgroups within each of the treatment types, pointed out that for the proportion of level 2 IMs there was a significant difference between GO and PO cases for the STPP subgroups, but not for the CBT subgroups, while for the proportion of level 3 IMs there was a significant difference between GO and PO cases for the CBT subgroups, but not for the STPP subgroups. These findings suggest that, while for the GO STPP cases level 3 IMs seem not to have been of central importance, for the CBT group the discursive articulation of reconceptualization IMs was decisively associated to clinically good outcomes. These findings strengthen the assumptions around the centrality of reconceptualization IMs for effective personal change, at least for CBT patients, but are quite puzzling as former research (Gonçalves et al., 2016) suggested that reconceptualization IMs are rare in CBT cases, and occur more frequently in therapeutic models from the constructivist paradigm, e.g. narrative, emotion-focused or dilemma-focused therapies, which, more or less deliberately, seek to bring about these kind of innovations in a person's meaning-

framework. These findings suggest that further research on the specific mechanisms that enable some therapeutic approaches more than others to facilitate the occurrence and expansion of IMs strongly associated to effective therapeutic change, are in order. Anyhow, we must point out that, while in the formerly cited study on CBT (Gonçalves et al., 2016) actual therapy sessions were used, in the present study the coded material were posttreatment interviews which specifically focused on the occurrence of change and invited the adolescents to reflect upon possible reasons and facilitative factors. Consequently, these considerations have to take into account that the IMs found throughout the interviews may be as much a result of the treatments, as of the stimulating qualities of the interviews used for data collection, by that rendering the interview itself a tool not only for the gathering of descriptive accounts of personal changes, but also for the deepening and anchoring of narratively constructed change. Indeed, the interviews used for the present study, centred on the adolescents' personal retrospective considerations about their psychotherapeutic process, questioned explicitly about changes that had occurred, possible reasons and facilitative factors – the two dimensions of reconceptualization or level 3 IMs – and, consequently, confronted the adolescents with the task to descriptively (or even constitutively) narrate and order their experiences lived-through during psychotherapy into a coherent and meaningful whole.

In this context, taking into account that the interview schedules actually directed the participants towards the production of high-order IMs, the proportion of level 3 IMs could be expected to be higher, at least we believe it would have been in an adult sample interviewed under these conditions. Regarding this question, some considerations on developmental differences between adults and adolescents are in order, and certainly, considering that the "life story serves to create a sense of coherence, unity, and purpose, which is considered to be of prime importance for mental health and well-being" (Habermas & Silveira, 2008, p. 708), the ideas on a meaningful and coherent self-narrative as the goal of psychotherapy converge with research on identity and life story development. Even more so in the context of psychotherapy with adolescents, where the topic of identity development (Erikson, 1968), accomplished through a gradual refinement and integration of how the life story is narrated (McAdams, 1985), is a central tenet. Thus, a gradual integration between the IM model and these research traditions, focused on the emergence and development of narrative ability in childhood and adolescence, seems a

promising first step towards a development-sensitive perspective on narrative change in psychotherapy with (children and) adolescents. Indeed, certain cognitive and metacognitive abilities involved in autobiographical reasoning, that enable the creation of temporal, causal and thematic coherence, but have been found to only develop later on in adolescence (Habermas & Silveira, 2008), are most likely crucial prerequisites for the meaningful articulation of higher-order IMs and their integration into the self-narrative. Consequently, not only researchers, but also therapists, working from a narrative perspective on change, would be well advised to adapt to the developmental levels of young clients and scaffold their narrative efforts towards change accordingly. However, in this study, we found no significant correlations between the age of participants and the proportions of IMs. Albeit, this might be due to the formerly stated strong concentration of participants' ages around seventeen and eighteen years.

All-in-all, our findings are convergent with previous studies and strengthen the assumptions around the importance of level 2 and level 3 or reconceptualization IMs for effective change in psychotherapy. From a practical stance, just as previous in studies (e.g. Gonçalves et al., 2017; Montesano et al., 2017), these findings invite us to reflect on ways to promote personal change by enabling and expanding narrative innovations throughout therapy. One approach, resulting from the findings that highlight the importance of level 3 IMs for change in self-narratives, would be to prompt reconceptualization IMs by introducing questions that elicit and link their two components, such as "what is better/different than before?" or "what were the main changes in therapy?" for contrasts, and "how did you achieve those changes?" or "what helped you getting to where you are now?" for processes (Gonçalves et al., 2017, p. 10-11). For instances, the interviews of the IMPACT-ME study seem to have been a tool that scaffolded the adolescents' narrative accounts by prompting reflections around change and reasons for change, and in fact, many instants in which further of such narrative scaffolding would have been possible were found during the analyses of the interview transcripts.

Regarding limitations of this study, the small sample size must be mentioned, and especially the results of the subgroup comparisons must be considered with care, as the sizes varying between five and seven cases, frankly, do not allow for trustworthy generalizations.

In turn, while on the one hand the kind of data used in this study, posttreatment interviews focused on the changes that had (or not) occurred in the adolescents' lives, allowed for interesting findings on how changes were understood and integrated into the self-narratives from a retrospective stance, and harnessed support for the applicability of the IMCS to this kind of data. On the other hand, it did not enable analyses on the step-by-step processes occurring throughout the psychotherapeutic treatments, as access to actual therapy sessions does. Additionally, as explained before, the use of this kind of data made it necessary to operate some adjustment to the coding procedures, chiefly, the exclusion of level 1 IMs, which could not be identified without considerable disagreement between independent coders. In the future, to enable a deeper understanding of change processes during the course of psychotherapy, especially the longitudinal patterns of IMs production and the role of level 1 IMs as well as AMs, research that makes use of full therapeutic sessions is necessary.

Finally, in accordance with the priorities stated in the IMPACT and IMPACT-ME studies (e.g. Midgley et al., 2014), regarding the urgency for treatment options that allow for effective relapse and recurrence prevention among youth depression, further studies that focus on the associations between IMs and therapeutic gains in the long-term are in order. Indeed, from the theoretical perspective that IMs, and foremost reconceptualization IMs, constitute a bridge-building process that highlights innovation, but allows to overcome identity gaps and assures for personal coherence throughout the narrative construction of change in oneself, the emergence (and skilful enabling) of these discursive instances, would be expected to contribute to deeply rooted and long-lasting psychotherapeutic gains (as formerly suggested by Gonçalves et al., 2017). We intend to pursue this research focus, making use of the before-mentioned 1-year follow-up interviews (T3) conducted with the adolescents of the sample used in this study.

5. Conclusion

This study aimed at further understanding psychotherapeutic change processes with adolescents through a narrative lens on process research, exploring IMs and ambivalence, by applying the IMCS and the ACS to data from a sample of

depressed adolescents. The preliminary findings were quite encouraging, and expectations regarding significant associations between IMs and symptomatic improvement and significant differences between the production patterns of IMs in PO and GO cases were fulfilled. These findings suggest that the IMs model's coding systems may be used and tend to bring forth similar findings with adolescents as with adults. Accordingly, future research targeting at adolescent psychotherapy process research, theoretically anchored in a narrative perspective on personal change - the IMs model -, seems promising. These efforts should mainly focus on associations between IMs, especially reconceptualization IMs, and long-term treatment outcomes, on step-by-step analyses of narrative change throughout therapy, and aim to shed light into the singularities of the adolescent population by building bridges to research on the development of autobiographical reasoning and narrative ability in the early lifecycle.

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Appendix A

Problems, level 2 and 3 IMs, and AMs retrieved from the pre and posttreatment interviews analysed in the study

Examples of problems identified in the pretreatment interviews, and used for the formulations of patients' problematic narratives or frameworks:

(…) sometimes I just like, I feel like tired of… mentally and physically and I'm completely weak… like I can't do anything (…) [Problem list: "depression moments: feeling weak, feeling unable to do anything, feeling mentally and physically tired", etc.].

(…) I've been irritable lately (…); (…) I've been more angry lately (…); (…) I get angry faster at smaller things (…) [Problem list: "being irritable, getting angry easily", etc.].

Examples of IMs found in the posttreatment interviews:

Level 2 IM: *(…) my life has completely changed now… I have a group of friends that I really like… and also other friends from societies I joined… I'm a lot happier (…)* [contrasting past and present].

Level 2 IM: *(…) I could say everything is fine I suppose... I don't know if you can use the term cured but I think I've been cured... I don't feel depressed at all anymore (...)* [contrasting past and present].

Level 2 IM: *(…) and helped me realise "they actually want me to come back..." like it made me feel needed again... and that I wasn't completely useless, that someone wanted me to be there (...)* [change process].

Level 3 IM: *(…) I remember one time feeling really angry, I just really wanted to fight someone, and that sort of stuck with me and after that I really felt a turning point* [contrasting past and present] *with me understanding myself (…) about how I really found the link between getting angry with things that maybe I shouldn't have really got angry about and letting go of things* [change process] *and that had a link with me feeling happier and better* [contrasting past and present]*, I think that was quite important (…).*

Level 3 IM: *(…) A.: I've sort of got like a different mindset and I've looked back on it and just thought a lot I guess...* [change process] *I'd probably just say I'm more optimistic…* ***I.: and has the way that you kind of make sense of how things became… the way they were and the difficulties you were having, do you think your understanding of that has changed…*** *A.: it's definitely changed…* [contrasting past and present] ***I: do you have any ideas kind of in what way it's changed?*** *A.: seeing it all happen like… I can see what led up to what and how… like the domino effect… it just happened… how the one event triggered a lot more…* ***I.: do you think that's the way that you're able to see it now that you wouldn't be able to see it back then?*** *A.: yeah…* [change process] ***I.: I'm just wondering how have things changed, how are things now compared to when you first joined the IMPACT study…*** *A.: I think everything's got a lot better really… I'm more optimistic… more talkative… just happier all round (…)* [contrasting past and present].

Examples of AMs found in the posttreatment interviews:

(…) things have been going fine recently... My anger hasn't popped up as much [IM]*, still pops a bit… that still gets a burden on me* [AM] *(…).*

(…) now I actually feel really happy so that's good... let's call it that my therapy worked... [IM] *erm... I mean sometimes I still feel really really bad and depressed* [AM] *(…)*.