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THERAPEUTIC CHANGE, INNOVATIVE MOMENTS, AND THE RECONCEPTUALIZATION OF THE SELF: A DIALOGICAL ACCOUNT

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ABSTRACT. Innovative moments (IMs) are exceptions toward the problematic self-narrative that brought the client to therapy, which emerge in the therapeutic conversation. Dialogically, an IM might be conceived as an expression of an alternative I-position which challenges the dominance of problematic voices, thus having the potential to transform the self-narrative as they are expanded and elaborated. Reconceptualization is a particular type of IM which usually emerges in the middle of the process of a successful treatment, increasing steadily until the end. Moreover, reconceptualization seems to be a distinctive feature of a successful psychotherapy process, as it is almost absent in poor outcome cases. This IM has two main features: the presence of a contrast between a previous self-narrative and a new emergent one, and the access to the process which allowed for the transformation from the former to the last. This innovative moment clearly involves a special I-position which Hermans has characterized as a meta-position. We discuss four functions of this type of IM in the change process: (1) providing a narrative structure for change; (2) bridging the past and present self-narratives; (3) facilitating the progressive identification with the new self-narrative; and (4) allowing surpassing the ambivalence often involved in the change process.

For the past years we have been developing a research program which addresses how novelties emerge and evolve in the therapeutic process. This program, inspired in the narrative tradition in psychology (Bruner, 1986; McAdams, 1993; Polkinghorne, 1988; Sarbin, 1986), conceives people as narrators, providing meaning to their lives through the construction of stories. From a dialogical perspective (Hermans & Kempen, 1993; Hermans & Dimaggio, 2004; Hermans & Konopka, 2010) these narratives are built through dialogical processes, given that, for each narrative told, there was a voice that was telling a story to an audience. Of course, the narrator and the audience are often internal, as we frequently tell stories to ourselves. From a narrative-dialogical perspective, the construction of knowledge involves the creation of stories, told by

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motivated narrators (Hermans & Hermans-Jansen, 1995), whether these stories are functional or dysfunctional, adaptive or pathological.

It is beyond the scope of this paper to characterize dysfunctional self-narratives or the dialogical processes involved in their creation or maintenance. We recommend the special section of the *Journal of Constructivist Psychology* for a comprehensive discussion of this subject (Dimmagio, 2006; see also Gonçalves & Ribeiro, in press). For the topic we are developing here, it suffices to say that dysfunctional self-narratives which bring clients to therapy are, as clinicians know very well, resistant to change. As Frank and Frank (1991) stated, one could expect that as dysfunctional patterns, or assumptions (to use his term), are the target of intrapersonal (e.g., bringing suffering) and interpersonal invalidation (e.g., creating relational problems), they should be easy to change. However, as Frank and Frank emphasized, the opposite occurs, given all the processes that create strong bias in the construction of knowledge, protecting the dysfunctional assumptions from revision. Virtually all clinical models have created theories that explain how these processes develop, from cognitive errors and attributional bias in cognitive therapy, to defensive processes in psychodynamic theory. From a dialogical standpoint, these processes of self-narrative dysfunctional stability could be described as a tension between different I-positions that struggle to be heard, in which a dominant voice, or coalition of voices, keeps itself in the foreground and manages to push others to the periphery (Hermans & Konopka, 2010). When new voices emerge, a novelty appears and a new story can develop from there. These novelties do not need to be powerful transformations, and are often very subtle in the beginning of the change process, as the following hypothetical example evidences:

> "My life is a misery, I feel depressed all the time, without the strength to do anything. I do not have any pleasure in living. For me life is a burden. Curiously, yesterday I had some pleasure playing with my son and it felt good."

In this very simple sentence one can infer the presence of two different voices. One dominant (life is a misery) and another more peripheral one (I had pleasure playing with my son). From our point of view, the second voice, implicit in the client's discourse, represents what we call an *innovative moment* (IM), that is, a challenge to the dominant self-narrative. Therapists from the narrative tradition (e.g., White & Epston, 1990; White, 2007) call these occurrences *unique outcomes*, in the sense that they represent an exception toward a dominant problematic self-narrative. In the solution-focused tradition (de Shazer, 1991; Miller, Hubble, & Duncan, 1996) experiences like this are simply called *exceptions* and are viewed as windows of opportunity in the change process. Strategic therapists also claim the importance of small changes which could catalyze more important changes through a domino effect (Watzlawick, Weakland, & Fisch, 1974). In line with these ideas, Valsiner (2008), from a developmental perspective, claims that it is the direction of meaning construction—rather than the actual meanings constructed—that can tell us something about

development. Thus, our approach tracks the small changes that occur in psychotherapy, which, by accumulation and also by a *gestalt* effect (i.e., through the interaction between different innovative moments; Gonçalves, Matos, & Santos, 2009), can lead to more significant changes, transforming the self-narrative.

As change starts to develop, innovative moments necessarily occur, as new voices come to the foreground and the formerly dominant ones are pushed to the background or transformed in the dialogical relationship with the new voices. According to the narrative tradition (White & Epston, 1990), change can be started by the therapeutic elaboration of innovative moments, by developing a therapeutic curiosity toward what could be different narrative accounts (see White, 2007, for the clinical guidelines of this process), different possibilities of living. However, even when other therapeutic tools are used to prompt the revision of the former problematic self-narrative (e.g., empty-chair work), novelties necessarily emerge as the former problematic pattern is revised. Hence, from our view, regardless of looking at innovative moments as processes of change or products of change, there is no change without the emergence of innovative moments.

Our research program has been tracking innovative moments (IMs) along treatment in different models of therapy and with several samples (Matos et al., 2009; Mendes et al., in press). Research allowed us to systematically identify 5 types of IMs in the clients' discourse: action, reflection, protest, reconceptualization, and performing change IMs:

1. *Action* IMs are specific behaviours which are different from what the problem impels the person to do.
2. *Reflection* IMs refer to new ways of thinking, feeling and new understandings about the implications of the problem in the client's life that allow him or her to defy the demands of the problematic self-narrative.
3. *Protest* IMs entail new behaviours (like action IMs) and/or new thoughts (like reflection IMs) against the problem, representing a refusal of its assumptions and prescriptions. This active refusal is the key feature which allows distinguishing protest from action and reflection.
4. *Reconceptualization* IMs are a more complex and multifaceted type of IM which enables the clients' comprehension about what is different about him or herself and the process which fostered this transformation. These IMs require the clients' description of two components: 1) the contrast between the self in the past (problematic self-narrative) and the self in the present and 2) the depiction of the process which allowed for this change.

5. *Performing Change* IMs represent the performance of change, new ways of acting and being that emerge from the change process. They also represent a process of transforming in-therapy outcomes into extra-therapy changes.

In other publications (Gonçalves, Matos, & Santos, 2009) we have described how these IMs develop in successful psychotherapy, contrasting it with what was found in poor outcome cases. For the purpose of this article, it is enough to say that action, reflection and protest emerge in both good and poor outcome cases. However, good outcome cases are also characterized by the emergence of reconceptualization IMs in the middle phase of the treatment, which often become the most dominant IMs as therapy progresses. This does not happen in unsuccessful psychotherapy. Thus, one interesting question is why are reconceptualization IMs so important in the process of change? What kind of dialogical processes are present in these IMs? In this article we reflect upon the importance of reconceptualization in the therapeutic change, trying to grasp what are the main functions of this type of innovation.

Reconceptualization and meta-position

As we stated before, reconceptualization has two main components: 1) a description of a formerly dominant way of functioning (previous problematic self-narrative) contrasting it with a new way of functioning, which represents an alternative self-narrative; 2) and the processes through which the change from the former to the last occurred. It is important to emphasize that the new self-narrative, emergent in reconceptualization IMs, is not a complete or finished story, as it is a provisional, faltering *first draft* of what a new self-narrative could be. As we shall see below, one of the functions of reconceptualization IMS is the lively rehearsal of potential new forms of being.

Let us look at the following example of a reconceptualization IM, from the Lisa case (Gonçalves et al., 2010), a well known client treated with emotion-focused therapy. Lisa had a problem being assertive with others, particularly with her husband.

Lisa: Yeah, yeah get back into my feelings, yeah and that's, *I guess, because the awareness I know is there now* [Process of change], and before I never knew it existed (laugh). So I'm an individual, I realize I'm an individual, and I have the right to vent my feelings and what I think is right or good for me and that's been the improvement of the therapy.

Therapist: Yeah, really finding your feet.

Lisa: Mm hm, as an individual yeah, which before I-I thought I was glued to him [the husband] [Contrast between the self in the past and the self in the present] . Yeah, I didn't have an existence and now I do, and that's a good feeling.

In this example Lisa states that now she is attentive to her feeling ("the awareness I know is there now"), that is, she described the process which allowed for change to take place. Through this process, the former dominant self-narrative ("before I never knew it existed") turned into a new emergent one ("I'm an individual, and I have the right to vent my feelings"). The therapist reflects upon this change ("really finding your feet") and Lisa expands the new emergent self-narrative, again by contrast with a former pattern ("I thought I was glued to him" / I found my feet "as an individual").

In this example we have the client reflecting, or more precisely meta-reflecting, over a change process. It is very interesting that, in successful psychotherapy, change is constructed by expanding these types of IMs. We should notice that all IMs are exceptions toward a problematic self-narrative. However, without reconceptualization the other IMs seem insufficient for sustained therapeutic change to unfold, as suggested by our data.

From a dialogical perspective, reconceptualization contains implicitly three I-positions: the position of the past self, the position of the present (new) self and an observing position which has access to the change process (more on this below). The concept of reconceptualization is very similar to the concept of meta-position, as proposed by Hermans (2003). Recently, Hermans and Konopka (2010) suggested that meta-positions are important because of their three main functions: unifying, executive, and liberating. The meta-position puts diverse I-positions in contact, connecting different voices (unifying function); it has the power to make decisions, for instance privileging one position over others in a given situation (executive function); and finally it facilitates the ability to stop habitual or automatic patterns, associated with common positions, and give priority to new ones, less automatic (liberating function). As we stated elsewhere (Gonçalves & Ribeiro, in press) "These functions are very clear in reconceptualization: past and present have a temporal integration which gives meaning to the transition (unifying function), present position is preferred and gets priority (executive function), and former habitual patterns, present in the dominant (problematic) self-narratives are disrupted and stopped (liberating function)." (p. XX). To this proposal we added (see Gonçalves & Ribeiro, in press) a fourth function, which, from our view, turns reconceptualization into a special type of meta-position: a developmental function. A meta-position can connect different positions that are present at the same time, or can connect positions that are present in different time frames. Of course, as the positions are connected they are in a sense present at the same time. But the point here is that reconceptualization facilitates the connection between well developed positions (previous problematic self-narrative) and emergent ones (alternative self-narrative), prompting change. This type of IM produces an articulation of past and present selves, privileging the new in detriment of the old, allowing at the same time the old self-narrative to be integrated into the new pattern. Along these lines,

an interesting question is how reconceptualization facilitates this developmental function.

Developmental function of reconceptualization

In this section we reflect upon the features of reconceptualization that prompt development and change. We suggest that reconceptualization has four intertwined main functions: (1) providing narrative structure to the change process, (2) facilitating self-continuity, (3) advancing the progressive identification with the new self-narrative, and (4) facilitating the resolution of ambivalence over the change process.

Narrative structure

Contrarily to the other IMs, reconceptualization has a well developed structure and is closer to a narrative product, by the emphasis on a time frame: the past self-narrative versus the present self-narrative. Contrast the following reflection IM with a reconceptualization IM of Jan, a client who "felt that she had to be perfect in every respect in order to be lovable" (Goldman & Greenberg, 1997, p. 423)

Session 1

C: I guess I put myself into that role of superwoman and maybe I'm not happy in that role any longer [Reflection IM]

Session 13

C: I guess I don't feel like I have the whole weight of the world on my shoulders, like I'm responsible for everybody [Contrast between the self in the past and the self in the present] (…) looking at some of the things that happened and some of the hurts that I had maybe I never dealt with some of the things that happened to me; by sort of talking about them, bringing them out here, I was able to deal with them and put them where they belong in [Process of change], not being so timid, you know, part of me like was very outgoing and an extrovert and aggressive and then the other very timid person that was afraid to speak up ... it's almost like really a split personality (…) but the timid one never really came out. I sort of kept it hidden all the time.

T: that was this sort of vulnerable little girl inside that was scared and…

C: …that always has to do good things to be accepted, to be liked

T: …yeah the good little girl that has to be good or nobody would really, like me or accept me... you've been doing that for a long time

C: but

T: as I remember last week, you said you didn't want to do it anymore

C: no, I'm not a little girl anymore [Reconceptualization IM].

This is not an uncommon example. Reconceptualization often occupies more time of the session than other IMs, which are more episodic in nature. Probably these IMs scaffold the narrative elaboration of a new identity, better than any other type of innovation, contributing to an integrative account of the client's life. Often clients come to therapy with a fragmentary account of themselves, having difficulties integrating in their self-narratives the diversity of events and experiences they have lived, as it is nicely described by the assimilation model of psychotherapy (Honos-Webb & Stiles, 1998; Stiles, 1999, 2002; Stiles et al., 1990). To create an integrative account of one-self, which facilitates adaptive experiences, is a very important aim of psychotherapy.

Narrative structure, as Baerger and McAdams (1999) have empirically demonstrated, is highly correlated with psychological adjustment. Moreover, not only does the narrative structure present in the reconceptualization allow for the construction of an integrated account of the self, but it also facilitates the construction of an integrated account of the change process ("...sort of talking about them, bringing them out here, I was able to deal with them and put them where they belong in..."). Congruent with the narrative model, meaning - in this case, meaning about the transformation in one's life - is organized into a narrative frame.

Another related feature is the presence inside of reconceptualizations IMs of other types of IMs (mainly action and reflection, but also protest performing change IMs). Accordingly, we have suggested (Gonçalves, Matos, & Santos, 2009) that reconceptualization IMs have a *gravitational* effect over other innovations, thus producing cascades of innovative experiences. In this sense, the first function of reconceptualization is to create a narrative structure in the process of change, which allows for articulating diverse IMs, giving meaning to the previously emerged IMs (e.g., action, reflection). After the emergence of reconceptualization IMs, new action, reflection and protest IMs surface, expanding the former reconceptualization IMs, creating this way a sort of virtuous cycle. That is to say, as the client views him or herself different than before (reconceptualization IMs) the subsequent emergence of action, reflection and protest IMs provides for a further proof that significant changes are in fact taking place, which in turn reinforces the transformation process.

Self-continuity through the contrast

The contrast present in the reconceptualization allows for the rupture (Zittoun, 2007) between a past self and a new self to be solved, creating a sense of self-continuity. The self is the same, although different, and the person knows that a transition has occurred and why it has occurred. Take the following example of Jan's Case (previously described) who revealed "an unmet need for approval from her mother. Jan still longed to be the 'good little girl' who always did right by her parents...." (Goldman & Greenberg, 1997, p. 423):

Session 13

C: I think I'm learning how to deal with my mother one-on-one adult level not as her little daughter (…) which I think has helped me an awful lot. *I went by my parents' house last week to ask my mother and she was telling me she doesn't feel well, so I said okay mom, I said, what would you like me to do, whereas before I'd tried to, you know, how- how- what I used to try to do, like, try to talk to her, try to console her, try to make her feel better, or you know or whatever* [Contrast between the self in past with the self in the present], like right now I just left it up to her, like she doesn't feel well, okay, what do you want me to do, like you- you say it

T: kind of what do you want from me?

C: yes, you know, what can I do about it, like I'm not a doctor, I'm not a magician, what can I do?

T: mm-hm, and that's different from

C: as before, I tried to sort of solve her problems (…) like I'm her keeper and ah I'm responsible for how she feels. Well, I'm not, I can't be!

T: mm-hm, that's- that's quite a move, eh, for you?

C: yeah (laughs) it is, and I didn't feel guilty about it afterwards, like I didn't feel like, you know, oh, you shouldn't be talking to your mother that way, you know, that's something, you've hurt her feelings, or whatever, um, so now it's going to make things worse and she's going to take it out, you know, she's going to be annoyed and she's going to make, you know, take it out on my dad, because I think a lot of that was my motivation, is like, trying to do anything she wanted of me to keep her happy so she didn't take out her anger on my father

T: so was- that was your job

C: that was my role in the family

C: that's right, but now *I realized that no matter what I do she's still going to be the way she is with my father and he's going to have to deal with her - it's not my job to protect him (...) I realize like, I can't do it, it's not my job and I think I'm not I'm not capable of doing it* [[Process of change - Jan legitimates her need of giving up on her role in the family]

In this example reconceptualization allowed to bridge the past problematic self ("I tried to sort of solve her problems") with the present emerging self ("I'm not a doctor, I'm not a magician, what can I do?"). In the absence of reconceptualization there would be a kind of an identity *jump*, in which a position which formerly dominated the self would be substituted by another one. Clinicians know well that, when a jump like this occurs in the therapeutic conversation, the "natural" move is to try to explore what

happened that facilitated the transition. Curiously, this often prompts the emergence of a reconceptualization IM because, through the interaction with the therapist, the process that facilitates the "jump" between the problematic self-narrative and the emergent one is discovered. This is also associated with the unifying function of meta-positions as described by Hermans and Konopka (2010). That is, the meta-position present in reconceptualization creates a connection between the past and the present self that is meaningful for the client ("I realized that no matter what I do she's still going to be the way she is with my father and he's going to have to deal with her").

Thus, reconceptualization can be conceived as a meaning bridge (Brinegar et al., 2006; Osatuke et al., 2004) between the past and the new emergent self, advancing the development of new ways of being, feeling, and thinking. A meaning bridge is a sign which has a similar meaning for two or more positions, which facilitates the assimilation between different positions of the self. In the case of reconceptualization, the meaning bridge connects the familiar past with the unknown future, making the future predictable, as it has now some contours defining it. Thus, reconceptualization allows escaping self -fragmentation and facilitates the development of the new, emergent self.

Progressive identification with the newer self-narrative

One interesting finding is the repetition throughout the treatment of reconceptualization IMs, turning them into one of the most elaborated forms of innovation after the middle of the therapeutic process. Why does reconceptualization keep repeating itself? It is our proposal that the meta-position involved in reconceptualization does not involve a mere self-observation of the client's internal processes, but necessarily entails a performance of agency and compromise. By narrating reconceptualizations the person is always demonstrating to him or herself that he or she is changing and what its possible direction is. Moreover, the client is narrating this to an external other: the therapist. The therapist is an involved partner who facilitates the exploration and elaboration of novelties. Thus, the repetition of reconceptualization IMs, having the therapist as interlocutor, is certainly an important form of consolidating the therapeutic change.

Thus, we are suggesting, as Wortham (2001), that the self involves two interrelated processes: the content being narrated and the act of narration. Wortham suggests that an alignment between these two components (the content and the narration act) could be a very powerful way to create a particular view of the self:

"While telling their stories, auto-biographical narrations often enact a characteristic type of self, and to such performance they become that type of self" (p. XII).

Notice that if the only things that mattered were the content of the self-narrative, only one reconceptualization would be enough for change to occur, and in this case it would be a kind of retrospective account of the change process. The occurrence of repetitions and the way reconceptualizations are co-constructed between client and therapist in the therapy process leads us to believe that these narrative products are more than retrospective accounts, as they play an active role in the change process. They are not an epiphenomenon of change, they are active elements shaping its construction.

The process of repetition allows the person to experiment the change before it becomes familiar. It is a way of calibrating the movement the self is involved in, as one position of the self shows the rest of the self how is the person's present functioning, what is accepted and what is rejected, as illustrated in the following example of Jan's case:

Session 12

C: I'm feeling sort of sad saying goodbye to the daughter that they thought they had 'cause I don't want to be like that anymore I don't want to be the good daughter anymore, I want to be me and I want to go on from here in a new relationship [Contrast between the self in the past and the self in the present - an innovative position of the self shows the rest of the self how is the person's present functioning, what is accepted and what is rejected]it's been a very difficult life trying to living up to, ah, what everybody else thought of me and I guess it's made me very sad that I can't - I wasn't myself [Process of change – Jan realizes that acting as perfect daughter was impeding her of being herself]

T: What's that it feels like, to say that's what you weren't yourself?

C: It's like a burden being lifted off my head

T: felt sad to think or feel you really weren't yourself, you weren't allowed to be - you

C: no, I was acting out as this perfect daughter that they think that they have and I'm not a very good actress and I think I was believing that's who I was.

Cunha, Gonçalves, and Valsiner (in press) explored how the repetition of reconceptualization operates as a form of consolidating a progressive identification with a new self-narrative, simultaneously facilitating the disengagement with the old one. They described a case-study in which, even after the emergence of reconceptualization IMs, a back and forth movement between the old and the new self-narrative kept on going, suggesting the need that the person has to slowly accommodate the changing process.

We also developed a study which explored how IMs emerge in solving life difficulties with a sample of adults without psychopathology (Meira, Gonçalves, Salgado, & Cunha, 2009). Similarly to the kind of design developed in psychotherapy

studies, we split the sample in two groups: one equivalent to the good outcome cases and another one equivalent to the poor outcome group. These groups were constructed from self-reports of the subjective change from the point of view of the participants. One interesting finding from this study was that reconceptualization emerged mainly in the group with successful changes, but only in the final session. The group without significant change has virtually none reconceptualization IMs. What seems interesting here is that, contrarily to psychotherapy, in which reconceptualization IMs emerge from the middle of the treatment on, in this particular sample reconceptualization discriminates successful from unsuccessful change cases, but these IMs only emerge in the last session. It is important to note that these reconceptualization IMs emerge after a clear invitation of the interviewer, when she asked the participants to reflect on the change process. However, people from the unsuccessful group were not able to elicit reconceptualization IMs, not even when prompted by the interviewer.

One way to interpret these differences, between therapeutic samples and daily life change, is that the therapist is a much more involved partner than a research interviewer, or even a significant other that witnesses the change process, inviting more actively the elaboration of reconceptualizations. Only when clearly invited by the interviewer, as in the last session of the project, participants who meaningfully changed elicited reconceptualization IMs. It is very likely that if those IMs were prompted before by the interviewer they would have emerged, as it happens in psychotherapy.

This function is similar to what Hermans and Konopka (2010) refer to as the executive function of the meta-positions. We have also described this function (Gonçalves, Matos, & Santos, 2009), from a narrative perspective, as an authoring position, from which the change process is elaborated and expanded. The meta-position over the change process allows for the person to create his or her own development and change. Change is not something that happens to the person, the client is an active agent creating it, assigning its meaning, and shaping the contours of the present and the future self-narrative.

Resolution of ambivalence over the change process

Change is not linear, as people have several different and even contradictory voices in their selves. As Arkovitz and Engle (2007) emphasize, clients are often ambivalent towards the change process, which is frequently interpreted by the clinicians as resistance to change.

Our research program explores ambivalence from a dialogical perspective, using the concept of mutual in-feeding as proposed by Valsiner (2002, see also Gonçalves, Matos, & Santos, 2009). Mutual in-feeding is a dialogical process in which two opposing voices keep asserting its position by rejecting the other, as in:

Voice A: Life is good

Voice B: Life is bad (Valsiner, 2002, p. 257).

This process, although dynamic, contributes to the stability of the self, as each voice dominates the self intermittently. As Gonçalves and Ribeiro (in press) have stated:

"This alternation between two opposite positions is more monological (at least as an outcome) than dialogical. This relates to a proposal from Hermans and Konopka (2010) about the nature of "good dialogue". Also, from their point of view the presence of two or more positions (internal and/or external) does not guarantee that dialogue will occur. One of the features of good dialogue is the production of some form of innovation, in which each participant takes the other into consideration and is open to change their own perspective in response to the other. This is exactly what is absent when mutual in-feeding is not resolved." (p. XX).

We have been studying the process of mutual in-feeding in therapy through the identification, in the sessions, of return to problem markers. These are discursive indicators of a return to the problem (that is, the problematic self-narrative), after the emergence of an IM, like in:

"I really wish to go out and cope with my depression, but I just can't".

In this sentence a reflection IM emerges ("I really wish to go out and cope with my depression"), but, as it emerges, its potential for change is aborted by an emphasis on the problematic self-narrative. There is now empirical evidence showing that these occurrences are more common in poor than in good outcome cases (Gonçalves et al., in press).

The process of mutual in-feeding, as it is empirically observed through markers of return to the problem, is, in a sense, the opposite of reconceptualization. In both processes we have two positions, but in the mutual in-feeding there is an alternation between both. In reconceptualization not only is one of the positions advanced and the other relegated to the past, but the client is clearly involved in the process of advancing the emergent self-narrative. The process of mutual in-feeding is devoid of any executive control (Hermans & Konopka, 2010) and the person is a powerless actor of the alternation of voices, while in the reconceptualization the person is an active author of it, as we emphasized before.

Curiously, we have also been studying how mutual in-feeding is solved in therapy (see Gonçalves & Ribeiro, in press) and all resolutions seem to involve reconceptualization IMs. Until now we have identified two processes that allow for mutual in-feeding's resolution (Gonçalves & Ribeiro, in press). In the first one, the non-dominant voice, present in the IM, takes over the formerly dominant voice, present in the problematic self-narrative, and becomes a dominant position in the self. Let us look at the following example of Sarah's case (Honos-Webb, Stiles & Greenberg, 2003; see

also Cunha, Gonçalves, Valsiner, Mendes, & Ribeiro, in press), a client who was excessively reliant on the approval of others, dismissing her own desires and needs in benefit of others'. In the beginning of therapy, whenever she followed her own feelings and intuitions, that is, as IMs (non-dominant voice) emerge, she frequently found herself consumed afterwards with doubts and guilt, and also afraid of not being appreciated by other people (dominant voice), returning to the problematic self-narrative. Mutual in-feeding decreased along therapy as the non-dominant voice became stronger, taking over the formerly dominant one, as it occurs in the following example.

Session 10

C: I'm making sure, like for myself, that what I do like if it suits me that's okay and that I don't have to live up to anybody's expectations (…) like to I don't know do whatever about it if I decide to go for a change or that I need a change or whatever, and just like none of that trying to please people I'm sick of it [Contrast between the self in the past and the self in the present].T: so, yeah, like I don't have to be something that I'm not, just to please other people and I guess that's where I feel the sense of who I am is okay (…) it's okay to not please other people. There's also the sense of it's enough to be me.

C: It's definitely, yeah, being less dependent on other people, even so I guess it's kind of always nice when you get some kind of acknowledgement or acceptance but I also make really consciously an effort like to try, like looking at myself and what I do and get like satisfaction out of that and say yeah like I did this well and yes I know I can do this and nobody else has to tell me that I'm an alright person [Process of change - the non-dominant voice takes over the formerly dominant one].

In the second form of resolution the two opposed positions present in mutual in-feeding are transformed into the dialogue between both. This is curiously akin to what Hermans and Konopka (2010) call good dialogue. The positions are not just reacting to each other, asserting its primacy when the other emerges; they are now involved into a negotiating process, listening to each other and transforming themselves in this dialogue, as it occurred in Jan's case. In the beginning of therapy, whenever she expressed feelings of dependency and weakness (non-dominant voice), i.e., experienced IMs, she frequently restated the need of being strong and independent (dominant voice), returning to the problematic self-narrative. Mutual in-feeding decreased along therapy, as the non-dominant and formerly dominant voices engaged in dialogue and joint action. Let us look at the following example, from Jan's case:

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C: It was almost like I could sort of step back and look at myself [during a two-chair dialogue] as two different people [referring to the non-dominant voice and the

dominant one] and I think these two people are in conflict all the time (…) *the strong part of me - if anybody offers help, no, no, it's okay, I can handle things on my own, I can do things on my own, and then there's the other part of me that - feels that always has to give in whether it's because ... to be liked or ... you know, not to make confrontation or whatever ... must have a split personality* [Contrast between the self in the past and the self in the present]

T: so they're always kind of going in opposite directions?

C: *a nice medium ground would be acceptable* [Process of change - opportunity of dialogue between the non-dominant voice and the dominant one] (…) well, there's got to be a happy medium where you can be strong at times and you also be, you know, weak and be, you know (…) looked after and be feminine or the stereotype of what feminine is supposed to be like

T: so you can be a big girl and a little girl at the same time?

C: *by me giving in and being a little girl does not mean that I'm giving up something ...why can't it be the two of them working hand-in-hand* [Process of change - non-dominant voice and the dominant one engaged in joint action]

We have argued (Gonçalves & Ribeiro, in press) that the second resolution seems more elegant, and perhaps more dialogical than the first, but we also speculated that in more disturbing clinical situations the first resolution may be important, at least at the beginning of the change process.

In sum, not only is mutual in-feeding typical of poor outcome cases and reconceptualization typical of good outcome cases, and from a dialogical perspective they seem to be the opposite of each other, but mutual in-feeding is also solved through the elaboration of reconceptualization IMs.

Concluding remarks

In this article we have elaborated upon four interrelated functions of reconceptualization that make it a fundamental innovation in the process of change. Reconceptualization allows for the elaboration of the changing process, providing for an integrated account of change; facilitates the articulation between the past and the emergent self, allowing for a rupture to be solved; the new self is advanced and experienced through the repetition of the reconceptualizations; and finally, it allows (probably because of the three preceding functions) to solve situations of ambivalence toward change.

We have developed, so far, several empirical studies on the last function (e.g., Gonçalves et al., in press), but further research is needed for grounding these theoretical speculations empirically through the study of clinical samples and cases studies. So far,

our data clearly shows that ambivalence is always resolved through the emergence of reconceptualization, regardless of the path through which resolution occurs.

Another interesting question to be studied is the role reconceptualization plays in daily life changes. If the suggestions offered here are correct, how reconceptualization emerges in life transitions outside psychotherapy becomes a central question. We have seen that people who changed their lives are able to produce reconceptualization when invited by the interviewer (Meira et al., 2009), but we have no idea how they are produced and performed in their daily lives. In psychotherapy they are produced and co-constructed with the therapists, so one can speculate that in daily life the audiences which are involved in the construction of reconceptualization must be significant others that somehow are involved witnesses of the change process. We strongly believe that, as reconceptualization are performances of the self, in which the new self is advanced and a bridge between the old and the new self is built, significant others play a pivotal role in this performance, without which no significant change is possible. From our view this is an important consequence of conceiving the self dialogically: without others (internal and external) no change would be possible, and, of course, without change, no self would be viable.

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