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Self-narrative reconstruction in emotion-focused therapy: A preliminary task analysis

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Abstract

Objective: This research explored the consolidation phase of emotion-focused therapy (EFT) for depression and studies—through a task-analysis method—how client–therapist dyads evolved from the exploration of the problem to self-narrative reconstruction. **Method:** Innovative moments (IMs) were used to situate the process of self-narrative reconstruction within sessions, particularly through reconceptualization and performing change IMs. We contrasted the observation of these occurrences with a rational model of self-narrative reconstruction, previously built. **Results:** This study presents the rational model and the revised rational-empirical model of the self-narrative reconstruction task in three EFT dyads, suggesting nine steps necessary for task resolution: (1) Explicit recognition of differences in the present and steps in the path of change; (2) Development of a meta-perspective contrast between present self and past self; (3) Amplification of contrast in the self; (4) A positive appreciation of changes is conveyed; (5) Occurrence of feelings of empowerment, competence, and mastery; (6) Reference to difficulties still present; (7) Emphasis on the loss of centrality of the problem; (8) Perception of change as a gradual, developing process; and (9) Reference to projects, experiences of change, or elaboration of new plans. **Conclusions:** Central aspects of therapist activity in facilitating the client's progression along these nine steps are also elaborated.

Keywords: self-narrative reconstruction; task analysis; innovative moments; narrative change; emotion-focused therapy

A growing number of researchers have highlighted that the elaboration of narrative novelties is an important aspect of change, not only specific to narrative therapy but also in other therapeutic modalities (Angus & Kagan, 2013; Angus & Mcleod, 2004; Angus & Rennie, 1989; Boritz, Angus, Monette, Hollis-Walker, & Warwar, 2011; Gonçalves, Ribeiro, Mendes, Matos, & Santos, 2011; Gonçalves & Stiles, 2011; Mendes et al., 2010; Mendes, Ribeiro, Angus, Greenberg, & Gonçalves, 2011). According to this view, the narrative reconstruction of the self during psychotherapy is achieved through a new sense of agency, authorship, and the integration of recently acquired (emotional, cognitive,

and/or behavioral) changes in a new self-narrative (Adler, Skalina, & McAdams, 2008). However, how this becomes co-constructed in therapy still needs further clarification. With the aim of contributing to this issue, we present a model that displays the necessary steps for achieving the reconstruction of self-narratives in emotion-focused therapy (EFT) for depression, derived from the method of task analysis (Angus & Greenberg, 2011; Greenberg, 2007; Pascual-Leone, Greenberg, & Pascual-Leone, 2009). Task analysis is a specific research strategy to study significant in-session change events in psychotherapy, used to differentiate the necessary steps that clients take to successfully achieve a specific

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change (cf., Greenberg, 2007). This topic is further elaborated below.

Narrative Change in Emotion-Focused Therapy

According to the narrative perspective of psychotherapy, clients seek help when they feel constrained by problematic self-narratives that evidence problems and personal deficits (e.g., Angus & Greenberg, 2011; Angus & Mcleod, 2004; Botella, Herrero, Pacheco, & Corbella, 2004; Gonçalves & Stiles, 2011; Salvatore, Dimaggio, & Semerari, 2004; White & Epston, 1990). Therefore, the elaboration of narrative novelties in psychotherapy has been conceptualized as a powerful tool to break the dominance of problems and facilitate self-transformation (Angus & Kagan, 2013; Angus, Lewin, Bouffard, & Rotondi-Trevisan, 2004; Gonçalves, Matos, & Santos, 2009; Gonçalves & Stiles, 2011; Levitt, Korman, & Angus, 2000; White & Epston, 1990).

More specifically, in EFT the articulation of significant personal events into meaningful stories and the subsequent narrative change (Angus et al., 2004; Greenberg & Angus, 2004) has been linked, for example, with emotion transformation during treatment (Missirlian, Toukmanian, Warwar, & Greenberg, 2005) and changes in autobiographical memory in depression (Boritz, Angus, Monette, & Hollis-Walker, 2008; Boritz et al., 2011). These studies led Angus and Greenberg (2011) to propose

that successful EFT evolves around four phases: (1) Promoting dyadic bonding, narrative unfolding of significant personal experiences and experiential awareness; (2) Supporting emotional evocation/exploration and the articulation of core emotion-schematic memories and themes; (3) Transforming maladaptive into adaptive emotions and developing new story outcomes; and, finally, (4) Facilitating the consolidation of changes and self-narrative reconstruction. In this study, we focus on this last phase of EFT, specifically on the task of self-narrative reconstruction.

The Innovative Moments Coding System and the Role of Reconceptualization IMs in Self-narrative Reconstruction

Within the narrative approach to psychotherapy, a recent research program has studied how problematic self-narratives are transformed during successful psychotherapy by the elaboration of IMs (Gonçalves et al., 2011). The concept of *innovative moments* (IMs) refers to different kinds of novelties, new experiences, actions, and thoughts that emerge in the therapeutic conversation and contrast with the problematic self-narratives (initially presented by the client). Five types of IMs have been observed and reliably identified with the Innovative Moments Coding System (IMCS): action, reflection, protest, reconceptualization, and performing change (cf., Gonçalves et al., 2011). The several IMs are

Table I. The Innovative Moments Coding System.

Types of IMs

Action IMs

Action IMs refer to events or episodes when the person acted in a way that is contrary to the problematic self-narrative

Reflection IMs

Reflection IMs refer to new understandings or thoughts that undermine the dominance of the problematic self-narrative. They can involve a cognitive challenge to the problem or cultural norms and practices that sustain it or new insights and understandings about the problem or problem supporters. These IMs frequently can also assume the form of new perspectives or insights upon the self while relating to the problem, which contradict the problematic self-narrative

Protest IMs

Protest IMs involve moments of critique, confrontation or antagonism toward the problem and its specifications and implications or people that support it. They can be directed at others or at the self. Oppositions of this sort can either take the form of actions (achieved or planned), thoughts, or emotions, but necessarily imply an active form of resistance, repositioning the client in a more proactive confrontation to the problem (which does not happen in the previous action and reflection IMs). Thus, this type of IMs entails two positions in the self: one that supports the problematic self-narrative and another that challenges it. These IMs are coded when the second position acquires more power than the first

Reconceptualization IMs

Reconceptualization IMs always involve two dimensions: (a) a description of the shift between two positions (past and present) and (b) the transformation process that underlies this shift. In this type of IMs there is the recognition of a contrast between the past and the present in terms of change, and also the ability to describe the processes that lead to that transformation. In other words, not only is the client capable of noticing something new, but also capable of recognizing oneself as different when compared to the past due to a transformation process that happened in between

Performing change IMs

Performing change IMs refer to new aims, projects, activities, or experiences (anticipated or already acted) that become possible because of the acquired changes. Clients may apply new abilities and resources to daily life or retrieve old plans or intentions postponed due to the dominance of the problem

Source: Adapted from Gonçalves, Mendes, Ribeiro, Angus, and Greenberg (2010).

described in Table I. In the current study we will focus our attention on the more developed IMs, which are associated with self-narrative reconstruction, particularly reconceptualization IMs (more on this below).

Previous research has shown that significantly more IMs occur in recovered than unchanged cases, particularly reconceptualization IMs, which clearly distinguish recovered from unchanged cases, after the middle of the treatment. This finding was replicated across several samples (narrative therapy—Matos, Santos, Gonçalves, & Martins, 2009; EFT—Mendes et al., 2010; client-centered therapy—Gonçalves et al., 2012; constructivist therapy—Alves, Mendes, Neimeyer, & Gonçalves, 2012). *Reconceptualization IMs* have two main features that probably make them central in psychotherapeutic change: a contrast and a meta-perspective over that contrast (Gonçalves & Ribeiro, 2012). In a reconceptualization IM, clients recognize and describe a contrast between a past, problematic version of oneself, and an emerging, adaptive one, and describe the processes that according to them were involved in this change (i.e., meta-perspective). Below is an example from the EFT case of Lisa, drawn from Gonçalves et al. (2010, p. 285):

Lisa: Yeah, yeah get back into my feelings, yeah, and that's, I guess, because the awareness I know is there now, 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, like that I think of me and myself.

Therapist: Yeah, really finding your feet.

Lisa: Mm-hm, as an individual yeah, which before I... I thought I was glued to him (laugh). Yeah, I didn't have an existence and now I do, and that's a good feeling.

After the emergence of reconceptualization IMs in the middle phase of recovered cases, performing change IMs start to appear, thereby extending changes into the future. The subsequent repetitive occurrence of reconceptualization IMs (or reconceptualization and performing change IMs) suggest a consolidation of changes, allowing self-narrative reconstruction in psychotherapy (Gonçalves et al., 2009; Gonçalves et al., 2012). Thus, in this study the emergence of these more developed IMs will be used as markers of self-narrative reconstruction.

However, previous intensive analyses of reconceptualization IMs from the middle and from the final phases of therapy have suggested that a qualitatively different level of self-narrative integration happens over the course of therapy, a process which is probably connected with a consolidation of overall client changes (cf., Cunha, Gonçalves, & Valsiner, 2011;

Cunha, Gonçalves, Valsiner, Mendes, & Ribeiro, 2012). The Assimilation of Problematic Experiences Scale (APES) derived from the assimilation model created by Stiles (1999, 2001) is a developmental model of psychotherapy that could be useful to analyze the differential narrative integration of reconceptualization IMs along psychotherapy. This scale focuses on how clients relate to problematic experiences, describing a progressive assimilation of difficult or painful experiences during the evolution of successful psychotherapy (Stiles, 1999, 2001). The stages of the APES are developmental and organized in a sequence that begins with the dissociation of the problematic experiences (i.e., level 0—Warded off/dissociated) and ends when these are properly integrated in the self (i.e., level 7—Integration/mastery). According to Stiles (1999, 2001), any shift from lower to higher levels of assimilation is considered therapeutic progress.

Given that the APES and the IMCS have previously been considered complementary measures of the change process by their main proponents—Gonçalves and Stiles (see Gonçalves et al., 2014)—we suggest that the APES can be used as a tool to differentiate reconceptualization IMs, distinguishing them in terms of their productivity.

Arguments for a Task Analysis of Self-narrative Reconstruction in EFT

The task analysis of significant in-session change events, a method pioneered by Greenberg (1984, 2007) and refined with several colleagues (Greenberg & Foester, 1996; Pascual-Leone et al., 2009) has been an important method to study significant change processes and key moments in psychotherapy. Task analysis is usually applied within a research program requiring a series of different studies to discover and validate the processes that occur in the resolution of specific cognitive-affective problems, events, or experiences in psychotherapy (designated as tasks; cf., Greenberg, 1984, 2007; Pascual-Leone et al., 2009). Combining qualitative and quantitative methods, its application to the study of significant change events has helped to highlight client change processes involved in the successful resolution of several therapeutic tasks, such as unfinished business (Greenberg & Safran, 1987), creation of meaning (Clarke, 1989, 1996) and emotional processing events in EFT (Pascual-Leone & Greenberg, 2007). Furthermore, task analysis has also helped to differentiate productive client-therapist dyadic activity for the resolution of in-session ruptures in the therapeutic alliance during cognitive-behavior therapy (Aspland, Llewelyn, Hardy, Barkham, & Stiles, 2008; Cash, Hardy, Kellet, & Parry, 2014),

integrative psychotherapy (Safran & Muran, 1996) and also alliance-threatening transference enactments in cognitive-analytic therapy (Bennett, Parry, & Ryle, 2006).

According to Greenberg (2007), task analysis looks at significant in-session change events (i.e., in-session episodes), where participants achieve a high level of resolution, and directs the analysis to the differentiation of stages accomplished during the moment-by-moment unfolding of that change process across participants (i.e., steps to achieve task resolution of those in-session episodes). For this, task analysis involves a discovery phase (also known as preliminary task analysis) and a validation phase (see also Aspland et al., 2008; Greenberg, 1984, 2007; Pascual-Leone et al., 2009).

The discovery phase involves two main landmarks, achieved through systematic analytic steps: (i) the construction of a rational model, and (ii) the establishment of a rational-empirical model (i.e., both theoretical and empirical) of the change process. To achieve these landmarks, researchers primarily define the specific therapeutic task to be investigated, along with its in-session markers, being explicit about the assumptions and expectations involved in ideal task resolution. This allows, subsequently, portraying a rational model of the task that is, then, combined with the analysis of clinical examples (i.e., three “good performances” and three “poor performances” of the task). The rational model answers the researchers’ views on the question: *How do I think clients resolve this particular task?* and also acts as a baseline toward the next step: the empirical analysis. The *empirical task analysis* involves contrasting the rational model (i.e., an abstract model) with the analysis of actual performances, in order to synthesize a rational-empirical model (i.e., based on real in-session events). Each actual performance may lead to the refinement of the model through deletion, alteration, and addition of essential steps, until *saturation* is reached. This is considered the core of the discovery phase of task analysis (Greenberg, 2007). The model is then synthesized through a flow diagram, exhibiting the essential steps/components necessary for successful task completion. This rational-empirical model concludes the empirical task-analysis and the preliminary discovery phase of task analysis (it also corresponds to the procedures and findings presented below).

The next stage of task analysis is the validation phase and it is concerned with generalizability issues and the testing of hypothesis raised by the rational-empirical model (it will not be elaborated here as this is not the purpose of this study; cf., Greenberg, 2007; Pascual-Leone et al., 2009).

The Present Study

The present study aims to contribute to the understanding of self-narrative reconstruction as a specific task to be accomplished in the latter phases of EFT for depression (cf., Angus & Greenberg, 2011), through presenting the findings derived from a discovery phase of task analysis. According to several intensive case studies and a recent qualitative analysis of post-therapy change interviews (Angus & Greenberg, 2011), the process of self-narrative reconstruction occurs at a final phase of EFT, being important for the transformation of emotions and for identity reconstruction (Angus & Greenberg, 2011). However, up until now, the literature on EFT has not specified the necessary steps for this process across several case studies.

The process of self-narrative reconstruction will be operationalized here in its relation with reconceptualization IMs, given the previous studies conducted with the IMCS (revised above). That is, we equate the process of self-narrative reconstruction with the consolidation of reconceptualization IMs in psychotherapy—i.e., the emergence of several reconceptualization IMs within a same theme in the therapeutic conversation (or, alternatively, the emergence of performing change IMs after reconceptualization IMs). However, we have to look for productive reconceptualization IMs (i.e., achieving higher stages in the APES) to select in-session episodes with higher level of resolution, according to the methodological requirements of task analysis (Greenberg, 2007; Pascual-Leone et al., 2009; more details below).

Our goal here is to detail the necessary steps to successfully achieve a self-narrative reconstruction in EFT, by presenting a preliminary (rational-empirical) model of client process and therapist activity. We consider this process as a dyadic achievement since it refers to a change in the client’s internal organization of the self that is facilitated through the therapeutic conversation. We hope to contribute to the understanding of this task by providing a moment-by-moment description of this particular client process and specific guidelines to help therapists facilitate it. By departing from archival data from previous studies (e.g., Mendes et al., 2010, 2011), this study will focus on the in-session process of client self-narrative reconstruction and address the following questions: (1) How do client and therapist depart from the exploration of a problem and its evolution and arrive at the self-narrative reconstruction of the client? (2) Which steps can EFT therapists take to facilitate this process? (3) What distinguishes resolved from unresolved episodes?

Table II. Distribution of successfully resolved episodes in the recovered EFT cases and sessions from which they were extracted.

Recovered EFT cases and length of treatment	Number of successfully resolved episodes identified	Sessions and number of episodes selected
Lisa (15 sessions)	3	Session 11 ($n = 1$); 15 ($n = 2$)
Jan (16 sessions)	6	Session 14 ($n = 2$); 15 ($n = 2$); 16 ($n = 2$)
Sarah (18 sessions)	9	Session 10 ($n = 1$); 16 ($n = 2$); 17 ($n = 2$); 18 ($n = 4$)

Method

Participants

Clients. The three cases used were drawn from the EFT condition of the York I depression study (Greenberg & Watson, 1998), where each client was randomly assigned to EFT or client-centered therapy (CCT) (15–20 weekly sessions). This sample includes three recovered cases, transcribed to allow for intensive qualitative studies (e.g., Gonçalves et al., 2011; Greenberg & Angus, 1995; Honos-Webb, Stiles, & Greenberg, 2003; Honos-Webb, Surko, Stiles, & Greenberg, 1999; Mendes et al., 2010, 2011). All clients (three females; two married, one divorced; all Caucasian) were clinically depressed (according to diagnostic criteria of the DSM-III-R) and completed an average of 16.33 sessions ($SD = 1.53$) of EFT. Their ages ranged from 27 to 48 years old ($M = 36.33$, $SD = 10.69$). The clients analyzed in the present study (cf., Table II, Procedures and Results section) are all recovered clients, known in the psychotherapy literature by their fictional names of Sarah, Lisa, and Jan (they have been intensively studied elsewhere; cf., Angus, Goldman, & Mergenthaler, 2008; Brinegar, Salvi, & Stiles, 2008; Cunha, Gonçalves, Hill, et al., 2012; Gonçalves et al., 2010; Honos-Webb et al., 1999, 2003; Mendes et al., 2010, 2011).

Outcome was classified based on a reliable change index (RCI) analysis (Jacobson & Truax, 1991) analysis of pre to post-treatment scores on the Beck Depression Inventory (BDI—Beck, Steer, & Garbin, 1988; Beck, Ward, Mendelson, Mock, & Erbaugh, 1961). This analysis of BDI scores classified these clients as having met the criteria for recovery (i.e., passed both a BDI cut-off score of 11.08 and RCI criteria) at treatment termination (according to Lambert & Ogles, 2004; McGlinchey, Atkins, & Jacobson, 2002). The average BDI scores of these recovered cases decreased from 30.00 ($SD = 5.00$) in pre-treatment to 4.00 ($SD = 1.00$) in post-treatment.

Further details on the specific scores of these clients can be found in Mendes et al. (2011).

Therapists. These three cases involved three therapists (all female) with diverse levels of education (from advanced doctoral students to Ph.D. level clinical psychologists). All participated in a 24-week training in EFT using the manual for the York I depression study (Greenberg, Rice, & Elliott, 1993). This training included eight weeks for CCT, six weeks for systematic evocative unfolding, six weeks for two-chair dialogue, and four weeks for empty-chair dialogue training.

Researchers. This study involved three researchers that worked on qualitative data analysis (two Ph.D. female students with training in EFT; and a MA female student) and a senior researcher acting as an auditor (Ph.D. male researcher). All researchers were Portuguese (English speakers as a second language), familiarized with the EFT cases through reading transcripts. Two judges (Ph.D. students) had previously coded the six cases with the IMCS (in Mendes et al., 2010) and two other judges (a Ph.D. student and an MA student) coded the same cases using the APES (Cunha et al., 2016).

Treatment

EFT intends to facilitate the client's process of experiencing and exploration of core organismic needs, leading to the transformation of maladaptive emotions into more adaptive ones (Greenberg, 2006; Greenberg et al., 1993; Greenberg & Watson, 2005). This is accomplished by the integration of the client-centered relationship stance (congruence, unconditional positive regard and empathic attunement with the client) with process directive interventions, derived from other experiential therapies (e.g., Gestalt—Perls, Herline, & Goodman, 1951; and Focusing—Gendlin, 1981). This means that the EFT therapist balances between following the client (through the client-centered relationship stance) and leading the client (guiding the client's attention to further processing of emotional experience in the here-and-now through "active empathy"; Greenberg, 2006). Therapist guidance is particularly visible after the detection of certain process markers in the client (such as problematic reactions, self-critical splits, unfinished business) that lead to specific therapeutic tasks (such as two-chair work or empty-chair work, among others; Elliott, Watson, Goldman, & Greenberg, 2004; Greenberg, 2006; Greenberg et al., 1993; Greenberg & Watson, 2005).

Measures

Innovative Moments Coding System. This coding system presents five mutually exclusive categories of IMs—action, reflection, protest, reconceptualization and performing change—coded from transcripts or videos of therapy sessions (cf., Gonçalves et al., 2011—Table I). This system uses IMs' proportion as a measure (calculated as the percentage of words in transcripts). Previous studies presented strong inter-judge agreement on the coding of IMs (according to Hill & Lambert, 2004; cf., Gonçalves et al., 2012; Matos et al., 2009). Mendes et al. (2010) coded previously the present sample of EFT cases, achieving 89% agreement for proportion of IMs and an average kappa of .89 for IM types, between the two judges involved in the independent coding.

Assimilation of Problematic Experiences Scale. The APES describes a progression of eight qualitatively distinct stages in the assimilation of problematic experiences during psychotherapy (Stiles, 1999, 2001). Each stage has specific cognitive and affective features describing how clients relate to problematic experiences. The eight stages are organized in the following sequence: (0) Warded off/dissociated; (1) Unwanted thoughts/active avoidance; (2) Vague awareness/emergence; (3) Problem statement/clarification; (4) Understanding/insight; (5) Application/working through; (6) Resourcefulness/problem solution; and (7) Integration/mastery. Any shift from lower levels to higher levels of assimilation is considered therapeutic progress (Osatuke et al., 2011; Stiles, 2001; for further details on the APES and the assimilation model, see Stiles, 1999, 2001). The coding of the APES, according to previous studies, can either be carried out by consensual coding (cf., Honos-Webb et al., 1999, 2003) or independent coding (cf., Caro-Gabalda, 2008). For the present study, the segments were consensually coded with the APES by two judges, who consulted with a more experienced auditor (following Honos-Webb et al., 1999, 2003—see Procedures section below).

Procedures

The procedures adopted in the present study are on archival data and involved three main phases: Phase 1 was carried out by Mendes et al. (2010, focusing on a sample of six EFT cases: the three recovered cases analyzed here, plus other three unchanged EFT cases). Phase 2 was carried out by Cunha et al. (2016, focusing on the same sample of EFT cases analyzed by Mendes et al., 2010); and Phase 3 was carried out specifically for the present task-analytic

study (this stage of the analysis focused only on the three recovered cases mentioned above, due to the selection criteria explained below).

Phase 1: coding of IMs. All the sessions were coded for IMs using the IMCS in a previous study (cf., Mendes et al., 2010). For that study, two researchers (Ph.D. students in clinical psychology) coded all sessions of six cases selected from the EFT treatment condition in the York 1 Depression study (Greenberg & Watson, 1998): three recovered cases (focused in the present task-analysis with the fictional names of Sarah, Lisa, and Jan, described above), plus other three unchanged cases (not analyzed here). During this study, the judges were unaware of outcome status for each case and achieved a strong reliability in the independent coding of IMs (see above; cf., Mendes et al., 2010).

Phase 2: coding of reconceptualization IMs with the APES. Later on, another study conducted an assimilation analysis of all reconceptualization IMs identified by Mendes et al. (2010) in her sample of six EFT cases (cf., Cunha et al., 2016). This study adopted the procedures of assimilation analysis drawn from Caro-Gabalda (2008) and Honos-Webb et al. (1999, 2003). This involved three steps: *familiarization*, *cataloguing*, and *analysis of excerpts* with the APES. Two judges were involved in this analysis (one Ph.D. student and one MA student in clinical psychology), being one of them unaware of the outcome status of the cases (i.e., the MA student). During the *familiarization* stage (step 1), both judges read the transcripts and met to discuss and arrive at the client's presenting problems, necessary for the following assimilation analysis. In the *cataloguing* stage (step 2), all sessions with reconceptualization IMs were selected for further analysis and then judges identified conversation themes—i.e., the problematic experiences in focus (under the assimilation model terminology; cf., Caro-Gabalda & Stiles, 2012), and where these began and ended in the session. Finally, the judges conducted the *analysis of excerpts* (step 3) according to the APES, assigning one of its stages to each reconceptualization IM. These coding procedures (steps 2 and 3) followed the parameters of *consensual qualitative research* (Hill et al., 2005, adapted to assimilation research). That is, segments were coded by the judges and then judges met to discuss the APES codings attributed to reconceptualization IMs, expressing and justifying their views and arriving at consensus judgments.

This study by Cunha et al. (2016) analyzed 108 reconceptualization IMs appearing in this sample of six cases and showed that the majority of reconceptualization IMs appeared in the three recovered

cases (93.5%; $n = 101$; cf., also findings from Mendes et al., 2010). Reconceptualization IMs exhibited an increasing pattern of assimilation across the different phases of the recovered EFT cases: in the initial phase, the mean APES level of reconceptualization IMs was 3.0; in the middle phase, the mean APES level was 4.35; and, in the final phase of EFT, the mean APES level was 5.58. Furthermore, in the three unchanged cases, only seven reconceptualization IMs appeared (with a median APES of 2.86).

Given these results, the APES was used here as an external validity measure (Campbell, 1986; Greenberg, 2007) for subsequent analytic procedures, described on phase 3. That is, the APES was used as a measure to triangulate the development of reconceptualization IMs (given that the assimilation model is a developmental model of change, independent of IMs). We argue that the articulation of the two systems here is useful for purposes of convergent validity (Campbell, 1986; Greenberg, 2007). Thus, the APES was used to select which units of analysis (session segments) would be subject to the task-analysis procedures presented below (more on this below). Therefore, only the three recovered cases (from the sample of six cases analyzed by Mendes et al., 2010 and Cunha et al., 2016) were selected for further analysis (phase 3).

Phase 3: steps of the task analysis. According to Greenberg (1984, 2007; see also Pascual-Leone et al., 2009), the method of task analysis involves two sequential phases: the discovery-oriented phase and the validation phase. We will elaborate here only the first phase since validation is not the focus of this article. In the first phase (discovery-oriented), researchers need to carry out six systematic analytic steps (Greenberg, 2007; Pascual-Leone et al., 2009): (1) Specify the therapeutic task (i.e., its beginning and end points) and its in-session markers; (2) State the researcher's assumptions and expectations involved in ideal resolution; (3) Define task context/environment; (4) Depict a rational model of the task—i.e., *Rational analysis*; (5) Contrast the rational model with the analysis of actual performances—i.e., *Empirical task analysis*; and (6) Synthesize the rational-empirical model (i.e., refine the model through deletion, alteration, and addition of essential steps, every time a new client–therapist performance is analyzed). Below we specify these steps conducted for this study.

Specify the therapeutic task and its markers. We assumed that the task begins with the exploration of the problem and its evolution in the session (beginning point). Task initiation includes the following three criteria (all three required):

- (a) Recent recollections of the problem (e.g., autobiographical memories of significant, painful events that emerged during the week; experiences related to the problems that led clients to seek help, such as procrastination during the last days);
- (b) References to emotions activated by those experiences (e.g., negative humor, feeling weighed down, disappointment, anger, guilt);
- (c) References to personal efforts carried out to contradict problematic experiences (e.g., attempts to be more assertive, introducing small changes to contradict negative habits).

The *successful* end markers of the task are expressions of a changed view of the self, organized in a new self-narrative (end point). The following criteria for *successful resolution* of the self-narrative reconstruction task were established:

- (i) During the dyadic exploration of a problematic theme, a reconceptualization IM with high levels of assimilation ($APES \geq 6$) emerges;
- (ii) Within that same theme, reconceptualization is consolidated—that is, after the first reconceptualization IM, another reconceptualization IM appears or, alternatively, a performing change IM appears.

If both these requisites are met, the episode is considered successful (i.e., a resolved episode) and selected for posterior task-analytic steps. We stress here that the unit of analysis—the task-analytic episode—encompasses the complete theme in that session, not only the reconceptualization IMs (reconceptualization IMs are used as criteria for task resolution, as explained before). Congruently, if a reconceptualization IM does not emerge within a given conversational theme, this was considered *unsuccessful* task resolution (i.e., an unresolved episode) (according to Greenberg, 2007, two unresolved episodes are needed subsequently to allow for comparisons and contrast during the empirical task analysis procedures; here, we used three to establish contrast, see below).

State the researcher's assumptions and expectations. Taking into account the findings from previous studies using the IMCS, the personal training of researchers and their research experience in experiential and narrative therapies, we endorsed the assumption that self-narrative change is a product of co-construction that entails both client and therapist processes: that is, EFT therapists act as empathic facilitators, attuned to and guiding client process and amplifying client changes. Therefore, we decided to focus on the client–therapist dyad in the EFT treatment of depression to put the activity of both interlocutors in focus. Generally,

most task-analysis models developed by Greenberg and colleagues focus only on client process (e.g., Greenberg & Foester, 1996; Greenberg & Safran, 1987; Pascual-Leone & Greenberg, 2007). We chose to focus on the dyad, hoping to highlight the contributions of both client and therapist, as more congruent with the view that narrative change is a product of co-construction.

Define task context/environment. The self-narrative reconstruction phase of EFT involves the client's articulation of new meanings attributed to the problem and the development of an explicit, causal explanation for problems and experienced emotions, in parallel with a revision of the way the client views him/herself. According to Angus and Greenberg (2011), this EFT stage deals more directly with the articulation between emotion and narrative processes, as clients integrate problematic experiences in their life stories. The authors point out that:

self-identity reconstruction in this stage occurs in two major ways: (a) the integration of a new narrative and new personal meanings into preexisting views of self or others or (b) the radical reorganization of the self-narrative and the articulation of new emotionally significant ways of viewing and understanding self and others. (p. 32)

During this phase of the therapeutic process, EFT therapists facilitate active reflection and new meanings about experiences of emotional change, in an empathic, exploratory, and internally focused relational environment that is characteristic of this modality.

Rational analysis. Drawing on the preexisting literature, researchers specified a model of how they thought the task of self-narrative reconstruction unfolded. The rational model of the task was produced through consensual discussion by the investigators and had 10 steps (presented and elaborated in the Results section).

Empirical task analysis. To conduct the empirical task analysis, the rational model was contrasted with actual successfully resolved tasks derived from EFT cases for depression. To allow this, the following steps were taken first: (a) Sampling of in-session episodes were the task appeared; (b) Categorization of these episodes according to *successful resolution* criteria to be analyzed subsequently (see the subsection "Specify the therapeutic task and its markers" of the Procedures section); (c) Initial contrast of three successfully resolved episodes and three unresolved episodes; (d) Extension of the contrast between the rational model and several successfully resolved episodes until reaching saturation (i.e., a new episode

does not add further alterations or deletions); and (e) Synthesis of the new rational-empirical model.

- (a) *Sampling of in-session episodes were the task appeared:* The selection of episodes was conducted by two Ph.D. researchers (the first and second authors), taking into account the APES coding conducted in the former study of Cunha et al. (2016, described above in Phase 2 of the procedures).
- (b) *Categorization of these episodes according to successful resolution criteria:* According to the criteria for successful resolution, successfully resolved episodes only appeared in a final phase of EFT in this sample of three recovered cases (cf., Table II). As stated above, the APES was used here as a global index of resolution of the task, distinguishing the productivity of reconceptualization IMs.

Table II shows the distribution of the episodes across sessions of the EFT cases. A total of 18 in-session episodes fulfilled the resolution criteria. (One additional episode that satisfied these criteria was excluded because the focus was not self-narrative reconstruction but therapy termination.) The reconceptualization IMs that reached an APES level equal or higher than 6 accounted for 41.6% ($n = 42$) of the reconceptualization IMs in this EFT sample (in a total of 101 reconceptualization IMs, according to Cunha et al., 2016).

- (c) *Initial contrast of three successfully resolved episodes and three unresolved episodes:* From this stage on, these two researchers compared three unresolved episodes with three successfully resolved episodes in order to distinguish successful from unsuccessful task resolution, by consensual discussion (see Results section below).
- (d) *Extend contrast of the rational model with several successfully resolved episodes until reaching saturation:* Afterwards, the rational model was refined in the contrast with other resolved episodes (through deletion, alteration, and addition of essential steps) until saturation. Model saturation occurred after nine episodes analyzed, although the investigators kept analyzing until the 12th episode.

Synthesis of the rational-empirical model. Finally, the rational-empirical model was synthesized into a diagram and subject to an auditing process (by the sixth author and his research team). At this stage, the rational-empirical model was also presented to the fourth author and discussed with her research team (the model is explained and exemplified in the Results section below.)

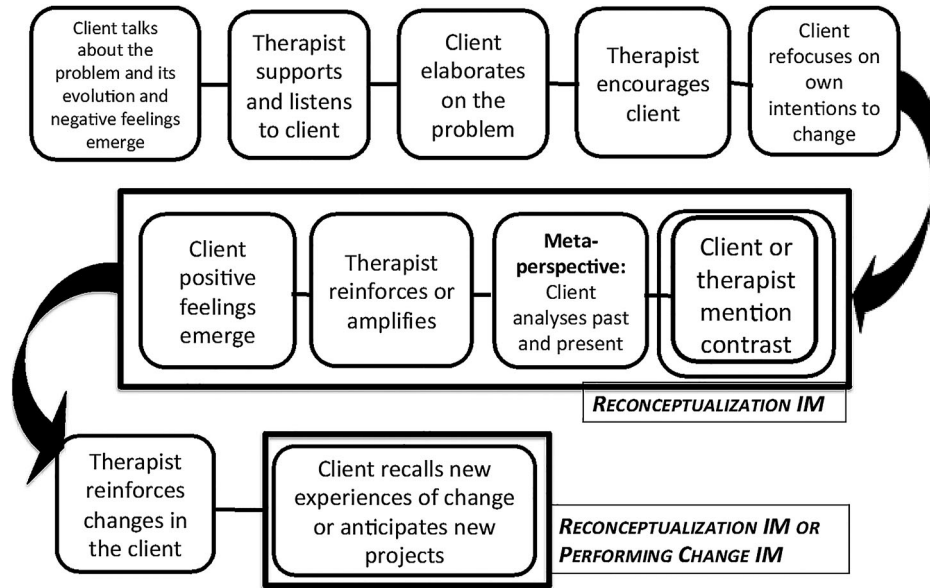


Figure 1. Rational model.

Results

Rational Analysis

The rational model displays 10 steps (Figure 1). It was proposed that after the identification of the beginning marker—*client talks about the problem and its evolution*—negative feelings would appear. A successful resolution of the task would start with *therapist support and active listening* (step 1), as the therapist responds by providing space to listen to the client and evidencing support to the experience of the problem and negative feelings that accompany it. This guides the *client to further elaborate on the problem* (step 2) and to *therapist encouragement* (step 3). This process of problem elaboration and encouragement facilitates a conversational move, as the *client refocuses on personal intentions to change* (step 4), leading the way to the emergence of a reconceptualization IM. This type of innovation can either start with *client or therapist mentioning contrast* between the present and the past (step 5), in terms of client’s efforts to produce changes and steps already achieved in that direction. In turn, the *client further analyzes the past and the present, showing a developed meta-perspective upon the self* (step 6). This is *reinforced or amplified by the therapist* (7) and then *client positive feelings emerge* (8), ending the reconceptualization IM. Subsequently, the *therapist reinforces the changes experienced by the client* (9) and this facilitates the *client’s recollection of new experiences of change* that were already practiced in real life, with the re-emergence of a new reconceptualization that ends the successful resolution of the episode (step 10—that is, reconceptualization repeated within the same theme). Alternatively, the last step of the model can appear in the form of a performing change IM instead of a

reconceptualization IM. In this case, the *client anticipates new projects or experiences of change, or expresses new personal resources* that were developed to deal with similar problems in the future.

Empirical Analysis

We identified 18 successfully resolved episodes in the three EFT cases. As Table II shows, the distribution of successfully resolved episodes indicates that they were more frequent at a later or final stage of these cases. Sometimes, several episodes were located within the same session (e.g., session 15 of Lisa exhibited two successfully resolved episodes), as these usually corresponded to multiple dimensions of the same problematic themes. Episode length in a session varied between 75 and 440 lines of transcribed text ($M = 223$).

The empirical task analysis led to the synthesis of the rational-empirical model of self-narrative reconstruction, displayed in Figure 2, for these recovered EFT cases. According to the findings, the successful resolution of the task involved nine steps, occurring after the identification of the beginning marker. All of these nine steps were present in every episode; therefore, these were the client change processes considered necessary for task resolution (there were also some optional features, which will be elaborated below as well). We will now proceed to a step-by-step elaboration of the model, accompanied with illustrative excerpts drawn from one episode in a specific dyad. Due to space constraints, the speaking turns were shortened and edited to avoid speech repetition and hesitations. Commentaries to the segments appear within brackets.

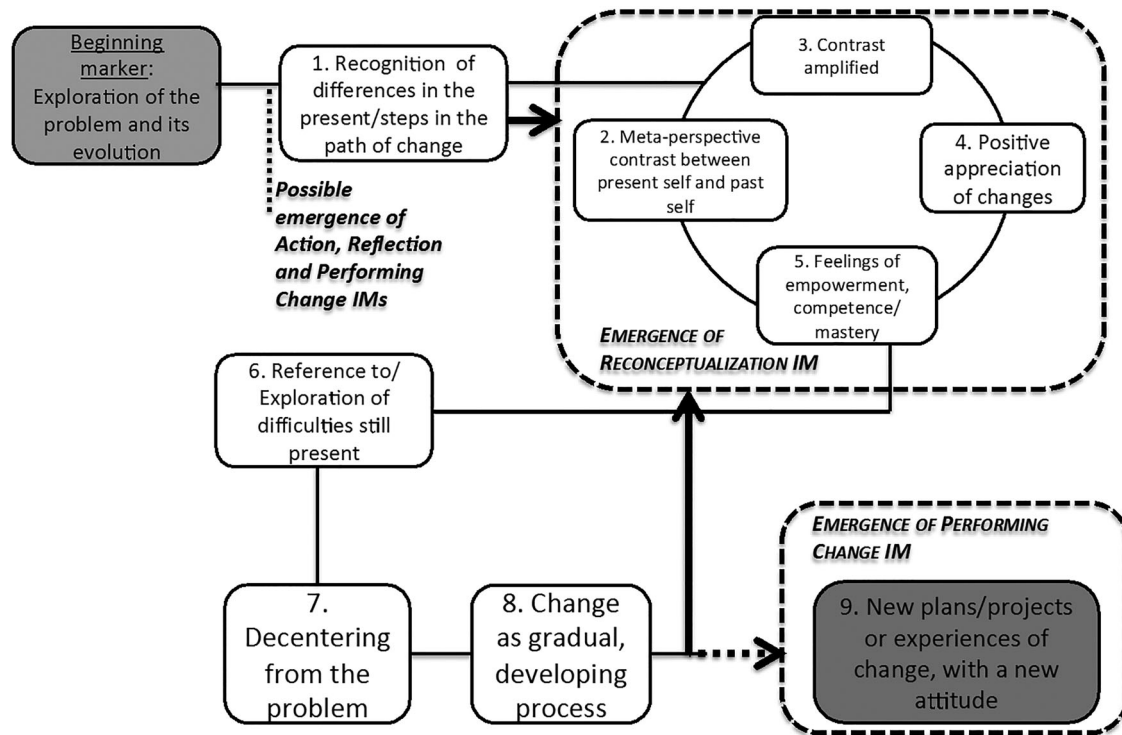


Figure 2: Rational-empirical model of narrative reconstruction in EFT for depression.

Beginning marker: exploration of the problem and its evolution. In the confrontation with actual client–therapist performances, we realized that either client or therapist can carry out the identification and exploration of current problems and its evolution and that this exploration of more or less recent autobiographical memories usually occurs with a positive affective tone, already entailing (at least implicit) references to change. These references may take the form of an IM (usually of reflection type). For example, the client may talk about past attempts to address the problem or a problematic experience that had an unexpected positive ending. Alternatively, the therapist may initiate conversation by exploring where the client is at the present moment (without directing to problem elaboration) and the client responds by elaborating on change, implicitly referencing the problem. Therefore, IMs can follow the beginning marker.

This illustrative episode was drawn from session 16 of one dyad: Sarah and her therapist. In this episode, Sarah still acknowledges some difficulties in structuring her daily activities, dealing with procrastination and with potential criticism from others. The therapist suggests working on these lingering current problems.

Therapist (T): [...] we still have time to talk and it's good that we're able to note the positive but we can also still work on things that are troubling or

Client (C): Once I start this volunteer work I said already like I want to do it in the mornings and that's just to be in a place and people expecting me and I've made a commitment, so it's not going to be a problem to get moving on [...]

T: Yeah, so your ideal would be that you could get up a seven, be self-motivated, jump out of bed and do everything (client laughs)

C: Yeah, but I somehow think well or at least right now, I really don't think I can do this on my own [...] then, uhm, yeah, it's just easier for me like to have this commitment to other people

Step 1: explicit recognition of differences in the present and steps in the path of change. At this stage, all clients explicitly acknowledged differences concerning how they dealt with the problem and that some progress had been achieved in the path to significant changes. Several IMs appeared here, mainly of the reflection type (but also performing change or action IMs). These types of innovation led the way to the emergence of subsequent reconceptualization IMs further ahead. Therapists frequently developed the process of acknowledging differences by underlining the client's agency beneath the changes and through metaphor use.

T: But you know what you're doing is saying well this was my ideal but right now I'm not going to reach that

ideal so at least I'll find a way that works for me [C: yeah, yeah] and accepting that maybe you need the structure, some people do and at least doing that you know what you need to do and taking a step to do it for yourself

- C: Yeah, I know, I know what you are saying, like it's kind of nice to have this ideal but then at the same time this is just how it works for me, so I've got to find a way of working around it [...] but I mean like just by going to this interview, for this volunteer thing, it was really interesting because she asked us all these questions [...] it was just really surprising and amazing to notice that, uhm, yeah, I just took a completely different approach to, uh, to answering the question and representing like what's important to me and why I want to do that. (Reflection IM underlined)

Step 2: development of a meta-perspective contrast between present self and past self (emergence of a reconceptualization IM) .

In the elaboration of the reconceptualization IM clients adopted a meta-perspective stance upon themselves and depicted a contrast in the self: the self in the present as distinct from the self in the past. This frequently led them to recognize something new about the problem or the self. This meta-perspective usually appeared linked to the recognition of problematic patterns (e.g., in interpersonal relationships, in the access to problematic feelings and primary emotions or in the reaction to specific environmental triggers) and was usually expanded by the therapist (through the use of exploratory questions, empathic or evocative reflections or restatements). Furthermore, the development of such meta-perspective in the self also allowed the client's disengagement with a former self-narrative.

- T: mm-hm, so like I do have something to say and I can say it in a way [C: yeah] that comes across well and I've done all these things
- C: [First reconceptualization IM, underlined, begins; APES level 6] oh yeah, because I mean one of the things for sure that, uhm, with every course, an enriching environment, I learned about new aspects and different perspectives but then that always has been a thing for me, like there are all these different points of views and if there is a conflict or a problem, uh, it has to be resolved some way so all the parties are going to be satisfied [...] just sharpening my awareness in regards to that.

Step 3: amplification of contrast in the self.

The amplification of the contrast was carried out through the elaboration of the differences between the present and the past, for example, in terms of behaviors, interpersonal, or emotional reactions, and different client attitudes. It frequently appeared

and was expanded through therapist activity (exploratory open-ended questions, restatements or reflections of feelings, such as empathic affirmation or evocative reflections), capturing the most poignant aspects of client's experience. The elaboration of reconceptualization continues here.

- T: [Reconceptualization IM, underlined, continues] somehow those criticisms don't hit you that hard, or you haven't answered to them [C: yeah, yeah] they don't throw you off as much or
- C: uhm, no, it doesn't throw me off and I guess usually I'm a pretty quiet and reserved person but when people in a group like talk about—well I guess especially if they talk down on minority groups, that's one big thing, then I cannot shut up, then I have to say something, and I just find that observation really very interesting because now—I am saying something, whereas before I just wouldn't [...] no I don't care what they think about it, I've got to have my say [...]

Step 4: a positive appreciation of changes is conveyed.

In this phase of the process, a positive affect tone was present in all the episodes, as clients valued the changes already achieved and elaborated them in the conversation. Affect was usually optimistic, content, and proud. Therapists always responded by validating and encouraging the client's efforts and trajectory toward change, sometimes through the use of metaphors in evocative responses and empathic affirmation. This step is still part of the reconceptualization IM.

- T: [Reconceptualization IM, underlined, continues] so you felt now there is a reason for the degree, there is a purpose, it makes sense
- C: Oh yeah, I was really, I was very pleased with myself (laughs) [T: yeah] yeah, that was very, very important and it came at a good time [...] and then, yeah, oh it just has been really, really good and I'm also able to stand up to criticisms of some people saying "oh well you know once you've got your degree, then what, what are you going to do?" I just felt well, it's not just going to prove that I can read and write, but it's going to be a lot more than that or I know it is a lot more.

Step 5: feelings of empowerment, competence, and mastery emerge.

The positive affect tone that clients expressed as changes became more concrete and real and the problem more distant led to a renewed feeling of empowerment in the way they dealt with problematic experiences, with higher sense of personal competence and mastery in present life. This appeared explicitly or implicitly in the conversation. Therapists

consequently validated, encouraged and reinforced this process through paraphrasing or mirroring the most poignant aspects of client's experience (sometimes through metaphors about change). The end of this step coincides with the end of the first reconceptualization IM.

- C: [Reconceptualization IM, underlined, continues] yeah, and that's in itself like a big, big change too, because I mean like before I always—I had taken on this behaviour, felt like no matter what I say I will not be listened to, things will not change—and I mean like I knew this somehow in my head but—well, yeah, I am entitled to speak up and to have my own opinion but this was what made it so difficult sometimes because I knew well, yes, I'm entitled like to come forward with this but I felt like I have to exert way too much energy with the other fears so I just wouldn't take it on [T: mm-hm] whereas now I have—it's just—
- T: somehow even though before you sort of knew in your head you were entitled, now you feel you're entitled and you also feel, I think, that you can have an impact
- C: yeah, uhm, I mean—to a certain extent I have known all these things in my head but it somehow didn't work for me [...]

Step 6: reference to or exploration of difficulties still present. After the positive attitude that marked the previous elaboration of accomplished changes, all clients directed the therapeutic conversation toward the reference or exploration of difficulties still present. Therapists responded to the expression of difficulties by showing several forms of validation of suffering—frequently through empathic affirmation, normalization of the difficulties or portraying change as a work in progress. Usually, IMs were not found at this stage.

- C: uhm, and yeah, and just keeping that in front of me because I guess like what sometimes happens is that people kind of misunderstand it and add their suggestions but it's not really what I want (laughs), [...] so, yeah, it's really a sense of self and what's at the core of myself, like what are the important things, what I want rather than other people, and that in itself has been really misunderstood, probably because I wasn't aware myself of it or wasn't very clear about it [Reconceptualization IM, underlined, ends]
- T: you know, it sounds like you kind of know some of those fears and criticisms that would get so overwhelming at those times like you'll never be able to do it [C: mm-hm] or you won't have an impact, you won't say it right, and those somehow have lost some of their strength or somehow you're able to overcome them

Step 7: emphasis on the loss of centrality of the problem. Therapist's validation of suffering

was followed by a reference to the loss of centrality of the problem in the client's lives. This usually indicated a shift in the expectations regarding change, frequently by portraying a more moderate and realistic perspective or by assigning more importance to other dimensions of life (further away from the problem). This process usually involved IMs (e.g., reflection IMs).

- C: uhm, because well you learn from your mistakes, I suppose, and also, uhm, it doesn't have to be perfect as long as I know I did the best I could and I didn't get too stressed up about it,—that helps too [Reflection IM underlined]
- T: I think that's really important because we've talked a lot about other people saying things—but I think in the end it comes down to how we're able to support ourselves and somehow you're saying now there's that part which is able to say, well, it's okay S., it's okay to goof up, you don't have to be perfect [C: yeah] and that's kind of a self-support system, being more compassionate towards yourself [C: yeah, yeah] I think that's really important because it doesn't depend on other people and it's almost like having some kind of internal support regardless of what's happening outside.

Step 8: perception of change as a gradual, developing process. At this stage, all clients explicitly expressed the idea of change as a process still unfolding and happening gradually over time, instead of a dramatic shift in their lives. There was more serenity accompanying a clearer orientation toward what they needed to do to understand how to deal with remaining obstacles or challenges, no longer feeling overwhelmed by them. Therapists frequently reinforced this process, through metaphors, restatements and empathic reflections of feelings. Sometimes IMs were present (e.g., reflection IMs).

- C: I mean it's—I mean it's very slow [T: mm-hm] but, uh, I can see it, I recognize it, that things are becoming easier and that's really good [...] and that's what I really wanted, like there are no voices, it's just like certain things are coming up and I just can't stop myself and I just have to blurt it out and that's great, I'm hopefully getting better [Reflection IM underlined]
- T: yeah, maybe like you said the little voices have changes or I wonder if they're sort of little voices that say you know you can do it, you could have an impact, go ahead and try it out
- C: yeah, it's—it's kind of like more self-acceptance and also—well, yeah, I do have my goals and my ideas and all these things, but nothing is really one hundred percent, [...] and then also well, it's okay to goof up [T: mm-hm]

Step 9: reference to, or elaboration of new plans, projects, or experiences of change, with a different attitude. The joint reflection about change within therapeutic conversation always triggered an elaboration upon new experiences of change, new plans and projects that clients were anticipating or already experiencing, with a different and reinvigorated attitude to life. This elaboration led more frequently to the emergence of new reconceptualization IMs (when clients focused experiences that already happened; bold arrow in Figure 2 or, alternatively, to performing change IMs (if they focused more on the anticipation of new experiences of change; dotted arrow in Figure 2).

- C: [Second reconceptualization IM, underlined, begins, APES level 6] yeah, that plus, uhm, well, I kind of have really worked hard on trying to figure out what's really important to me [T: mm-hm] and it doesn't matter who is on the outside, like what are the things which are really important to me, which are of interest to me regardless of the people around me and what they interested in and uh—
- T: so keeping very centred on your goals and your needs
- C: and yeah, like just kind of keeping that in mind and not being swayed almost (laughs) [Second reconceptualization IM, underlined, continues further]

Central Focus of EFT Therapist Activity

The role of the therapist was already evidenced in the examples provided above. However, we will now proceed to address the central aspects of therapist's contribution at specific junctures for a successful task resolution in the cases studied.

During the *explicit recognition of differences in the present and steps in the path to change* (step 1 of the model, Figure 2), whenever clients talked about the present changes without explicitly referencing their role in them (e.g., portraying these as somewhat random), therapists always intervened with the aim of stressing client's agency in the process (e.g., "I don't see it as much as a coincidence, it sounds like you're making some changes."—Sarah's therapist, session 10). This seems to facilitate the shift to the emergence of a meta-perspective in clients (step 3 and beginning of reconceptualization IMs).

Another productive moment of therapeutic activity relates to *therapist validation and encouragement* (gray circle A in Figure 2) that allowed the progression from steps 2 to 5 of the model. This validation and encouragement while clients were talking about changes in the self and renewed agency seemed central to feed the circular steps within reconceptualization, thus facilitating the identification with a new self-narrative and the consolidation of a narrative reconstruction of the self.

Therapist validation of suffering (gray circle B in Figure 2) was another important process, contingent to client's *reference or exploration of difficulties still present* (step 6 of the model). This process seemed to allow the important shift from problem elaboration to reflection on change. This particular step from therapists was consistent across the several episodes, even though it could appear in several forms (as empathic affirmation, empathic exploration, or reflection of feelings). A particular alternative that appeared optionally at this stage was *therapist normalization of difficulties*, sometimes providing an expert reassurance quality to therapist validation (e. g. "but you're also aware that, you know, this is sixteen sessions and there are still lots of things in there and there will be setbacks"—Jan's therapist, session 16; "suddenly you realize hey, lots of people are struggling with lots of different things"—Sarah's therapist, session 10).

Therapist interventions were most frequently characterized by non-directive interventions, capturing the core aspects communicated by clients (such as emphatic affirmations, reflections of feelings, and restatements). Also, therapists typically presented metaphors as a way to convey rich images and amplify the poignant aspects of the change process, through evocative responses (e.g., "you opened doors that weren't easy to open"—Jan's therapist referring to the therapeutic process, session 16).

Contrast Between Resolved and Unresolved Episodes

As we stated above, unresolved episodes were classified as such if reconceptualization IMs is lower than level six in the APES, or, if higher, there is no consolidation of change at the end of the episode by the emergence of a new reconceptualization IM or a performing change IM. The three unresolved episodes drawn from these recovered cases for comparison purposes followed a distinct evolution from the resolved episodes, characterized above. We provide also a brief illustration of an unresolved episode drawn from Sarah, session 5.

The beginning markers of unresolved episodes were always characterized by negative emotions triggered by the problematic experiences reported by clients: "It's almost like people have figured out that sometimes I have this need to be accommodating and pleasing to people... and it's just like it does not work for me at all." More specifically, none of the clients exhibited a positive affective tone in these unresolved episodes even when they were addressing their personal efforts to deal with the problem. Thus, unresolved episodes initiate very differently from the successfully resolved episodes. Additionally, none of the steps of the

rational-empirical model of the self-narrative reconstruction task presented above appear in the unresolved episodes.

Instead, as these episodes develop from a narrative exploration of these events, therapists' exploration (through open questions, empathic reflections, and affirmations) lead clients to focus inwards and further explore their difficulties, sometimes by establishing connections between these recent experiences and their main difficulties:

I wanted to look at things I experience with other people and how this possibly relates to the relationship with my father ... it's like people want something from me whatever it is and I'll be nice and polite and say—No, I'm not interested—and they, it's almost like they can't take not for an answer and keep pressuring me.

The internal focus facilitates the exploration, evocation, and articulation of problematic, painful, or interrupted feelings, such as a sense of discouragement, resentment and/or guiltiness, self-criticism, and feelings of being stuck: "I got one remark in regards to that, that I don't show my emotions but I just want to play it safe." The differentiation of client experience is then linked with specific process-experiential tasks (e.g., to work on self-evaluative or self-interruption splits, or unfinished business) that are followed through subsequently: "I really feel you have certain expectations, and I just can not, I don't want to live up to it because my live does not center around living to your expectations" (this segment was drawn from an empty-chair work for unfinished interpersonal issues with Sarah's father, carried out during this episode). Thus, the unresolved episodes analyzed here (occurring in a working-through phase of EFT) evolve in a very different way than the resolved episodes (all from a latter phase of EFT).

Discussion

In this study, we investigated the process of self-narrative reconstruction that occurs in three recovered cases of EFT for depression, through the method of task analysis (findings of the discovery-oriented phase). We focused on a characterization of the essential components of client change processes and also looked at productive aspects of therapist activity. Given that the repetition of reconceptualization IMs and the emergence of reconceptualization were found as markers of good outcome therapy in previous studies (Gonçalves et al., 2012; Matos et al., 2009; Mendes et al., 2010, 2011), we used these IMs to locate and capture this fluid process within the EFT sessions. Even though we focused only on a very small sample of cases ($N = 3$), the sampling

of 18 successful episodes provided some support to the idea that this task is probably more typical of a final phase of EFT, occurring after the work on emotion processes (Angus & Greenberg, 2011).

While we suggested in the rational model 10 steps for the successful completion of the self-narrative reconstruction task, the rational-empirical analysis of these three EFT cases identified nine essential components. Therefore, after the detection of the beginning marker—exploration of the problem and its evolution—the successful completion of the task evidenced in this sample of cases involved the explicit recognition of differences in the present and steps in the path of change (step 1); the development of a meta-perspective contrast between present self and past self [emergence of reconceptualization IM] (step 2); the amplification of contrast in the self (step 3); the positive appreciation of changes (step 4); feelings of empowerment, competence, and mastery emerge, accompanied by therapist validation (step 5). Steps 2 (amplification of contrast in the self) through 5 (feelings of empowerment, competence, and mastery emerge) occurred during a reconceptualization IM. The task then evolved to a reference or exploration of difficulties still present (step 6), a process supported by therapist validation of suffering, leading to an emphasis on the loss of centrality of the problem (step 7) and portraying change as a gradual, developing process (step 8). The task ended with the reference to or elaboration of new plans, projects, or experiences of change (step 9) that were reported by the client, evidencing a refreshed and reinvigorated attitude to life.

The comparison of unresolved with resolved episodes evidenced some differences. First, the beginning marker of unresolved episodes only included references to and arousal of negative emotions. No positive affective tone was detected in clients' conversation, even when they described their attempts to overcome problems and problematic experiences; on the contrary, the global affective tone was characterized by discouragement, frustration, or sadness. These unresolved episodes evolved then to the differentiation of process-experiential markers that lead to specific EFT tasks and their respective unfolding (such as empty-chair or two-chair dialogue or others).

Beyond de main reconceptualization IM (steps 2–5), throughout the self-narrative reconstruction task, other IMs were present at several stages. They appeared during the exploration of the problem and change (beginning marker) and also during the explicit recognition of differences in the present and steps in the path of change, being mainly instances when clients were talking about themselves in a different way. Although step 6 was related to the termination or absence of IMs, these usually emerged again during step 7 (emphasis on the loss of centrality of the problem),

and also during step 9 (reference to or elaboration of new plans, projects, or experiences of change, with a different attitude), where they were either new reconceptualization or performing change IMs.

Regarding the present task of self-narrative reconstruction we can say that therapeutic activity appeared as a collaborative effort that was constant across the several steps of the model. This is congruent with the emotion-focused therapeutic stance, which has been evidenced in other studies with EFT for depression (e.g., Ribeiro et al., 2016). Moreover, several instances of dyadic interaction also evidenced *tangential processes* (defined as moments of dyadic activity appearing in the form of *if-then* contingent actions—if the client does X, then the therapist does Y; cf., Bennett et al., 2006) that become explicit at specific junctures of the therapeutic conversation.

The first tangential process appeared when clients were elaborating the contrast in the self, adopting a meta-perspective, or feeling positive and proud of what they have accomplished so far. In the current sample, this always led to therapist validation of these changes: that is, the therapists not only supported clients when they were talking about their new sense of self, but also expanded this self-observation standpoint and worked through this meta-perspective. There is strong agreement in the psychotherapy research literature that this is an important self-reflective process, which mediates therapy change. Such process has been addressed from various angles as the development of meta-cognitive skills (Dimaggio & Semerari, 2004; Salvatore et al., 2004), a new sense of authorship (Angus & Mcleod, 2004; Botella et al., 2004; Gonçalves et al., 2009), client self-reflexivity (Angus et al., 2004) and/or the enhancement of an observer position in the self (Leiman, 2012). This reflects a general agreement across therapeutic modalities upon the importance of enhancing client self-observation or self-reflexivity skills in psychotherapy. Nevertheless, further attention needs to be paid addressing more systematically how therapists could enhance client self-reflexivity within specific dyadic contexts and dealing with possible difficulties.

A second tangential process appeared when clients were referencing some difficulties still present in the change process or exploring them (step 6), which was always followed by therapist' validation of suffering. The contingency of these processes suggests that therapists' acknowledgement of client difficulties, consistent with the client-centered relationship stance, is still important at an advanced or final phase of therapy and is consistent with a good practice of EFT. Likely this is also important in the adoption of a more realistic view upon the change process, leading the dyad to acknowledge the loss of centrality of the problem (step 7).

Interestingly, several steps of this model involved the activation of specific autobiographical memories in clients combined with positive feelings. In the current sample, this usually happened when clients explore the problem (step 1), disclosed present difficulties in the change process (step 6) or talked about new experiences of change, articulated as reconceptualization or performing change IMs (step 9) and expressing empowerment, optimism and pride in their accomplishments. This is certainly an important process since, as Boritz et al. (2008, 2011) and Angus and Greenberg (2011) have discussed, good treatment outcomes in EFT of depression are favored when depressed clients are able to present more specific autobiographical memories in combination with higher levels of positive emotional arousal at therapy termination.

The study of these cases suggests that the therapeutic strategies are essentially related with a collaborative style from therapists characterized by non-directive, empathic, and exploratory interventions expected at this phase (Angus & Greenberg, 2011; Greenberg, 1984, 1991; Greenberg et al., 1993; Ribeiro et al., 2016). Furthermore, exploratory interventions have also been related to reconceptualization and performing change IMs in a previous study with this sample (Cunha, Gonçalves, Hill, et al., 2012), suggesting their key role in the productivity of EFT. A final note concerning the use of metaphor and evocative language by these three EFT therapists: Metaphor construction, although not an essential component of the task, was also noteworthy across several steps of this process. Previous studies on metaphor use conducted by Angus and colleagues (Angus & Rennie, 1988, 1989; Levitt et al., 2000) have pointed out that therapist participation in metaphor generation, particularly when adopting a collaborative style, characteristic of EFT, is useful for facilitating the experiential engagement of clients, the description of subjective experiences and the discovery of new forms of self-narrative expression, important for the narrative reconstruction of the self.

Limitations and Implications for the Future

The small sample of three recovered cases is a major limitation of this study and we should see these results as merely exploratory and a starting point for further research on self-narrative reconstruction in EFT. Another concern is that all these clients were women, and we are not sure whether gender plays a role in this type of client process. Another important limitation was the fact that we only had access to transcripts for this study, which means that our present findings might have been impoverished due to limited access to fundamental non-verbal

components of client–therapist interaction. Hence, future studies should expand this preliminary task-analytic model with analysis done with audio and video recording of real performances to see if further refinement needs to be carried out before pursuing other empirical goals.

Some of these limitations could be overcome in the future by securing a broader sample of EFT client–therapist dyads in the treatment of depression and accomplishing the validation phase of task analysis, according to the guidelines of the method (Greenberg, 2007; Pascual-Leone et al., 2009). This would increase confidence in the preliminary conclusions presented here, if these become confirmed in a broader sample of EFT dyads analyzed by independent judges.


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References

- Adler, J. M., Skalina, L. M., & McAdams, D. P. (2008). The narrative reconstruction of psychotherapy and psychological health. *Psychotherapy Research, 18*, 719–734.
- Alves, D., Mendes, I., Neimeyer, R., & Gonçalves, M. (2012). Innovative moments in grief therapy: Reconstructing meaning following perinatal death. *Death Studies, 36*(9), 795–818.
- Angus, L., Goldman, R., & Mergenthaler, E. (2008). Introduction. One case, multiple measures: An intensive case-analytic approach to understanding client change processes in evidence-based, emotion-focused therapy of depression. *Psychotherapy Research, 18*(6), 629–633.
- Angus, L. E., & Kagan, F. (2013). Assessing client self-narrative change in emotion-focused therapy of depression: An intensive single case analysis. *Psychotherapy, 50*(4), 525–534.
- Angus, L., Lewin, J., Bouffard, B., & Rotondi-Trevisan, D. (2004). “What’s the story?” Working with narrative in experiential psychotherapy. In L. Angus & J. McLeod (Eds.), *Handbook of narrative and psychotherapy: Practice, theory, and research* (pp. 87–101). Thousand Oaks, CA: Sage.
- Angus, L., & McLeod, J. (Eds.). (2004). *The handbook of narrative psychotherapy: Practice, theory and research*. London: Sage.
- Angus, L. E., & Greenberg, L. S. (2011). *Working with narrative in emotion-focused therapy: Changing stories, healing lives*. Washington, DC: American Psychological Association.
- Angus, L. E., & Rennie, D. L. (1988). Therapist participation in metaphor generation: Collaborative and noncollaborative styles. *Psychotherapy: Theory, Research, Practice, Training, 25*, 552–560.
- Angus, L. E., & Rennie, D. L. (1989). Envisioning the representational world: The client’s experience of metaphoric expression in psychotherapy. *Psychotherapy: Theory, Research, Practice, Training, 26*, 372–379.
- Aspland, H., Llewelyn, S. P., Hardy, G. E., Barkham, M., & Stiles, W. (2008). Alliance ruptures and rupture resolution in cognitive-behavior therapy: A preliminary task analysis. *Psychotherapy Research, 18*, 699–710.
- Beck, A. T., Steer, R. A., & Garbin, M. G. (1988). Psychometric properties of the Beck Depression Inventory: Twenty-five years of evaluation. *Clinical Psychology Review, 8*, 77–100.
- Beck, A. T., Ward, C. H., Mendelson, M., Mock, J., & Erbaugh, J. (1961). An inventory for measuring depression. *Archives of General Psychiatry, 4*, 561–571.
- Bennett, D., Parry, G., & Ryle, A. (2006). Resolving threats to the therapeutic alliance in cognitive analytic therapy of borderline personality disorder: A task analysis. *Psychology and Psychotherapy: Theory, Research and Practice, 79*, 395–418.
- Boritz, T. Z., Angus, L., Monette, G., & Hollis-Walker, L. (2008). An empirical analysis of autobiographical memory specificity subtypes in brief emotion-focused and client-centered treatments of depression. *Psychotherapy Research, 18*, 584–593.
- Boritz, T. Z., Angus, L., Monette, G., Hollis-Walker, L., & Warwar, S. (2011). Narrative and emotion integration in psychotherapy: Investigating the relationship between autobiographical memory specificity and expressed emotional arousal in brief emotion-focused and client-centred treatments of depression. *Psychotherapy Research, 21*(1), 16–26.
- Botella, L., Herrero, O., Pacheco, M., & Corbella, S. (2004). Working with narrative in psychotherapy: A relational constructivist approach. In L. E. Angus & J. McLeod (Eds.), *The handbook of narrative and psychotherapy: Practice, theory, and research* (pp. 119–1136). Thousand Oaks, CA: Sage.
- Brinegar, M. G., Salvi, L. M., & Stiles, W. B. (2008). The case of Lisa and the assimilation model: The interrelatedness of problematic voices. *Psychotherapy Research, 18*, 657–666.
- Campbell, D. T. (1986). Relabeling internal and external validity for applied social scientists. In W. M. K. Trochim (Ed.), *Advances in quasi-experimental design and analysis. New directions for program evaluation* (pp. 67–77). San Francisco, CA: Jossey-Bass.
- Caro-Gabalda, I. (2008). Assimilation of problematic experiences in linguistic therapy of evaluation: A case study. *Journal of Constructivist Psychology, 21*, 151–172.
- Caro-Gabalda, I., & Stiles, W. B. (2012). Irregular assimilation progress: Reasons for setbacks in the context of linguistic therapy of evaluation. *Psychotherapy Research, 23*, 35–53. doi:10.1080/10503307.2012.721938
- Cash, S. K., Hardy, G. E., Kellet, S., & Parry, G. (2014). Alliance ruptures and resolution during cognitive behaviour therapy with borderline personality disorder. *Psychotherapy Research, 24*, 132–145. doi:10.1080/10503307.2013.838652
- Clarke, K. M. (1989). Creation of meaning: An emotional processing task in psychotherapy. *Psychotherapy: Theory, Research, Practice, Training, 26*, 139–148.
- Clarke, K. M. (1996). Change processes in a creation of meaning event. *Journal of Consulting and Clinical Psychology, 64*, 465–470.
- Cunha, C., Gonçalves, M. M., Hill, C. E., Sousa, I., Mendes, I., Ribeiro, A. P., ... Greenberg, L. S. (2012). Therapist

- interventions and client innovative moments in emotion-focused therapy for depression. *Psychotherapy*, 49, 536–548. doi:10.1037/a0028259
- Cunha, C., Gonçalves, M. M., & Valsiner, J. (2011). Transforming self-narratives in psychotherapy: Looking at different forms of ambivalence in the change process. In R. Jones & M. Morioka (Eds.), *Jungian and dialogical self perspectives* (pp. 43–66). Basingstoke: Palgrave.
- Cunha, C., Gonçalves, M. M., Valsiner, J., Mendes, I., & Ribeiro, A. P. (2012). Rehearsing renewal of identity: Reconceptualization on the move. In M. C. Bertau, M. M. Gonçalves, & P. Raggat (Eds.), *Dialogic formations: Investigations into the origins and development of the dialogical self* (series editor: Jaan Valsiner) (pp. 205–233). Charlotte, NC: IAP, Information Age.
- Cunha, C., Martins, J., Mendes, I., Ribeiro, A., Stiles, W. B., Angus, L., ... Gonçalves, M. M. (2016). *Reconceptualization and assimilation on the spotlight: How can one psychotherapy change model inform another?* Manuscript in preparation.
- Dimaggio, G., & Semerari, A. (2004). Disorganized narratives: The psychological condition and its treatment. How to achieve a metacognitive point of view restoring order to chaos. In L. Angus & J. McLeod (Eds.), *Handbook of narrative psychotherapy: Practice, theory and research* (pp. 263–282). Thousand Oaks, CA: Sage.
- Elliott, R., Watson, J. C., Goldman, R., & Greenberg, L. S. (2004). *Learning emotion-focused therapy: The process-experiential approach to change*. Washington, DC: American Psychological Association.
- Gendlin, E. T. (1981). *Focusing* (2nd ed.). New York, NY: Bantam Books.
- Gonçalves, M. M., Gabalda, I. C., Ribeiro, A. P., Pinheiro, P., Borges, R., Sousa, I., & Stiles, W. B. (2014). The innovative moments coding system and the assimilation of problematic experiences scale: A case study comparing two methods to track change in psychotherapy. *Psychotherapy Research*, 24(4), 442–455.
- Gonçalves, M. M., Matos, M., & Santos, A. (2009). Narrative therapy and the nature of “innovative moments” in the construction of change. *Journal of Constructivist Psychology*, 22, 1–23.
- Gonçalves, M. M., Mendes, I., Cruz, G., Ribeiro, A. P., Sousa, I., Angus, L., & Greenberg, L. S. (2012). Innovative moments and change in client-centered therapy. *Psychotherapy Research*, 22(4), 389–401. doi:10.1080/10503307.2012.662605
- Gonçalves, M. M., Mendes, I., Ribeiro, A., Angus, L., & Greenberg, L. S. (2010). Innovative moments and change in emotional focused therapy: The case of Lisa. *Journal of Constructivist Psychology*, 23, 267–294.
- Gonçalves, M. M., Ribeiro, A., Mendes, I., Matos, M., & Santos, A. (2011). Tracking novelties in psychotherapy process research: The innovative moments coding system. *Psychotherapy Research*, 21, 497–509. doi:10.1080/10503307.2011.560207
- Gonçalves, M. M., & Ribeiro, A. P. (2012). Therapeutic change, innovative moments and the reconceptualization of the self: A dialogical account. *International Journal of Dialogical Science*, 6(1), 81–98.
- Gonçalves, M. M., & Stiles, W. B. (2011). Narrative and psychotherapy: Introduction to the special section. *Psychotherapy Research*, 21, 1–3.
- Greenberg, L. (1984). Task analysis: The general approach. In L. Rice & L. Greenberg (Eds.), *Patterns of change: Intensive analysis of psychotherapeutic process* (pp. 126–148). New York, NY: Guilford Press.
- Greenberg, L., & Angus, L. (1995). *How therapy works*. Canadian Social Sciences and Humanities Council Standard Grant. Unpublished manuscript.
- Greenberg, L., & Angus, L. (2004). The contributions of emotion processes to narrative change in psychotherapy: A dialectical constructivist approach. In L. Angus & J. McLeod (Eds.), *Handbook of narrative psychotherapy: Practice, theory, and research* (pp. 331–349). Thousand Oaks, CA: Sage.
- Greenberg, L. S. (1991). Research on the process of change. *Psychotherapy Research*, 1(1), 3–16.
- Greenberg, L. S. (2006). Emotion-focused therapy: A synopsis. *Journal of Contemporary Psychotherapy*, 36, 87–93.
- Greenberg, L. S. (2007). A guide to conducting a task analysis of psychotherapeutic change. *Psychotherapy Research*, 17, 15–30.
- Greenberg, L. S., & Foester, F. (1996). Resolving unfinished business: The process of change. *Journal of Consulting and Clinical Psychology*, 64, 439–446.
- Greenberg, L. S., Rice, L. N., & Elliott, R. (1993). *Facilitating emotional change: The moment-by-moment process*. New York, NY: The Guilford Press.
- Greenberg, L. S., & Safran, J. D. (1987). *Emotion in psychotherapy*. New York, NY: Guilford Press.
- Greenberg, L. S., & Watson, J. (1998). Experiential therapy of depression: Differential effects of client-centred relationship conditions and process interventions. *Psychotherapy Research*, 8, 210–224.
- Greenberg, L. S., & Watson, J. (2005). *Emotion-focused therapy for depression*. Washington, DC: American Psychological Association.
- Hill, C. E., & Lambert, M. J. (2004). Methodological issues in studying psychotherapy processes and outcomes. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (5th ed., pp. 84–135). New York, NY: John Wiley.
- Hill, C. E., Thompson, B. J., Hess, S. A., Knox, S., Williams, E. N., & Ladany, N. (2005). Consensual qualitative research: An update. *Journal of Counseling Psychology*, 52, 196–205.
- Honos-Webb, L., Stiles, W. B., & Greenberg, L. S. (2003). A method of rating assimilation in psychotherapy based on markers of change. *Journal of Counseling Psychology*, 50, 189–198.
- Honos-Webb, L., Surko, M., Stiles, W. B., & Greenberg, L. S. (1999). Assimilation of voices in psychotherapy: The case of Jan. *Journal of Counseling Psychology*, 46, 448–460.
- Jacobson, N. S., & Truax, P. (1991). Clinical significance: A statistical approach to defining meaningful change in psychotherapy research. *Journal of Consulting and Clinical Psychology*, 59, 12–19.
- Lambert, M. J., & Ogles, B. M. (2004). The efficacy and effectiveness of psychotherapy. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (5th ed., pp. 139–193). New York, NY: Wiley.
- Leiman, M. (2012). Dialogical sequence analysis in studying psychotherapeutic discourse. *International Journal of Dialogical Science*, 6, 123–147.
- Levitt, H., Korman, Y., & Angus, L. (2000). A metaphor analysis in treatments of depression: Metaphor as a marker of change. *Counselling Psychology Quarterly*, 13, 23–35.
- Matos, M., Santos, A., Gonçalves, M. M., & Martins, C. (2009). Innovative moments and change in narrative therapy. *Psychotherapy Research*, 19, 68–80.
- McGlinchey, J. B., Atkins, D. C., & Jacobson, N. S. (2002). Clinical significance methods: Which one to use and how useful are they? *Behavior Therapy*, 33, 529–550. doi:10.1016/S0005-7894(02)80015-6
- Mendes, I., Ribeiro, A., Angus, L., Greenberg, L., Sousa, I., & Gonçalves, M. (2010). Innovative moments and change in emotion-focused therapy. *Psychotherapy Research*, 20, 692–701.
- Mendes, I., Ribeiro, A. P., Angus, L., Greenberg, L., & Gonçalves, M. M. (2011). Narrative change in emotion-focused psychotherapy: A study on the evolution of reflection and protest innovative moments. *Psychotherapy Research*, 21, 304–315.

- Missirlian, T. M., Toukmanian, S. G., Warwar, S. H., & Greenberg, L. S. (2005). Emotional arousal, client perceptual processing, and the working alliance in experiential psychotherapy for depression. *Journal of Consulting and Clinical Psychology, 73*, 861–871.
- Osatuke, K., Reid, M., Stiles, W. B., Kasckow, J., ZIsook, S., & Mohamed, S. (2011). Narrative evolution and assimilation of problematic experiences in a case of pharmacotherapy for schizophrenia. *Psychotherapy Research, 21*, 41–53.
- Pascual-Leone, A., & Greenberg, L. S. (2007). Emotional processing in experiential therapy: Why “the only way out is through”. *Journal of Consulting and Clinical Psychology, 75*, 875–887.
- Pascual-Leone, A., Greenberg, L. S., & Pascual-Leone, J. (2009). Developments in task analysis: New methods to study change. *Psychotherapy Research, 19*, 527–542.
- Perls, F. S., Herline, R. F., & Goodman, P. (1951). *Gestalt therapy*. New York, NY: Julien Press.
- Ribeiro, E., Cunha, C., Teixeira, A. S., Pires, N., Santos, B., Basto, I., Salgado, J., & Stiles, W. B. (2016). Therapeutic collaboration and the assimilation of problematic experiences in emotion-focused therapy for depression: Comparison of two cases. Submitted manuscript.
- Safran, J. D., & Muran, J. C. (1996). The resolution of ruptures in the therapeutic alliance. *Journal of Consulting and Clinical Psychology, 64*, 447–458.
- Salvatore, G., Dimaggio, G., & Semerari, A. (2004). A model of narrative development: Implications for understanding psychopathology and guiding therapy. *Psychology and Psychotherapy: Theory, Research and Practice, 77*, 231–254.
- Stiles, W. B. (1999). Signs and voices in psychotherapy. *Psychotherapy Research, 9*, 1–21.
- Stiles, W. B. (2001). Assimilation of problematic experiences. *Psychotherapy: Theory, Research, Practice, Training, 38*, 462–465.
- White, M., & Epston, D. (1990). *Narrative means to therapeutic ends*. New York, NY: Norton.