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RESEARCH ARTICLE

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Innovative moments with young patients treated for depression: An analysis of post-therapy interviews

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Abstract

Introduction: Innovative moments (IMs) pinpoint new and more adaptative meanings that emerge in clients' discourse during psychotherapy. Studies with adult clients have found a greater proportion of IMs in recovered compared to unchanged cases, but similar studies have yet to be conducted with adolescents.

Aims: The paper aims (1) to study retrospectively the emergence of IMs in therapy, using a post-therapy interview, in adolescents that underwent psychotherapy for depression, and (2) to characterize the themes present in IMs identified retrospectively in the interviews.

Method: Semi-structured post-treatment interviews conducted with 24 adolescents on the experience of taking part in a clinical trial of youth depression, were coded using the *Innovative Moments Coding System*. After identifying IMs, a thematic analysis identified the prominent themes within them.

Results: Higher presence of IMs were found in recovered compared to unchanged cases. Two main themes emerged in the IMs, changes that occurred with therapy and attributions of changes. Recovered cases presented more IMs centred on the self, whereas unchanged cases identified more non-specific changes.

Conclusion: This study suggests that it is possible to code IMs, identified retrospectively, based on post-therapy interviews with adolescents. Meaningful differences were found between recovered compared to unchanged cases. Therapeutic recovery was associated with a higher focus on the self and more specificity in clients' representations of the change process.

KEYWORDS
adolescence, change events, depression, innovative moments, psychotherapy, qualitative research

1 | INTRODUCTION

Depressive disorders have an impact on daily life, psychosocial, family and academic functioning, with about 2.8% of children under the age of 13, and 5.6% of those between 13 and 18, meeting criteria for formal diagnosis (Costello et al., 2006). Children and youth suffering from depression are likely to have other difficulties, with comorbidity levels ranging between 40% and 90%, most commonly some form of anxiety disorder, but also disruptive disorders, ADHD and substance abuse (Birmaher et al., 2007). The levels of relapse are high, with as many as 67% of young people who experience depression having a further episode within 6 to 24 months (Robberegt et al., 2023). In turn, long-term consequences are considerable, with an increased risk of self-harm, suicide, depression, physical illness, substance misuse,

interpersonal and work-related problems in adulthood (Weissman et al., 1999). Consequently, the identification of effective treatments for depression early in life must be a public health priority.

Given the serious long-term consequences of depression in adolescence, identifying effective treatments is a high priority. The findings of the Improving Mood with Psychoanalytic and Cognitive Therapies trial (IMPACT, Goodyer et al., 2017), showed the absence of significant differences in the effectiveness of the treatments (cognitive-behavioural and psychoanalytic psychotherapy), with an average 49%–52% reduction in depressive symptoms one-year after treatment ended. Studying changes in personal meanings of adolescents treated for depression may deepen the understanding of the nature and processes of change that contribute to effective and lasting clinical gains and recovery from youth depression. In order to systematically track such changes, we used the concept of innovative moments (IMs).

1.1 | INNOVATIVE MOMENTS IN PSYCHOTHERAPY

IMs are an empirical operationalization of what narrative therapists White and Epston (1990) termed 'unique outcomes'. According to the narrative perspective, psychological problems result from problematic self-narratives that coerce peoples' lives and hinder their personal and relational well-being, by creating an *internalization* of the problem ('Me as a depressive person', instead of 'me dealing with depression'). Unique outcomes refer to instances in which the client's experience is outside of the influence of the problematic self-narrative, moments in which the client feels, acts or thinks in a way that represents something new. The emergence of IMs has been studied with adults in different psychotherapies, such as narrative therapy (e.g., Gonçalves et al., 2015), client-centred therapy (e.g., Gonçalves et al., 2012), emotion-focused therapy (e.g., Mendes et al., 2010), dilemma-focused therapy (e.g., Montesano et al., 2015), cognitive-behavioural therapy (e.g., Gonçalves, Silva, et al., 2017) and brief dynamic therapy (Nasim et al., 2019). These studies are usually structured in process-outcome designs, contrasting recovered with unchanged cases and exploring IMs' evolution patterns throughout psychotherapy. These studies have suggested that IMs emerge both in unchanged and recovered cases, but with different patterns. Firstly, they occupy more time in the sessions in recovered cases (Gonçalves et al., 2021). Secondly, IMs are associated with pre-post change (i.e., more IMs along therapy are associated with better outcomes, e.g., Alves et al., 2014; Mendes et al., 2010) or with longitudinal outcomes in treatment measured session-to-session. In fact, two small studies have shown that IMs predicted improvement in distress in the following session, above the prediction of distress on subsequent IMs (Gonçalves, Silva, et al., 2017; Gonçalves et al., 2016), while in another study distress was predictive of IMs in the following session (Gonçalves, Batista, et al., 2022).

Thirdly, IMs that emerge in recovered cases are more complex than those present in unchanged cases (e.g., Gonçalves, Ribeiro, et al., 2017; Matos et al., 2009; Mendes et al., 2010). The empirical findings allow for the differentiation of three levels of complexity of IMs (see Gonçalves, Ribeiro, et al., 2017). Below we give illustrations and characterized the three levels of IMs from an adolescent with a problematic pattern involving feelings of discomfort around other people, isolation and loneliness, lack of motivation in school and depressive moods.

Level 1 IMs are the most elementary forms of innovation, including new meanings that allow for the creation of distance or differentiation from the initial problematic pattern (e.g., 'I've been thinking that there is actually no reason for me to be so shy and fearful around other people'). These IMs can occur in the form of thoughts, as in the example above, and also in the form of actions (e.g., 'I signed up for a book club, I really want to start going out more').

Level 2 IMs are centred on the elaboration of alternative patterns (regarding the original, problematic pattern). Most of the time, these IMs emerge in the form of contrasts between a problematic past and a new emerging present (e.g., 'I really enjoyed spending time with my friends this week, but before I didn't'), or some form of elaboration on the change processes involved (e.g., 'I thought, if you mess something up just go back and correct it or move ahead rather than obsessing over it …').

Finally, level 3 IMs, also termed reconceptualization IMs, contain an articulation of a contrast and a process and appear to capture a sophisticated change process, one that involves assuming a reflexive position that allows the patient to bridge past problematic elements and innovative elements into a coherent meaningful whole

Key Practitioner Messages

- Innovative moments are understood as moments where exceptions to the problematic pattern that brought clients to therapy emerge. They are probably important events that the therapists should be attentive of.
- In this study, adolescents elaborated retrospectively innovative moments around two main themes: changes that occurred because of therapy (what changed) and attributions of change (how change occurred). The former was much more frequent than the latter.
- Recovered cases elaborated more clearly changes in the self, while unchanged cases were more non-specific on the types of changes that took place. Similarly, recovered cases attributed changes more often to an internal shift, while unchanged cases were more non-specific.
- Taking these results into consideration, it may be helpful for therapists to be particularly attentive to the adolescent's verbalization of changes in the self, facilitating the elaboration of them in therapy.
- It is unclear at this stage of research if these markers are primarily outcome markers, or if the therapeutic elaboration of them in therapy may be beneficial in itself.

(e.g., Fernández-Navarro et al., 2018; Gonçalves & Ribeiro, 2012). Consider the following example: 'I feel a lot happier now, I feel more comfortable around people and have made some new friends (contrast) … I think it's because my thinking has changed, I talked it through with my tutor, and now I try to see the opportunities in things and get the most out of them (process)'. In the above example, we may infer three positions of the self: the past problematic position, the emergent new position, and a meta-position that allows to make sense of the shift. There are some similarities between the concept of insight (Castonguay & Hill, 2007) and level 3 IMs, but we speculate that not all occurrences of insight would be coded as level 3 IMs, as for such a coding this dual nature of contrast plus process is needed. However, all reconceptualization IMs are probably insights (see Gonçalves & Ribeiro, 2012).

The majority of studies using IMs in psychotherapy were developed by tracking these events in each session of psychotherapy, in process-outcome studies or intensive case studies. In one study (Montesano et al., 2015), instead of coding all the sessions, a final interview (*The Client Change Interview*, Elliott et al., 2001) was coded to identify IMs retrospectively, and the results were very similar to the ones found by coding sessions in treatment, as described above. In this study we sought to apply this approach, coding IMs in post-therapy interviews with adolescents, as this provides a less resource-intensive approach to studying IMs which to date has not been done with adolescents. Thus, despite the reference to IMs below, for the sake of simplicity, we emphasize that we are referring in this study to retrospective accounts of IMs, as elaborated in the post-treatment interview.

To the best of our knowledge, there are no studies on IMs in the domain of psychotherapy with adolescent. This exploratory study addresses this gap, aiming to analyse if the Innovative Moments Coding System (IMCS) is applicable with this population, and if IMs, identified retrospectively in a post-therapy interview, emerge more in recovered cases. This study also sought to explore what themes are present in these retrospective IMs. Two main research questions guided the research:

1. Do IMs emerge in interviews conducted with adolescents at the end of their psychotherapy treatments?
2. What are the themes present in the IMs identified in the interviews?

2 | METHOD

2.1 | Participants and sample selection

The participants of this study were young people who took part in the IMPACT-My Experience study (IMPACT-ME, Midgley et al., 2014). This was a qualitative, longitudinal study exploring the experience of adolescents who took part in the London arm of the IMPACT trial (Goodyer et al., 2017). All participants were diagnosed with unipolar depression, moderate to severe impairment, and were aged between 11 and 17 years at the start of the trial. Participants received either cognitive-behavioural therapy, short-term psychoanalytic psychotherapy, or a brief psychosocial intervention, the last of which was not included in the current study (for full details of the IMPACT trial, see Goodyer et al., 2011, 2017). Participants (and parents, where applicable) gave written consent to take part in the IMPACT trial and IMPACT-ME sub-study.

Cognitive-behavioural therapy (CBT) was a 20-session therapy based on an individual formulation of problems and associated antecedents, precipitating and maintaining factors, with emphasis on collaborative empiricism, and developing explicit, tangible and shared goals. CBT involved structured sessions, including psychoeducation, monitoring methods, behavioural activation, activity scheduling, linking thoughts, feelings and behaviours, challenging negative automatic thoughts and developing adaptive thoughts, and relapse prevention strategies.

Short-term psychoanalytic psychotherapy (STPP, Cregeen et al., 2017) was a 28-session therapy that assumes that our behavioural and emotional responses are rooted in our internal worlds, and reflect our early experience of relationships (Goodman & Midgley, 2019). STPP aims to explore these connections by working with the transference and countertransference in the therapeutic relationship, in order to help the adolescents challenge patterns of relating to themselves and others and develop greater emotional insight and awareness.

For the present study, inclusion criteria were that the participants had received either CBT or STPP as part of the IMPACT trial and (a) had completed the *Mood and Feelings Questionnaire* (MFQ, Angold et al., 1987) at baseline and post-treatment (36 weeks), as well as the *Expectations of Therapy Interview* at baseline and the *Experience of Therapy Interview* (Midgley et al., 2011a, 2011b) at post-treatment (36 weeks) and follow-up (86 weeks) and (b) that their outcomes could be classified as either recovered or unchanged, to allow for comparisons between these groups. The distinction between recovered and unchanged cases was based on the symptom scores obtained with the *Mood and Feelings Questionnaire* (MFQ, Angold et al., 1987). In order to be considered a recovered case, as suggested by Midgley et al. (2014), two conditions had to be fulfilled: (a) the post-treatment symptoms score had to be beneath the clinical cut-off of 28 points and (b) symptomatic improvement had to be at least 50% (i.e., the difference between the pre-treatment and the post-treatment scores had to be equal to or greater than half of the pre-treatment score). Unchanged cases were the ones in which these two conditions were not met.

Out of 43 cases in the IMPACT-ME study (22 CBT, 21 STPP), 16 had missing data and so did not meet the first inclusion criteria (nine CBT, seven STPP), and three met one, but not both criteria for recovered cases, and so did not meet the second inclusion criteria (one CBT, two STPP). These cases were therefore excluded from the study (see Figure 1).

The final sample comprised 24 participants, aged between 12 and 18 years ($M = 16.50$, $SD = 1.69$), 14 females and 10 males. Twelve participants met both criteria for recovered cases and 12 participants

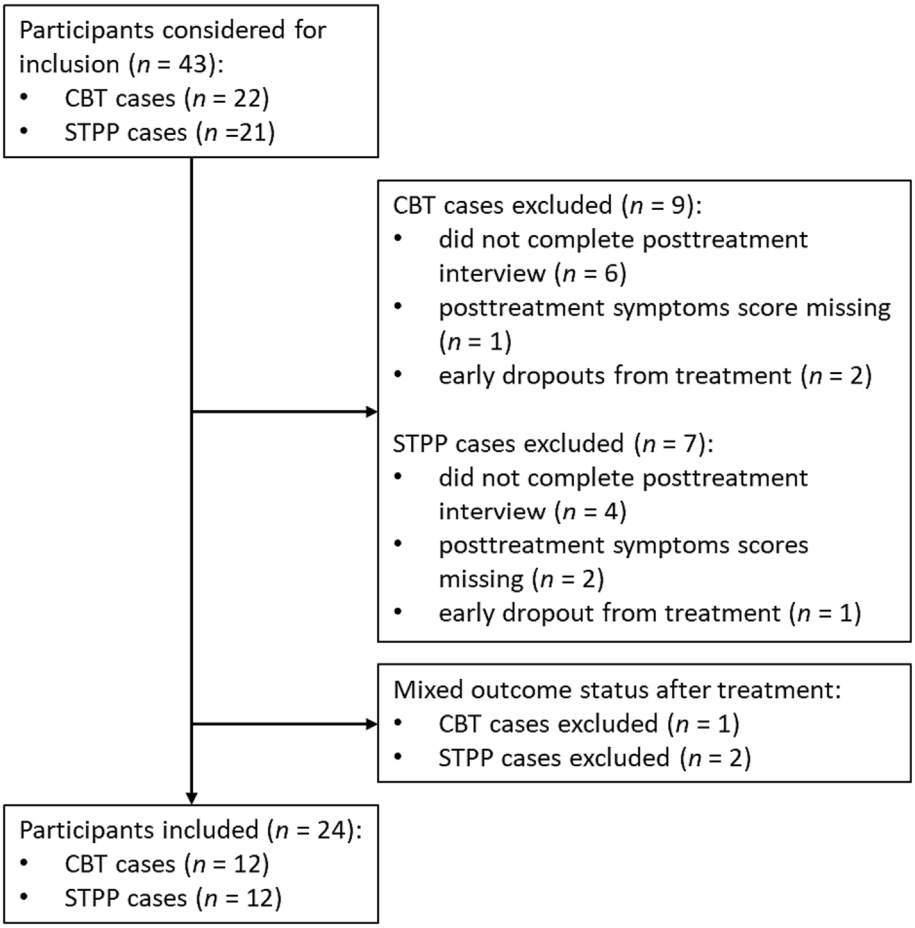

FIGURE 1 Sample selection and participant exclusion. Abbreviations: CBT, cognitive-behavioural therapy; STPP, short-term psychoanalytic psychotherapy.

were considered unchanged cases, as they met neither of the two criteria. Twelve of the participants were in the CBT arm of the study (seven recovered and five unchanged) and 12 in the STPP arm (five recovered and seven unchanged).

2.2 | Materials and measures

2.2.1 | The expectation of therapy and the experience of therapy interviews

During the IMPACT-ME study, participants took part in semi-structured interviews that were carried out at three timepoints: before the start of treatment (pre), using the *Expectation of Therapy Interview* (Midgley et al., 2011a), at the end (post) and 1 year after the end of treatment (follow-up), using the *Experience of Therapy Interview* (Midgley et al., 2011b). In this study, only the post-therapy interview was used. The interview schedules for the IMPACT-ME study built on Elliott's (1999) Change Interview, which explores the change that a person has noticed since therapy began, what the person attributes these changes to, and helpful and unhelpful aspects of therapy; but they were adapted to be more specific to adolescent depression and included more focus on pre-treatment experiences and reflections on being part of a research study. The interview schedules cover several topics but were used in a flexible way. The pre-treatment interview focused on (a) what brought the adolescents to treatment and how their difficulties had been affecting the lives of the adolescents and those around them; (b) the adolescents' understanding of those difficulties; (c) hopes for change and ideas about what could lead to meaningful change; (d) and ideas and expectations about therapy. In turn, the post-treatment and follow-up interviews revisited the pre-treatment interview and explored the adolescents' experience of therapy and change over time, with a focus on the processes that led to each individual's outcomes, as well as the broader contextual factors which young people felt contributed to those outcomes. Finally, they explored the participants' experience of being involved in the research trial.

All interviews were carried out by postgraduate psychologists who had been trained in conducting semi-structured interviews with young people. The interviews took place in a location selected by the young person (usually their own home, but sometimes a room in the child mental health clinic) and were audio-recorded and transcribed verbatim. In the present study, the verbatim transcripts of the pre- and the post-treatment interviews of the selected participants were used. It is important to emphasize that the interviews were done without any aim to find IMs, as the interviewers of the original researchers were unaware of the IMs research at the time the interviews were conducted.

2.2.2 | The innovative moments coding system

The IMCS (Gonçalves, Ribeiro, et al., 2017) is a qualitative procedure used to analyse psychotherapy sessions or interviews, that involves several tasks: (a) consensually define the problematic meaning framework of each client (akin to a list of problems in a case formulation). This step usually involved the familiarity of coders with the first two sessions of therapy. When other materials are used, it needs to be defined how the problem could be identified (e.g., interviews and case formulations); (b) at least two coders independently identify moments in which exceptions to the problematic meaning framework emerge (i.e., IMs). That is, all the instances in the sessions (or interviews) in which an exception from the problematic meaning occurs is considered an IM, no matter the significance of the deviation; (c) identifying the beginnings and endings of the IMs, that is the portion of text of video that corresponds to each IM; and (d) classifying the level of each IM (from level 1 to level 3).

The pre-treatment interviews (*Expectation of Therapy*) were used for the identification and clarification of each participant's difficulties (i.e., their problematic patterns of meaning), and the post-treatment interviews (*Experience of Therapy*) for the coding of retrospective IMs.

The intercoder reliability of the IMCS in previous studies was around 90% for the proportion of IMs (of time spent if working with recordings, or of text if working with transcripts), and Cohen's Kappa above 0.90 for IMs classification (Gonçalves, Ribeiro, et al., 2017).

2.2.3 | The mood and feelings questionnaire

Depressive symptoms before and after treatment were assessed in the IMPACT study using the MFQ (Angold et al., 1987), a 33-item, standardized, self-rated questionnaire of depressive symptoms, in which symptom-related statements regarding feelings and behaviour in the preceding 2 weeks are rated on a three-point Likert-scale, and a score of 28 and above has been used to identify adolescents with major depression. Examples of the questionnaire's items are 'I felt miserable or unhappy' and 'I did everything wrong'. The measure has good test–retest reliability over a 2-/3-week period ($r = 0.78$) and good internal consistency (Cronbach's $\alpha = 0.82$) (Kent et al., 1997; Wood et al., 1995). Construct validity has been demonstrated as the MFQ is highly correlated with the Children's Depression Inventory ($r = 0.75$; Sund et al., 2001).

2.3 | Procedures

2.3.1 | Innovative moments coding procedures

The IMCS was used to identify the IMs in all the participants' interviews by a Masters student formerly trained in the use of the system (first author). The post-treatment interviews of 12 cases (50% of the sample) were randomly selected for double coding with two independent judges (two experienced researchers, second author and sixth author). All the judges were unaware of the participants' outcome status or type of treatment attended. The interrater reliability was calculated based on these independent judges. Whenever significant disagreements occurred, divergent options were discussed and a final consensual decision was made.

Double IMs identification entailed two main steps: (a) the consensual definition of each participant's problematic pattern of meaning, operationalized as a list of problems based on the adolescent's complaints and reflections in the pre-treatment interview; (b) the identification of IMs in the post-treatment interviews, which required the definition of each IM's beginning and end, as well as its classification into the respective level (1 to 3).

It was found that a clear identification of level 1 IMs was not possible, leading to the decision to exclude this category in the present study. In level 1 IMs, although pinpointing efforts to overcome the client's difficulties, the discursive focus remains on the problematic experiences, not on change. Consequently, the dividing line between mere ruminations and the formulation of new insights and understandings (that would be considered as level 1 IMs) often only becomes apparent throughout the progressive unfolding of change during the psychotherapeutic sessions and was found not to be clearly traceable in the retrospective interviews, conducted at a single point in time.

Inter-rater reliability was found to be adequate, both for the definition of IMs' proportions, with agreements for individual cases ranging from 80.9% to 100% (94.3% on average), and for the classification into level 2 or 3 IMs, with a global Cohen's Kappa of 0.82.

2.4 | Quantitative data analysis

Data on the proportions of level 2 and level 3 IMs, the MFQ scores at pre- and at post-treatment, change in MFQ scores (pre-post), and the categorization as recovered or unchanged, for each case, was compiled and analysed using Microsoft Excel® and IBM SPSS Statistics 25®.

Regarding the statistical testing of associations between variables and the comparisons between contrasting groups, considering that most variables of interest were not normally distributed (Shapiro-Wilks tests $p < 0.05$), and the small number of participants in each group, Mann–Whitney *U*-Tests were used. Although these non-parametric tests resort to data ranking, means (*M*) and standard deviations (*SD*) were used as descriptive measures.

The distribution of themes from the TA was analysed descriptively, taking into account the treatment outcomes (recovered vs unchanged). Non-parametrical Mann–Whitney *U*-Tests were performed to compare the distribution of the themes in the outcome groups. Given the small sample size and the lack of balance between treatment groups (five recovered cases for STPP and seven for CBT), we did not compare CBT with STPP.

2.5 | Thematic analysis

Thematic analysis (TA) is a flexible way of organizing and analysing qualitative data, allowing for the description of the themes included in

a given data set. The TA followed the recommendations of Clarke, Braun, and Hayfield (2015) and Clarke and Braun (2018) and entailed three steps: (1) first, reading and code selection (i.e., IMs extracts), (2) coding the data and (3) defining the themes. Three coders were involved in the TA, the second, fifth, and sixth authors. Considering that the second and sixth authors were already involved in the IMs coding, a third coder (fifth author) ensured an independent analysis. All the coders were unaware of the cases' outcomes.

The first step was conducted by the second author, who read all the IMs and defined a set of codes including the different changes referred by the clients. A critical realistic epistemological approach was chosen, albeit considering that the studied phenomenon is centred on each patient's subjective/psychological view. At the end of this step, the coders met and discussed the identified codes and possible themes. Codes resulting from the discussion were arranged before the independent coding. The second step was conducted by the second and fifth authors, who coded all the data independently. Each IM was considered a meaning unit that could include several codes. However, each code could only be identified once in each IM. A code was only identified when explicit references to its content were present. At the end of step two, the two coders met and discussed disagreements to reach a consensus. The third step started with a re-reading of the materials in order to consolidate the codes (i.e., merging codes that were similar) and a first attempt to aggregate the codes into themes. After re-reading the data the three coders met to discuss the resulting themes. The coders considered that horizontally defined themes were closer to the phenomena than inferring a hierarchy within the themes, due to the diversity of changes experienced by the clients. The resulting organization of codes in themes was revised several times until the coders considered that it reached the double criteria of internal coherence and external diversity (Braun & Clarke, 2006; Patton, 1990). This means that each theme is coherently defined and is distinctive from the other themes and that the whole set of themes is an adequate description of the phenomena. The TA followed a codebook approach, considering that a set of codes were defined as a first step (step 1), from the data, that were used in the subsequent coding (step 2) and themes definition (step 3).

2.6 | Authors' reflexivity

Following Walsh (2003) and Olmos-Vega et al.'s (2022) dimensions of reflexivity, the TA coders took into consideration personal and methodological reflexivity through collaborative reflection from the onset of the analysis. Although the coders were unaware of the interviewees' outcome, there were expectations regarding the closeness of themes to the IMs definition. In this sense, coders maintained the themes definition close to interviewees own words and were attentive to excessive inference. The coders had several meetings throughout the process to discuss how their views could bias the results and to ensure that the TA was following the adequate steps. Moreover, one of the coders of the TA was not actively involved with IMs research, to ensure an independent look at the data.

3 | RESULTS

3.1 | IMs and treatment outcomes

To ascertain comparability between recovered and unchanged cases, Mann–Whitney U-Tests were conducted and revealed no significant differences (all $p > 0.05$) for participants' age, pre-treatment symptoms scores, and length of post-treatment interviews. Thus, the differences between groups cannot be attributed to symptom severity at treatment onset, different ages or different degrees of elaboration in the interviews at the end of treatment. Proportions of IMs reported below use as the denominator the entire text of the interview.

The comparisons between groups revealed significantly greater proportions of IMs in the post-treatment interviews from the recovered group, both for level 2 IMs (recovered: $M = 8.3\%$, $SD = 2.9\%$ vs. unchanged: $M = 2.9\%$, $SD = 3.1\%$, U $[N_{rec.} = 12, N_{unch.} = 12] = 17.00$, $z = -3.17$, $p = 0.001$) and for level 3 IMs (recovered: $M = 4.4\%$, $SD = 3.2\%$ vs. unchanged: $M = 0.2\%$, $SD = 0.6\%$, U $[N_{rec.} = 12, N_{unch.} = 12] = 19.50$, $z = -3.38$, $p < 0.001$). This shows that participants from the recovered group produced more IMs, both level 2 and 3, than unchanged cases.

Throughout the post-treatment interviews, considerable segments of the adolescents' narratives were coded as level 2 and level 3 IMs (see Table 1). The proportion of IMs ranged from less than 1% in some unchanged cases to 20% in one recovered case. Level 2 and level 3 IMs were generally higher for recovered than for unchanged cases. While the majority of recovered cases did articulate level 3 IMs, such IMs were almost completely absent in unchanged cases, with the exception of one. However, two outliers, both in the recovered (case 9) and in the unchanged (case 15) group, must be noted.

3.2 | Themes present in the IMs

Text coded as IMs was analysed with TA. The TA performed on all 197 IMs of the 24 participants, identified two main themes and eight subordinate themes, comprising 19 codes. The two main themes were identification of changes (theme A) and the attribution of changes (theme B), with four subordinate themes each (Figure 2). Below, we underline the main themes and used italics to identify the subordinate themes, to facilitate the readability of the results.

3.2.1 | Themes description

The identification of changes theme included subordinate themes in which participants elaborated upon what was different in their lives after treatment. The first subordinate theme, *changes in the self (A1)*, included codes that referred to positive modifications in self characteristics (e.g., being more confident, calmer) or increased self-validation or self-acceptance. The second subordinate theme, *changes in performance and achievement (A2)*, comprised codes such as concrete modifications in behaviour, improved mastery in coping skills

TABLE 1 Proportion of level 2 and 3 IMs coded in each case.

Case	Outcome status	Treatment type	Proportion of level 2 IMs in %	Proportion of level 3 IMs in %
1	Recovered	CBT	11	8
2	Recovered	CBT	11	9
3	Recovered	CBT	11	7
4	Recovered	CBT	10	7
5	Recovered	CBT	5	3
6	Recovered	CBT	5	4
7	Recovered	CBT	8	6
8	Recovered	STPP	11	0
9	Recovered	STPP	4	0
10	Recovered	STPP	8	6
11	Recovered	STPP	4	3
12	Recovered	STPP	11	0
13	Unchanged	CBT	1	0
14	Unchanged	CBT	2	0
15	Unchanged	CBT	11	0
16	Unchanged	CBT	3	0
17	Unchanged	CBT	<1	0
18	Unchanged	STPP	2	0
19	Unchanged	STPP	5	2
20	Unchanged	STPP	<1	0
21	Unchanged	STPP	1	0
22	Unchanged	STPP	<1	0
23	Unchanged	STPP	2	0
24	Unchanged	STPP	5	0

Note: Proportions of level 2 and 3 IMs coded in each case.
Abbreviations: CBT, cognitive-behavioural therapy; IMs, innovative moments; STPP, short-term psychoanalytic psychotherapy.

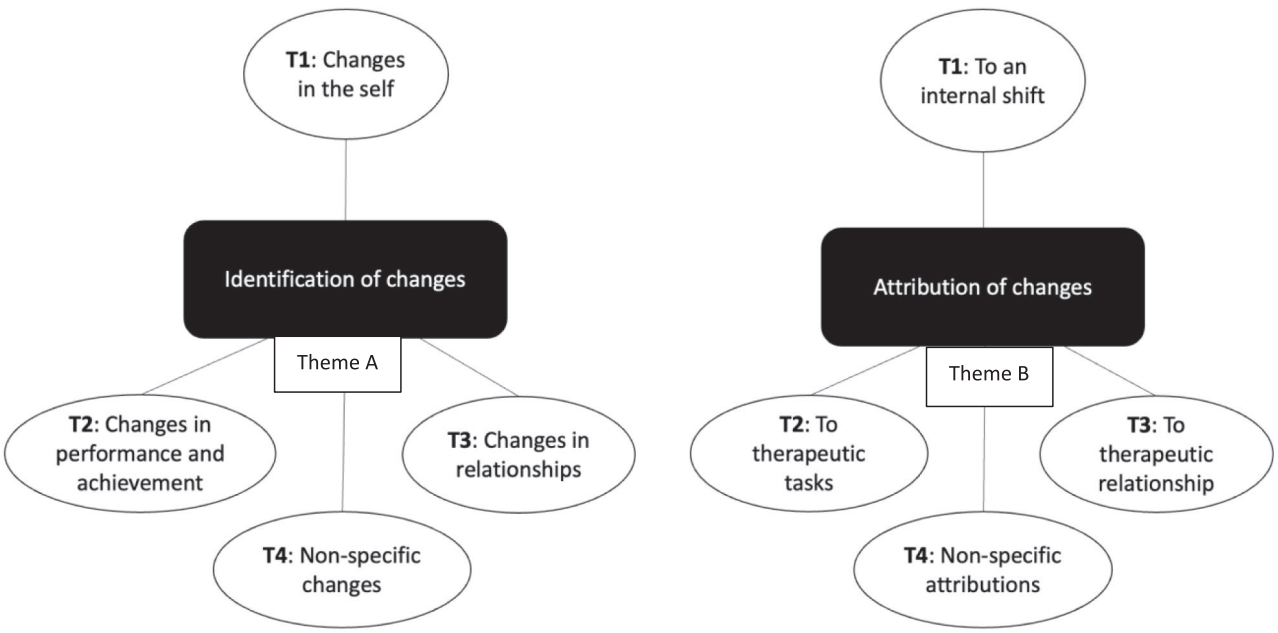

FIGURE 2 Organization of the themes.

and/or an increase in work, school or life achievements. The third subordinate theme, *changes in relationships (A3)*, included the following codes: identification of changes at the interpersonal level, either in family, school or work contexts, feeling of being validated by others, be it peers, teachers or family. The fourth subordinate theme, *non-specific changes (A4)*, included codes referring to general or non-specific changes such as 'things are better now'. This theme was only coded when no other was identifiable, that is, when the participants did not refer to what was better or different in their lives.

The attribution of changes main theme included subordinate themes in which participants elaborated upon the possible causes for their improvements. The first subordinate theme, *attribution of changes to an internal shift (B1)*, included a code in which participants explained the improvements by a change in perspective. In other words, participants attributed their changes to an internal shift, such as thinking differently (e.g., thinking on the consequences of actions), having a new interest in spirituality, or being motivated by therapy to change. The second subordinate theme is *attribution of changes to therapeutic tasks (B2)*, with codes in which participants explained their improvements by relatively specific tasks, either in-session (e.g., discussing problematic patterns or alternative behaviours) or between-session (e.g., writing a journal, doing homework or practicing breathing exercises). The third subordinate theme, *attribution of changes to therapeutic relationship (B3)*, comprised codes that involved the justification of changes by aspects of the therapeutic relationship, such as feeling understood or not judged by the therapist. Finally, subordinate theme four was *non-specific attribution of changes (B4)*, in which participants did not address clearly how or why they changed, mostly referring to therapy as having helped them to get better or that things in their lives improved after letting the therapist help, but without further elaboration. This theme was only coded when no other was identifiable, that is, when the participants did not explain how therapy helped them. Table 2 contains a complete description and illustration of the two main themes with the eight subordinate themes.

Following consensual qualitative research categories (Hill, 2012), the main theme identification of changes (theme A) was general (present in all of the cases), while attribution of changes (theme B) was typical (present in more than half of the cases). Considering the subordinate themes, none of them were general. All the subordinate themes from identification of changes (i.e., themes A1, A2, A3, A4) were typical, as well as theme B3 (*attribution to therapeutic relationship*) from attribution of changes. The other subordinate themes (i.e., themes B1, B2 and B4) were variant (present in half or less than half of the cases). Considering the heterogeneity of the sample, the absence of consistently present themes at the subordinate level is understandable.

3.2.2 | Themes distribution and outcomes

The recovered group presented a mean of 1.85 subordinate themes per IM (252 categories/136 IMs), whereas the unchanged group presented a mean of 1.33 (76 categories/57 IMs). This difference was statistically significant ($z = -2.20$, $p = 0.028$). This means that the IMs of the recovered cases have more themes of change, compared to those of the unchanged cases.

The two main themes were identified in both groups and identification of changes (theme A) was more prevalent than attribution of changes (theme B), in both groups, corresponding to 78.95% of the codes in the unchanged cases and to 73.41% in the recovered group. Thus, the description of changes was more common than the attribution or explanation of those changes, in both groups.

Figure 3 shows the proportion of each subordinate theme in the recovered and unchanged groups, and the results of the Mann–Whitney *U*-Tests. In the recovered cases most identified changes were *in the self* (A1, 30.16%) and in *performance/achievement* (A2, 23.41%), followed by *changes in relationships* (A3, 11.51%), and lastly *non-specific changes* (A4, 8.33%). Attributions of changes were mainly distributed by *internal shift* (B1, 7.54%), *therapeutic tasks* (B2, 7.54%) and *therapeutic relationship* (B3, 6.75%), and lastly *non-specific attributions* (B4, 4.76%).

In unchanged cases *non-specific changes* was the most frequent subordinate theme (A4, 25%), followed by *changes in performance/achievement* (A3, 23.68%) and *changes in the self* (A1, 21.05%), and lastly by *changes in relationships* (A3, 9.21%). Most changes were attributed to *specific therapeutic tasks* (B2, 11.84%), followed by attributions to the *therapeutic relationship* (B3, 3.95%), *non-specific attributions* (B4, 3.95%) and lastly to an *internal shift* (B1, 1.32%).

Significant differences between groups were observed for theme A1 (*changes in the self*), and A4 (*non-specific changes*) of the main theme identified changes, and for theme B1 (*attribution of changes to an internal shift*) of the main theme attributions of changes. *Changes in the self* (A1) were more typical in the recovered group ($z = -2.59$, $p = 0.010$), while the *non-specific changes* (A4) theme was significantly more frequent in the unchanged group ($z = -2.62$, $p = 0.009$). Lastly, attributions of changes to an *internal shift* (B1) were significantly more frequent in the recovered group ($z = -2.62$, $p = 0.009$).

4 | DISCUSSION

This study entailed two main contributions: the retrospective identification of change markers (the IMs) in a novel population (adolescents), and the tracking of the main themes present in the IMs. The results confirm previous findings with post-therapy interviews (Montesano et al., 2015) and is in line with studies with adults (Gonçalves, Ribeiro, et al., 2017) that IMs centred on change (level 2 and level 3 IMs) are more frequent in recovered cases.

The thematic analysis of the IMs showed that most of the level 2 and level 3 IMs were centred on two main domains, the identification of changes (what changed) and attributions of changes (how/why did it change), with the first domain being much more frequent than the second. Moreover, the IMs of recovered participants contained significantly more themes, indicating that on average these participants were able to elaborate on more topics in each IM. The

TABLE 2 Main themes, subordinate themes and codes included and examples.

Main themes	Subordinate themes	Codes included and examples
Identification of changes Theme A	**THEME 1 Changes in the self**	- ***Changes in facets of the self*** - identification of changes in characteristics of the self, such as being less stubborn, more optimistic, having increased self-understanding or emotional expression. *P: I think that's part of the reason why people describe me as an extrovert it's just … not coz I'm an extrovert but they just think that because I'm more confident like I'm more open coz it's like I just don't care it's like … (…) I don't care about what people think about me (…)* [Case 1] - ***Changes in emotional states*** - changes in mood (less sadness, anger, frustration), feeling lighter, happier, feeling less stressed/calmer, less fear and worry. Being more emotionally stable. *P: (…) when I look back and think how I was I like-I just can't believe it like it-it was so horrible … and compared to how I am now like I'm-I just feel so much happier… (…) you know like if I get-if like I get into a mood or something I can get out of it really easily and I don't dwell on it (…)* [Case 2] - ***Self-validation and self-acceptance/normalization*** - validation of own experience, increased self-esteem, more confidence, normalization of problematic experience, increased self-acceptance and feeling good about oneself. *P: When I joined a society as well like that was taught me like just take every single opportunity coz it's like you just think like what's the worst could happen … (…) and like even if something bad did happen you're still learning so …* [Case 1]
	THEME 2 Changes in achievement/ performance	- ***Behavior changes*** - identification of concrete and specific changes in behavior, such as getting involved with new activities or going back to old ones, being assertive and not wanting to hurt or kill him/herself. *P: so … I'm going back to school … (…) sort of regularly … (…) I'm basically back on track so that's good …* [Case 3] - ***Increased coping skills*** - increased coping skills in dealing with problematic behaviors. *P: normally I would just oh I feel really down and make myself feel worse like think about even worse things but now I'm just more likely like I did something like I tried to think about something else I knew why I felt depressed and…* [Case 10] - ***Increased achievement*** - references of being able to achieve more in school, at work and/or in life. *P: Err, I just think ya know, like your kind of physical health helps your mental health, and it realises sort of certain chemicals and endorphins (…), and then the same fing as with kind of working and stuff, it manages to give you a bit of a sense of achievement (…) just do more wiv your day* (…) [Case 21]
	THEME 3 Changes in relationships	- ***Validation from others*** - feeling validated from others, including the therapist. *P: 'she [therapist] helped me realise like they actually want me to come back I'm… like it made me felt-feel needed again… (…) like and that I wasn't completely useless that someone wanted me to be there…'* [Case 11] - ***Improved family relationships*** - improvements in family context, better communication, less conflicts, etc. *P: I know my relationship with-with my family has… got a bit better since I've been with IMPACT… there's like… now I can get along with… my family I can talk to them for a whole week without arguing like 600 times with them…* [Case 16] - ***Improved social relationships*** - improvement in social relationships in general, with peers, teachers, etc. *P: (…) now I love socialising I love have people round I love sort of talking to people on skype like.. sort of got everyone comin round at 6 to ha-have a little s-like catch-up sesh… watch skins or something this is what I enjoy now …* [Case 13]
	THEME 4 Non-specific changes	- ***Non-specific indication of change*** - general indications of change, without any specification (e.g., 'my life changed a lot' or 'things are better now'). *P: but it's a lot better than before, how it was*. [Case 17]
Attribution of changes Theme B	**THEME 1 Attribution to an internal shift**	- ***Change of perspective*** - attribution of change to thinking differently and/or a change of perspective, having an insight, anticipation of events, interest in spirituality, etc. Includes attribution of the perspective change to therapy. *P: also CBT which helped me change my thought patterns and like especially the destructive ones and the ones the self … the self-hate has definitely reduced, I mean I don't think it's there anymore, it's not, like I'll have feeling, I'll criticize myself (almost whipers this) but it isn't hate … (…) and … yeah I think it's just ME*. [Case 20] - ***Willingness to recover & noticing improvements*** - attributions of changes to the will and motivation to get better, or to noticing improvements due to therapy, leading to further engagement in therapy. *P: ummm … seeing it all happen like … I can see what led up to what and how … (…) like the domino effect it just happened … (…) I guess coz … how … the one event triggered … a lot more*. [Case 3]

(Continues)

TABLE 2 (Continued)

Main themes	Subordinate themes	Codes included and examples
	THEME 2 **Attribution to therapeutic tasks**	- ***Doing things differently in-between sessions*** - attribution of change to doing things in between sessions proposed by therapists or as a direct consequence of sessions. *I: so things that you would kind of talk about together and then you would go and do them, yeah okay erm and how did you find that …* *P: yeah I think that was quite helpful it was a lot more helpful than just talking about it … (…) because like it made sure that there's an actual link between being … between therapy and the rest of my life … so that's how I could actually make an impact …* [Case 1] - ***Doing cognitive/analytic work*** - attribution of change to in-session work such as identifying solutions and how to implement them, doing pros and cons, discussing problematic patterns. *P: umm I think the therapy was a big part of that … (…) erm and it sort of just helped me … order things in my life I guess … (…) like a puzzle just … making sure everything fits together …* [Case 3] - ***Doing therapeutic specific exercises*** - attribution of changes to specific exercises such as breathing exercises to calm down, writing feelings, etc. *P: 'I was going to cut myself for some whatever reason… and… I just wrote down the reasons not to… (…) and the reasons to do… er and I just found the reasons not to were other people so I just didn't do it that kind of helped me not do it…'* [Case 6]
	THEME 3 **Attribution to therapeutic relationship**	- ***Comparing with the therapist*** - attribution of change to positive comparison with the therapists, leading to more self-confidence. *P: what I found like the most helpful was when she [therapist] would talk about her personal life, it wasn't like personal it was just like … I did this-like … yeah I went to [name of place], and then I did this and then I did that … coz I remember … it just meant that I could see … more about other people's lives that I could compare … (…) so it's kind of like I would have like a real example and that would give me more hope (…)* [Case 1] - ***Being listened by the therapist*** - attribution of change to effects of therapeutic relationship, such as feeling understood, not feeling judged, being able to express feelings and thoughts with the therapist. *P: so with the… the therapist it was just sort of like… I could just let it out… and say what I wanted to say coz yeah that she didn't know me that well but also… like… I can't explain it but… it's really hard to explain… it is the distance but it's sort of like she was there for that-that reason and the reason only I suppose… so nothing else mattered it didn't really matter if she thought I was weak or whatever she had seen loads of other people with it as well…* [Case 11]
	THEME 4 **Non-specific attributions of change**	- ***Non-specific attributions of change*** - attribution of changes to therapy or therapist without specification (e.g., 'things improved when I let therapist help' or 'therapy helped me to get better'). *P: yeah … and I think … only in the last kind of … few session like the last maybe three or four … I kind of realised that, it was actually helping me, I mean in-in the session-all I really did was talk like how I'm talking to you just telling her what happened during the week and I'd go off into all sorts of other stories and that are completely irrelevant and then like I you know and now I look and I think all that time you know I hear I mean it must have helped me like I'm cured (laughs) if you wanna put it like that …* [Case 2]

identified changes covered several aspects of participants' lives and were mainly attributed to an internal shift but also to dimensions associated with psychotherapy. Other studies, with different methodologies (e.g., repertory grid), also found changes in self-knowledge as associated with a reduction in depressive symptoms in adolescents (Paz et al., 2019).

The main differences between the recovered and the unchanged group in regard to the nature of their IMs were the larger focus on the self in the former and the higher identification of non-specific changes in the latter. The focus on the self in recovered cases occurred both for the identification of changes (main theme A) and for the attributions of changes (main theme B). These results suggest that besides the differences in IMs levels, there may also be differences in the content of IMs, and this study is the first known study to evaluate this with a thematic analysis of IMs. In this study, recovered participants consistently described more changes in themselves, which may indicate that the achieved changes were deeper and more meaningful, affecting them as a person, and not only their behaviour or relationships. By contrast, unchanged participants identified vaguer, non-specific changes. At the same time, recovered participants attributed the changes to a shift in their perspective, suggesting a more agentic appropriation of the process of change. These results are consistent with theories that emphasize the central role of personal agency, such as the self-efficacy theory (Bandura, 1989) or the self-determination theory (Ryan & Deci, 2000). Narrative therapists (White, 2007; White & Epston, 1990), from whom the concept of IMs emerged, refer to this as restoring a position of authorship, that was threatened by the constraints of the problematic view of the self, which is part of the depressive presentation. Other therapeutic models also emphasize this dimension (e.g., CBT and psychodynamic therapy), given the demoralization (Frank & Frank, 1993) that affects clients and that therapists address at the onset of therapy.

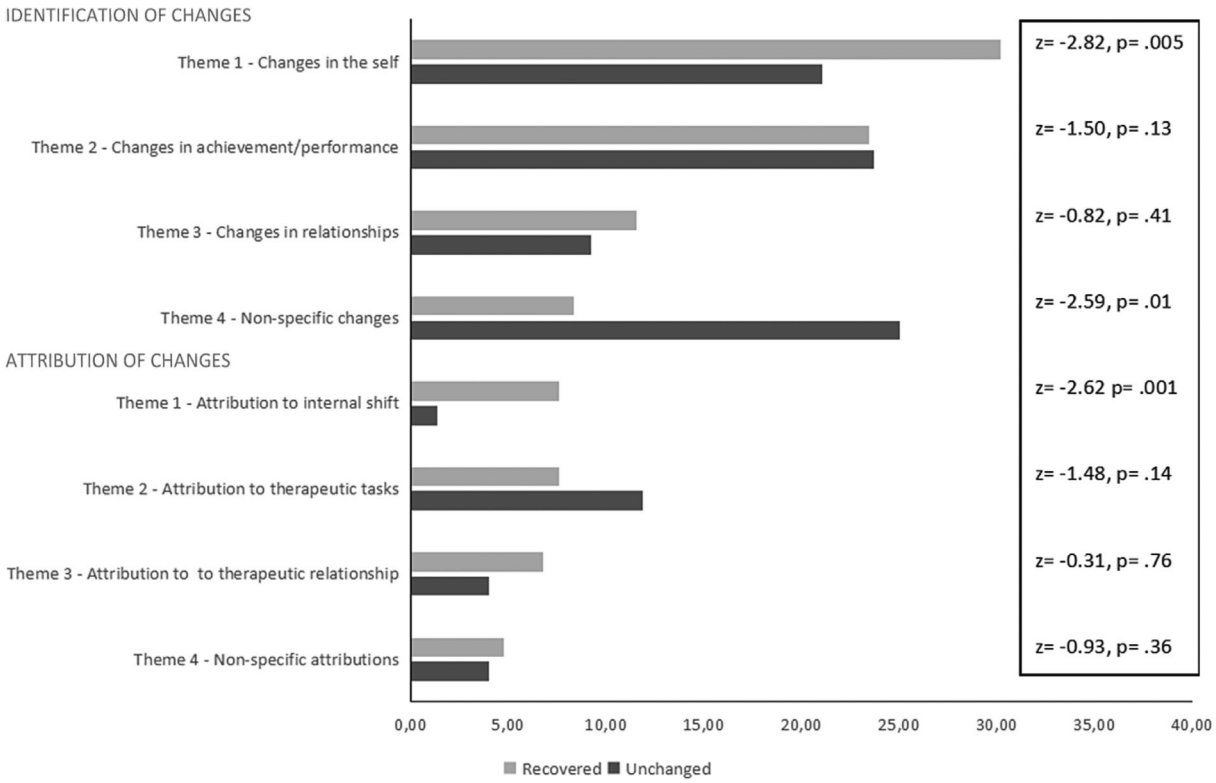

FIGURE 3 Theme proportions in the recovered and unchanged groups. Note: Proportions were used due to the unbalanced number of codes in the two groups.

Heatherington et al. (2012) conducted a study in which they asked a sample of clients ($N = 76$) about their perspective on 'corrective experiences', with two main questions. One centred on how clients viewed these experiences (experiences of changes, or meaningful experiences) that took place during therapy, and one centred on who or what facilitated the changes. Regarding the first question, six categories emerged, such as changes in the sense of the self, new experiential awareness, new perspectives (more cognitive than the previous one), recognition of hope, acquisition or use of new skills and changes in behaviours. The first four categories are consistent with the theme changes in the self of our study, and the authors found that the second (new experiential awareness) and the third category (new perspectives) accounted for more than half of the responses. Regarding the second question (what allowed change to occur), almost half of the responses focused on something that the client did (other responses were something that the therapist did, something that client and therapist did together, and something external). This latter question does not fit entirely with the categories of our study, as there was an emphasis on 'doing'. Nonetheless, the results from this study highlight the importance of centring the process of change on the client, including their sense of agency (see also Tallman & Bohart, 1999).

Other studies also found changes in the self as relevant to change in psychotherapy, such as acceptance, self-appreciation in depression (Fernández et al., 2022) or gaining new perspectives, becoming more in touch with one's own emotions, experiencing relief, feeling empowered or accepting self/problem (Ladmanová et al., 2022). This latter study, which is a review of 17 qualitative studies on helpful and hindering events, also found many helpful events consistent with the themes found in our theme attribution of changes. These centred on the therapeutic relationship, such as feeling heard, understood and accepted, having a sense of reassurance/feeling supported/having a sense of hope, feeling safe with and trusting the therapist, experiencing a personal connection with the therapist and feeling engaged in the therapeutic process.

It should be noted that the studies referred to above were not based on the framework of IMs, and were largely focused on adult clients, and as such studies captured core helpful events from an observer perspective, using IMs as clinical markers of relevant moments (although assessed retrospectively). Nonetheless, studies conducted with adolescents in non-clinical settings also converged with the notion that early agency beliefs have a strong impact on school adjustment (Walls & Little, 2005) and that self-efficacy beliefs determine both task performance and coping (Tsang et al., 2012).

From a developmental stance, perspectives on the narrative construction of self and identity (e.g., Fivush & Haden, 2003; McAdams, 1993) have pointed out that the 'life story serves to create a sense of coherence, unity, and purpose, which is considered to be of prime importance for mental health and well-being' (Habermas & de Silveira, 2008, p. 708). Cognitive and metacognitive autobiographical reasoning processes, that allow for the narrative elaboration of temporal, causal and thematic coherence, develop gradually during

adolescence (Habermas & Bluck, 2000), enabling youth to address the central developmental challenge to construct a coherent self-narrative. The central role of the self, regarding the identification and attribution of changes, found in IMs of youth that recovered from depression, suggests that these participants were able to meaningfully relate, elaborate and integrate experiences and insights achieved throughout treatment into their self-narratives. For the participants who did not recover, the question is warranted whether a less developed narrative self may have hindered the elaboration and integration of changes, and prevented these participants from fully retrieving the benefits of their therapeutic work. These issues should be addressed in future research on therapeutic work with youth, and may highlight the importance of scaffolding emergent autobiographical reasoning processes and the gradual refinement of how the life story is narrated, according to each young person's needs.

If the results from this study are replicated in future research, it would suggest that therapists working with adolescents should make an effort to identify and facilitate therapeutic exploration and elaboration of changes occurring in the client's self, and on how the self has changed. Furthermore, therapists may take references to non-specific changes as a probable sign of lack of meaningful or deep changes. As in previous studies with adults (e.g., Gonçalves, Ribeiro, et al., 2017; Montesano et al., 2017), such findings invite us to reflect on ways to promote therapeutic change by fostering personal agency and authorship regarding self-narrative innovations and their consolidation.

4.1 | Limitations and future directions

The small sample size with two types of therapy is a major limitation of this study, along with the outcome imbalance between therapeutic groups, which prevented comparisons of the therapeutic modalities (i.e., CBT and STPP). Moreover, although the production pattern of IMs across the sample followed the expected trends, some intriguing outliers must be noted, and it could prove fruitful to study such cases in more detail.

To avoid bias the main judge of IMs and the main coder of themes were different researchers. However, the main researcher who coded the themes is part of the team that studies IMs, which may have biased the coding process. In the future, identification of themes present in IMs should preferably be made by coders that are unaware of IMs coding. Related to this, the themes present in IMs may just reflect the Experience of Therapy Interview schedule, that is, the changes over time and the processes that led to the individuals' outcomes.

Another limitation refers to the cultural background of these patients, a sample collected in the United Kingdom, leaving it unclear if participants with other cultural characteristics would elaborate IMs involving a different conception of agency, less centred on the self and more centred on community (Markus & Kitayama, 1991).

Furthermore, the post-treatment interviews used in this study did not allow for the analysis of the step-by-step change processes across the therapeutic sessions, nor for a study of the temporal relationship between unfolding IMs and improvements in depressive symptoms. Future research on therapy sessions with adolescents is necessary to enable a deeper understanding of change processes within and across the course of psychotherapy with adolescents. This would enable exploration of the longitudinal patterns of IM production, the role of level 1 IMs, and their temporal relationship with personal change and improvement in symptoms. The IM judges had the impression that the difficulty in identifying level 1 IMs was the result of studying IMs retrospectively, although other implications are possible. One of these possibilities is that level 1 IMs are not important to the change at least in adolescents. Future research should thus clarify the role of level 1 IMs for therapeutic gains.

On the positive side, these findings on how changes in psychotherapy were understood by the clients themselves seem relevant and invites future research endeavours. Making use of post-therapy or post-session interviews rather than session transcripts allows for less resource-intensive coding procedures and thus enables studies with larger samples. Additionally, interviews may be used to focus on specific phenomena involved in personal change, on particular treatment variables, on specific moments in time, previous to, during or after therapy or on specific circumstances, facilitative or hindering factors for change, in accordance with the research questions and priorities in hand.

The focus on changes in the self, both at the level of 'what changed', and of 'attributions of changes', is an interesting finding associated with recovered cases; while a focus on non-specific changes, associated with unchanged cases, could be a useful prompt for therapists to reflect on what may be working less well with these clients, preventing them from identifying more specific changes. Finally, the hypothesis that there may also be differences in the content of IMs should also be studied in different samples to confirm these results.

In sum, despite some limitations, this study illustrates the relevance of studying IMs in a sample of adolescents in psychotherapeutic treatment and provides further support for the applicability of the IMCS to retrospective interviews (at least for high-level IMs). It suggests that the frequency of IMs in adolescents' narratives can meaningfully distinguish between recovered and unchanged cases and that there may also be differences at a thematic level between how these two groups speak about what has changed, and how they understand that change has taken place. The findings encourage more process-outcome research with this population, particularly important to understand change processes and improve our efforts to ameliorate mental health outcomes in young people.

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