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Innovative Moments in Humanistic Therapy I: Process and Outcome of Eminent Psychotherapists Working with Bereaved Clients

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This project entailed an intensive qualitative analysis of six-session psychotherapies conducted by three eminent humanistic psychotherapists working with bereaved clients. The Innovative Moments Coding System (IMCS), rooted in narrative therapy, is designed to measure change across therapy orientations. Research using the IMCS suggests that the psychotherapy change process occurs through the emergence, elaboration, and expansion of identifiable change moments for a client—*innovative moments* (IMs)—which present as exceptions to a client's presenting problematic narrative. There are five identified types of IMs: action, reflection, protest, reconceptualization (RC), and performing change (PC). The current study aimed to inform theory regarding the patterns of IMs across three humanistic approaches—constructivist, person-centered, and existential—when working with bereaved clients, while linking these patterns to observable change in each client's functioning. The alliance between each client and therapist was also assessed across the therapy process, showing consistently strong alliances across the three cases. Findings from the current study reinforce the salience of reflection, RC, and PC IMs in successful grief therapy cases, and also suggest the importance of meaning-making interventions in grief therapy. Clinical implications and suggestions for future research are also addressed.

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Most individuals will experience bereavement at some point in their lives, typically losing several significant people throughout their life spans. Therefore, loss is a universal human experience that is naturally followed by grief, which facilitates adjustment to life in the wake of loss. Most bereaved individuals respond to their changed worlds resiliently, experiencing minimal or no changes in functioning, and remaining stable over time (Bonanno, 2004; Bonanno & Kaltman, 2001). In fact, some individuals find that loss catalyzes a movement toward new identities, social roles, and goals (Stroebe & Schut, 1999) in a way that leads to positive growth (Bonanno, Wortman, & Nesse, 2004; Calhoun & Tedeschi, 2006). Conversely, losses can fracture a bereaved individual's previously held beliefs and understanding of the world. This threat to one's meaning system can be impairing, leaving the bereaved individual in a world that appears chaotic and incomprehensible (Neimeyer, Burke, Mackay, & van Dyke-Stringer, 2010). In such cases, bereaved adults might become functionally impaired when facing life without the deceased, experiencing the clinical symptoms of depression, anxiety, or posttraumatic stress disorder (PTSD) for 1 to 2 years following the loss (Bonanno & Mancini, 2006). Furthermore, a subset of approximately 10% to 15% of bereaved individuals will experience protracted symptoms of complicated grief (CG; Shear et al., 2011), also known as prolonged grief disorder (PGD; Boelen & Prigerson, 2007; Prigerson et al., 2009). This reaction entails persistent and debilitating preoccupation with the loss, including role confusion, a diminished sense of self, difficulty accepting the loss, lowered trust in others, problems moving toward valued goals, feeling numb, and experiencing life as without purpose (Prigerson et al., 2009).

Meaning Making in Bereavement

The search for meaning after loss has been demonstrated across various populations of bereaved individuals, such as those contending with sudden and traumatic losses resulting from motor-vehicle accidents (Lehman, Wortman, & Williams, 1987), homicide loss (Currier, Holland, & Neimeyer, 2006), sudden infant death syndrome (McIntosh, Silver, & Wortman, 1993), and suicide (Murphy, Johnson, & Lohan, 2003), as well as in the context of more normative losses through natural causes (Holland, Currier, & Neimeyer, 2006). The ability to create meaning following loss has been linked to several positive outcomes, such as less intense grief reactions (Schwartzberg & Janoff-Bulman 1991) and more positive adjustment across social, physical, and psychological domains (Bower, Kemeny, Taylor, & Fahey 2003; Coleman & Neimeyer, 2010; Davis, Wohl, & Verberg, 2007; Keesee, Currier, & Neimeyer, 2008; Murphy et al., 2003; Stein, Folkman, Trabasso, & Richards, 1997).

When meaning is not attained, however, a grieving individual might experience a problematic worldview that is narrowly constricted by loss. Contemporary models of grief, such as the dual process model (DPM; Stroebe & Schut, 1999), suggest that healthy grieving involves not only attending to loss but also attending to restoration-orienting strategies, such as exploring new relationships and goals. However, the oscillation between loss and restoration processes becomes increasingly difficult if mourners are unable to make meaning of their experiences. This crisis of meaning can produce grief complications that hinder the natural trajectory of grief.

A Humanistic Framework for Grief Therapy

Professionals often are called upon to help bereaved individuals who struggle in the wake of loss. Research indicates that individuals who experience such complicated or prolonged grief

responses are well served by professional intervention (Currier, Neimeyer & Berman, 2008; Prigerson et al., 2009; Shear et al., 2011). However, research has only recently begun addressing the active ingredients within effective grief therapy (Shear, Boelen, & Neimeyer, 2011), and more understanding of this topic is needed. Humanistic therapy approaches, which promote meaning regeneration and focus on the natural struggle with existential questions (such as those about death and aloneness), are well positioned to contribute to this effort. In the current project, grief-related therapy sessions conducted within the humanistic traditions of person-centered, humanistic-existential, and constructivist therapies were analyzed. Although these approaches vary in their conceptualization of distress and its treatment, all three modalities are characterized by the pursuit of relational attunement, with the therapist being empathically responsive to clients' unique conceptualization of the world, as well as their own specific wants and needs.

Person-Centered Therapy

Carl Rogers (1951, 1959) pioneered the development of client-centered therapy, which he later named person-centered therapy. His conceptualization of clients' innate growth tendencies shaped his therapy approach, which was notably different from behaviorist and psychoanalytic approaches of the time. Person-centered therapy was based on Rogers' theory that when clients are provided with sufficient conditions, they naturally develop in the direction of greater well-being. The role of a person-centered therapist, therefore, is to facilitate that natural process. As humanistic therapist Art Bohart (2003) explained, "Growth and healing happen from within the person, though external processes can facilitate or retard that growth . . . plants and children both grow themselves, though farmers and parents can foster or retard that growth" (pp. 119–120). This approach prioritizes the creation of a safe space in which clients can creatively and intuitively resolve their struggles. To attain such an environment, attitudes of congruency (in which the therapist is genuine with the client), unconditional positive regard (viewing the client with warmth and "prizing"), and empathic understanding (taking on the client's frame of reference) are viewed as both "necessary and sufficient" for change to occur (Rogers, 1957). Importantly, these attitudes must not only be enacted by the therapist but also be perceived by the client. Following the development of person-centered therapy, Rogers pioneered empirical research to document the process and outcome of person-centered psychotherapy. The core relational conditions of person-centered therapy are now considered primary facilitators of change in many therapy traditions, as documented by a good deal of research to better understand these dynamics across orientations (see Norcross, 2011).

Humanistic-Existential Therapy

Humanistic-existential (H-E) therapy is rooted in philosophical questioning about the struggles of human existence, and is guided by the overarching values of self-exploration, experiential reflection to identify the person one is becoming, and responsibility to respond to the discoveries yielded by self-reflection (Schneider, 2003). Therapists aim to cultivate a relational sense of "presence" to the client's unfolding experience, being aware of the "whole human being—conscious and nonconscious, past, present, and evolving" (Schneider, 2003, p. 153). Therapists aim to facilitate client self-awareness and personal growth by encouraging clients to grapple with the struggles inherent in the human condition, identified by Yalom (1980) as death, freedom, isolation, and meaninglessness. H-E therapists also use presence to help clients reconnect to their suffering

as well as find freedom in identifying opportunities to address these struggles in a more adaptive way. Therapists aim to help the client “find choice—meaning, clarity, and direction—in his or her life, in spite of (and sometimes, in light of) all the threats to these possibilities” (Schneider, 2003, p. 155).

H-E therapists use a variety of experiential techniques to help clients toward these aims, including role play, visualization, and embodied meditation (Schneider, 1995, 1998), but therapists are largely integrative (Schneider, 2007), using a variety of approaches as the client’s needs arise in the moment-to-moment unfolding of therapy. H-E therapists also call attention to client resistance, with aims to attune clients to “blocks to their aliveness,” allowing them to then intentionally respond instead of having to “succumb to the paths that beckon them” (Schneider, 2003, p. 167). In this portion of therapy, therapists aid clients in their “quest to actualize their life meaning” (p. 167) by inviting clients to explore potential new relationships, roles, and aspirations while also being attuned to social and spiritual contexts of clients’ intersubjective worlds.

Constructivist Therapy

Constructivist therapy is grounded in the human search for meaning to sustain a sense of psychological coherence and understanding of an otherwise disjointed world of experience. Constructivist therapists attempt to understand these internal worlds by eliciting the client’s self-narrative, which is “an overarching cognitive-affective-behavioral structure that organizes the ‘micro-narratives’ of everyday life into a ‘macro-narrative’ that consolidates our self-understanding, establishes our characteristic range of emotions and goals, and guides our performance on the stage of the social world” (Neimeyer, 2004, pp. 53–54). This coherent narrative serves to “create a sense of predictability in a rather unpredictable world” (Alves, Mendes, Gonçalves, & Neimeyer, 2012, p. 796). However, in efforts to do so the self-narrative can become restrictive, in which “the construction of reality is characterized by redundancy and loss of complexity” and “experiential diversity is rejected or ignored” (Gonçalves, Matos, & Santos, 2009, p. 3). For example, when a bereaved individual’s self-narrative becomes dominated by particular themes (such as the theme of loss), all new experiences are filtered through this problem-saturated story. Therapists working in this orientation enter into clients’ worlds of meaning by paying particular attention to clients’ language, affect, and use of metaphor, and using these in therapy.

This approach is “technically eclectic but theoretically consistent” (Neimeyer et al., 2010, p. 76), allowing for a variety of techniques to be used toward the goal of meaning making (Neimeyer, 2009, 2012). Some therapeutic tools include narrative exercises (e.g., letter writing to the deceased), experiential exercises (e.g., evocative visualization, empty chair dialogues), and the intentional engagement of resistance by eliciting the prosymptom positions that maintain the client’s problematic positions (Ecker & Hulley, 1996; Neimeyer, 2009, 2011). These and various other narrative and experiential techniques are used to aid the client in moving from the problem-saturated narrative to one that is more expansive and adaptive.

Tracking the Process of Therapeutic Change

These therapy approaches are united by overarching humanistic principles, but they vary in specific conceptualizations of how to create meaningful change in psychotherapy. Despite these differences, the Innovative Moments Coding System (IMCS; Gonçalves et al., 2009) provides a transtheoretical approach to analyzing the process of psychotherapeutic change. This coding

system has been applied to various therapy approaches but is rooted in the tradition of narrative therapy. In this perspective, clients present to therapy with a problematic self-narrative. Gonçalves and colleagues (2011) noted that this narrative-based concept parallels conceptualizations across several therapy orientations, such as cognitive schemas in cognitive therapy (Beck, 1976), core conflictual relationship themes (CCRT) in psychodynamic therapy (Luborsky, 1997), core constructs in constructivist therapy (Kelly, 1955) and affective problem markers in emotion-focused therapy (Goldman & Greeberg, 1997). Gonçalves and colleagues (2011) described two overarching similarities between these concepts. First, they asserted that these concepts describe several areas of clients' lives, including thoughts, feelings, behaviors, and social relationships. Second, they noted the repetitive pattern of these systems that lead to distress and dysfunction. Therefore, they suggested that the common goal of therapy across these theoretically differing orientations is to disrupt these patterns in order to "create alternatives of feeling, thinking, acting, and relating" (p. 498). The goal in narrative-based grief therapy, for example, is to help the bereaved individual find alternative meanings of the loss that will ultimately coalesce into a more adaptive self-narrative (Gonçalves et al., 2009). They asserted that this shift occurs by the identification, elaboration, and expansion of novel occurrences in the client's self-narrative. Gonçalves and colleagues (e.g., Gonçalves et al., 2009) conceptualized these deviations from the problem-saturated narrative as "innovative moments" (IMs), similar to the identification of "unique outcomes" by White and Epston (1990). These novelties emerge within the dialogue between client and therapist, but they describe any occurrences outside or inside the therapy session that deviate from the dominant problem-narrative. In other words, an IM occurs when a client feels, thinks, or behaves differently than the problem-saturated story would direct.

The Innovative Moments Coding System

The IMCS (Gonçalves, Ribeiro, Matos, Santos, & Mendes, 2010; Gonçalves, Ribeiro, Mendes, Matos, & Santos, 2011) is a qualitative analysis procedure developed to track the evolution of these novelties (i.e., innovative moments) throughout the therapy process. Prior to coding, a list of the client's presenting problems is created, which is closely aligned with the client's discourse and not based on a particular theoretical conceptualization (Gonçalves et al., 2011). Researchers have demonstrated the applicability of this system across several therapy approaches (i.e., client-centered, narrative, constructivist, and emotion-focused therapies) and with various clinical presentations (e.g., complicated grief, depression, survivors of intimate partner violence) in both good and poor outcome cases (e.g., Alves et al., 2012; Gonçalves et al., 2012; Gonçalves, Mendes, Ribeiro, Angus, & Greenberg, 2010; Matos, Santos, Gonçalves, & Martins, 2009). The IMCS was developed to code for contributions from both the therapist and client, with the theoretical underpinning that meaning in therapy is coconstructed (Angus, Levitt, & Hardtke, 1999). An IM can arise independent of the therapist's influence but might also result from the interaction of therapist and client. However, when offered by the therapist, an IM can be coded only if the client accepts the therapist's offering (e.g., question, observation, insight).

Types of IMs

The coding system has evolved from its initial version, which was based on an inductive analysis of narrative therapy sessions with intimate partner violence victims (Matos et al., 2009).

However, the five types of IMs identified in the original study have remained (Gonçalves et al., 2011): action, reflection, protest, reconceptualization, and performing change. Descriptions of each IM follow, along with illustrative vignettes generated by the present researchers.

Action IMs are specific behaviors demonstrated by the client that are incongruent with the problematic self-narrative. These can include new coping behaviors, searching for new solutions, or seeking information about the presenting problem.

Client (C): Last night, I socialized with friends for the first time in weeks.

This action performed by the client differs from the problematic pattern (i.e., self-isolation). This action will be coded again as an IM if the client mentions this activity later in therapy, as long as the client expresses that this activity brings forth change.

Reflection IMs occur when the client forms new understandings that challenge the problematic narrative and help create distance from the problem. This can include the client reconsidering what caused the problem and the ways the problem impacts the client's life. It can also include self-instructions by the client that promote more adaptive responses, or an intention to defy the problem in the future. These are sometimes accompanied by feelings of well-being.

C: I've realized that I've been isolating myself a lot because I'm scared of crying in front of my friends. But I'm starting to see now that it's just making things feel worse.

In this example, the client expresses a new awareness of the reason she is isolating herself, as well as the negative effects of her behavior.

Reflection can also refer to the client's reflection on the change process itself (termed reflection 2). Such moments include the client reflecting about the process of therapy or considering ways to overcome a presenting problem, sometimes with a new position emerging when faced with the problem.

C: It seems like coming here and talking to you in therapy has been helping. I find myself feeling hopeful again at times.

Here, the client reflects on changes created by the therapy process.

Protest IMs are similar to action and reflection IMs in that they involve new behaviors or thoughts that are incongruent with the problematic self-narrative. They differ, however, in that in addition to these components, the client also criticizes the problem and those who support the problem. Protest IMs can occur in two ways. The first refers to the client's critique of the problem or those supporting it (although it excludes client self-criticism).

C: I'm tired of my friends telling me I have to be so strong about her death! I'm not going to tiptoe around people and hide in my house just so they won't have to see me sad!

This example illustrates a moment in which the client repositions herself toward the problematic pattern (i.e., hiding her grief-related emotions out of fear of negative social interactions) and rejects this previous pattern with strong emotion.

The second form of protest IM (termed protest 2) involves the emergence of new, self-empowering positions, repositioning oneself in a different way toward the problem.

I'm not going to live like a hermit anymore! I can't live like this! I need to feel free to be myself, and that includes whatever emotions come with that—wherever I am!

This example is similar to the first in that the client emotionally rejects the problematic pattern but also asserts a realized need that was previously ignored.

Reconceptualization IMs are a form of “meta-reflection” (Gonçalves et al., 2011, p. 500) composed of two parts. First, there is a shift between the client’s past and present position toward the problem, and the client recognizes this change. Second, the client describes the process that enabled this change.

C: Today when I went to my daughter’s soccer game, I realized that I have come so far, coming out of my house and being able to engage with people again. I still have the sadness, but I’m not afraid of showing it like I used to be. I think it just took me testing the waters, trying out my fear of being vulnerable in front of others, and seeing that nothing catastrophic is going to happen if I cry. Now, I know, I’m just human, and people realize I’m going to be sad and cry sometimes.

Here, the client illustrates a shift from her former problematic self-narrative (i.e., It is important to isolate myself because it is unsafe to show emotion around others), and she is able to clarify the underlying process (i.e., testing a previously held belief without the feared outcome occurring) that helped this shift occur.

Performing change IMs include times when the client has made changes that allow for the enactment or anticipation of engagement in new activities, projects, relationships, or experiences. The client might describe versions of the self that were neglected while immersed in the problematic self-narrative.

C: I’m feeling ready to start joining activist organizations to help prevent gun violence. I feel stronger now to move forward, even though I’ll never be completely healed from her death. I can feel a new me coming through. I’m ready to make a difference in other people’s lives, because I couldn’t save hers.

In this example, the client talks about a new version of self that makes clear a shift from the problematic position, as well as subsequent activities and plans that are made possible with this new position.

IMCS Model of Change

Gonçalves and colleagues (2009) developed a heuristic model of change (see Figure 1) that has been more clearly refined by the numerous hypothesis-testing studies examining the application of the IMCS to good outcome (GO) and poor outcome (PO) therapy cases (e.g., Cunha et al., 2012; Gonçalves et al., 2012; Mendes et al., 2010; Santos, Gonçalves, & Matos, 2011) and application to single-case designs (e.g., Alves et al., 2012; Gonçalves et al., 2010).

Although IMs typically occur from beginning to end of therapy in both GO and PO cases, the GO cases have significantly more IMs than PO cases. Also, the patterns of IMs differ between GO and PO cases. Specifically, in PO cases, action, reflection, and protest are the primary IMs identified in the change process. However, in GO cases, these IMs emerge during the early and middle phases of therapy and then evolve into reconceptualization and performing change IMs, which involve more complexity—a pattern less typical for PO cases. Therefore, Gonçalves and colleagues suggested that action, reflection, and protest are necessary components of the change process, but they are insufficient in solidifying a new self-narrative. They surmised that

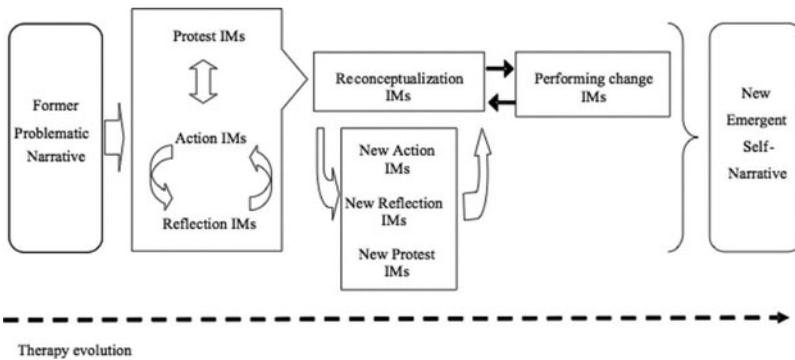


FIGURE 1 IMCS heuristic model of change in good outcome cases (Gonçalves et al., 2009). Used with permission.

the emergence of reconceptualization IMs is central to the formation of a new self-narrative, requiring the client to inhabit a meta-position that allows not only for a shift in past and present positions but also for the awareness of how the change occurred. This change process can then yield new action, reflection, and protest IMs. Also, performing change IMs are typically found after reconceptualization IMs, as these mark new experiences and goals that occur as a result of the client's change. Gonçalves and his colleagues (2015) provided direct support for this conceptualization of IM markers of meaning transformation prospectively predicting symptomatic change across the course of therapy, to a greater extent than symptom improvement predicts subsequent IMs.

The Present Study

The current project aims to contribute to the growing body of research exploring IMs—reliably identifiable moments of change for a client—and how they unfold both within and across sessions of humanistic therapy. This study highlights therapy conducted by three leaders in the field using their respective humanistic approaches, with an additional focus on their work with bereaved clients. The resulting study should inform theory regarding the types of IMs characteristic of each respective therapy modality when working with grief and loss issues, and suggest links to observable therapeutic change and working therapy alliance between client and therapist.

METHOD

Participants

The following therapists and clients participated in a commercially distributed video series created by the American Psychological Association (APA) to be used as a learning tool for students and professionals. As part of the *Psychotherapy in Six Sessions* series, eminent therapists across major therapy paradigms were invited to work with client volunteers over the course of six therapy sessions. This time-limited therapy model is representative of the movement toward brief

therapy (Hoyt, 2011) and is supported by a large-scale research study of nearly 2,000 clients that suggested significant clinical improvement is not necessarily dependent on treatment duration (Barkham et al., 2006). The videos include high-quality sound and audio footage of each therapy session in its entirety, with additional commentary available from the practicing therapist. The three following client-therapist dyads were selected for inclusion in the present study because of their commonalities in both humanistic therapy approaches, and working with clients facing varying bereavement-related issues. Brief descriptions of the therapists and their clients are offered below.

Therapists

David J. Cain, Ph.D., ABPP, is a contemporary leader of teaching and practice in person-centered therapy. He is a diplomat and fellow in clinical psychology of the American Board of Professional Psychology, and a member of the National Register of Certified Group Psychotherapists. He founded the Association for the Development of the Person-Centered Approach (ADPCA) in 1981, with the endorsement of Carl Rogers. He is active in supervising graduate and professional therapists and instructing, writing, editing, and presenting professional workshops on topics applicable to person-centered approaches (e.g., learning and teaching empathy, optimal conditions for therapeutic change). He serves as psychotherapy editor of *The Journal of Humanistic Psychology* and as a consulting editor of *The Humanistic Psychologist*. He has contributed several works on person-centered therapy (e.g., Cain, 2010, 2012a, 2012b). Currently, he teaches and supervises at the California School of Professional Psychology, San Diego, of Alliant International University and in the psychology department at Chapman University.

Kirk J. Schneider, Ph.D., is a licensed clinical psychologist who has extensively contributed to the development of contemporary practices and teaching of existential-humanistic psychology. He is a fellow of the Humanistic, Clinical, and Independent Practice Divisions of the APA, and is vice-president of the Existential-Humanistic Institute (EHI). Schneider received the Rollo May award from the Humanistic Psychology Division of the APA. He is a consulting editor for *The Humanistic Psychologist* and is senior consulting editor for *The Journal of Humanistic Psychology*. He also serves as adjunct faculty at Saybrook University and the California Institute of Integral Studies. Schneider has contributed many scholarly writings about H-E psychotherapy (e.g., Schneider, 2007; Schneider, Bugental, & Pierson, 2002; Schneider & Krug, 2009; Schneider & May, 2012) and is a leading spokesperson in H-E therapy, frequently engaging in conferences and media appearances.

Robert A. Neimeyer, Ph.D., is a licensed clinical psychologist and professor at the University of Memphis. He has an active psychotherapy practice and supervises graduate clinicians in various humanistic approaches, including constructivist therapy. He is a fellow of the Clinical Psychology Division of the APA and has contributed to theoretical and empirical literature on various topics such as meaning making (Neimeyer, 2001; Neimeyer & Raskin, 2000), constructivist psychotherapy (Neimeyer, 2009), and techniques of grief therapy (Neimeyer, 2012; Neimeyer, Harris, Winokuer, & Thornton, 2011). Neimeyer speaks about these topics at conferences and workshops both nationally and internationally. He serves as editor of *Death Studies* and *Journal of Constructivist Psychology*. He has served as president of the Association for Death Education and Counseling (ADEC), and chair of the International Work Group on Death, Dying, and

Bereavement. Neimeyer has received lifetime achievement awards from both ADEC and the International Network for Personal Meaning.

Clients

The current study includes therapy conducted with three clients who presented to therapy with varying distress levels related to grief and loss. A brief summary of each client's demographics and presentation is provided below.

Cain used a person-centered therapy approach in his work with Tina, an African-American woman in young adulthood. Tina presented to therapy after the recent and sudden loss of her father to cancer. She described vacillating between emotional stoicism in the presence of others and overwhelming sadness and crying when alone. She also found it difficult to reconcile the memory of a father she respected and loved with the "monster" who sexually abused her sister for years. Tina faced family tension as she struggled to square these very different personas of her father.

Schneider used an existential-humanistic approach with a Caucasian woman in her late 40s named Anita. She initially presented to therapy with a history of loss, including the death of her mother in childhood. Anita had been tasked to help parent her brother in the absence of her mother. She and her younger brother were raised by her father, who struggled with alcohol, and throughout her youth she encountered abuse, depression, and subsequent self-esteem problems. After the second therapy session, Anita's brother was tragically killed, presenting another significant loss in her life.

Neimeyer used a constructivist approach in his work with Deborah, a Caucasian woman in her mid-40s. Deborah lost her elderly mother over two years prior to the therapy, and had served as her mother's caretaker as her illness progressed until her death. Despite years having passed, Deborah continued to have intense yearning for her mother's presence and support. She also described feeling impaired in her ability to complete daily tasks and a dwindling sense of purpose and meaning, as she also struggled with tensions with her adult siblings in the home they shared with their frail father.

Researchers

The primary researcher (EPB) is a 33-year-old female clinical psychologist, with 6 years of supervised therapy experience applying various humanistic approaches. Additional researchers aided in the collaborative data coding process. One researcher is a postdoctoral member of the research lab that developed the IMCS, with extensive experience using this system. The remaining coders include doctoral student researchers with psychotherapy experience. A participating therapist in the study (RAN) provided editorial and conceptual feedback about the project but was uninvolved in data coding.

Measures

Innovative Moments Coding System

The IMCS (Gonçalves et al., 2009, 2011) was applied to the transcripts of all therapy sessions to track the change process (see below for procedural details). Gonçalves and colleagues (2011)

summarized findings of interjudge reliability across published studies using the IMCS and found a range between 84% to 94% (current study ranged between 82% and 93%), with Cohen's kappa ranging between 0.80 and 0.97 (current study averaged across each respective case was 0.47, 0.52, and 0.58). In the current study, The IMCS has also shown convergent validity (Martínez, Mendes, Gonçalves, & Krause, 2009; Pinheiro, Gonçalves, & Caro-Gabalda, 2009) when compared to the assimilation of problematic experiences scale (APES; Stiles, 2002) and the generic change indicators scale (Krause et al., 2007). The IMCS also demonstrated discriminant validity (Martínez et al., 2009) when applying the coding system to cases in which alliance ruptures were previously identified.

Global Assessment of Functioning

The Global Assessment of Functioning (GAF; Endicott, Spitzer, Fleiss, & Cohen, 1976) was used as an observer-rated measure of client functioning across several domains: social, occupational, and mental health. Using this measure, information was gathered from each therapy session, both by reading the transcript and by watching the therapy videos, to assess functioning as therapy progresses. A rating was given from 1 to 100, with a higher score reflecting higher levels of functioning in these areas. This measure has demonstrated reliability among researchers (Aas, 2010; Hilsenroth et al., 2000).

Segmented Working Alliance Inventory—Observer-Based Measure (S-WAI-O)

The WAI (Horvath, 1982; Horvath & Greenberg, 1989) was used in its modified observer-rated form (Berk, Safran, Muran, & Eubanks-Carter, 2010) to assess the therapeutic alliance between each therapy dyad. This tool is based on Bordin's (1979) conceptualization of the therapy alliance and measures agreement between client and therapist on treatment tasks, as well as the development of a bond that facilitates the collaborative process. The segmented version of this measure was developed to track alliance changes throughout a therapy session, with raters coding from video recordings sessions every 5 minutes. In this measure, there are 12 items total, with 6 each related to task and bond assessment. Ratings are given on a 7-point Likert scale (1 = never and 7 = always). Four items have negative valence, and once these are reverse scored, an average of all items is calculated, with higher scores indicating more collaboration and bond in the therapy alliance. This measure has shown to be valid, and pilot studies indicated good internal interrater reliability of ICC = .82 (with current study's average of ICC = .99) and showed statistically significant correlations ($\chi^2(1) = 4.02, p = 0.05$) with client self-report of alliance ruptures (Berk et al., 2010).

Procedure

Following review of the proposed study by the university's institutional review board, all 18 therapy sessions were transcribed for use in coding IMs. The coding procedure (described below) was based on the *Manual for Innovative Moments Coding System* (Gonçalves et al., 2009). A doctoral student researcher and the first author coded for client's symptoms using observer-rated measures to track symptoms related to global functioning and therapeutic alliance.

IMCS Training

The first author (EPB) was trained in the IMCS by a postdoctoral researcher (DRA) who has extensive experience with this methodology. EPB then trained a second doctoral student researcher (MAS), who served as a collaborative coder. Training was guided by a manualized process that proceeded as reading published articles about the IMCS, identifying types of IMs from previously identified sections of text, defining problematic narratives after reviewing transcripts of psychotherapy cases, and identifying IMs in psychotherapy transcripts. Each coder's reliability was assessed at each stage by comparing answers with those of expert judges who developed the IMCS. Researchers were allowed to code sessions for the current project once they had achieved a Cohen's kappa higher than 0.75.

IMCS Coding Procedures

EPB served as the primary researcher and independently coded all 18 therapy sessions. Each therapy case (6 sessions each) required an additional coder to help in this collaborative process in addition to an auditor, who provided feedback on coding decisions. The pair of coders for a given therapy case reviewed the case in its entirety and independently developed a list of the client's problem narratives, along with specific examples from the text. The coders discussed each list and developed the consensual definition of each problem. Once the coders established this list, they coded each session sequentially, and then convened after each to calculate intercoder reliability and to resolve all coding differences, with the final coding reflecting complete consensus. Once all coding of a case was complete, an audit was performed by an IMCS expert to provide feedback to the primary coders and, on occasion, to resolve instances in which coders questioned how to categorize an IM. The coders also calculated intercoder agreement regarding the amount of text identified as IMs, regardless of IM categorization (further described below).

Consensual Definition of Client's Problems

Researchers began the coding process by engaging in intensive reading of their assigned therapy cases. Coders independently identified their conceptualization of the problematic narrative(s) and listed all related problems (see Tables 1–3). Then coders met to discuss and define the problematic narratives present, which guided the coding of IMs, in which exceptions to the problematic narrative “rules” existed.

Identification of IMs

After identifying the problematic patterns of a given case, the pair of coders independently read therapy transcripts in sequential order and marked any section of text as an IM when an exception to the problematic rule(s) was expressed in therapy. During this process, coders identified the specific points in the text and video at which each IM begins and ends. This step allowed the primary coder to later calculate *salience*—a measurement of the proportion of text (*textual salience*) and time (*temporal salience*) an IM occupies in a given session or across sessions (Gonçalves et al., 2011).

TABLE 1
Tina's Problematic Self-Narrative and IMs

<i>Problematic Self-Narrative</i>	<i>Examples of IMs</i>
Grief	<p>C: I haven't had time to deal with the grief. T: I would guess you're missing him. C: Yes, very much so. And uh, it's been crazy because I was 9 months pregnant C: umm, well when I'm driving I get these overwhelming feelings sometime, T: uh huh C: I feel like I want to burst.</p> <p>C: Dad wasn't perfect. Dad had some, dad was a monster. T: he was a monster? C: yes he was, but not to me, at least I don't think he was T: ok C: but to others he was. T: hmm. So you saw the dark side of him too. C: Oh my god. That man, he is an angel in my eyes. He's daddy. He's my hero, but I know about the things that he did to other people. And he might have done it to me and I'm just too young to remember . . .</p>
Struggle to Integrate Conflicting Views of Deceased Father	<p>C: I can't go back in time, I can't change it, I can't bring him back, I can't ask him questions. Just move on. T: Now it is what it is, and you have to somehow sort out how to let it go C: mmmmm T: and let it be what it is, and make whatever adjustments you need to make in your therapy to come to terms with this as best you can so it doesn't, doesn't affect you in some bad way. C: right, exactly</p> <p>C: I can't stop thinking or being the way that I am or how I am. I just hope he knows that it does not change my love for him. C: thinking that I'm thinking bad thoughts about him. But I had to get that out there and I had to express what was really going on in me. I can't sugar coat it and make it seem like everything was perfect, because there were so many other things going on. T: Yes, I know that was wrenching to try to reconcile those C: Yeah T: views of your dad, and I know it took a lot of courage for you. C: Yeah</p> <p>C: I almost lost my temper, and I have to sometimes remember to not do that because I could put myself in danger. T: Hmm. Get too aggressive, you mean? C: Yeah, I could very well put myself in danger</p>
Anger/Resentment	<p>T: Sometimes you get resentful that you get the hard job sent to you. C: Yes, all the time, I got to be the bearer of bad news, all the time. When dad died, who was at the nursing home at 6 o'clock in the morning looking at his dead, limp body? Me. Who had to call all the sisters and brothers and tell them? Me. Who had to call the aunty? Who had to tell Mom? Who had to do everything? Who made the arrangements, who paid for this, who paid for that? Me</p>

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TABLE 1
Tina's Problematic Self-Narrative and IMs (Continued)

<i>Problematic Self-Narrative</i>	<i>Examples of IMs</i>
Avoiding Emotional Expression	<p>T: Can you just let yourself be with that sadness for a moment? Because what you're telling me is it's been hard to kind of grieve your dad. Can you just let it be there for a moment. C: I can try. It's hard for me to do that T: I know. But, some part of you wants to pull away from it maybe, but your eyes and your face are telling me your sadness is starting to come up for you. C: Mnhmm (looking down; long silence) I'm good. T: You're good? C: (nods head) T: Where'd that sadness go C: Umm, I learned how to put it in a jar and save it for later.</p> <p>C: Sometimes if she don't have the money, she asks me, and of course I don't want to support her habit, but she makes me feel guilty.</p>
Guilt	<p>T: But you're learning to set clear boundaries C: yeah T: and say no. C: Yeah. T: I'm not going to enable you C: Right T: You're not going to trick me, you're not going to con me, you're not going to play my guilt. C: Right</p>
Anxiety	<p>C: And I think if I don't stress as much, I can get rid of my headaches. If my headaches, then I can function better. C: But there is such a thing as being too rigid T: mnhmm C: too together to the point of where you stress over everything.</p> <p>C: I had to, uh, let down my guard and . . . try to give her a chance to make up for the wrong that she did T: Ok C: so that required me to try and trust her and let her in T: Yes C: so T: you trusted her and you gave her the benefit of the doubt for a while C: Yeah, yeah</p>
Difficulty Trusting Others	<p>C: Mnhmm. Just like I told them, I said, "With a father who's a molester and a mother that's an alcoholic, the people I'm supposed to trust, why would I trust anybody? Why would I?"</p>

TABLE 2
Anita's Problematic Self-Narrative and IMs

<i>Problematic self narrative</i>	<i>Examples of IM's</i>
Grief/Sadness	C: I do feel my brother is finally at peace, really, really, really at peace C: you he died at, that I needed to cry, and I needed to stand there, and me and my boyfriend cried together and the blood was still there T: (nodding, eyes closed) wow C: some of it. And we laid a little cross in the blood
Guilt	C: but I have this, you know, I still have this guilt where I convinced my father not to take him in, you know
Lacking Assertiveness	C: but all my insecurities came right up front (snaps fingers). I had no confidence. I don't like telling people what to do.
Delegitimizes Own Needs/Feelings	C: And I mostly stayed in my bedroom. You know, if I walked around, I walked quietly. . . . I don't wanna end up that way again, moving into my boyfriend's house. I don't wanna like T: where you're just pleasing him all the time, trying to appease C: and trying to keep away from everybody so I'm not in everybody's way
Anxiety/Fear	C: . . . I'm not afraid of death, I'm always afraid of those who are near me that'll die C: I'm afraid of being lost in it. If I don't stay on top of it, you know, like when I was that child and my aunt lost her mind in that moment . . . that scared me, I never wanted to go to that place, you know
	C: He was on a destructive path, you know, and there wasn't anything that any one of us coulda done to change that
	C: I wanna be strong. I uh, don't wanna be intimidated . . . I wanna be able to have an opinion and not to back down because somebody says, "Oh, I didn't know that's how you felt, I'm sorry," and then feel sorry for them. You know, I don't wanna own other people's things, I wanna be able to stand up
	T: . . . what else comes up for you when I say, "Anita is worth fighting for"? C: (chuckles) uh, I feel proud, you know, I feel like I'm graduating and, and being applauded . . . I feel empowered to hear somebody else say that. . . . Maybe there's like these two voices at war and when you say that, it overpowers that voice that says to be submissive . . .
	C: and I want to be fully free and not terrified of that dark spot, you know, where, like the Bermuda Triangle kind of thing

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TABLE 2
Anita's Problematic Self-Narrative and IMs (Continued)

<i>Problematic self narrative</i>	<i>Examples of IM's</i>
Resentment	<p>C: ... I don't know if it makes me mad, I think there's no point in really getting mad about it T: yeah C: because there isn't anything I can do with anger in that point but get myself all rattled</p>
Constricted Emotional Expression	<p>T: but that feels important. How is it that it's shifted ... into feeling a little better? C: I, I think, maybe, cuz I allowed myself to cry T: uhuh C: and it, and more importantly allowed myself to cry with others. I never did that before. I would cry silently, but it's like oh, I don't have no, nowhere, no privacy anymore</p>
Lacking Healthy Boundaries with Son	<p>C: You know, time goes by fast, and I would just, if, you know my son's always struggling financially, and I'm bailing him out, for the most part</p>
History of Drug/Alcohol Abuse	<p>C: and, um, as I said ... I lived in the world of drugs</p> <p>At least I had the opportunity, or the willingness, to stop. And you know, once I stopped putting, filling that hole up, with drugs and alcohol T: mmhmm C: I was able to let some more positive things, which leads me to this point in my life. You know, it's just a process</p>

TABLE 3
Deborah's Problematic Self-Narratives and IMs

<i>Problematic Self-Narrative</i>	<i>Examples of IMs</i>
Grief	<p>C: ... realizing that ... my mom is in a better place ... T: uhuh C: ... You're writing over and over again knowing that um her presence is still within ... T: mhm C: I actually seen my sister washing her dishes and it reminded me of her. T: ahhh C: yea, So it was a little, um refreshing</p> <p>C: ... but it's kinda like that depression block has been removed and uh even though there's still some sadness and some grief that I'm sure I'll go through and I'll have times you know especially with her upcoming birthday and stuff like that. But it's like a T: mhm C: quiet sense of peace is kind of trickling in with that so I can T: uhuh C: live with it.</p>
Depression	<p>C: It's always that, um, it's I don't know how to put it, the, it's always doom and gloom realm ... T: but you saw it's always doom and gloom? ... C: Yeah I always think the negative is going to happen ... and I stay in it</p>
Cognitive Problems	<p>C: Mostly the reason why I am here is cause since her death, I have a problem remembering things. T: ahh C: My mind goes blank.</p>
Anxiety	<p>C: I was getting pains, and I know it wasn't like heart attack-related but it was something like that, you know. A void, um, that wasn't filled, and um T: Where did you experience that void? Did it have a kind of physical place within you? C: um, It was just like right around the heart, you know. And that's why I had to double check and went and saw the doctor because I was having this anxiety. And I thought that I even had to have my sister to take my blood pressure sometimes ...</p>

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TABLE 3
Deborah's Problematic Self-Narratives and IMs (Continued)

<i>Problematic Self-Narrative</i>	<i>Examples of IMs</i>
Family Strain	<p>C: ... it's just, I don't know, it's dysfunction, and I don't know where that dysfunction came from. T: At the family level you're talking about? C: Right at the family level.</p> <p>C: ... I was kind of isolating myself from new individuals and people in my life ... because you're scared after you've lost somebody that you love so much. ... And to have new relationships with my family ... based on ourselves as brother and sister or my dad T: Not just as a surrogate of mom. C: right, right. T: Not your mom's relationship with people but really yours ... C: Right, because she was always there, she was kind of the glue, and now we're having to you know get our own paste together to, to grow and to know each other ... individually. ... Because when you get somebody removed from your life if gives you more time with the other people in your life.</p> <p>C: And then I thought to myself does it really matter, you know? She was there in other areas of my life. And, just the gratitude that by the time, you know, my daughter came around, she was retired and she was able to be there for us that way.</p>
Resentment	<p>C: ... when I was in the 6th grade I was in the play ... T: mhm C: Nobody showed up. T: mhm C: A neighbor actually had to drop me off there ... T: uhuh C: and just like feminine care and stuff like that. I didn't learn any of that from my mom. Everything I learned was from school T: yeah C: or trial and error ... T: yeah C: I tend to get bound in that resentment.</p>
Trying to Fill Deceased Mother's Role	<p>C: ... I have to, you know, I think that since my mom has been gone I've been trying to be her piece T: trying to be her piece C: and I don't think that's a good place for me to be. And it's something that ... pretty much the family doesn't have acceptance with anyway.</p> <p>C: I just thought I was being the caregiver ... and doing things I wanted to do. And then ... when we shined that light a little deeper I seen that I was trying to, you know, keep my mother alive by being what she was to people in my family. T: Wow. C: So I was trying to keep my mother alive by being what she was to my family. T: And shinning the light deeply on that really seemed to begin to change it for you. C: Right. It also helped me to, um, better, um, get an association with the fact that she is gone T: yeah C: that I'm able to keep the traits that are good and I don't have to keep everything or be her, I can still be me and still have her spirit, you know, alive and well ... it's real cool.</p>
Weight Struggles	<p>C: ... I'm trying to close that door on the fat me as well, so I just told myself, "Self, if you gain the weight back, then you're gonna have to earn some money to buy new clothes."</p>

Categorization of IMs

As IMs were identified, coders independently classified them into one of the five IM categories. In cases in which an IM could be categorized in more than one way, the coders were instructed to choose the more complex IM category. The IMCS authors have identified action and reflection as the first and most basic level. Protest IMs are considered to be at the second level, followed by reconceptualization and performing change at the third and most complex level.

Measuring Salience of IMs

In the current study, both *textual* and *temporal salience* were derived from therapy transcripts and videos. First, coders identified the proportion of the total text or time accounted for by each type of the five IM categories in each session. Second, coders identified the overall salience of IMs as a whole in a given session, regardless of the type of IM. This calculation was derived from the sum of words in all IMs divided by the total number of words in a session, as well as the sum of time in all IM segments divided by the total time in a session. Third, the mean salience across treatment was calculated for both specific type of IM and overall IMs. This calculation resulted from the mean of the percentage of each type of IM and overall IMs identified in the two aforementioned steps—for both textual and temporal salience. Inter-coder salience agreement was also calculated to identify overlapping salience identified by both judges.

Coding Procedures for Observer-Rated Outcome and Alliance Measures

The first author trained a doctoral student researcher to use the GAF as an objective measure of functioning. Next, they both watched grief therapy videos (not included in the current sample) and applied the GAF to each session until consensus was achieved. Both coders then independently coded each therapy session in the current study, and an average rating between coders was taken for each GAF score.

The first author trained the same researcher to use the *S-WAI-O* to assess the alliance of each therapy dyad across sessions by analyzing grief therapy case examples (not included in present study) together to form consensus about the application of the anchors used in the measure. The researcher coded all 18 sessions in the current study at 5-minute intervals. The first author applied the *S-WAI-O* to 20% of the data (identified by random number generator to identify two sessions within each therapy case), with aims of achieving a minimum of 80% reliability, which was met, indicating further reliability checks were not warranted. As suggested by the *S-WAI-O* developers, control charts (Eubanks-Carter, Groman, & Muran, 2012) were used to statistically detect alliance ruptures. For the current study, an alliance score would be considered as a rupture if the score fell below the lower control limit (a 95% confidence interval set at two standard deviations from the mean alliance).

RESULTS

The following sections explore the therapy cases of Deborah, Anita, and Tina in terms of overall and specific IM salience, working therapy alliance scores, and functioning across therapy, with

TABLE 4
Global Working Alliance Scores Across Therapy, M (SD)

<i>Client</i>	<i>Session 1</i>	<i>Session 2</i>	<i>Session 3</i>	<i>Session 4</i>	<i>Session 5</i>	<i>Session 6</i>
Deborah	5.63 (0.22)	6.07 (0.32)	6.29 (0.42)	6.51 (0.40)	5.87 (0.26)	6.98 (0.04)
Anita	5.43 (0.31)	5.78 (0.51)	6.19 (0.23)	6.06 (0.43)	6.18 (0.26)	5.84 (0.37)
Tina	5.43 (0.31)	6.09 (0.11)	6.30 (0.27)	6.31 (0.26)	6.32 (0.69)	6.74 (0.23)

links to findings from comparable cases in the literature, where data exist. When reporting salience, textual salience values will be presented, as temporal and textual salience values were strongly correlated ($r(457) = .97, p < .05$).

GLOBAL WORKING ALLIANCE SCORES ACROSS THERAPY

Research has consistently identified the therapy alliance as a predictor of outcome across therapy orientations (e.g., Martin, Garske, & Davis, 2000), including brief therapy interventions (Falkenstrom, Granstrom, & Holmqvist, 2014). In the current study, global alliance scores, illustrated in Table 4, were derived by averaging each 5-minute alliance rating across a given session. These scores indicate that Deborah, Anita, and Tina each maintained strong alliances with their therapists over the course of therapy.

In the case of Deborah, global alliance scores increased over the course of the six sessions, with the exception of session five, in which the alliance score decreased but remained high. In the last session, Deborah and her therapist's average alliance score neared the maximum rating possible. Alliance scores for Tina and Cain trended toward increasing strength, with somewhat of a plateau between sessions 3 and 5, and increasing again in session 6, terminating therapy with a strong alliance. Anita and Schneider also maintained a strong therapy alliance, but with slightly more variability in their scores across sessions. Global working alliance peaked in session 3 during the session in which Anita spoke of the loss of her brother. Scores then stayed relatively the same until termination, when Anita and Schneider had lower alliance ratings than the other therapy dyads but were strong nonetheless.

OVERALL IM SALIENCE ACROSS THERAPY

The overall salience of IM categories across the sessions of Deborah, Anita, and Tina (see Figure 2) showed patterns consistent with GO grief therapy cases (e.g., Alves et al., 2012, 2013; Alves, Fernandez-Navarro, Ribeiro, Ribeiro, & Gonçalves, 2014).

Deborah's overall IM salience across therapy and for each specific IM differed from the cases of Anita and Tina, primarily in that Deborah and her therapist spent over twice as much time across therapy elaborating IMs. In similar research studies measuring IMs across grief therapy, overall salience ranges between 20% and 30% (Alves et al., 2012, 2013, 2014), with Deborah's case exceeding this range. The case of Deborah also contrasts those of Anita and Tina in terms of overall salience of each IM category. Although all three cases involved the elaboration of RC IMs, which are primarily found in GO cases, Deborah's therapeutic process involved over four times

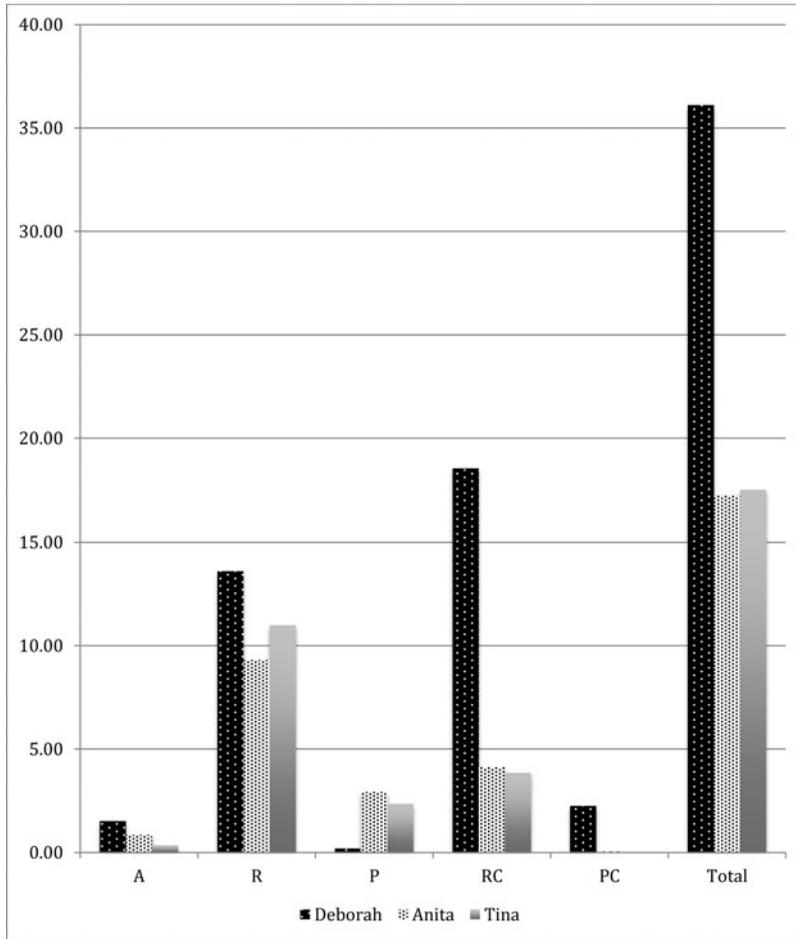


FIGURE 2 IM overall textual salience across cases.

as much elaboration of RC IMs than the other two cases, and greatly more than other GO grief therapy cases reported in the literature, with reports between 3.6% and 8.5%. Notably, this finding includes a comparable case study (i.e., the case of Cara; Alves et al., 2012) involving Deborah’s therapist, using the same six-session format and meaning reconstruction therapy approach, as well as other complicated grief therapy cases using the same meaning reconstruction format (Alves et al., 2013).

Anita and Tina showed similar levels of RC IMs between their respective cases, and both showed the greatest salience occurring in the form of reflection IMs, as is found in the literature of IMs across grief therapy cases (ranges between 12.7% and 17.5%). In Deborah’s case, reflection was the second most salient IM, with ranges also consistent with comparable GO therapy cases in the literature.

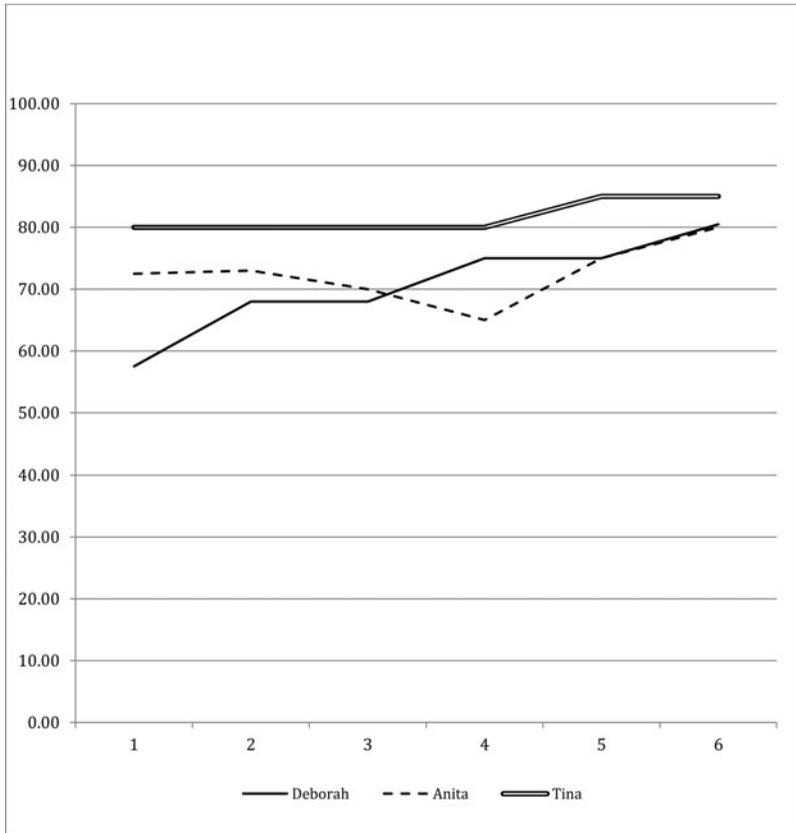


FIGURE 3 GAF Scores Across Therapy.

Findings regarding the presence of protest IMs in grief therapy cases, which have been reported to occur below 3%, were consistent with the current findings across the three cases. Anita and Tina showed similarities in their inclusion of protest IMs, both showing low salience at similar levels, whereas Deborah's protest IMs were nearly nonexistent. Deborah's case included higher overall salience of PC IMs, and these IMs were nonexistent in the case of Tina, and nearly so in the case of Anita. These findings are again consistent with comparable studies (with ranges between 1.7% and 3.5%). All three cases showed similar low salience in their elaboration of action IMs, again consistent with literature findings (i.e., salience < 3%).

OVERALL CHANGES IN FUNCTIONING ACROSS THERAPY

Global functioning for each respective therapy case was measured across each therapy session using the GAF (see Figure 3). This session-by-session tracking allowed for a more continuous examination of client change in relation to IMs as opposed to the traditional "good" versus "poor" outcome categories used throughout the IMCS literature. Nevertheless, the current configuration

would also lend itself to a more global categorization of outcome, using the GAF as an indicator of overall change between beginning and end of therapy. In a recent study, Coutinho, Riberio, Sousa, and Safran (2014) used GAF scores to identify “unsuccessful” versus “successful” cases, with the latter reflecting a clinically meaningful GAF increase (e.g., from moderate symptoms at the beginning of therapy to mild at the end). Using this same rubric in the current study, all therapy cases in the current study would be considered “successful” overall, and they will be explored in a session-by-session format in a companion article that follows the current study in the same issue.

ASSOCIATION OF ALLIANCE WITH IMS AND CLIENT FUNCTIONING

Alliance ratings were derived for each 5-minute segment of therapy across the cases of Deborah, Anita, and Tina using direct observation of video-recorded therapy sessions, allowing the raters to assess verbal and nonverbal markers of alliance in the moment-to-moment unfolding of therapy. Control chart methods were applied to the data in attempts to statistically detect alliance ruptures (two standard deviations below the mean alliance) and repairs. However, no ruptures were detected within any of the therapy dyads. Given the lack of statistically significant variation among alliance ratings across each 5-minute segment and the uniformly high alliance ratings across the cases, further exploratory analyses were not conducted to examine the relationship between alliance with specific IM categories or changes in functioning.

GENERAL ASSOCIATION BETWEEN IMS AND CLIENT FUNCTIONING

In an exploratory analysis of the relation between psychotherapy process and outcome in the three cases, correlations between IMs and GAF scores within and across cases were examined. The first of these concentrated on the association between the salience of all IM categories considered collectively and client functioning as measured by the GAF within a given session, yielding notable relations across the three cases. This correlation was very strong in the cases of Tina ($r = .82$), strong in the case of Deborah ($r = .61$), and moderate in the case of Anita ($r = .31$). This finding also held when all cases were averaged ($r = .67$). These initial findings suggest the importance of the presence of IMs, regardless of category, in predicting client functioning. Furthermore, strong contemporaneous relations were identified between the presence of RC IMs and GAF scores in the case of Anita ($r = .41$) and Deborah ($r = .65$), with a very strong association in the case of Tina ($r = .88$). This finding also held when all cases were averaged, with RC IM salience and GAF score being strongly correlated ($r = .76$).

The second exploratory analysis examined the relation between IM salience in a given session (1–5) and client functioning in the subsequent session (2–6). The relation between total IM salience and later functioning was strong in the case of Anita ($r = .57$), and very strong in the case of Tina ($r = .88$). The presence of RC IMs in a given session also predicted client improvement (measured by GAF scores) in subsequent sessions in the cases of Anita ($r = .67$) and Tina ($r = .61$). Such relations were not found in Deborah’s case ($r = .23$), possibly due to the notable decrease in IMs in session 5, with the highest IM occurrence (including RC) in session 6, which is unaccounted for in this correlation. Nevertheless, these patterns generally corroborate other findings in the literature and suggest the importance of innovative moments overall, and

in the form of RC IMs, in the contemporaneous and prospective prediction of client functioning over the course of grief therapy.

DISCUSSION

The current study aimed to further refine theory about grief therapy and possible mechanisms of change by examining three cases of bereaved clients working within humanistic therapy traditions. A growing body of psychotherapy research has examined the role of IMs in reconstructing problematic-narratives with bereaved clients (Alves et al., 2013, 2012). The current study builds on the program of research focused on the IM paradigm, extending the previous work by demonstrating a closer and more specific association between IMs and client functioning on a session-by-session basis.

The findings across the current case studies suggest the importance of IMs in the contemporaneous and prospective prediction of client functioning over the course of therapy, and showed IM patterns consistent with those found in GO grief therapy cases in the literature (e.g., Alves et al., 2012, 2013, 2014). Consistent with previous findings, the current results highlight the prominence of reflection and RC IMs in successful cases of grief therapy. Deborah's case was especially notable in this way, as she and her therapist produced significantly more RC elaborations than the cases of Anita, Tina, and other GO cases in the literature—including another case study of a complicated griever working with Deborah's therapist in the same six-session format. Although Deborah initially presented with the lowest functioning of all the cases, she also made significant gains in functioning early in treatment, following a narrative reconstruction exercise, which Deborah noted was transformative for her in moving toward a healthier, more adaptive stance in her loss. By the end of this brief therapy, Deborah was able to both find new meaning in the loss and articulate the processes that allowed for this change. Specifically, she noted the importance of reconnecting with her mother, which helped her to integrate this loss into her life in a coherent way. The importance of meaning reconstruction in Deborah's case was also found in similar cases of narrative-constructivist grief therapy and is supported by randomized controlled trials investigating the use of narrative interventions (Lichtenthal & Cruess, 2010), including those situated within CBT-oriented grief therapy (Wagner, Knaevelsrud, & Maercker, 2006). These findings further converge with recent research by Gonçalves and colleagues (2015) documenting the role played by IMs in predicting subsequent therapeutic improvement, rather than vice versa. This growing body of supporting evidence, ranging from theory-generating case studies to those using experimental design methodology and sophisticated statistical modeling, suggests the utility of meaning-generation interventions in facilitating change in psychotherapy.

Deborah's changes in her self-narrative fostered new goals, behaviors, and versions of self in the form of PC IMs; however, these occurred with low salience for Deborah, and were nonexistent or nearly so in the cases of Anita and Tina. Although PC IMs have been shown to occur in GO cases of grief therapy, they have been reported with low salience across the literature. A recent study of six complicated grievers engaged in 15 sessions of meaning-reconstruction therapy (Alves et al., 2013) found a higher probability of PC IM occurrence in the final sessions of the therapy, especially in cases with greater symptomatic improvement. Therefore, it is plausible that the clients in the current study would have yielded more PC IMs given more time, especially in the case of Deborah, who gained greater functional improvement. It is possible that six sessions

of therapy is inadequate to foster both integration of new versions of self and enactment of goals, plans, and behaviors related to this change. Further investigation is warranted in this area, especially given contemporary models of healthy grieving, such as the dual process model (DPM; Stroebe & Schut, 1999), which emphasizes the oscillation between both attending to loss and attending to restoration-orienting strategies that foster exploration of new relationships and goals.

Also consistent with previous findings, the proportion of action and protest IMs occurred with low overall salience across the cases. This pattern is distinct from previous research on IM elaboration within treatment focused on depression (Gonçalves et al., 2012; Mendes et al., 2010) and intimate partner violence (Matos et al., 2009). In such cases, action and protest IMs played a more central role in narrative transformation. However, grief therapy processes of IM elaboration might differ from problems involving the need for assertion and empowerment. As suggested by Alves and colleagues (2013), this particular pattern of IMs found in grief therapy might “orient the therapist toward a more reflective and integrative meaning reconstruction rather than the stimulation of a position of criticism regarding the problematic story of loss” (p. 15). The current study supports this position in that protest IMs were nearly nonexistent in Deborah’s case, and minimal across the cases of Tina and Anita. Furthermore, when clients in the current study elaborated protest IMs, they were often linked to problematic narratives outside the scope of grief (e.g., lacking assertiveness, feelings of resentment). Future investigations might examine if this same pattern is found in grief therapy cases using different therapy orientations, such as complicated grief therapy (Shear, Frank, Houck, & Reynolds, 2005), which incorporates cognitive, behavioral, and meaning reconstruction interventions.

The current study also aimed to investigate how the therapy alliance might affect the moment-to-moment unfolding of IMs and changes in functioning. Across the three cases, alliance ratings were consistently high. This finding is perhaps unsurprising given that the therapy alliance is viewed as integral within the variations of humanistic therapy. Moreover, the humanistic therapists in this study are experts in their traditions and would likely be highly skilled at navigating therapy relationships in a collaborative fashion. Nevertheless, it is unclear how the alliance factored into the elaboration of IMs. A recent case study (Riberio et al., 2014) investigated the interplay of IMs and therapy collaboration in a PO therapy case of narrative therapy. In this case, IM production was low and “return to the problem markers” (RPM; Gonçalves, Ribeiro, Santos, Gonçalves, & Conde, 2009)—times in which the client returns to the problem narratives following IMs—were high. They found that this pattern of IMs and RPMs occurred despite high observer- and self-reported global alliance ratings. Using a process measure of therapeutic collaboration (TCCS; Riberio, Riberio, Gonçalves, Horvath, & Stiles, 2013), the researchers found that interventions that challenged clients beyond their therapeutic zone of proximal development led clients to reject or ignore the therapist’s intervention, returning to the problematic narrative. They suggested a balance between “supporting and challenging” clients so that “new experiences can be better tolerated, considered, and integrated” (p. 348). These initial findings, in conjunction with others about the pattern of IMs and RPMs, suggest that future studies might include not only measures of the therapy alliance but also measures that identify the dynamics of the therapy dyad (such as the TCCS) and how moment-by-moment interactions between therapist and client might impact IM elaborations and outcome.

In terms of measuring session-by-session changes in symptoms and functioning, the current investigation included previously recorded sessions, and allowed only for an observer-rated measure of functioning. However, future studies measuring the interplay of IMCS and proximal

outcome would benefit from using more standardized measures designed to track grief symptoms, such as the *Inventory of Complicated Grief (ICG)* (Prigerson et al., 1995), and depression symptoms, such as the *Beck Depression Inventory-II (BDI-II)* (Beck, Steer, & Brown, 1996), as a more sensitive measure would allow for greater detection of symptomatic change. Likewise, especially in the case of humanistic therapies featuring a strong emphasis on the construction of meaning in relation to difficult losses and life transitions, well-validated measures of meaning making (e.g., Gillies, Neimeyer, & Milman, 2014 [GMRI]; Holland, Currier, Coleman, & Neimeyer, 2010; Holland, Currier, & Neimeyer, 2014 [ISLES]) could be useful to include as possible mediators of outcome, or as outcome measures in their own right. Finally, it would be informative to include follow-up measures to track the sustainability of change following termination of grief therapy.

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