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Innovative Moments in Humanistic Therapy: Three Cases of Eminent Psychotherapists Working with Bereaved Clients

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INNOVATIVE MOMENTS IN HUMANISTIC THERAPY: THREE CASES OF EMINENT PSYCHOTHERAPISTS WORKING WITH BEREAVED CLIENTS

by

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Dedication

I would like to dedicate this dissertation to Sophia and Henry. You both inspire me daily with enduring love, optimism, and patience. May this shared journey remind our family what is possible when you follow your passion with fortitude, perseverance, and hope.

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Abstract

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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 5 identified types of IMs: action, reflection, protest, reconceptualization and performing change. 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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Introduction

Most individuals will experience bereavement at some point in their lives, typically losing several significant people throughout their lifespan. 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 towards 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 symptom of depression, anxiety, or post-traumatic stress disorder (PTSD) for 1-2 years following the loss (Bonnano & Mancini, 2006). Furthermore, a subset of approximately 10-15% of bereaved individuals will experience protracted symptoms of Complicated Grief Disorder (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 responses to loss, including role confusion, a diminished sense of self, difficulty accepting the loss, lowered trust in others, problems moving towards valued goals, feeling numb, and sensing life as meaningless (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 experience. This crisis of meaning can produce grief complications that hinder the natural trajectory of grief.

A Humanistic Framework for Grief Therapy

Professionals are often 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 (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. Humanistic techniques also tend to be experiential and process-oriented, using creative and evocative methods to promote change, as opposed to ones that are highly manualized or technique driven (Cain & Seeman, 2002; Neimeyer, 2009).

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 must 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 inherit 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 towards these aims, including role-play, visualization, and embodied meditation (Schneider, 1995, 1998), but therapists are largely integrative (Schneider & May, 1995), utilizing 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, where "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 utilizing 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 towards 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 pro-symptom positions that maintain the client's problematic positions (Ecker & Hulley, 1996; Neimeyer 2010; 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

The aforementioned therapy approaches are united by overarching humanistic principles, but 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 collegues (2011) note 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 his 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 their loss that will ultimately coalesce into a more adaptive self-narrative (Gonçalves et al., 2009). They assert 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) conceptualize 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 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, and/or behaves differently than the problem-saturated story would direct.

The Innovative Moments Coding System. The Innovative Moments Coding System (IMCS; Gonçalves, Ribeiro, Mendes, 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, Ribeiro, Mendes, Matos, & Santos, 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, Mendes, Gonçalves, & Neimeyer, 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 co-constructed (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 only be coded 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 5 types of IMs identified in the original study have remained (Gonçalves, Ribeiro, Mendes, Matos, & Santos, 2011): action, reflection, protest, reconceptualization, and performing change. Descriptions of each IM follow, along with illustrative vignettes generated by the researcher.

Action IMs. 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.

Clinical vignette. 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. Reflection IMs occur when the client forms new understandings that challenge the problematic narrative. Reflections occur when the client develops new conceptualizations that 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.

Clinical vignette. 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. 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.

Clinical vignette. 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. Protest IMs are similar to Action and Reflection IMs in that they involve new behaviors and/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/or 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 (which can include the client).

Clinical vignette. 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 towards the problematic pattern (i.e., hiding her grief-related emotions out of a fear of negative social interactions), and rejects this previous pattern with strong emotion.

The second form of Protest IM involves the emergence of new, self-empowering positions, repositioning oneself in a different way towards the problem.

Clinical vignette. 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. Reconceptualization IMs are a form of "meta-reflection" (Gonçalves et al., 2011, p. 500) comprised 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.

Clinical vignette. 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 previously a held belief without the feared outcome occurring) that helped this shift occur.

Performing Change IMs. 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 self that were neglected while immersed in the problematic self-narrative.

Clinical vignette. 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 his 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, Ribeiro, Angus, Greenberg, Sousa, & Gonçalves, 2010; Santos, Gonçalves, & Matos, 2011) and application to single-case designs (e.g., Alves et al., 2012; Gonçalves et al., 2010).

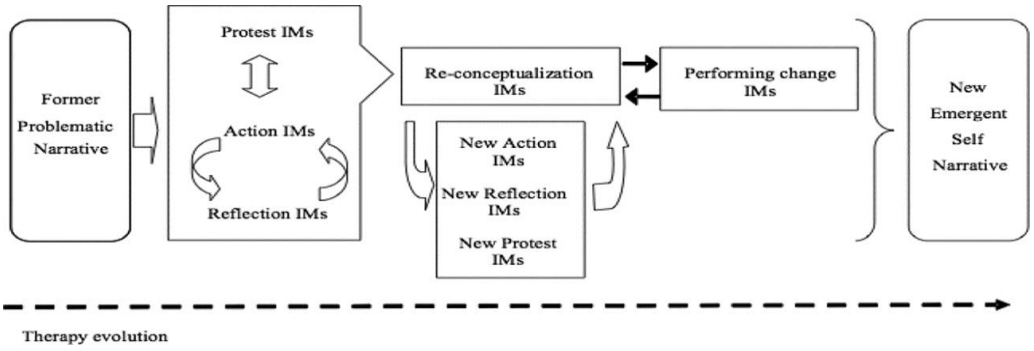

Figure 1. IMCS Heuristic model of change in good outcome cases (Gonçalves, Matos, & Santos, 2009). Used with permission.

While IMs typically occur from beginning to end of therapy in both good and poor outcome 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 reconceptualiation and performing change IMs, which involve more complexity—a pattern less typical for PO cases. Therefore, Gonçalves and his colleagues

suggest that action, reflection and protest are necessary components of the change process, but are insufficient in solidifying a new self-narrative. They surmise that 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 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.

The Present Study

The current project aims to contribute to the growing body of research exploring innovative moments--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* video 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 towards brief therapy (Hoyt, 2011) and is supported by a large-scale research study of nearly 2,000 clients that suggests 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 diplomate 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 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 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 American Psychological Association, and is vice-president of the Existential-Humanistic Institute (EHI). Dr. Schneider received the Rollo May award from the Humanistic Psychology Division of the American Psychological Association. He is a consulting editor for the journal, *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, Bungental, & 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 gradate clinicians in various humanistic approaches, including constructivist therapy. He is a Fellow of the Clinical Psychology Division of the American Psychological Association, 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, Winokeuer, & 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, and is a Fellow of the Clinical Psychology Division of the American Psychological Association. Neimeyer has received several awards for his contributions to research on death, dying and bereavement, as well as from the Viktor Frankl Association for his contributions to the study of human 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. Tina 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 reconcile these very different personas of her father.

Schneider used an existential-humanistic approach with a Caucasian woman in her late 40's 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 encountered abuse and 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-40's. 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 32-year-old female clinical psychology doctoral student, with four years of supervised therapy experience applying various humanistic approaches. Additional researchers aided in the collaborative data coding process. Two researchers (DRA and JB) are post-doctoral members of the research lab that developed the IMCS, with extensive experience using this system. The remaining coders include doctoral student researchers (MAS, EAC) 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 (IMCS). The IMCS (Gonçalves et al.,2009; Gonçalves et al., 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 inter-judge 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, 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 where alliance ruptures were previously identified.

Global Assessment of Functioning (GAF). 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 watching the therapy videos, to assess functioning as therapy progresses. A rating was given from 1-100, 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, 1981, 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 five mins. 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 or ICC = .82 (with current study's average of ICC = .993) 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 IRB, 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 doctoral student researcher (MAS), who served as a collaborative coder. Training was guided by a manualized process which 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 have 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 convened after each to calculate inter-coder 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 inter-coder 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, where exceptions to the problematic narrative "rules" existed.

Table 1
Deborah's Problematic Self-Narratives and IMs

Problematic self narrative		Examples of IM's
Grief	C: Yeah that's the only thing that I can target, is that it was the only big change you know in my life was my mom's death…. T: mhm. now, She died about 2 years ago? C: Yeah…. And it seems like it gets worse, not better	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
Depression	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	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.
Cognitive Problems	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.	C: …I've gotten a big wrap on my emotional status…I used to have outbreaks to where I would go blank, and not even know what to do next T: right yeah C: …. it's just not happening in my life now and I think that with the reflection that this has helped me out immensely.

Table 1 (continued)

Problematic self narrative		Examples of IM's
Anxiety	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…	C: It's really, uh, a wonderful thing to be able to have um a sense of ok-ness and not to have that anxiety. T: mhm C: you know, anxiety brings more anxiety because then you're worried about the anxiety.
Family Strain	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.	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 you're 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 you life if gives you more time with the other people in your life.

Table 1 (continued)

Problematic self narrative		Examples of IM's
Resentment	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.	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.
Trying to fill deceased mother's role	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.	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 shining 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.

Table 1 (continued)

Problematic self narrative		Examples of IM's
Weight Struggles	C: I was holding on to this one size, indeed I was worried that I would gain back that weight.	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."

Table 2

Anita's Problematic Self-Narrative and IMs

Problematic self narrative		Examples of IM's
Grief/Sadness	C: but I do know that I went to the scene, and I needed to be where I felt 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	C: I do feel my brother is finally at peace, really, really at peace C: you know and uh, I don't wanna do that, I don't wanna live my life in that deep sadness. You know, it's like that uh, black hole thing T: right C: I don't wanna go there
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	C: He was on a destructive path, you know, and there wasn't anything that any one of us coulda done to change that
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.	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

Table 2 (continued)

Problematic self narrative		Examples of IM's
Delegitimizes own needs/feelings	C: And I mostly stayed in my bedroom. You know, if I walked around, I walked quietly…it's like…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	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…
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: and I want to be fully free and not terrified of that dark spot, you know, where, like the Bermuda Triangle kind of thing
Resentment	C: I was very angry that…nobody took me to counseling… it made me feel that…I wasn't worthy enough T: yeah C: I wasn't important enough. And when I tried to talk to my other aunt, my mother's sister, about this, as years went by it would still haunt me, and she would tell me 'at least you weren't raped, you were just molested.'	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

Table 2 (continued)

Problematic self narrative		Examples of IM's
Constricted emotional expression	C: … you know, once I'm loving I get taken advantage of	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
Lacking healthy boundaries with son	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	C: Actually I don't give him whenever he wants it anymore. He's actually paid me back in some aspects T: Mmhmm C: Or I've had him paint walls. So I've made some changes C: And, um, and I do tell him upfront that this has to stop. That if he continues to make bad decisions, that I can't continue to be there
History of drug/alcohol abuse	C: and, um, as I said…I lived in the world of drugs	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

Table 3

Tina's Problematic Self-Narrative and IMs

Problematic self- narrative		Examples of IM's
Grief	C: and 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.	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: mmhmm 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
Struggle to integrate conflicting views of deceased father	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…	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

Table 3 (continued)

Problematic self- narrative		Examples of IM's
Anger/Resentment	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	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
Avoiding Emotional Expression	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: Mmhmm (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.	C: I'm fixing to tell her how I feel, because I can't bottle it up anymore C: I don't know, it was so profound. They actually made me cry, and I never cry T: Hmm C: Yes, they made me cry. T: That's unusual for you C: Yes it is. I don't cry in therapy T: Especially in front of people, I imagine. C: Right. But they got to me.

Table 3 (continued)

Problematic self narrative		Examples of IM's
Guilt	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.	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
Anxiety	C: …but I can't figure out why I couldn't sleep. Just a lot of stuff going on in my head. T: yeah C: and when I worry, the body worries and it doesn't let you relax.	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: mmhmm C: too together to the point of where you stress over everything.
Difficulty trusting others	C: Mmhmm. 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?	C: I had to, uhh, 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

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 where each IM begins and ends. This step allowed the primary coder to later calculate *salience*--a measurement of text (*textual salience*) and time (*temporal salience*) that an IM occupies in a given session—or across sessions (Gonçalves, Ribeiro, Mendes, Matos, & Santos, 2011).

Categorization of IMs. As IMs were identified, coders independently classified them into one of the five IM categories. In cases where 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 salience of each type of the five IM categories by identifying the percentage of words and time occupied by a given type of IM 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 consesus 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 2 sessions within each therapy case), with aims of achieving 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, 2010) 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 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 (Fakenstrom, 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.

Table 4

Global Working Alliance scores across therapy, M (SD)

Client	Session 1	Session 2	Session 3	Session 4	Session 5	Session 6
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)

In the case of Deborah, global alliance scores increased over the course of the six sessions, with the exception of session five, where 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 towards

increasing strength, with somewhat of a plateau between sessions 3-5, and increasing again in session 6, terminating therapy with a very 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 three during the session in which Anita spoke of the loss of her brother. Scores then stayed relatively the same, until termination, where 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 good outcome grief therapy cases (e.g., Alves et al., 2012; Alves et al., 2013; Alves, Fernandez-Navarro, Ribeiro, Ribeiro, &, Gonçalves, 2014).

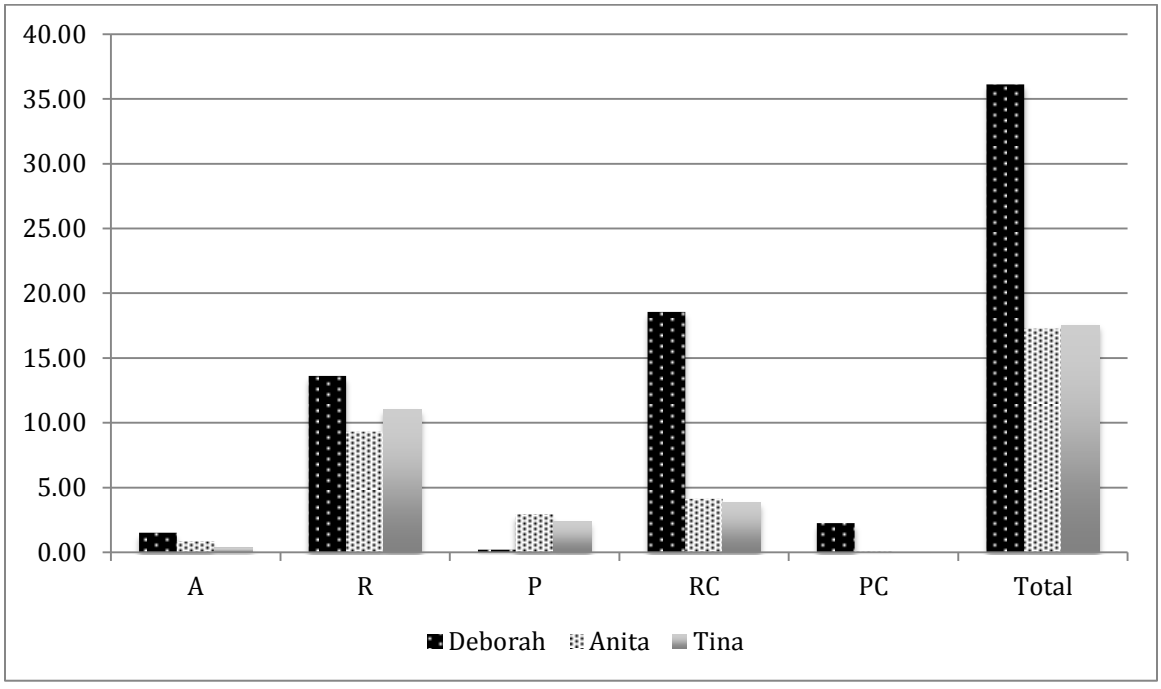

Figure 2. IM Overall Textual Salience Across Cases

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%-30% (Alves et al., 2012; Alves et al., 2013; Alves et al., 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. While all three cases involved the elaboration of RC IMs, which are primarily found in good outcome cases, Deborah's therapeutic process involved twice as much elaboration of RC IMs than the other two cases, and greatly more than other good outcome grief therapy cases reported in the literature, with reports between 3.6% - 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%-17.5%). In Deborah's case, reflection was the second most salient IM, with ranges also consistent with comparable good outcome therapy cases in the literature.

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, while 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%-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 will be explored in a session-by-session format in latter parts of the results section.

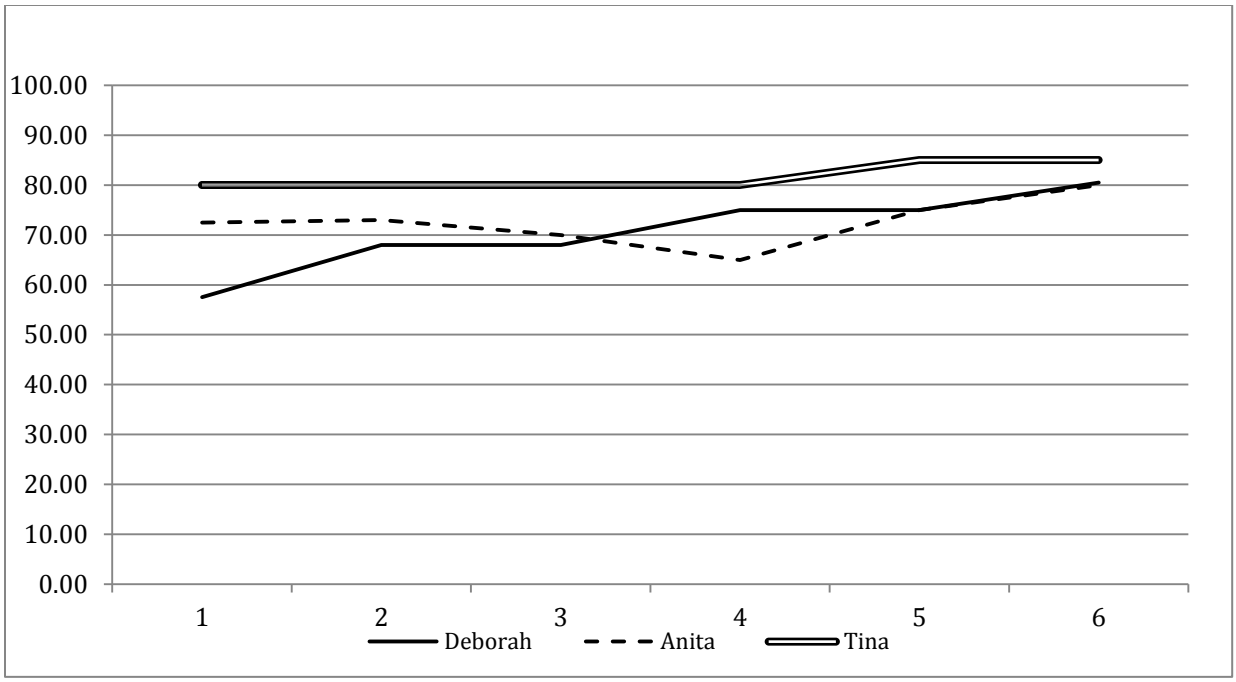

Figure 3. GAF Scores Across Therapy

Association Between Alliance with IMs and Client Functioning

Alliance ratings were derived for each 5-min. 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-min. 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 cases of Anita (r = .57), and very strong in the case of Tina (r = .88), but did not hold when the cases were averaged (r = .12). 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). This relation was moderate when the cases were averaged (r = .30). 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.

Specific IM Categories and Functioning Across Therapy

The three therapy cases were each carefully analyzed to yield in-depth understanding of the pattern and function of each IM category across each respective six-session course of good-outcome humanistic therapy following bereavement. Given the uniformly high alliance ratings, they will not be integrated here. In the following section, each therapy case will be presented separately to elucidate the interplay between client functioning, IMs, and therapy procedures, with specific examples provided for greater context. Notable similarities and differences between a given case and others in the current study will be included as warranted.

The Case of Deborah

Deborah's case is distinct in that she entered therapy with poorer functioning than the other therapy case participants, with her initial GAF of 57.5 indicating significant impairment in her daily functioning. Upon therapy termination, however, Deborah's functioning had substantially improved, with her GAF score of 80.5, indicating transient symptoms with minimal to no impairments in functioning. Her case also differed in that the dialogue between her and her therapist yielded more IMs both overall and in all specific IM categories, with the exception of Protest IMs. Figure 4 illustrates the progression of IMs and functioning across six sessions of constructivist therapy, but does not include action and protest IMs given their low salience.

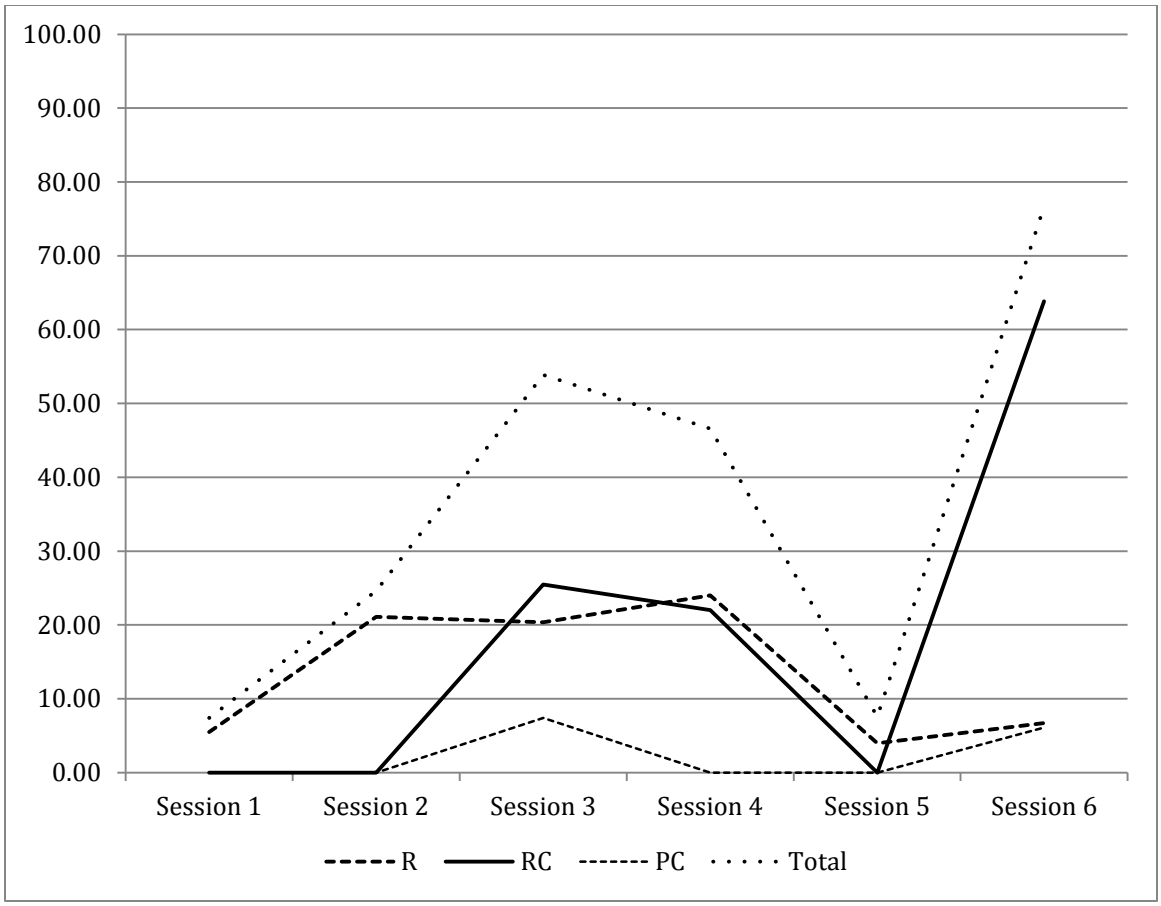

Figure 4. IM Salience Across Deborah's Therapy

Session 1. Deborah and her therapist began to uncover the ways in which this loss had impacted her life. This exploration entailed describing the ways in which her mother's death two years prior had left her emotionally, cognitively, interpersonally, and functionally "getting worse, and not better," to the point that she was unable to fold laundry and put it in the appropriate drawer, or organize a few simple materials for a class she was taking at a local community college. Nevertheless, despite Deborah's monotonic and tearful demeanor throughout the session, action, reflection and protest IMs began to appear, though with low salience. At the end of this session, taking a cue from Deborah's anguished yearning for her mother over two years following her death,

Neimeyer suggested a writing exercise to "reopen the conversation with her that was closed by death," in which Deborah was invited to write a letter to her mother about her needs in the wake of loss. Though initially daunted by this prospect, Deborah collaborated with Neimeyer by dictating the first two sentences of the letter in session through a veil of tears, and concluded with the hopeful statement that "writing the letter sounds like a good idea…. It could give me a chance to reconnect with some of her positive thoughts." Accepting the opening lines transcribed by Neimeyer, she committed to completing it as between session homework.

Session 2. As was immediately apparent in her affect, eye contact, vocal modulation and even way of dressing, Deborah's change in functioning, as measured by the GAF (score of 68) increased dramatically from the first to the second session, as did overall IM salience, with a particular increase in reflection IMs. Deborah reflected on the changing relationship between her and her deceased mother after writing several iterations of the letter over the previous week. Deborah described adaptive ways of understanding her mother's death and her success in releasing lifelong resentments held toward her mother, stemming from childhood neglect. Reading the letter aloud to her mother in session at Neimeyer's invitation, Deborah elaborated on these movements towards reconnection: "I know you are in a better place and I will see you again…. My prayer is that…I am able to concentrate on the gift God gave me of having a mother like you for 43 years." In reconnecting with her mother, Deborah began creating distance from the problem of being immersed in debilitating grief. These initial changes prompted Deborah to question and gain insight into her own interactions with the family, reconsidering her how the loss of her mother had led her to adopt her mother's managerial role in relation to her (resistant) older siblings, some of whom, like Deborah,

continued to live in the family home with their father. Deborah expressed intentions to "let that go, and just let them be them," but she expressed a hesitation to do so, which at her therapist's inquiry, seemed to require her mother's permission. Neimeyer therefore invited Deborah to engage in an additional homework exercise to communicate with her mother about this need, which ultimately included Deborah's adaptive self-instructions to "return my mom's legacy to herself." She elaborated new understandings and adaptive thoughts, saying, "…I'll always have her wisdoms instilled in me, but I don't have to keep trying to push it down everybody else's throat…. Life is different now…. She's not the holder of all things and the answerer to all questions."

As Deborah explored ways to relinquish responsibility of her family that her mother used to carry, a new position of empowerment emerged, as she protested, "You know [the family's] refrigerator is full of fast food containers and, um, it just sickens me…. I've always been the one to clean out the refrigerator, and I said 'I'm not doing it anymore.'" This position related not only to her disengaging in her mother's role as caretaker, but also to Deborah's repositioning against her struggle with obesity, and desire to maintain changes she had made in her weight.

Session 3. Deborah's functioning remained the same as in the previous session; however, she entered the session with increased clarity about the impact of the writing exercise on her reconnection with her mother's spirit, and disengagement from the task of fulfilling her mother's role. Overall IM salience increased substantially, and the RC and PC IMs emerged for the first time. This evolution occurred despite the occurrence of the monthly anniversary of her mother's death, which Deborah described as a typically very difficult time, but which now, for the first time in 26 months, she experienced merely with "nostalgia."

In this session, Deborah elaborated the contrast between her current emerging self and the former version of self that represented her mother's role. Deborah emphasized the importance of her letter writing as a process of change, and described the transformative process of learning to connect with her own self-identity without enacting her mother's role in her daily life. Deborah further elaborated the process of change underlying the shift, and explained that writing "was a way of…identification. First, I had to identify that I was doing these things…as I typed them and acknowledged them and made them real it gave me an understanding that I could let them go." In this session, Neimeyer invited Deborah to read the letter that she had crafted to her mother. This exercise prompted novel conceptualization and adaptive self-instructions:

> I am returning your legacy to you…. I cannot help somebody unless they ask for help. I need to let go of other people's difficulties and understand that in order to help others I need to let go of my own negativity in order to progress…. Mom, I'm asking you permission to be me.

Deborah continued to elaborate on a new position with a contrast to her former self in the absence of her mother, saying about her family, "…We're all adults…. I've seen them pick up and kind of move into their own…. I wasn't doing that, and this week's been a lot of that." Deborah also began to reflect on how this new positioning of self would impact the dynamic in the relationships she had with her own daughter, and she reflected on a "transition between us that needs to be made" that would allow her to relinquish some of the responsibility of her adult daughter.

As Deborah further explored her reignited sense of self, PC IMs emerged, elaborating Deborah's assertively seeking an employment interview from a casual acquaintance who was

managing an organization providing support to seriously ill children, which was a behavior that would have been impossible when Deborah was consumed with debilitating grief. She explained, "…she [employer] was telling me that she needed someone that was a good typist and had great organizational skills, and I said, 'Why not me?' [laughing]." Deborah later explained the meaning she derived from this job:

> C: It's just a really beautiful, beautiful thing to be able to give back to society…
>
> T: So at personal levels but also for larger, altruistic, social motives, it feels right. And it feels almost like rather than having to *look* for people or…perceive needs in them in the family…here the needs are *real*…
>
> C: And it fills a real need for me too. It gives me a salary…. It makes me feel productive.

In response to Deborah's shifting identity, Neimeyer later invited Deborah to engage in an experiential exercise in which she took the perspective of her deceased mother as Neimeyer interviewed her about the changing person Deborah was becoming. This intervention allowed Deborah to articulate new instructions to herself, but through her mother's perspective, which gave final clarification that Deborah now could move forward in her life as an individual, without enacting the narrative of taking over her mother's role. Neimeyer wrote these prescriptions from mom (e.g., the courage to stand on her own decisions, permission to relinquish being the family caregiver) and provided them to Deborah at the end of the exercise, to which Deborah, with tears of gratitude, reflected on ways she would use these in the future, saying, "...these are words of wisdom… .a good practicing tool for me. When I want to hear her words, then I have them."

Session 4. Overall and categorical IM salience remained comparable to session three; however, Deborah's functioning continued to improve. She explained how her grief had changed tremendously, and explained the "peace" that had been brought by her acceptance of her mother's death, explaining her previous position, "There were times… I would actually be thinking that she would come back" and her current position, "…it was so unrealistic…. There's nothing I can do to change it anyway, so I might as well come to terms with what is." She continued to describe how her sleep, anxiety, and stress levels changed because of this acceptance, and also anticipated ways to proactively identify problems if they arise in the future.

Deborah continued to describe a decreased need to be the caregiver in her family, and her intentions to "…figure out what's mine and what's mom's" as her identity evolved. Deborah narrated in this session the ways in which her grief had previously dominated her life, and she described a "void" that was left in the wake of her mother's death. Neimeyer worked experientially with Deborah in this session to connect to any current physical experiences of this void. This exploration created a sustained period of reflective IMs, as Deborah described connecting with a "beacon of light" that was "embracing" her and bringing her "comfort", "wisdom", and "understanding." Deborah ultimately named this experience "a hug from heaven" which helped her contact the "peace" she was finding in her grief. Deborah elaborated on her intentions to revisit the void in the future to "write down some of the void, some of the things I'm missing from her."

Session 5. Deborah's functioning remained the same as in the previous session, although IM salience levels dropped precipitously. Deborah explained that in the time between sessions four and five she had been physically ill, and was also feeling increasing

pangs of grief as her mother's birthday approached. Within this session, Deborah digressed into telling a story unrelated to her presenting issues. This material might partially account for the decrease in IMs. As the session came to a close, Neimeyer invited Deborah to spend time reflecting on changes that have occurred during the weeks of their therapy together, which Deborah agreed would be useful.

Session 6. In the final session, Deborah's functioning peaked to its highest level throughout therapy (GAF = 80.5), as did overall IM salience, with well over half of the therapy session involving the elaboration of RC IMs. Deborah and Neimeyer spent a significant portion of the session discussing the changes in Deborah's grief and functioning, and the fundamental processes underlying these changes. Early in session six, Deborah explained her contrasting past and present grief, saying, "I've gotten a big wrap on my emotional status…. I have sadness but I used to have outbreaks to where I would go blank, and not even know what to do next…it's just not happening in my life now." She explained the process underlying this transformation:

> I didn't even really realize that I was trying to step into my mother's shoes when we started out…. When we shined that light a little deeper, I seen that I was trying to…keep my mother alive by being what she was to people in my family.

Deborah later further elaborated, "I think I was blocking… a healing process… cluttering it up with this trying to become her." She explained, again, the importance of the letter writing in her change, stating, "I really haven't felt, since we began after the first letter, I haven't had that mental blankness that I used to get. And… my sleep patterns are better." Deborah continued to explore her contrasting narratives: "…. I would always be crying… getting upset…. That's hard to be around for two years…. I'm more open and able to accept things

and to, um, have a more happy note just in life itself." In the remaining minutes of their final therapy session together, Deborah and Neimeyer elaborated on a meta-change Deborah experienced regarding her perception of death. She explained this change process occurred by "allowing myself simple pleasures… and not to be wound up so tight." She also identified, again, the importance of releasing the role her mother created, and the numerous changes that occurred from this process, including her views of death:

> C: I definitely have a better outlook on this and I think [about] death in general and as well as my mom being gone, um, differently…
>
> T: Could you say something more about that? That really intrigues me, the idea that in this, your very view of death has changed.
>
> C: Yeah…. I don't see it, you know, as an ending as I did, as a sharp, critical ending… but just a starting place… it leaves space for somebody else…. And that also, at any moment, life is just for a season. And any moment that you have with someone who, um, blesses you and allows you to feel love, is just such a great thing. And that it doesn't end there, you know, just because my mom's not here anymore, the greatness that I was able to be loved and able to love… is just phenomenal…. To have had that experience… death doesn't take all that away…. It just secures it.

Neimeyer encouraged Deborah to provide feedback about the therapy process in working with him, and she explained, "I think that everything you did for me was perfect for me." She commented on Neimeyer's flexibility in his approach, saying, "You gave me an option. I think as human beings we need that. It wasn't 'we're going to do this.'… It was… opened, and I… think that was good." She concluded, "I'm kind of astounded about the whole thing and the way it transpired."

The Case of Anita

Anita's case differed from Deborah's and Tina's in that she did not enter therapy with grief as a primary focus, and her functioning, as measured by the GAF (72.5), was only slightly impaired. Anita's initial problematic narratives patterns were, however, linked to the death of her mother when Anita was a child, and the lasting impacts this had on her developing sense of self (e.g., fear of intimacy, boundary difficulties, resentment). The theme of grief became more central as she tried to make meaning of the violent death of her brother, which occurred between Anita's second and third therapy sessions with Schneider. Her functioning decreased following this loss (GAF = 70) until the fifth session (GAF = 75) and she finished therapy with only transient symptoms (GAF = 80). Figure 5 represents her levels of functioning and the textual salience of IM categories across the 6 sessions of therapy, but does not include action, protest or PC, as they all occurred <3% overall salience.

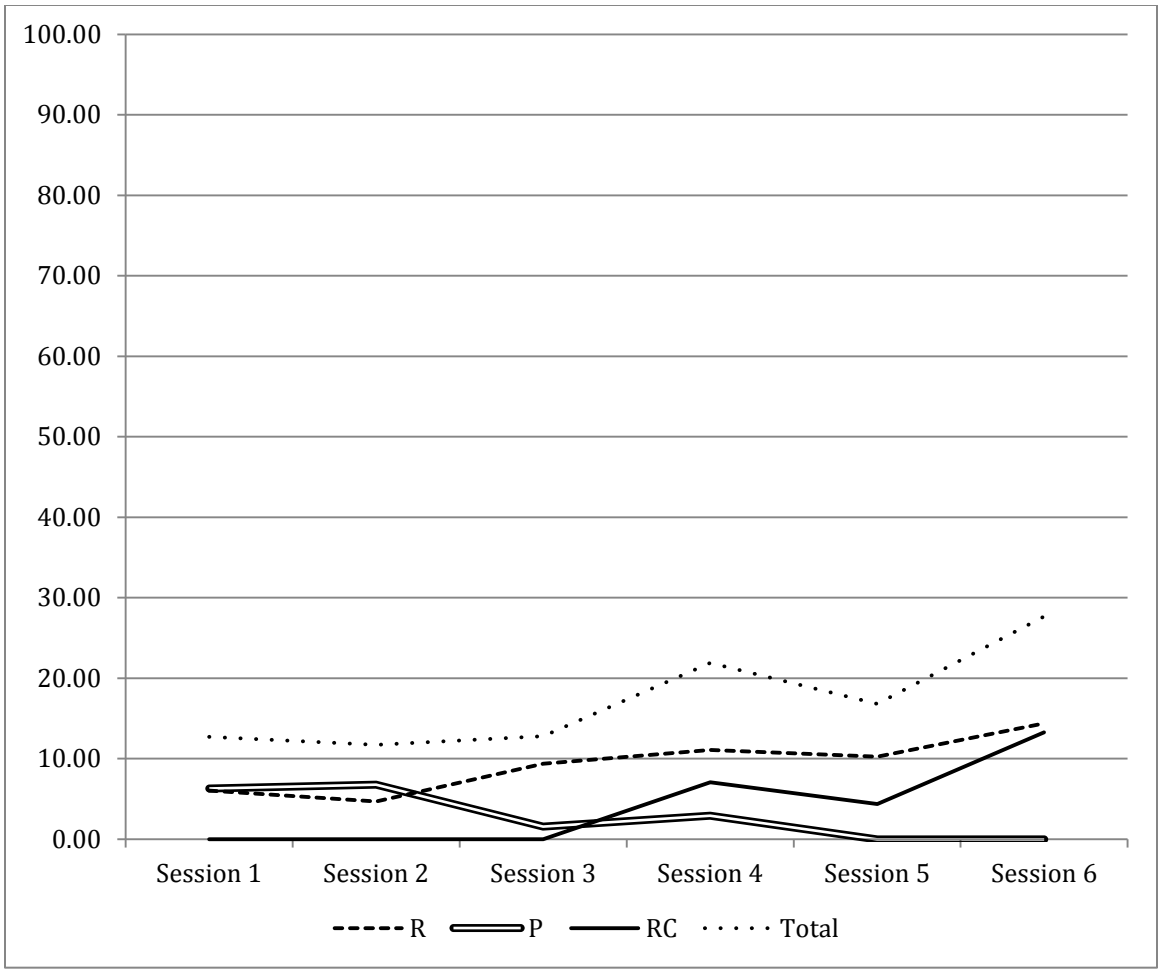

Figure 5. IM Salience Across Anita's Therapy

Session 1. Anita entered therapy with slight impairments in functioning. She elaborated on her fears of losing her independence, as she prepared to move in with her boyfriend of 8 years. She described the context of her struggle, including a childhood fraught with chaos, loss, and physical, verbal, and sexual abuse. As a child, Anita's mother died unexpectedly, and she helped parent her younger brother, who eventually struggled with mental illness, addiction, and numerous suicide attempts. Anita explained how her past linked to her own addition to alcohol (though currently sober for 16 years), physical decline, extreme feelings of guilt and responsibility, and involvement in

unhealthy and sometimes abusive relationships with men. She viewed her current romantic relationship as healthy; however, her history of abuse and loss prompted feelings of fear as she took steps towards sharing a home with her partner. She also described her struggle in interacting assertively with other men in her job as an electrician, a "man's field" where she often felt meek and easily intimidated.

Within her problematic narrative elaboration, Anita also began to express exceptions in the form of--and in nearly equal parts-- protest and reflection IMs. Action IMs appeared, but with extremely low salience. Protest IMs connected to Anita repositioning herself towards her problematic narrative of lacking assertiveness and confidence, and occurred in the context of her past as a child being forced to take care of others (e.g., "I never wanna repeat that cycle again… that child who's taking care of somebody… because then I teach somebody that they can do that to me…"), and in the contemporary context of her lacking assertiveness with her boss and her son. Schneider invited Anita to engage in an experiential role-play with her boss, in which she continued to elaborate an assertive position, generating further protest IMs. Anita also began to express reflection IMs, particularly around her desire to live a fuller life. In one such example, she expressed, "I've come a long way… but… I don't want to just exist and I don't wanna just have survived and just be strong. I want to go above that…. I want to take charge."

Session 2. Anita presented with the same levels of functioning, and nearly identical expression of IM salience across reflection, protest, and action as in the previous session. Most innovative elaborations revolved around Anita's desire to be more assertive and set clearer boundaries with her son, who was struggling with addiction and

employment problems. Anita's guilt had prevented her from taking steps towards changing this dynamic with her son, and she explained her ultimate fear was that her son would die by suicide. However, in this session, Anita elaborated on new positions of assertiveness and relinquishing responsibility and guilt over her son's choices. Schneider facilitated a role-play, enacting Anita's son, while Anita practiced her new position, prompting reflection IMs (e.g., "…I have to tell myself I'm not responsible for his choices") and protest IMs (e.g., "I'm not bailing you out this time. You're on your own", "…you meet with me, otherwise you don't get another dollar from me."). Anita's new position grew stronger by the end of the session, and Schneider prompted Anita to consider how this would translate into action. Anita committed to talking with her son in the upcoming week about setting healthier boundaries.

Session 3. Anita incurred the tragic and violent loss of her brother. Anita explained he was armed and perceived as dangerous by police after placing a suicide call, and was subsequently killed. As Anita tried to make sense of this tragedy, she showed minimal changes in functioning from the previous sessions. Overall IM salience remained nearly the same, but protest IMs decreased substantially, while reflection IMs increased.

In the wake of this tragedy, Anita was faced again with feelings of guilt for setting boundaries with her brother, and reflection IMs involved elaborations of how she could not be responsible for her brother's choices (e.g., "He was on a destructive path…there wasn't anything that anyone of us could've done.", "…I know really that I'm not guilty."). She and Schneider also elaborated on adaptive self-instructions to fight a recurrence of depression in the face of her loss (e.g., "I want to be fully free and not terrified of that dark spot…", "I don't want to live in that lifestyle of trying to find the

sunshine and not being able to find it."). She explored positive strategies implemented in order to gain support from others (e.g., "Usually I'll cry by myself, and I was like, I don't have to cry by myself today…. I'll call up my friend…"), and was able to reference feelings of well-being when thinking fondly of her lost brother and the "peace" he found in death (e.g., "I feel now he knows he's complete.").

Anita paralleled her experience of setting uncomfortable, but necessary, boundaries with her brother (prior to death), to her evolving boundaries with her son. In one reflection IM she explained, "I had to be totally tough with him, and listen to none of his excuses… putting the responsibility in his field… so that brings up… the same thing with my son." She explained that she had spoken with her son, as planned, in the previous week. She continued to elaborate on how she would like to "respected" and not "intimidated" personally and professionally.

Session 4. As Anita's bereavement progressed, she experienced a decrease in functioning, explaining the week of grieving had been "horrible" but that she had been "forcing" herself to "show up in life." In this session, Anita explained, "Today I feel… much stronger." In this session, overall IM salience increased substantially, and RCs were introduced for the first time. In one such example, Anita talked about her changing grief, and the process of emotional expression that promoted this shift:

C: I feel like it's getting better

T:…That feels important. How is it that it's shifted?...

C: …I think… because I allowed myself to cry.

T: uhuh

C: …and more importantly, allowed myself to cry with others. I never did that before. I would cry silently….

However, Anita continued to elaborate on feelings of guilt about her "tough" stance with her brother, and feeling guilty for how she encouraged her father to enact the same role. In attempts to reconcile her grief with her changing sense of self, Reflection IMs in the session revolved around meaning she had created from her brother's death (e.g., "I had to be so tough with him… otherwise… he would take over my life."), including a renewed sense of strength to face challenges. Schneider also engaged Anita in an imaginary role-play in with her father, prompting innovative elaborations of intentions to speak with her dad about her feelings of guilt in her brother's death.

Anita and Schneider continued to explore counteracting Anita's narratives of guilt and insecurity. Following a protest IM, empowering Anita and her developing sense of worth, Schneider asked Anita her reaction to him expressing to her that "Anita is worth it." Anita elaborated an RC IM on a shifting narrative of "I feel like I'm graduating" and "I feel empowered to hear somebody else say that." She then presented a metacognitive understanding of this process change:

Maybe there's like these two voices at war and when you say that, it overpowers that voice that says to be submissive, to put my head down, that I'm guilty, it's your fault. When I hear you say that, it almost validates the other voice that says, he made his own choice… you know, I've done a lot of hard work…

Session 5. Anita's functioning reached its highest since beginning therapy. There was a slight decrease in overall IM and RC salience, and reflection and action IMs remained comparable to the previous session. PC IM presented for the first, and only

time, during Anita's therapy, in which Anita explained a new position of being more connected with her son within the context of setting clearer boundaries, which also related to a RC IM about the process underlying this shift, which connected to lessons learned from her brother's death, and her need to pair "tough love" with vulnerability.

Anita's communication with her father prior to the fifth session brought about new intentions to continue decreasing her unhealthy sense of guilt (e.g., "…the conversation went really well…. I just reminded my father that… no matter what road we took, it was the decisions of my brother that continued to drink the way he did, or to take pills… and the two just don't mix."), and to generalize this insight into her interactions with her own son (e.g., "I gotta make sure that he understands how much I love him… not to forget the love out of the tough love process… if that's one thing I could take out of my brother's death."). Anita and Schneider refocused on developing Anita's desire for closer relationships and connecting fully with life (e.g., "I really try to stay in the moment…. I have a great boyfriend, I have a loving son…"; "I want to be in tune with those things… and… not be lost with all this worldly stuff."). Anita also reflected on her "comfort" within the therapy relationship with Schneider.

Session 6. In Anita's final session, her functioning increased, and there was a substantial increase in overall IM salience, as well as in specific categories of reflection and RC. Schneider invited Anita to engage in an embodied meditation, in which Anita gained compassion and "patience" for herself, as she spontaneously visualized herself as a small girl hiding in a closet. She described that this shift released some of her anger she held towards herself, explaining, "I need to… warm her out of that closet to come out, out of that darkness," further noting, "I was angry at first, but then I became patient and

empathetic to the point of stepping inside…" She elaborated on a new developing sense of soothing and caring for herself and intentions to cope with problems in the future by elaborating ways to engage in self-comfort (e.g., "I can get myself back into journaling… concentrating on that little girl… talking to myself about not being afraid…"). Anita explained a tangible way she intended to care for the "little girl" that she encountered in the meditation by nurturing the developing relationship with her granddaughter, saying, "I feel almost excited now to, now that I have this [little girl] who wants me to hold her… to pat and kiss her head…. if I could, when I do that with her… I can do it to me… at the same time… to allow that to be therapeutic for the little girl inside me."

The Case of Tina

Tina entered therapy after the very recent loss of her father, which occurred when Tina was nine months pregnant with her first child. Of the three therapy clients, she presented with the highest level of functioning at therapy initiation as indicated by the GAF of 80, indicating only transient symptoms. However, the loss of her father was a significant challenge for her as she attempted to reconfigure her role in the family, with attempts to relinquish the burden of responsibility she carried with her since childhood. She also worked with Cain to synthesize the conflicting views she held in regards to her father being both an "angel" and a "monster." By the end of therapy, Tina exhibited minimal to no symptoms (GAF = 85.0), and was demonstrating effectiveness in several domains of functioning (e.g., succeeding in graduate school, parenting, interpersonally).

Tina's therapy case paralleled Anita's in many ways. Despite the specific differences between the two, they shared many problematic narrative patterns (e.g., fear/anxiety, grief, anger/resentment, relationship/boundary difficulties, being overly responsible for others in

the family). Also, the salience of each IM category across the 6 sessions of therapy were strikingly similar, where the progression of IMs differed on a session-by-session basis, but the overall salience of each category presented as nearly the same. Figure 6 represents the textual salience of each IM category across the 6 sessions of Tina's therapy, with the exception of action and PC, given their low salience.

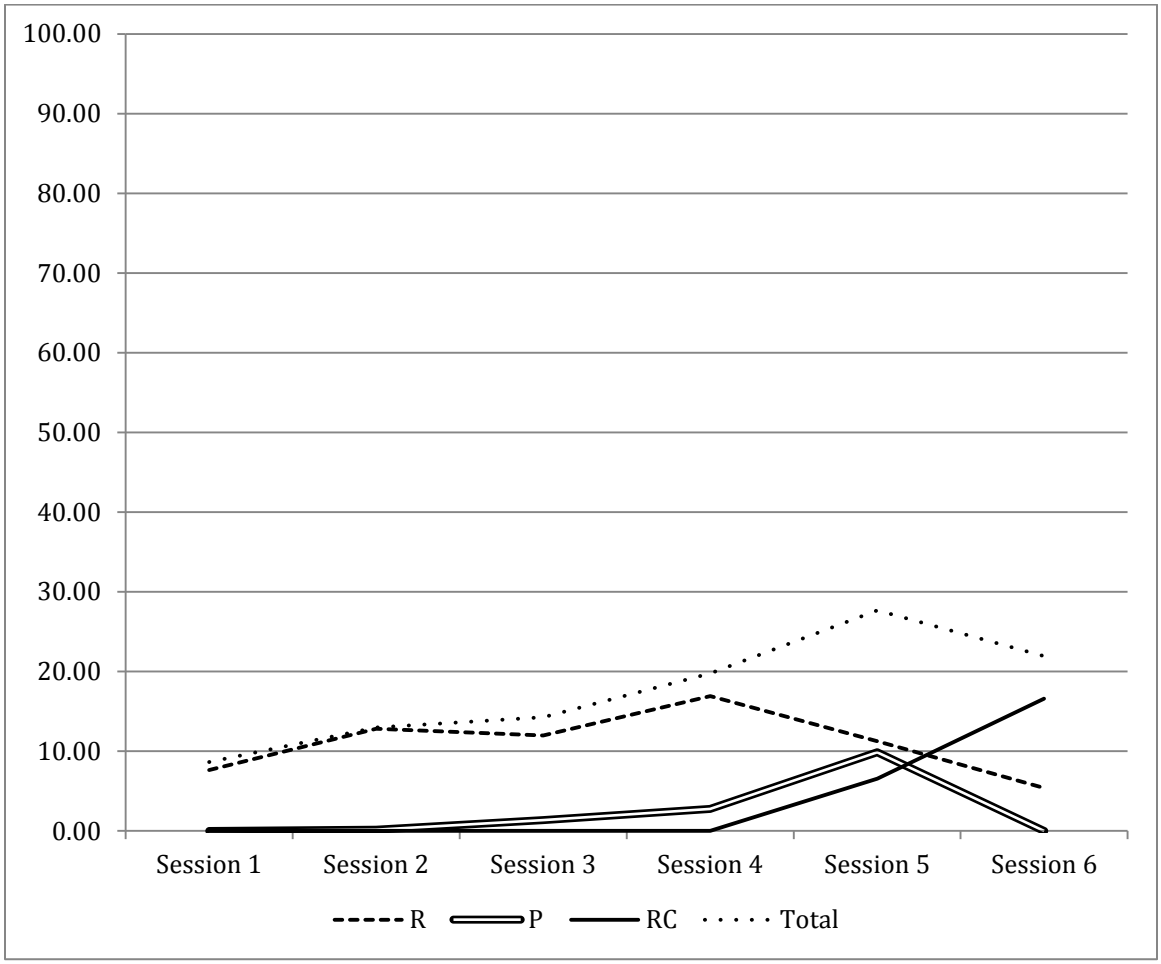

Figure 6. IM Salience Across Tina's Therapy

Session 1. Despite the recent loss of her father, Tina entered into therapy with the highest functioning of the three therapy cases, and the lowest overall IM salience in the first session, primarily composed of reflection IMs, and very low salience action IMs. Tina discussed her father's quick deterioration and death following a cancer diagnosis and explained she was nearing the end of her pregnancy at that time, and was tasked with numerous responsibilities related to her father's end-of-life care, and had not "had time to deal with the grief." As Cain tried to help Tina stay with her percolating experience of sadness in the session, she struggled with this task after trying, and said she was going to "put it [sadness] in a jar and save it for later." Her grief was made more complex in her conflicting and unresolved views of her dad as an "angel" to her, and "a monster…to others." She explained that her father molested her older sister, and Tina had pondered if the same had happened to her, and had spent time in therapy throughout her life trying to answer this question. Tina also witnessed her father "beat" her mother, who struggled with addiction. Her mother left Tina to be raised by her father, presenting feelings of abandonment from her mother, and feelings of gratitude for the role her father played in raising her.

Concrete, action-oriented IMs in the first session revolved around Tina's coping with emotional pain and grief (e.g., "I do grieve…. I cry a lot when I'm driving"; "I have to let go and let God [take over]"). She also talked about keeping a reminder of her father in the car that he purchased for her (e.g., "…I pasted his picture on the dashboard… of him when he was smiling.") and imagining her father in heaven. Tina also began elaborating reflection IMs, primarily around ways she was coping and making meaning in the wake of her father's death. For example, she spoke about remembering positive

aspects of her father, connecting with him spiritually and physically in the form of music and things they enjoyed together, and focusing on ways to accept the conflicting views of her father. She also elaborated on ways that these efforts brought her comfort and hope in her bereavement.

Session 2. Tina's functioning remained the same as in session one, but there was a slight increase in overall IM salience, with a slight increase in reflection IMs, and the introduction of protest IMs, though at a low salience. In this session, Tina opened with a reflection IM, generated around her intention to resolve her conflicting views of her father to "get rid of the guilt and anxiety" by understanding "it's something out of my hands… just learn to accept it, and move on." She continued to generate reflection IMs around connecting with her father spiritually, bringing her comfort. Many of the IMs in this session revolved around Tina trying to relinquish responsibility in her family (e.g., "I can't keep babying her [Tina's sister]. She'll never get out there and learn responsibility if I keep doing that") and reducing her own stress (e.g., "If I don't stress as much, I can get rid of my headaches…. Then I can function better"). She even elaborated on using her internalized voice of her father to remind herself to "calm down" when anxious, and begins to find positive similarities between her newborn son and her father.

Session 3. Tina's functioning stayed the same as in the previous two sessions, and IM salience was comparable to session two, but with a slight increase in protest and action IMs. Reflection IMs in session three were thematically similar and occurred with similar salience as session two. Tina continued to describe using her spirituality as a source of coping and as a connection with her dad. She also continued elaborating on reducing stress and setting boundaries in her family, while strengthening her resolve to

"be my own person." In one such example, Tina reflected on strategies she implemented, despite her father's wishes before death:

> … he [dad] told me not to give Deborah any of her money that he left her. But I knew that if I did that, I would continue to baby her, she wouldn't learn responsibility, and I'd be managing everything like I'm doing now. And I didn't want to do that, so I gave her the responsibility to take care of your own money. You [are] grown.

Cain furthered the exchange:

> T: But maybe a more important part is you sort of freed yourself from Dad's desire about how you should handle these things.
>
> C: Mmhmm, mmhmm
>
> T: So it looks like you can, you have some evidence that you can
>
> C: Mmhmm
>
> T: …go beyond what you think dad expects of you and do things your own way, a way that you think is right.
>
> C: Exactly, exactly. Because I know that what dad was doing when he was alive was stressing him out…

She later explained:

> C: Yeah. I'm learning to just pull back. Before I open my mouth and say, "I'll do it!" Just sit down and see what happens.
>
> T: You don't always have the be the first person to raise their hand and say, "I'll take care of it."

Tina elaborated on criticisms of the problematic narrative and efforts to assert herself in a new way. In one such example, Tina described her father's "dictating" that she make

decisions regarding his end-of-life care, despite Tina being near the end of her pregnancy. She protested in regards to her family, "Why wouldn't you volunteer to do something, please?!" and in regards to her father:

> Why would you give that responsibility to me?! What makes you think I want that responsibility?.... How would I be able to live with myself saying 'I don't know what God's plan was, but my plan was to pull his cord because he asked me to.' I mean, it's horrible.

Tina also elaborated a reflection IM about the therapy process, indicating "…I think it helps to hear myself and then when you… come in and intervene and notice the conflict, then I notice it like, "Well that doesn't make any sense!" She concluded, "It's very helpful."

Session 4. Tina's functioning continued to remain the same as the previous sessions, but this session brought an increase in overall IM salience, with increasing reflection and protest IMs. Tina continued to elaborate on developing positions of being more confident in setting healthy boundaries with her family, and specifically in this session, her mother. In regards to her mother, she asserted, "…I won't buy cigarettes, I won't buy booze…. If it's anything that's going to hurt you, I ain't buying it….." She later elaborated, "I am not your drug dealer on the corner that you need to manipulate, I'm your daughter." Tina also narrated ways in which she had relinquished some responsibility at school, and was considering asking for help in a class she anticipated would be difficult for her. At the end of the session, Tina remarked, "I think I've come a long way."

Session 5. Tina's functioning increased for the first time in therapy. This was paired with a substantial increase in overall IM salience, which included a marked increase in protest IMs, in addition to the first elaboration of RC IMs. In this session,

Tina continued to explore boundary setting and remarked it felt "liberating." She also elaborated on an "eye-opening experience" in which her younger sister "took care" of her by lending her a significant amount of money. Tina reflected, "My first instinct was to try to remember what I learned in therapy and try to accept it." She also later elaborated on a recent experience in which she said, "The question popped into my head… 'Are we taking on too much responsibility again?'"

Tina's protest elaborations peaked in this session when she disclosed the need to talk with an aunt who Tina saw as being insensitive to her bereavement due to a conflicted relationship her aunt had with her father. Cain engaged Tina in a two-chair experiential dialogue between Tina and her aunt, in which she asserted in an IM, "There are things that you do that hurt, and I'm not sure if you're aware of it…. I think it's about time that I step up and tell you what's going on, because I want to put an end to it." This intervention yielded several protest IMs, including one regarding her aunt's disclosure to Tina at a young age about her father's sexually abusive behavior towards Tina's sister. Tina expressed, "I was only 14. I was a kid… that should've been none of my concern. And you just don't talk bad to a kid about their parent. It's just really mean and immature to do that." These empowering stances were part of Tina's new identify forming in the aftermath of her father's death.

The empty-chair exercise between Tina and her aunt later yielded an RC IM in which Tina reflected on a similar family relationship she previously navigated, and how she was able to become more trusting, and the process that allowed this shift to occur (e.g., "I had to…let down my guard…and try to give her a chance to make up for the wrong she did."). Tina began elaborating intentions about applying this same interaction style with her aunt, at which point Cain noted, "You just shifted from being just angry at

her [Tina's aunt] to taking in the larger picture, being more understanding." Tina elaborated, "Yeah, when you're angry, it's really hard to do that because all you can focus on is what they did to you…. You don't stop and look at the other things…. There's always a story." Tina spoke about the process of how understanding another's life story can combat anger and resentment, another problematic narrative.

Session 6. Tina's functioning remained the same as in session five, and while overall salience remained high, there was a slight decrease. However, RC IMs peaked in this session, and comprised the majority of the overall IM salience. Tina elaborated on several new positions (e.g., trusting others, being emotionally vulnerable, and allowing others to take responsibility) along with the processes underlying these changes. In one RC example, Tina spoke about the reasons behind her lack of trust for others, and the process that helped her move beyond this. In this example, Tina was speaking to Cain about a recent experience she had in allowing herself to become emotionally vulnerable with classmates in a group exercise, where she cried in front of others and spoke about her life story. Within this RC, she explained:

> C: just like I told them, I said, "With a father who is a molester and a mother that's an alcoholic, the people I'm supposed to trust, why would I trust anybody?...
>
> T: mhmmm
>
> C: So… it took awhile for me to… move that aside… and not stereotype, not put that on everyone else just because that's all I've known or that's all I've seen. Because, there are good people out there.

Tina also reflected on the process and shift between her previous behaviors of being overly responsible for others:

> C: But I'm even more self-aware because the responsibility thing… and how I take on so much responsibility and don't let other people to do their part… that's like in my face now…. So I've learned to…let them do what they need to do to give the responsibility so they can do it…. Then it's not such a burden on myself.

Tina also spoke about the therapy process, and developing a more balanced view of her father:

> C: And I'm so glad that I did this thing, talk to you about my father
>
> T: Yeah
>
> C: and how on one end, I love him, I worship him, but on the other end, I still have thoughts in my head like, "Well, he did this."
>
> T: Yeah
>
> C: And that was so hard for me. It was like, "What if he's looking down at me?"
>
> T: Yeah
>
> 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….

Cain also invited Tina to reflect on the therapy process in this final session, and she spoke about ways in which therapy had been successful (e.g., “I felt like our relationship helped me too.”; “I appreciate everything you’ve given me… you put the responsibility on me to help work out my own problems… and that’s important.”).

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; Alves et al., 2012). The current study builds upon 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. This study also allowed for a unique opportunity to study bereaved clients working with eminent humanistic therapists who are leaders in the field, demonstrating their areas of expertise in a brief-therapy format.

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 good outcome grief therapy cases in the literature (e.g., Alves et al., 2012; Alves et al., 2013; Alves et al., 2014). Various experiential interventions were implemented across the current cases, and appeared to yield innovative elaborations. Such interventions included narrative writing assignments (e.g., Neimeyer et al., 2010), imaginal conversations (e.g., Shear et al., 2011), empty-chair dialogues (e.g., Elliott, Watson, Goldman, & Greenberg, 2003) visualization and embodied meditation (e.g., Schneider, 2008). These interventions were implemented within the context of reflective listening and empathic attunement-- foundational elements across humanistic therapies. Given previous research supporting the role of meaning-making interventions in grief therapy, with emphasis on also helping clients articulate the processes that led to

changes, we hypothesize that humanistic interventions like those in the current study would hold promise in grief therapy, and warrant further empirical investigation to document their efficacy in controlled studies.

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 good outcome cases in the literature--including another case study of a complicated griever working with Deborah's therapist in the same six-session format. While 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 towards a healthier, more adaptive stance in her loss. By the end of this very 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). This growing body of supporting evidence, ranging from theory-generating case studies to those using experimental design methodology, suggests the utility of meaning-generation interventions in facilitating change in grief therapy.

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 case of Anita and Tina. While PC IMs have been shown to occur in good outcome 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, where she 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 attending and to restoration-orienting strategies that foster exploration of new relationships and goals.

Also consistent with previous findings, 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 et al. (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 (CGT; 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 (Ribeiro et al., 2014) investigated the interplay of IMs and therapy collaboration in a poor outcome therapy case of narrative therapy. In this case, IM production was low, and "return to the problem markers" (RPM; Gonçalves, Ribeiro, Stiles et al., 2011)-- times in which the client return 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, 2012), the researchers found that interventions that challenged clients

beyond their therapeutic zone of proximal development (TZPD) led the client to reject or ignore the therapist's intervention, returning to the problematic narrative. They suggest a balance between "supporting and challenging" clients so that "new experiences can be better tolerated, considered, and integrated." 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 therapy dyad (such as the TCCS) and how moment-by-moment interactions between therapist and client might impact IM elaborations and outcome.

As more researchers use the IMCS to investigate change in grief therapy, the current study yields a few methodological considerations to guide these efforts. First, the results of this and other studies using humanistic therapy approaches in working with bereaved individuals suggest the importance of reflection, RC, and PC IMs. While action and protest IMs are more salient in work with other problematic narratives (e.g., depression, intimate partner violence), when studying grief therapy, the former IMs appear to warrant more attention. However, insofar as these findings arise within humanistic approaches, replication of this finding with other therapy orientations (e.g., CBT) is warranted. In other methodological considerations, the current study also collected temporal and textual salience across each therapy case, in efforts to determine how they might be measuring different parts of IMs. However, these measures were found to be highly correlated, suggesting that they do not yield meaningful distinctions, and that either transcript or video coding could be used at the preference of the researcher.

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. It would also be informative to include follow-up measures to track the sustainability of change following termination of grief therapy.

The current study design permits generalization of conclusions towards theory, but not to other cases by the same therapist, much less across different therapists or modes of therapy. These were non-manualized interventions, and the therapy clients had differences among their presentations (e.g., in their functioning, time since loss), demographics (e.g., ethnicity, age), and their cultural backgrounds, further limiting their direct comparison with one another. Furthermore, the current study only included female, adult clients. Future research might consider examining use of IMCS in therapy with children, adolescents or families, in addition to including male participants. Given these limitations, we are unable to draw definitive conclusions about the patterns of IMs and changes in functioning found in the current study, and are not attempting to generalize these findings across other cases of grief therapy. Another potential limitation is the researchers' professional relationships with a therapist in the study, Dr. Neimeyer; therefore, the researchers enlisted external auditors to review IM coding to decrease potential bias by the researchers. Despite these limitations, this study is relevant to the growing body of literature on process outcome links in humanistic grief therapies and was able to provide support for the utility of studying IMs in the context of grief therapy, and the findings support use of the IMCS in investigating change in grief

therapy. Furthermore, this study allowed for a rare opportunity to investigate eminent therapists in the field and the moment-to-moment unfolding of humanistic therapy with bereaved clients.

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Appendix: Measures

GLOBAL ASSESSMENT OF FUNCTIONING SCALE

(From DSM-IV-TR, p. 34.)

Consider psychological, social, and occupational functioning on a hypothetical continuum of mental health-illness. Do not include impairment in functioning due to physical (or environmental) limitations.

91 - 100 No symptoms. Superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his or her many positive qualities.

81 - 90 Absent or minimal symptoms (e.g., mild anxiety before an exam), good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns (e.g., an occasional argument with family members).

71 - 80 If symptoms are present, they are transient and expectable reactions to psychosocial stressors (e.g., difficulty concentrating after family argument); no more than slight impairment in social, occupational, or school functioning (e.g., temporarily falling behind in schoolwork).

61 - 70 Some mild symptoms (e.g., depressed mood and mild insomnia) *or* some difficulty in social, occupational, or school functioning (e.g., occasional truancy, or theft within the household), but generally functioning pretty well, has some meaningful interpersonal relationships.

51 - 60 Moderate symptoms (e.g., flat affect and circumstantial speech, occasional panic attacks) *or* moderate difficulty in social, occupational, or school functioning (e.g., few

friends, conflicts with peers or co-workers).

41 - 50 Serious symptoms (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) *or* any serious impairment in social, occupational, or school functioning (e.g., no friends, unable to keep a job, cannot work).

31 - 40 Some impairment in reality testing or communication (e.g., speech is at times illogical, obscure, or irrelevant) *or* major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood (e.g., depressed adult avoids friends, neglects family, and is unable to work; child frequently beats up younger children, is defiant at home, and is failing at school).

21 - 30 Behavior is considerably influenced by delusions or hallucinations *or* serious impairment, in communication or judgment (e.g., sometimes incoherent, acts grossly inappropriately, suicidal preoccupation) *or* inability to function in almost all areas (e.g., stays in bed all day, no job, home, or friends)

11 - 20 Some danger of hurting self or others (e.g., suicide attempts without clear expectation of death; frequently violent; manic excitement) *or* occasionally fails to maintain minimal personal hygiene (e.g., smears feces) *or* gross impairment in communication (e.g., largely incoherent or mute).

1 - 10 Persistent danger of severely hurting self or others (e.g., recurrent violence) *or* persistent inability to maintain minimal personal hygiene *or* serious suicidal act with clear expectation of death.

0 Inadequate information

Unpublished Manual for the Segmented Working Alliance Inventory Observer-Based Measure (S-WAI-O), Version 2, 2013

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The Brief Psychotherapy Research Program

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Coding Procedure

1. Use taped therapy sessions. While coding can be aided by the use of transcripts, transcripts cannot replace videotaped sessions, because important non-verbal communication including eye contact, tone of voice, etc. would be lost.
2. After five minutes of the session have elapsed, pause the session and code the twelve items of the measure. Each item is rated on a seven-point Likert scale, with four being No Evidence or Equal Evidence; one being Very Strong Evidence Against; and seven being Very Strong Evidence for. Be sure to assume an average alliance, which would be coded as a four, and deviate from this score only when there is evidence for or against an item within the segment. When first coding, be sure to read the detailed Likert ratings for each item in order to facilitate inter-rater reliability. Please remember that the examples in the anchors are just that—examples. Please infer from the examples in order to code. Note: Items 3, 4, 6 and 7 have negative valence.

3. Continue to code the session in five-minute segments, using a separate score sheet for each segment. Feel free to take breaks between segments as it is important to code each segment as its own unit. It may be helpful to take notes during each segment to help remember what happened during that segment.

An example of the Likert ratings

1	**2**	**3**	**4**	**5**	**6**	**7**
Very strong Evidence Against	*Considerable Evidence Against*	*Some Evidence Against*	*No Evidence or Equal Evidence*	*Some Evidence For*	*Considerable Evidence For*	*Very strong Evidence For*

Items of the Measure

Task:

1. Within this segment, there is agreement about the steps taken to help improve the client's situation.

2. Within this segment, there is agreement about the usefulness of the current activity in therapy (i.e., the client is seeing new ways to look at his/her problem).

3. There is a perception that the time spent in this segment is not spent efficiently.

4. The therapy process does not make sense to the client in this segment.

5. There is agreement about what client's role or responsibilities are in this segment.

6. The client is frustrated with what he/she is being asked to do in this segment.

Bond:

7. There is a sense of discomfort in the relationship.

8. There is good understanding between the client and therapist.

9. The client and the therapist respect each other.

10. There is mutual trust between the client and therapist.

11. The client is aware that the therapist is genuinely concerned for his/her welfare.

12. Both the client and therapist see their relationship as important to the client.

The Items with Defined Anchors

1. **Within this segment*, there is agreement about the steps taken to help improve the client's situation.***

    1. = Client directly states that tasks and goals are not appropriate, and does not generally agree on homework or in-session tasks. The client argues with the therapist over the steps that should be taken. The client refuses to participate in the tasks.
    2. = Client is hesitant to explore and does not follow therapist guidance. The client withdraws from the therapist and appears to merely "go through the motions", without being engaged or attentive to the therapist or the task.
    3. = The client appears to be unsure as to how the tasks pertain to his/her goals, even after some clarification by the therapist. The client seems either ambivalent or unenthusiastic about the tasks in this segment, and is passively resistant to the tasks (e.g., limited participation).
    4. *= No evidence or equal evidence regarding agreement and/or disagreement.*

5. = Client follows exploration willingly with few or no therapist clarifications needed. The client becomes invested in the process, and is an active participant in the task. There is a sense that both parties have an implicit understanding of the rationale behind the tasks in this segment.
6. = Client openly agrees on tasks and is enthusiastic about participating in tasks. Both participants are acutely aware of the purpose of the tasks and how the tasks will benefit the client. To this end, the client uses the task to address relevant concerns and issues.
7. = Repeated communication of approval and agreement, both before and after the task is completed. The client responds enthusiastically to interventions, gains insight, and appears extremely confident that the task and goal are appropriate.

2. Within this segment, ***there is agreement about the usefulness of the current activity in therapy (i.e., the client is seeing new ways to look at his/her problem).***

1. = Participants repeatedly argue over the task. The client refuses to participate in the task, claiming that it is of no use to his/her goals. There is tension between the therapist and the client, and issues are not explored.
2. = Client does not engage or invest in the task, though he/she may not openly dispute the usefulness of the task. The client fails to explore issues with openness.
3. = Client is hesitant to participate, but eventually becomes invested in the task. The therapist is able to accurately convey the rationale behind the activity so that the client is then able to understand how the task is relevant to his/her current concerns.
4. *= No evidence or equal evidence regarding agreement and/or disagreement.*

5. = Client does not question the usefulness of the task and engages in the task almost immediately.
6. = Participants engage in a meaningful task that addresses a primary concern of the client. The client may remark, "I never thought of that before" or something to this effect.
7. = Participants remark how important/useful the task is. There is openness to exploration of the task and enthusiastic collaboration between the participants.

3. Within this segment, *There is a perception that the time spent in therapy is not spent efficiently.*

4. = Participants work well together. The client seems open to all subjects, focuses on the task at hand with little to no redirection by the therapist, and clear progress is made.
5. = Client works at discussing all subjects, focuses well, and makes general progress. There may be some hesitancy or resistance on the part of the client, even though client is trying his/her best.
6. = Client attempts to discuss most subjects, but may need redirection from therapist. Slow progress is made.
7. *= No evidence or equal evidence regarding time efficiency and/or inefficiency.*
8. = Client has trouble discussing a few topics, and also may require redirection. The client's trouble with the task at hand may be obvious, and the participants seem to have trouble complementing one another's roles.
9. = Client avoids several topics and has trouble focusing. Little progress is made. The participants' attempts to improve the situation are mostly unsuccessful. The segment

gives the impression that there is a lack of focus; participants seem to be meandering from topic to topic, without clear direction or commitment to a plan.

10. = Client continually avoids or resists subjects. Focus is often redirected by the therapist, and no productive gains are made. The participants do not work well together.

4. Within this segment, *the therapy process does not make sense to the client.*

1. = Client has a strong understanding of the therapy process. The client actively collaborates with the therapist and seems to have a thorough understanding of why in-session and homework tasks are necessary. This may not always be spoken. The client is almost a co-facilitator of his/her own therapy.
2. = Client has a considerable understanding of the therapy process. The client rarely expresses a doubt openly nor does he/she attempt to implement a different strategy.
3. = Client has some understanding of the therapy process. The client does not often try to change tasks or express doubts.
4. *= No evidence or equal evidence regarding confusion and/or understanding.*
5. = Client shows signs that he/she is uncertain about what to do or that what he/she is doing will be beneficial. Signs may include topic shifts, awkward pauses, and/or frustrated expressions, bodily movements or vocalizations.
6. = Client verbally expresses doubt and confusion and may attempt to shift to a different topic or task.
7. = Client voices strong doubts persistently: challenging the therapist, suggesting other techniques and/or using different strategies (e.g., the therapist wants to use cognitive techniques while the client prefers a psychodynamic approach).

5. Within this segment, There is agreement about what client's roles and responsibilities are in this segment.

1. = Participants do not agree on what the client's responsibilities are in this segment. The client may refuse the therapist's direction, verbally disagree about homework, and seems reluctant to participate.
2. = Client has clear trouble accepting what the therapist wants him/her to do. The client may challenge or disregard the direction provided by the therapist, and may complain about a number of homework issues.
3. = Client seems reluctant about therapist's ideas. The therapist may attempt to be directive, but the client may not understand or accept the direction. The therapist may expend a lot of effort to encourage client participation.
4. *= No evidence or equal evidence regarding agreement and/or disagreement.*
5. = Client may have some hesitation but largely agrees with the therapist. The client offers little resistance to the therapist's ideas, and the session improves as time progresses. The client may also appear to be overly compliant, perhaps in order to avoid confrontation.
6. = Client generally acquiesces to therapist's suggestions, and is relatively enthusiastic about participating. For instance, the therapist may make a suggestion to the client that the client will acknowledge, but not seem excited about.
7. = Client is eager and willing to do what the therapist suggests in session and as homework. The client may also comment on the usefulness or how well the session appears to be going.

6. Within this segment, ***The client is frustrated with what he/she is being asked to do in the therapy.***

1. = Client is excited about all tasks in this segment. This enthusiasm may be verbalized or displayed through participation. The client may say things such as, "that was helpful," or even make suggestions about how to improve performance on in-session tasks.
2. = Client seems pleased and generally interested in most tasks and is able to perform most of the tasks well.
3. = Client seems cooperative. Although the client may not be able to perform all tasks perfectly, the client retains a positive attitude towards therapy.
4. *= No evidence or equal evidence regarding frustration and/or satisfaction.*
5. = Client shows minor frustration or shift tasks. The client may not understand tasks perfectly or may not need a re-explanation. May not be able to perform some tasks well. The client may have a good idea of the steps necessary for change but does not seem to be prepared to take action.
6. = Client spends considerable time resisting the task or is unable to do task. The client may require re-explanation of tasks and may still have difficulties after clarification. The client may show considerable annoyance, and may use sighs, body language, facial expressions or statements to display frustration.
7. = Client is unable or unwilling to perform most tasks. The client may not have the patience to wait for re-explanation. The client openly voices frustration in addition to frowning and sighing.

7. Within this segment, *there is a sense of discomfort in the relationship.*

1. = Participants appear extremely comfortable in this segment. The client approaches difficult topics very openly. The client and/or therapist may comment on how comfortable or relaxed the other is. Behavioral cues such as relaxed posture and smooth voice are evident.
2. = Client shows no apprehension toward topics in this segment. The client seems to approach and explore topics without hesitation, is not defensive, and appears to be relaxed during most of the segment. Behavioral cues suggest that the client is comfortable.
3. = Client discusses difficult topics with limited hesitancy, and appears to be relaxed (e.g., relaxed posture, little fidgeting, smooth speaking). The client may become hesitant during parts of the segment, but the therapist and client work through it appropriately.
4. *= No evidence or equal evidence regarding client comfort and/or discomfort.*
5. = Client is fidgety (only during part of the segment) and is generally hesitant to discuss deeply personal topics. The client appears to be unwilling to explore some specific content areas. The therapist may also show some physical signs of discomfort (e.g., fidgeting, shaky voice, frequent posture changes) during part of the segment.
6. = Client and/or therapist show(s) physical signs of discomfort. The client does not appear to become more comfortable as the segment progresses and/or may seem defensive throughout. Communication between the client and therapist may seem forced or uneasy.

7. = Client seems uncomfortable throughout the segment. The client appears extremely defensive and actively avoids difficult topics. Client may even state on multiple occasions that he/she is uncomfortable.

8. Within this segment, *there is good understanding between the client and therapist.*

1. = There is consistent need for clarification of ideas. The therapist makes inaccurate reflections and/or interpretations most of the time. The client becomes outwardly irritated or annoyed by the miscommunication. The tone of the therapist is very cold and mechanical. The therapist does not express warmth toward the client.
2. = Therapist makes several inaccurate reflections, and the client must correct them and ask for clarification at several points in the segment. The client appears to become mildly agitated as a result of the miscommunication.
3. = Therapist makes a few poor reflections. Occasionally, the therapist has a mechanical tone of voice. The client may ask for clarification of ideas on a few occasions.
4. *= No evidence or equal evidence regarding good and/or poor understanding.*
5. = Therapist is generally warm toward the client. There are few/no inaccurate reflections by the therapist. The client answers the therapist's inquiries without much confusion. Understanding improves over the course of the segment.
6. = Participants generally have efficient and warm communication with each other. The therapist makes accurate reflections during the segment.
7. = Therapist makes consistently empathic, insightful, and accurate reflections throughout the segment. The client rarely/never asks for clarification. The client may comment that the therapist truly understands him/her.

9. Within this segment, *the client and the therapist respect each other.*

1. = Participants show a great amount of dislike, disdain, and/or spite for each other.
2. = Participants show some disregard for each other, or one of the participants demonstrates a great amount of dislike, disdain, and/or spite for the other. One or both consistently interrupt and/or demonstrate a lack of effort in trying to understand the other, which could be exhibited by negative nonverbal behaviors including closed posture, and wandering eyes. The therapist could end the segment abruptly, without regard to the client's state.
3. = Participant actions include one or more of the following at times: interrupting each other, employing derogatory/supercilious statements or mechanical reflections, and/or not paying attention. This may cause an inaccurate therapist reflection and/ or the need to ask the client to repeat some content, or induce a client tendency to dismiss therapist ideas or persuasiveness.
4. *= No evidence or equal evidence regarding respect and/or disrespect.*
5. = Participants show some evidence that they are really paying attention to each other. The therapist may exhibit some notable acceptance of client problems.
6. = Participants show frequent signs that they are really paying attention to each other throughout the segment, such as by nodding or other minimal encouragers, insightful reflections by the therapist, and active participation by the client.
7. = Strong evidence that participants consistently and completely attend to the other's communications throughout the entire segment. The client voices strong confidence in the therapist's competence in some way. The therapist voices some note of encouragement that indicates respect for what the client is trying to do.

10. Within this segment, *there is mutual trust between the client and therapist.*

1. = Client states outright that he/she does not trust the therapist at all. The client does not openly discuss any significant issues. The therapist demonstrates a complete lack of confidence in the client's ability to discuss significant issues.
2. = Participants are considerably distrustful of each other. The client is very guarded in disclosing any intimate content, while the therapist also shows a lack of comfort. Questions concerning trust may arise.
3. = Participants are somewhat distrustful of each other. Client is a bit guarded in terms of content disclosed. Therapist may show a few signs of lack of comfort about the therapy situation.
4. *= No evidence or equal evidence regarding mutual trust between the participants.*
5. = Some willingness by the client to disclose personal concerns and some therapist acceptance of the client's statements at face value. The therapist does not override or interrupt a client's train of thought by redirecting focus.
6. = Client is receptive to therapist reflections, challenges, and/or suggestions, and discloses a considerable amount of more intimate/relevant information regarding his/her problem(s). The therapist seems comfortable with the overall situation and is not defensive at all. The client may express confidence in the therapist.
7. = Participants have complete faith in each other. The client is very comfortable about disclosing extremely intimate details or problems, and the therapist feels extremely comfortable.

11. Within this segment, The client is aware that the therapist is genuinely concerned for his/her welfare.

1. = No concern is shown in therapy. The therapist is non-attentive, cold, and statements are hostile and/or inappropriate. The client seems to not feel genuine concern from the therapist.
2. = Client seems to feel little concern from the therapist. The therapist may give a few statements of concern, but mostly acts in a mechanical and uncaring fashion, despite repeated attempts for responses from the client.
3. = Client seems to feel like therapist is listening, but does not care about the client. The therapist may pay attention, but only give some signs of emotion in response to the client.
4. *= No evidence or equal evidence regarding therapist concern and/or disinterest.*
5. = Client feels some concern from the therapist. The therapist is mostly attentive, shows some warmth using reflection, and may give a few statements of concern.
6. = Client feels like therapist is concerned and invested in this segment. The therapist is attentive and warm, demonstrates empathetic listening, and offers statements of concern.
7. = Client is confident that the therapist is genuinely concerned. The therapist is attentive, shows empathy using a variety of techniques, delivers statements in a warm and caring manner, and uses direct statements of concern.

12. Within this segment, *Both the client and therapist see their relationship as important to the client.*

1. = Client does not respect the therapist. The therapist may make frequent interruptions or seem uninterested indicating that he/she is not fully invested in the relationship. The client may frequently make derisive remarks towards the therapist. If the client opens up at all it is most likely a negative comment (e.g., "I feel that I am not getting what I need from you"). The client may be considering leaving therapy or is being forced to attend.
2. = Client puts little effort into the relationship. The client does not fully participate and rarely opens up. If the client does open up, it may be with a negative comment (e.g., "I feel that I am not getting what I need from you"). The client has little respect for the therapist. The client may not respect the therapy hour, arriving late or missing sessions.
3. = Client is not fully invested in the relationship. The client does not open up a great deal. The client may express a negative comment about the relationship.
4. *= No evidence or equal evidence regarding importance and/or unimportance.*
5. = Client puts some effort into the relationship, task participation and speaking about relevant topics.
6. = Client believes in the process and speaks freely about relevant topics. The client believes in therapist as the facilitator of change. The client looks forward to future sessions and may show concern about any breaks in therapy, such as a therapist or client vacation, etc.

7. = Participants believe that this relationship and the process of therapy will bring about change. This client is highly invested in therapy, and it is evident that he/she spends considerable time working on therapy homework or contemplating therapy outside of the therapy hour. Any breaks in therapy would be taken seriously by the client and could cause discomfort.

SWAI-O Scoring Sheet

Patient Acronym_____ Patient Number_____ Coder_____

Session Number _____ Session Date _____ Date Coded _____

Segment #_____ Segment Time Span_____

Task:

1. Within this segment, there is agreement about the steps taken to help improve the client's situation.

1 2 3 **4** 5 6 7

2. Within this segment, there is agreement about the usefulness of the current activity in therapy (i.e., the client is seeing new ways to look at his/her problem).

1 2 3 **4** 5 6 7

3. There is a perception that the time spent in this segment is not spent efficiently.

1 2 3 **4** 5 6 7

4. The therapy process does not make sense to the client in this segment.

1 2 3 **4** 5 6 7

5. There is agreement about what client's role or responsibilities are in this segment.

1 2 3 **4** 5 6 7

6. The client is frustrated with what he/she is being asked to do in this segment.

1 2 3 **4** 5 6 7

Bond:

7. There is a sense of discomfort in the relationship.

1 2 3 **4** 5 6 7

8. There is good understanding between the client and therapist.

1 2 3 **4** 5 6 7

9. The client and the therapist respect each other.

1 2 3 **4** 5 6 7

10. There is mutual trust between the client and therapist.

1 2 3 **4** 5 6 7

11. The client is aware that the therapist is genuinely concerned for his/her welfare.

1 2 3 **4** 5 6 7

12. Both the client and therapist see their relationship as important to the client

1 2 3 **4** 5 6 7

Scoring the Coding

To score the coding, first reverse code items 3, 4, 6 and 7, which have negative valence. Then calculate the average score for all the items for each segment—this will create an average working alliance score for each segment. Reliability should be checked for each segment by using an Interclass Correlation Coefficient (ICC).