Adolescents’ perspectives on change: Exploring innovative moments with young patients treated for depression

Fritz Mende[1], João Batista[2], Sally O`Keeffe[3], Nick Midgley[4], Rui Braga[2], & Miguel M. Gonçalves[2], & Margarida Rangel Henriques [1]

[1] Center for Psychology at University of Porto (CPUP), Faculty of Psychology and Education Sciences, University of Porto, Porto, Portugal

[2] Psychology Research Center, Psychotherapy and Psychopathology Lab, School of Psychology, University of Minho, Portugal

[3] School of Health and Psychological Sciences, City University of London, UK

[4]University College London (UCL) and the Anna Freud Centre, London, UK

Correspondence concerning this article should be addressed to João Batista.

Author Note

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Abstract

Introduction: Innovative moments pinpoint new and more adjusted meanings that emerge in clients' discourse during psychotherapy. Studies with adult clients have found a greater proportion of innovative moments in recovered compared to unchanged cases. ***Aims:*** (1) To study the emergence of innovative moments in a post-therapy interview, in adolescents that underwent psychotherapy for depression, and (2) to characterize the themes present in innovative moments, as this is the first study with adolescents. ***Method:*** Semi-structured post-treatment interviews conducted with 24 adolescents on the experience of taking part in a clinical trial of youth depression, were coded using the *Innovative Moments Coding System*. A thematic analysis identified the prominent themes in the coded innovative moments. ***Results:*** Higher presence of innovative moments were found in recovered compared to unchanged cases. Two main themes emerged in the innovative moments, changes that occurred with therapy and attributions of changes. Recovered cases presented more IMs centered on the self whereas unchanged cases identified more non-specific changes. ***Conclusion:*** The meaning changes tracked through the coding of innovative moments were associated with therapeutic recovery. Moreover, therapeutic recovery was also associated with a higher focus on the self and more specificity in clients' representations of the change process.

Keywords*:* psychotherapy; innovative moments; adolescence; depression; qualitative research; change events; clients' perspectives on change.

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Depressive disorders have an impact on daily life, psychosocial, family, and academic functioning, with about 2.8% of children under the age of 13, and 5.6% of those between 13 and 18, meeting criteria for formal diagnosis (Costello et al., 2006). Children and youth suffering from depression are likely to present other difficulties, with comorbidity levels ranging between 40% and 90%, most commonly some form of anxiety disorder, but also disruptive disorders, ADHD and substance abuse (Birmaher et al., 2007). The levels of relapse are high, with as many as 70% of young people who experience depression having a further episode within five years (Richmond & Rosen, 2005). In turn, long-term consequences are considerable, with an increased risk of self-harm, suicide, depression, physical illness, substance misuse, interpersonal and work-related problems in adulthood (Weissman et al., 1999). Consequently, the identification of effective treatments for depression early in life must be a public health priority.

Given the serious long-term consequences of depression in adolescence, identifying effective treatments is a high priority. The findings of the Improving Mood with Psychoanalytic and Cognitive Therapies trial (IMPACT, Goodyer et al., 2017), demonstrated evidence for the effectiveness of two conceptually distinct psychological therapies in alleviating depressive symptoms and improving social functioning: short-term psychoanalytic psychotherapy (STPP) and cognitive behavioural therapy (CBT). Studying changes in personal meanings of adolescents treated for depression, using post-psychotherapy interviews, may deepen the understanding of the nature and the

processes of change that contribute to effective and lasting clinical gains, and recovery from youth depression. In order to systematically track such changes, we used the concept of innovative moment.

Innovative moments in psychotherapy

Innovative moments (IMs) are an empirical operationalization of what narrative therapists White and Epston (1990) termed ‘unique outcomes’. According to the narrative perspective, psychological problems result from problematic self-narratives that coerce peoples’ lives, and hinder their personal and relational well-being, by creating an *internalization* of the problem (instead of “me dealing with depression”, “I as a depressive person”). Unique outcomes refer to instances in which the client’s experience is outside of the influence of the problematic self-narrative, moments in which the client feels, acts, or thinks in a way that represents something new. The emergence of IMs has been studied with adults in different psychotherapies, such as narrative therapy (e.g., Gonçalves et al., 2015), client-centred therapy (e.g., Gonçalves et al., 2012), emotion-focused therapy (e.g., Mendes et al., 2010), dilemma-focused therapy (e.g., Montesano et al., 2015), cognitive-behavioural therapy (e.g., Gonçalves, Silva, et al., 2017), and brief dynamic therapy (Nasim et al., 2019). Usually, these studies are structured in process-outcome designs, contrasting recovered with unchanged cases and exploring IMs’ evolution patterns throughout psychotherapy. These studies have suggested that IMs emerge both in unchanged and in recovered cases, but with different patterns. Firstly, they occupy more time of the sessions in recovered cases (Gonçalves et al., 2021). Secondly, IMs are associated with pre-post change or with longitudinal outcomes along treatment (Gonçalves et. Al, 2017; Gonçalves et al., 2021). Thirdly, IMs that emerge in recovered cases are more complex

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

Level 1 IMs are the most elementary forms of innovation, including new meanings that allow for the creation of distance, or differentiation, from the initial problematic pattern (e.g., “I’ve been thinking that there is actually no reason for me to be so shy and fearful around other people”). These IMs can occur in the form of thoughts, as in the example above, and also in the form of actions (i.e., to behave in a way that was not predictable from the original problematic pattern).

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

Finally, level 3 IMs, also termed reconceptualization IMs, contain an articulation of a contrast and a process and appear to capture a sophisticated change process, one that involves assuming a reflexive position that allows the patient to bridge past problematic elements and innovative elements into a coherent meaningful whole (e.g., Fernández-Navarro et al., 2018; Gonçalves & Ribeiro, 2012). Consider the following

example: “I feel a lot happier now, I feel more comfortable around people and have made some new friends (contrast)… I think it’s because my thinking has changed, I talked it through with my tutor, and now I try to see the opportunities in things and get the most out of them (process)”.

In the above example, we may infer three positions of the self: the past problematic position, the emergent new position, and a meta-position that allows to make sense of the shift. There are some similarities between the concept of insight (Castonguay & Hill, 2007) and level 3 IMs, but we speculate that not all occurrences of insight would be coded as level 3 IMs, as for such a coding this dual nature of contrast plus process is needed. However, all reconceptualization IMs are probably insights (see Gonçalves & Ribeiro, 2012).

The majority of studies using IMs in psychotherapy were developed by tracking these events in each session of psychotherapy, in process-outcome studies or intensive case studies. In one study (Montesano et al., 2015), instead of coding all the sessions, a final interview (*The Client Change Interview*, Elliott et al., 2001) was coded to identify IMs retrospectively. In this study we sought to apply this approach, coding IMs in post-therapy interviews with adolescents, as this provides a less resource intensive approach to studying IMs which to date has not been done with adolescents.

To the best of our knowledge, there are no studies on IMs in the domain of psychotherapy with adolescents, and this exploratory study addresses this gap, aiming to analyse if the Innovative Moments Coding System (IMCS) is applicable with this population, studying if IMs emerge more in recovered cases, and exploring what themes are present in these IMs. Three main research questions guided the research:

1. Do IMs emerge in interviews conducted with adolescents at the end of their

psychotherapy treatments? 2. Do the patterns of production of IMs replicate the findings from adult psychotherapy research? 3. What are the themes present in the IMs identified in the interviews?

Method

Participants and sample selection

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

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

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

For the present study, inclusion criteria were that the participants had received either CBT or STPP as part of the IMPACT trial, and: a) had completed the *Mood and Feelings Questionnaire* (MFQ, Angold et al., 1987) at baseline and post-treatment (36 weeks), as well as the *Expectations of Therapy Interview* and the *Experience of Therapy Interview* (Midgley et al., 2011) at baseline, post-treatment (36 weeks) and follow-up (86 weeks); and b) that their outcomes could be classified as either recovered or unchanged, to allow for comparisons between these groups. The distinction between recovered and unchanged cases was based on the symptoms scores obtained with the *Mood and Feelings Questionnaire* (MFQ, Angold et al., 1987). In order to be considered a recovered case, as suggested by Midgley et al. (2014), two conditions had to be fulfilled: a) the post-treatment symptoms score had to be beneath the cut-off of 28 points; and b) symptomatic improvement had to be at least 50% (i.e., the difference between the pre-treatment and the post-treatment scores had to be equal to or greater than half of the pre-treatment score).

Out of 43 cases in the IMPACT-ME study (22 CBT, 21 STPP), 16 had missing data and so did not meet the first inclusion criteria (nine CBT, seven STPP), and three met one, but not both criteria for recovered cases, and so did not meet the second

inclusion criteria (one CBT, two STPP). These cases were therefore excluded from the study (see Figure 1).

The final sample comprised 24 participants, aged between 12 and 18 years (M = 16.50, SD = 1.69), 14 females and 10 males. Twelve participants met both criteria for recovered cases and 12 participants were considered unchanged cases, as they met neither of the two criteria. Twelve of the participants were in the CBT arm of the study (seven recovered and five unchanged) and 12 in the STPP arm (five recovered and seven unchanged).

Materials and measures

The Expectation of Therapy and the Experience of Therapy Interviews

During the IMPACT-ME study, participants took part in semi-structured interviews that were carried out at three timepoints: before the start of treatment (pre), using the *Expectation of Therapy Interview* (Midgley et al., 2011a), at the end (post) and one year after the end of treatment (follow-up), using the *Experience of Therapy Interview* (Midgley et al., 2011b). The interview schedules cover several topics but were used in a flexible way. The pre-treatment interview focused on: (a) what brought the adolescents to treatment and how their difficulties had been affecting the lives of the adolescents and those around them; (b) the adolescents' understanding of those difficulties; (c) hopes for change and ideas about what could lead to meaningful change; (d) and ideas and expectations about therapy. In turn, the post-treatment and follow-up interviews revisited the pre-treatment interview and explored the adolescents' experience of therapy and change over time, with a focus on the processes that led to each individual's outcomes, as well as the broader contextual

factors which young people felt contributed to those outcomes. Finally, they explored the participants' experience of being involved in the research trial.

All interviews were carried out by postgraduate psychologists who had been trained in conducting semi-structured interviews with young people. The interviews took place in a location selected by the young person (usually their own home, but sometimes a room in the child mental health clinic) and were audio-recorded and transcribed verbatim. In the present study, the verbatim transcripts of the pre- and the post-treatment interviews of the selected participants were used. The pre-treatment interviews were used for the identification and clarification of each participant's difficulties (i.e., their problematic patterns of meaning), and the post-treatment interviews for the coding of IMs.

The Innovative Moments Coding System

The IMCS (Gonçalves, Ribeiro, et al., 2017) is a qualitative procedure used to analyse psychotherapy sessions or interviews, that involves several tasks: (a) defining the problematic meaning framework of each client (akin to a list of problems in a case formulation); (b) defining moments in which exceptions to the problematic meaning framework emerge (i.e., IMs); (c) identifying the beginnings and endings of the IMs; and (d) classifying the level of each IM.

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

The Mood and Feelings Questionnaire

Depressive symptoms before and after treatment were assessed in the IMPACT study using the MFQ (Angold et al., 1987), a thirty-three-item, standardized, self-rated questionnaire of depressive symptoms, in which symptom-related statements regarding feelings and behaviour in the preceding two weeks are rated on a three-point Likert-scale, and a score of 28 and above has been used to identify adolescents with major depression. Examples of the questionnaire's items are: “I felt miserable or unhappy” and “I did everything wrong”.

Procedures

Innovative moments coding procedures

All the participants' interviews were coded by an MSc student formerly trained in the use of the IMCS (first author). The post-treatment interviews of 12 cases (50% of the sample) were randomly selected for double coding with two independent coders (two experienced researchers, second author and sixth author). All the coders were unaware of participants' outcome status or type of treatment attended.

Double coding entailed two main steps: (a) the consensual definition of each participant's problematic pattern of meaning, operationalized as a list of problems based on the adolescent's complaints and reflections in the pre-treatment interview; (b) the identification of IMs in the post-treatment interviews, which required the definition of each IM's beginning and end, as well as its classification into the respective level (1 to 3). Intercoder reliability was calculated for agreement on IMs proportion and classification throughout the process, and whenever significant disagreements occurred, divergent coding options were discussed, and further coding guidelines established.

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

Coding reliability was found to be adequate, both for the definition of IMs' proportions, with agreements for individual cases ranging from 80.9% to 100% (94.3% in average), and for the classification into level 2 or 3 IMs, with a global Cohen's K of .82.

Thematic analysis procedures

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

The first step was conducted by the second author, who read all coded IMs and defined a set of codes including the different changes referred by the clients. A critical

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

Data analysis

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

Regarding the statistical testing of associations between variables and the comparisons between contrasting groups, considering that most variables of interest were not normally distributed (Shapiro-Wilks tests $p < .05$), and the small number of participants in each group, Mann-Whitney U-Test were used. Although these non-parametric tests resort to data ranking, means (*M*) and standard deviations (*SD*) were used as descriptive measures.

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

Results

IMs and treatment outcomes

To ascertain comparability between recovered and unchanged cases, Mann-Whitney U-Tests were conducted and revealed no significant differences (all $p > .05$) for participants' age, pre-treatment symptoms scores, and length of post-treatment interviews. Thus, the differences between groups cannot be attributed to symptom severity at treatment onset, different ages, or different degrees of elaboration in the interviews at the end of treatment.

The comparisons between groups revealed significantly greater proportions of IMs in the post-treatment interviews from the recovered group, both for level 2 IMs (recovered: $M = 8.3\%$, $SD = 2.9\%$ vs. unchanged: $M = 2.9\%$, $SD = 3.1\%$, $U(N_{rec.} = 12$,

$N_{unch.}$ = 12) = 17.00, z = -3.17, p = .001), and for level 3 IMs (recovered: M = 4.4%, SD = 3.2% vs. unchanged: M = 0.2%, SD = 0.6%, $U(N_{rec.}$ = 12, $N_{unch.}$ = 12) = 19.50, z = -3.38, p < .001). This shows that participants from the recovered group produced more IMs, both level 2 and 3, than unchanged cases.

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

Themes present in the IMs

Text coded as IMs was analyzed with TA. The TA performed on all 197 IMs of the 24 participants, identified two main themes and eight subordinate themes, comprising 19 codes. Interestingly, the two main themes coincide with the dimensions of contrast and process previously identified in IMs (Fernandez-Navarro et al., 2018): the identification of changes and the attribution of changes, with four subordinate themes each (figure 2). Below, we underline the main themes and used italics to identify the subordinate themes, to facilitate the readability of the results.

Themes description

The identification of changes theme included subordinate hemes in which participants elaborated upon what was different in their lives after treatment. The first

subordinate theme, c*hanges in the self*, included codes that referred to positive modifications in self characteristics (e.g., being more confident, calmer) or increased self-validation or self-acceptance. The second subordinate theme, *changes in performance and achievement*, comprised codes such as concrete modifications in behaviour, improved mastery in coping skills and/or an increase in work, school or life achievements. The third subordinate theme, *changes in relationships*, included the following codes: identification of changes at the interpersonal level, either in family, school, or work contexts, feeling of being validated by others, be it peers, teachers, or family. The fourth subordinate theme, *non-specific changes*, included codes referring to general or non-specific changes such as “things are better now”. This theme was only coded when no other was identifiable, i.e., when the participants did not refer what was better or different in their lives.

The attribution of changes main theme included subordinate themes in which participants elaborated upon the possible causes for their improvements. The fifth subordinate theme, *attribution of changes to an internal shift*, included a code in which participants explained the improvements by a change in perspective. In other words, participants attributed their changes to an internal shift, such as thinking differently (e.g., thinking on the consequences of actions), having a new interest in spirituality, or being motivated by therapy to change. The sixth subordinate theme is *attribution of changes to therapeutic tasks*, with codes in which participants explained their improvements by relatively specific tasks, either in-session (e.g., discussing problematic patterns or alternative behaviours) or between-session (e.g., writing a journal, doing homework or practicing breathing exercises). The seventh subordinate theme, *attribution of changes to therapeutic relationship,* comprised codes that

involved the justification of changes by aspects of the therapeutic relationship, such as feeling understood or not judged by the therapist. Finally, subordinate theme eight was *non-specific attribution of changes*, in which participants did not address clearly how or why they changed, mostly referring to therapy as having helped them to get better or that things in their lives improved after letting the therapist help, but without further elaboration. This theme was only coded when no other was identifiable, i.e., when the participants did not explained how therapy helped them. Table 2 contains a complete description and illustration of the two main themes with the eight subordinate themes.

Following consensual qualitative research categories (Hill, 2012), the main theme identification of changes was general (present in all of the cases), while attribution of changes was typical (present in more than half of the cases). Considering the subordinate themes, none of them was general. All the subordinate themes from identification of changes (i.e., themes 1, 2, 3, 4) were typical, as well as theme 7 (*attribution of change to therapeutic relationship*) from attribution of changes. The other subordinate themes (i.e., themes 5, 6 and 8) were variant (present in half or less than half of the cases). Considering the heterogeneity of the sample, the absence of consistently present themes at the sub-ordinate level is understandable.

Themes distribution and outcomes

The recovered group presented a mean of 1.85 subordinate themes per IM (252 categories/136 IMs), whereas the unchanged group presented a mean of 1.33 (76 categories/57 IMs). This difference was statistically significant ($z = -2.20$, $p = .028$). This means that the IMs of the recovered cases were richer in terms of themes of change, compared to those of the unchanged cases.

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

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

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

Significant differences between groups were observed for theme 1 (*changes in the self*), theme 4 (*non-specific changes*) and theme 5 (*attribution of changes* to an *internal shift*). *Changes in the self* were more typical in the recovered group ($z= -2.59$, $p= .010$), while the *non-specific changes* theme was significantly more frequent in the unchanged group ($z= -2.62$, $p= .009$). Lastly, attributions of changes to an *internal shift* were significantly more frequent in the recovered group ($z= -2.62$, $p= .009$).

Discussion

In the post-treatment interviews analysed in this study, IMs emerged in all the cases, and have a differential pattern for recovered and unchanged outcome cases, convergent with findings from previous studies conducted with adult clients and examining psychotherapy session transcripts (Gonçalves, Ribeiro, et al., 2017). The average proportion of about 13% of discourse coded as level 2 and 3 IMs found for the recovered group of this study, is similar to the 15% of high-level IMs (i.e., level 2 and 3) characteristic for successful therapy cases, which Montesano et al. (2017) found in their review of research conducted with the IMCS in adults.

Differences between outcome groups in the expected direction were found, that is, the recovered cases had a higher proportion of IMs compared to the unchanged cases, and this occurred for both levels of IMs coded in this study. A visual inspection of the pattern of IMs in each case suggests that only two cases were discrepant and may be considered outliers (case 9, a recovered case, and case 15, an unchanged case).

The thematic analysis of the IMs confirmed that most of the level 2 and level 3 IMs were centered on two main elements, the identification of changes (what changed) and attributions of changes (how/why did it change), with the first main theme much more frequent than the second. An interesting finding was that IMs of recovered participants contained significantly more themes, indicating that these participants were able to elaborate on more topics, thus making their IMs thematically richer. The identified changes covered several aspects of participants' lives, namely changes in the self (internal), in performance/behaviour (external), and in relationships

(interpersonal), and were mainly attributed to an internal shift, but also to dimensions associated with psychotherapy (e.g., relationship with therapist, therapeutic tasks).

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

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

In a more recent study, Fernández, Altimir, Reinel, Duarte and Krause (2022), identified several dimensions associated with recovery from depression in a sample of 40 adult patients. This study used a very different methodology but also identified changes in the self as very relevant to the recovery from depression (e.g., acceptance, self-appreciation).

In a review of seventeen qualitative studies on helpful and hindering events, Ladmanová, Řiháček and Ladislav (2022), found 12 helpful meta-categories, some of them consistent with our theme changes in the self, such as gaining a new perspective of the self, becoming more in touch with one's own emotions, experiencing relief, feeling empowered, or accepting self/problem. There are other similarities between the categories found in this study and our study, such as the overlap between changes in performance and achievement from our study, and developing new skills/coping strategies from the meta-analysis; and also between our theme on changes in relationships, and gaining a new personal view of others from the meta-analysis. Interestingly, there are many helpful events found in the review that are consistent with the themes found in our theme attribution of changes, centered on the therapeutic relationship, such as feeling heard, understood and accepted, having a sense of reassurance/feeling supported/having a sense of hope, feeling safe with and trusting the therapist, experiencing a personal connection with the therapist, and feeling engaged in the therapeutic process.

It should be noted that the studies referred to above depart were not base on the framework of innovative moments, and were largely focused on adult clients. The first study examined change from the perspective of corrective experiences, and the second focused on exploring helpful and hindering experiences. What links these studies is their emphasis on the perspective of the client regarding what is helpful in therapy. In this sense, the themes identified in our study seem to capture core helpful events from an observer perspective, departing from the concept of IMs.

If the results from this study are replicated in future research, it would suggest that therapists working with adolescents should make an effort to identify and

facilitate therapeutic exploration and elaboration of changes occurring in the client's self, and on how the self has changed, while taking references to non-specific changes as a probable sign of lack of meaningful or deep changes. Thus, from a practical stance, just as in previous studies with adults (e.g., Gonçalves, Ribeiro, et al., 2017; Montesano et al., 2017), such findings invite us to reflect on ways to promote therapeutic change by fostering personal agency and authorship regarding self-narrative innovations and their consolidation.

Limitations and future directions

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

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

Furthermore, the post-treatment interviews used in this study did not allow for analysis of the step-by-step change processes across the therapeutic sessions, nor for a study of the temporal relationship between unfolding IMs and improvements in depressive symptoms. To enable a deeper understanding of change processes within and across the course of psychotherapy with adolescents, especially the longitudinal patterns of IM production, the role of low-level IMs, and their temporal relationship

with personal change and improvement in symptoms, future research on therapy sessions with adolescents is necessary.

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

The focus on changes in the self, both at the level of “what changed”, and of “attributions of changes”, is an interesting finding associated with recovered cases; while a focus on non-specific changes, associated with unchanged cases, could be a useful prompt for therapists to reflect on what may be working less well with these clients, preventing them from identifying more specific changes.

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

important to understand change processes and improve our efforts to ameliorate mental health outcomes in young people.

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Table 1

Proportions of level 2 and 3 IMs coded in each case

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

Note. IMs - Innovative moments; CBT – Cognitive-behavioural therapy; STPP – Short-term psychoanalytic psychotherapy.

Table 2

Main themes, subordinate themes and codes included and examples

Maintheme	Subordinate theme	Codes included and examples
Identification of changes	**THEME 1** **Changes in the self**	**- *Changes in facets of the self*** - identification of changes in characteristics of the self, such as being less stubborn, more optimistic, having increased self-understanding or emotional expression. *P: I think that's part of the reason why people describe me as an extrovert it's just… not coz I'm an extrovert but they just think that because I'm more confident like I'm more open coz it's like I just don't care it's like… (...) I don't care about what people think about me (...)* [Case 1] **- *Changes in emotional states*** - changes in mood (less sadness, anger, frustration), feeling lighter, happier, feeling less stressed/calmer, less fear and worry. Being more emotionally stable. *P:* (...) *when I look back and think how I was I like-I just can't believe it like it-it was so horrible… and compared to how I am now like I'm-I just feel so much happier... (...) you know like if I get-if like I get into a mood or something I can get out of it really easily and I don't dwell on it (…)* [Case 2] **- *Self-validation and self-acceptance/normalization*** - validation of own experience, increased self-esteem, more confidence, normalization of problematic experience, increased self-acceptance and feeling good about oneself. *P: When I joined a society as well like that was taught me like just take every single opportunity coz it's like you just think like what's the worst could happen… (...) and like even if something bad did happen you're still learning so…* [Case 1]

	THEME 2 **Changes in performance and achievement**	**- *Behavior changes*** - identification of concrete and specific changes in behavior, such as getting involved with new activities or going back to old ones, being assertive and not wanting to hurt or kill him/herself. *P: so… I'm going back to school… (...) sort of regularly… (...) I'm basically back on track so that's good…* [Case 3] **- *Increased coping skills*** - increased coping skills in dealing with problematic behaviors. *P: normally I would just oh I feel really down and make myself feel worse like think about even worse things but now I'm just more likely like I did something like I tried to think about something else I knew why I felt depressed and...* [Case 10] **- *Increased achievement*** - references of being able to achieve more in school, at work and/or in life. *P: Err, I just think ya know, like your kind of physical health helps your mental health, and it realises sort of certain chemicals and endorphins (...), and then the same fing as with kind of working and stuff, it manages to give you a bit of a sense of achievement (...) just do more wiv your day* (...) [Case 21]
	THEME 3 **Changes in relationships**	**- *Validation from others*** - feeling validated from others, including the therapist. *P: "she [therapist] helped me realise like they actually want me to come back I'm... like it made me felt-feel needed again... (...) like and that I wasn't completely useless that someone wanted me to be there...* [Case 11] **- *Improved family relationships*** - improvements in family context, better communication, less conflicts, etc. *P: I know my relationship with-with my family has... got a bit better since I've been with IMPACT... there's like... now I can get along with... my family I can talk to them for a whole week without arguing like 600 times with them...* [Case 16]

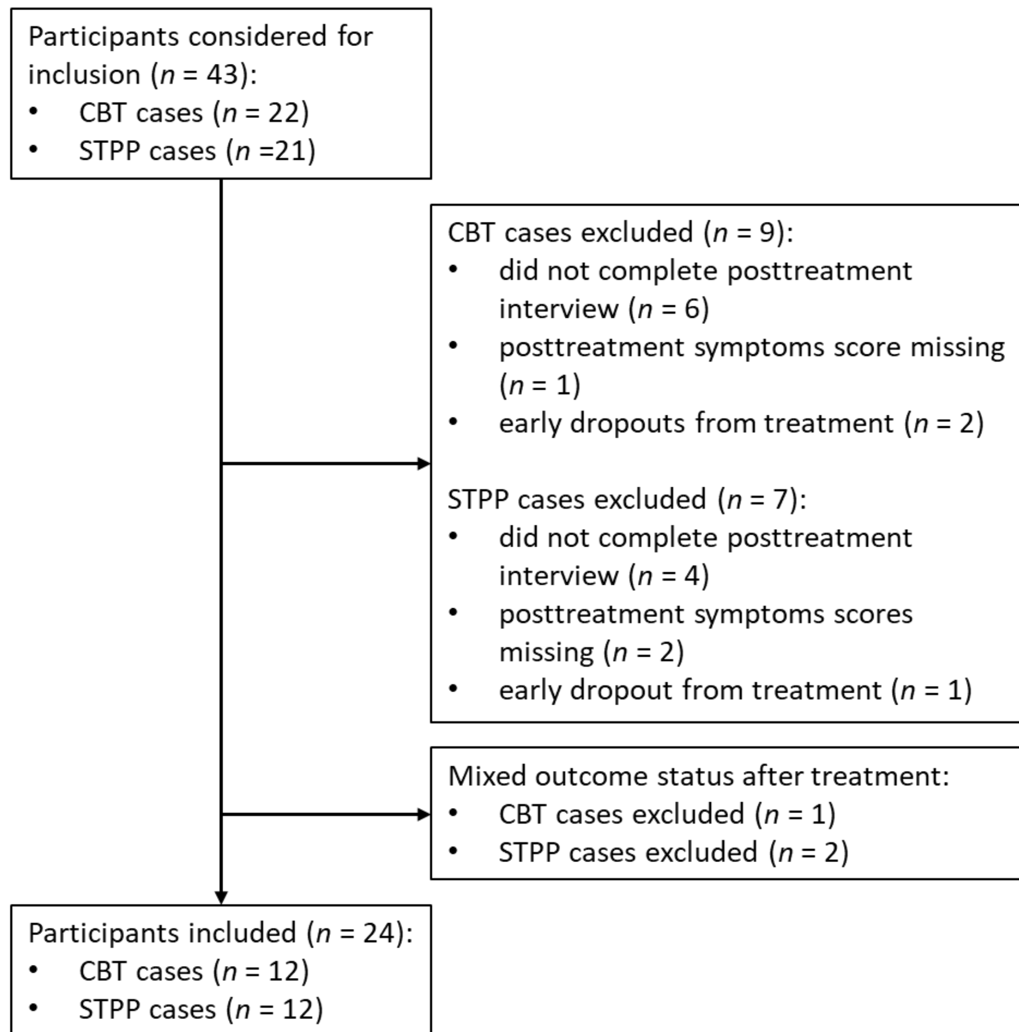
		- *Improved social relationships* - improvement in social relationships in general, with peers, teachers, etc. *P: (...) now I love socialising I love have people round I love sort of talking to people on skype like.. sort of got everyone comin round at 6 to ha-have a little s-like catch-up sesh... watch skins or something this is what I enjoy now…* [Case 13]
	THEME 4 **Non-specific changes**	**- *Non-specific indication of change*** - general indications of change, without any specification (e.g., "my life changed a lot" or "things are better now"). *P: but it's a lot better than before, how it was.* [Case 17]
Attribution of changes	**THEME 5** **Attribution of changes to an internal shift**	**- *Change of perspective*** - attribution of change to thinking differently and/or a change of perspective, having an insight, anticipation of events, interest in spirituality, etc. Includes attribution of the perspective change to therapy. *P: also CBT which helped me change my thought patterns and like especially the destructive ones and the ones the self… the self-hate has definitely reduced, I mean I don't think it's there anymore, it's not, like I'll have feeling, I'll criticize myself (almost whipers this) but it isn't hate… (...) and… yeah I think it's just ME.* [Case 20] **- *Willingness to recover & noticing improvements*** - attributions of changes to the will and motivation to get better, or to noticing improvements due to therapy, leading to further engagement in therapy. *P: ummm… seeing it all happen like… I can see what led up to what and how… (...) like the domino effect it just happened… (...) I guess coz… how… the one event triggered… a lot more.* [Case 3]
	THEME 6 **Attribution of changes to therapeutic tasks**	**- *Doing things differently in-between sessions*** - attribution of change to doing things in between sessions proposed by therapists or as a direct consequence of sessions.

		I: so things that you would kind of talk about together and then you would go and do them, yeah okay erm and how did you find that… *P: yeah I think that was quite helpful it was a lot more helpful than just talking about it… (...) because like it made sure that there's an actual link between being… between therapy and the rest of my life… so that's how I could actually make an impact…* [Case 1] **- *Doing cognitive/analytic work*** - attribution of change to in-session work such as identifying solutions and how to implement them, doing pros and cons, discussing problematic patterns. *P: umm I think the therapy was a big part of that… (...) erm and it sort of just helped me… order things in my life I guess… (...) like a puzzle just… making sure everything fits together…* [Case 3] **- *Doing therapeutic specific exercises*** - attribution of changes to specific exercises such as breathing exercises to calm down, writing feelings, etc. *P: I was going to cut myself for some whatever reason... and... I just wrote down the reasons not to... (...) and the reasons to do... er and I just found the reasons not to were other people so I just didn't do it that kind of helped me not do it..."* [Case 6]
	THEME 7 **Attribution of changes to therapeutic relationship**	**- *Comparing with the therapist*** - attribution of change to positive comparison with the therapists, leading to more self-confidence. *P: what I found like the most helpful was when she [therapist] would talk about her personal life, it wasn't like personal it was just like… I did this-like… yeah I went to [name of place], and then I did this and then I did that… coz I remember… it just meant that I could see… more about other people's lives that I could compare… (...) so*

		it's kind of like I would have like a real example and that would give me more hope (...) [Case 1] **- *Being listened by the therapist*** - attribution of change to effects of therapeutic relationship, such as feeling understood, not feeling judged, being able to express feelings and thoughts with the therapist. *P: so with the... the therapist it was just sort of like... I could just let it out... and say what I wanted to say coz yeah that she didn't know me that well but also... like... I can't explain it but... it's really hard to explain... it is the distance but it's sort of like she was there for that-that reason and the reason only I suppose... so nothing else mattered it didn't really matter if she thought I was weak or whatever she had seen loads of other people with it as well...* [Case 11]
	THEME 8 **Non-specific attributions of change**	**- *Non-specific attributions of change*** - attribution of changes to therapy or therapist without specification (e.g., "things improved when I let therapist help" or "therapy helped me to get better"). *P: yeah… and I think… only in the last kind of… few session like the last maybe three or four… I kind of realised that, it was actually helping me, I mean in-in the session-all I really did was talk like how I'm talking to you just telling her what happened during the week and I'd go off into all sorts of other stories and that are completely irrelevant and then like I you know and now I look and I think all that time you know I hear I mean it must have helped me like I'm cured (laughs) if you wanna put it like that…* [Case 2]

Figure 1

Sample selection and participant exclusion



Note. CBT – Cognitive-behavioural therapy; STPP – Short-term psychoanalytic psychotherapy.

Figure 2

Organization of the themes

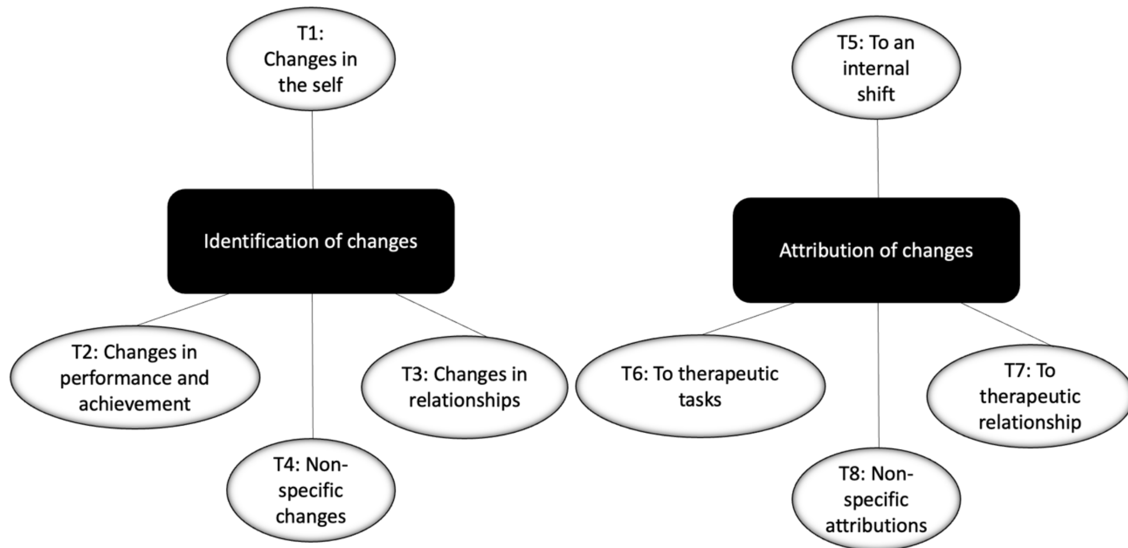
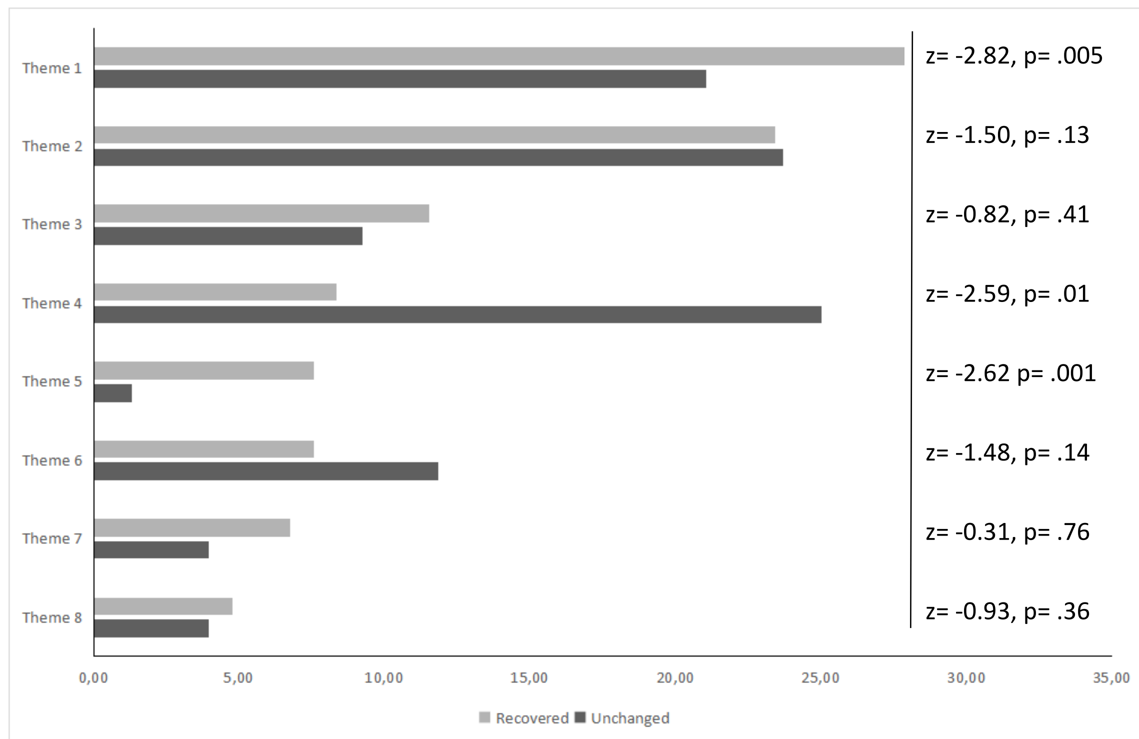


Figure 3

Theme proportions in the recovered and unchanged groups



Note. Proportions were used due to the unbalanced number of codes in the two groups.
The themes names are as follow - Theme 1: Changes in the self; Theme 2: Changes in performance and achievement; Theme 3: Changes in relationships; Theme 4: Non-specific changes; Theme 5: Attribution of change to an internal shift; Theme 6: Attribution of change to therapeutic tasks; Theme 7: Attribution of change to therapeutic relationship and Theme 8: Non-specific attribution of change.