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## Narrative Change in Psychotherapy: Differences Between Good and Bad Outcome Cases in Cognitive, Narrative, and Prescriptive Therapies



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This study aimed to clarify the relationship between changes in the patients' narratives and therapeutic outcomes. Two patients were selected from three psychotherapeutic models (cognitive, narrative, and prescriptive therapies), one with good therapeutic outcome and the other with bad therapeutic outcome. Sessions from the initial, middle, and final phases for each patient were evaluated in terms of narrative structural coherence, process complexity, and content diversity. Differences between patients' total narrative production were found at the end of the therapeutic process. Good outcome cases presented a higher statistically significant total narrative change than poor outcome cases. © 2008 Wiley Periodicals, Inc. *J Clin Psychol* 64:1181-1194, 2008.

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Following Osgood's work (1954, 1957) on the semantic differential technique, there has been an increased interest recently in studying language processes in psychotherapy research. Of particular interest are studies focusing on how the patient's language differs between psychotherapeutic models (Stiles, Shapiro, & Firth-Cozens, 1998), the patient and therapist response modes and their mutual influences (Stiles, Shapiro, & Firth-Cozens, 1988), change in verbal structure (Stiles

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& Shapiro, 1995), thematic content (Richards & Lonborg, 1996; Milbraith, Bauknight, Horowitz, Amaro, & Sugahara, 1995), the form in which patients and therapists construct and interpret different aspects of the therapeutic process (Heppner, Rosenberg, & Hedgespeth, 1992), theme discourse analysis (Madill & Barkham, 1997), the effects of verbs during the production of sentences (Shapiro, Brookins, & Nagel, 1991), metaphors in psychotherapy (Angus, 1992, 1996; Rasmussen, 1995; Rasmussen & Angus, 1996), and thematic change in psychotherapy (Deter, Llewellyn, Hardy, Barkham, & Stiles, 2006).

Despite the relatively large number of studies, most focus on specific aspects of language (i.e., grammatical elements, verbs, themes, response modes) rather than on evaluating how different elements of language contribute to the patient's narrative structural coherence, narrative process complexity, and narrative diversity content. This tendency could be related to a difficulty in conceptualizing and operationalizing language processes and its diverse components in an integrated, holistic, and comprehensive manner, so that a greater variety of elements related to the production of language (the construction of meanings, the interpretation of events, the interaction between variables and the linguistic expression) could be included.

Language processes include several psychological aspects that have not been addressed as a whole (for example, if evaluating only sentences or verbs, one is not evaluating the complex dynamics of capturing and transforming stimuli and experiences into psychological processes). In fact, narrative has been characterized by the way individuals use language connected to various psychological processes, such as memory, emotion, perception, and meanings (Angus & McLeod, 2004; Bruner, 2004; Gonçalves, Henriques, & Machado, 2004; McLeod & Balamoutsou, 1996; Neimeyer, 1995; Nye, 1994; Polkinghorne, 2004; Russell & Bryant, 2004; Russell & Wandrei, 1996). Thus, narrative has emerged as a trans-theoretical concept that allows for a more integrated comprehension of psychological functions.

Research on narratives has revealed the existence of language deficits in depressed patients (Emery & Breslau, 1989) and the existence of changes in neural circuitry of language before and after major depression treatment (Abdullaev, Kennedy, & Tasman, 2002). Chronically depressed individuals tend to use words with a more negative connotation than do other individuals (Alison & Burgess, 2003); depressed individuals use more negatively charged words than do never-depressed individuals (Rude, Gordtner, & Pennebaker, 2004). Emotional functioning in depressed and depression-vulnerable individuals differs from emotional functioning in depressed-/susceptible individuals (Pyszczynski & Greenberg, 1987; Rude & McCarthy, 2003), whereas interpretation and meaning construction resulting in cognitive bias predicts depression (Rude, Wenzlaff, Gibbs, Vane & Witney, 2002). Studies analyzing the life narratives of a group of self-identified depressed individuals suggested that a narrative approach to therapy could be useful in the treatment of depression, by helping patients to change meanings and to find alternative meanings for their life experiences (Robertson, Venter, & Botha, 2005).

Research on narratives of drug abuse patients revealed that there is a type of discourse among patients with a drug addiction that is highly associated with their self-identity; therefore, any approach to treatment may be enhanced by promoting change in self-identity and discourse (Bailey, 2005). Studies have shown that patient commitment language during motivational interviewing predicts drug use outcomes (Amrhein, Miller, Yahne, Palmer, & Fulcher, 2003); the discourse of young individuals and the interaction in different contexts mediates the risk for new or continued drug use (Jones, 2005), and that language deficits are an important risk

factor for drug abuse in adolescence (Najam, 1998; Snow, 2000). Recently, several authors have suggested that treatment for patients addicted to drugs should include opportunities to construct their identities and promote change, as suggested by Ricoeur's theory of narrative identity (Ricoeur, 1984; Taieb, Revah-Lévy, Baubet, & Moro, 2005).

Although research has given important contributions to the understanding of the language process in psychotherapy, research on narrative change as a trans-theoretical factor has been neglected. It would be valuable to determine whether narrative language changes can be obtained in studies using more holistic instruments than those used in previous studies (i.e., that measure as many language aspects as possible—not just coherence, process, or content), and whether treatment based on alternative therapeutic models achieve the same results. Psychotherapy is aimed to promote change in several domains (such as emotions, cognitions, meanings, etc.), whereas narrative change may reflect changes in several psychological domains, therefore, a difference in degree of narrative change in positive-outcome versus poor-outcome cases using three therapeutic models should be expected. The goal of this study was to evaluate the relationship between therapeutic outcomes (positive and negative/poor) of patients with comorbidity of depression and substance abuse with change in the patient's therapeutic narratives. The hypothesis of this study was that good outcome cases would present a higher degree of narrative change during the course of therapy than bad outcome cases.

## Method

### *Participants*

The participants in this study were drawn from a larger sample that comprised a National Institute of Drug Abuse (NIDA) funded project that was designed to evaluate the efficacy of the different treatments for patients with comorbid depression and substance abuse. The randomized clinical trial was conducted at the University of Santa Barbara, California (Beutler et al., 2003). Homogeneity of the sample (diagnosis, duration of illness, previous or additional treatments, age, sex, education, profession, and therapists' variables) was taken into account in designing the NIDA project sample (for details, see Beutler et al., 2003) when the sample of 6 out of 40 patients was selected. The NIDA study compared the therapeutic results among distinct manualized treatments (cognitive therapy, narrative therapy, and prescriptive therapy), using a sample of 40 patients with comorbid depression and substance abuse. Patients were randomly assigned to each treatment group and were evaluated at various points in time, including at pretreatment, posttreatment, and follow-up, using instruments like the General Assessment of Functioning, Minnesota Multiphasic Personality Inventory- 2 (MMPI-2), Dowd Therapeutic Reactance Scale, (TRS), State Trait Anxiety Inventory (STAI), Beck Depression Inventory (BDI), Hamilton Score Scale for Depression (HRSD), Addiction Severity Index (ASI), and Time-Line Follow-Back (TLFB; for details, see Beutler et al., 2003).

The present sample was selected from the original sample. Out of the 40 patients, those who had experienced the most positive and poorest outcomes within each of the three therapeutic models were identified. This selection was made by two psychologists who were asked to calculate the degree of change verified in each of the 40 patients from the first evaluation moment to the last evaluation moment in each instrument used in the NIDA work. The mean change registered by the several quantitative instruments was calculated and the case that presented the highest mean

improvement was selected from each therapeutic model as a good outcome case. In the same way, the case that presented the lowest mean change was selected from each therapeutic model to represent a poor outcome case. The intensive nature of the process analysis precluded a larger sample. Thus, six ( $N = 6$ ) cases were selected and are presented as an initial effort to identify the characteristics of productive and less-productive therapeutic work. The effect of the different therapeutic approaches was inspected in a separate study, which also confirmed that the outcomes associated with the different therapeutic models were in fact comparable (for details, see Beutler et al., 2003). Of the six patients, two received cognitive therapy—one with good outcome, and the other with bad outcome; two received narrative therapy—one with good outcome, and the other with bad outcome; and two received prescriptive therapy—one with good outcome, and the other with bad outcome).

For each patient, a session from the initial (session 3), middle (session 8), and final (session 14) phases was selected and transcribed. The number of sessions selected was based on the average of sessions from the different therapeutic processes. The sample for this study had 18 narratives: 6 for the initial phase, 6 for the middle phase, and 6 for the final phase of the treatment. In the sample of 18 narratives, 9 corresponded to cases of good therapeutic outcomes, and the other 9 to cases of poor therapeutic outcomes: there were 6 cases representing each therapeutic model.

### *Therapeutic Models*

The therapeutic models selected emphasize differently the role of language in the therapeutic process. Prescriptive (Beutler, Clarkin, & Bongar, 2000), cognitive (Beck, Wright, Newman, & Liese, 1993), and narrative (Gonçalves, 1995) therapies were therapeutic models used in a research project granted by NIDA (Beutler et al., 2003). These three psychotherapeutic models can be considered as differentially emphasizing the role of language in the therapeutic process. Prescriptive therapy (compared to cognitive and narrative therapies) can be considered as the model that gives less emphasis to the role of language processes in psychotherapy. Narrative therapy can be considered as the model that most emphasizes the language in the psychotherapy process. Following this reasoning, cognitive therapy can be considered as a model, which is at an intermediate level regarding the emphasis it gives to language processes in the therapeutic process. Prescriptive therapy is an empirically rather than a theoretically oriented model, using a wide range of techniques from different theoretical models. Prescriptive therapy gives special emphasis to fitting patient characteristics to the selection of therapeutic strategies. Cognitive therapy considers that languages processes have a central role in the therapeutic process and results. Narrative therapy is part of a group of models focusing on language within the therapeutic process, emphasizing the narratives' role in human development, psychopathology, and the psychotherapy process.

The therapists who participated in this study were those who participated in a study funded by NIDA. The therapists' selection and training followed the procedures of the NIDA study (for more details see Beutler et al., 2003).

### *Instruments*

To evaluate the different narrative dimensions, specific instruments were used to assess each narrative dimension: the narrative structural coherence coding system, the process complexity coding system, and the content multiplicity coding system.

*Narrative structural coherence coding system.* Narrative structural coherence refers to the way different aspects of experience relate to one another, in such a way that it engenders a feeling coherent with one's self. The narrative structural coherence coding system (Gonçalves, Henriques, & Cardoso, 2001) evaluates the structure and narrative coherence according to four dimensions. Orientation is a subdimension of the narrative, which provides information about the characters and the social context, time and space, and personal characteristics that influence behavior. Structural sequence is a subdimension of the narrative, which is composed of a series of events that is defined by the temporal sequence of an experience at the precise moment it was noticed. The evaluative commitment subdimension of the narrative refers to the degree of involvement or dramatic behavior of the narrator with the narrative. Integration subdimension of the narrative evaluates and measures the degree of diffusion or integration among various elements or stories that were presented to produce a meaning that binds the elements or stories together (Gonçalves et al., 2001). Each dimension is coded to reflect the degree to which the element is present, using a 5-point, anchored Likert scale. This instrument has earned high levels of fidelity in measures of interobservers (96%) and internal consistency (values of alpha between .79 and .92; Gonçalves et al., 2002).

*The narrative process complexity coding system.* Process complexity (Gonçalves, Henriques, Alves, & Rocha, 2001) refers to the individual's initial degree of openness to experience, as shown by the rated quality, variety, and complexity of the narrative process as it reflects on sensorial, emotional, cognitive, and meaning. The evaluation of narrative process complexity includes four subdimensions. The objectifying level refers to the diversity of the elements in the sensorial experience, present in the narrative (e.g., vision, audition, smell, taste, and physical sensations). The emotional subjectifying level reflects the degree in which the narrative presents a diversity of emotional experiences; the cognitive subjectifying level concerns the degree in which the patient includes and integrates several elements of his cognitive experience in his narrative; and the metaphorizing level refers to the diversity of metacognitive elements and meanings present in the narrative (Gonçalves, Henriques, Alves, & Rocha, 2001). Each subdimension is coded according to a degree of presence, using a 5-point Likert scale. This coding system presents high levels of fidelity among interobservers (89%) and internal consistency (values of alpha between .66 and .87; Gonçalves, Henriques, Alves, & Soares, 2002).

*The narrative content multiplicity coding system.* Narrative content multiplicity (Gonçalves, Henriques, Soares, & Monteiro, 2001) refers to the degree to which individual's narratives are characterized by diverse content and it is scored as four subdimensions. Theme subdimension concerns the diversity and multiplicity of themes present in the patient's narrative. Subdimension events refer to the diversity and multiplicity of events. Scenario analyses define the diversity and multiplicity of scenarios. Finally, the character subdimension evaluates the diversity and multiplicity of characters (Gonçalves, Henriques, Soares & Monteiro, 2001). Each subdimension was coded according to a degree of presence, using the 5-point Likert scale, based on scale anchors for the Likert-type rating scales. The coding system presents high levels of fidelity among interobservers (94%) and internal consistency (values of alpha between .86 and .90).

Methodological issues in terms of reducing complex interaction phenomena by using anchored, 5-point Likert scale coding procedures for the evaluation of narrative production in psychotherapy were considered. Although this methodology

may reduce complex interaction processes, it was chosen because it was the best methodology available for the evaluation of narrative dimensions and subdimensions. In fact, other authors, also aware of these methodological limitations, recognize that nevertheless there are benefits in using methodologies based on taxonomies and categories. Several studies using these methodologies (as rating scales) have been developed, providing interesting findings and important clues in both the study domain and the study methodology (e.g., Elliot, Hill, Stiles, Friedlander, Mahrer & Margison, 1987).

### *Procedure*

The therapeutic sessions (the object of analysis of the present study) were transcribed and then coded for narrative dimensions independently by two pairs of judges to establish interjudge agreement for each narrative dimension (structural coherence, process complexity, and content multiplicity). The judges were psychologists who had had 30 hours of training in each coding system. After the initial training, in which the judges were introduced to the coding concepts and methodology, 10 therapeutic sessions were evaluated. Once the pair of judges who obtained the highest levels of agreement was identified, 10 additional therapeutic sessions were distributed and rated to evaluate fidelity between judges. When interjudge agreement was equal or superior to 80%, the pairs of judges were then allowed to initiate the coding of the sessions used in this study. Narratives were coded by pairs of similarly trained judges presenting high levels of agreement (reliability on the actual sample was superior to 80% agreement). The first observation (initial phase sessions at the beginning of treatment) was used for the establishment of a narrative production baseline. The subsequent observations were compared with this baseline. Once the narratives were coded on each narrative variable of interest, the evolution of the narratives was calculated by comparing the narrative scores of each session with those obtained at baseline.

### *Data Analysis*

A statistical analysis of the differences between the two therapeutic groups (good and bad outcome cases) was performed using the nonparametric Mann-Whitney *U* test. The statistical analysis was conducted by using SPSS for Windows (V.11.5).

Additional analyses were conducted to assess the extent to which each patient could have evolved from the narrative production he or she initially exhibited. This was to ensure that the narrative change would be measured during the therapeutic process rather than being the result of the individual's ability to produce narratives, which is not an effect of the former. Thus, we started by measuring the initial narrative production of each patient before the treatment and we then calculated the possible evolution (the maximum narrative production possible). The evolution factor results from the difference between the maximum evolution possible ( $mep = 4$ ) and the narrative punctuation obtained at the beginning of the treatment, ( $x$ ):  $mep = (4 - x)$ . We took into consideration the individual differences on narrative production and calculated the change that occurred during the therapeutic process. To calculate the narrative change, we used the following formulae.

Maximum evolution possible:  $mep = 4$ . Because the maximum score possible of 5 minus the minimum score possible of 1 is 4, then  $mep = (5 - 1) = 4$ .

Evolutionary potential:  $ep = 5 - x$ . Evolutionary potential is the evolution one may accomplish considering the starting score obtained at the beginning of the process ( $x$ )

and the maximum score one can possibly obtain in terms of narrative production (which is 5). So the maximum score possible of (5) minus the narrative production score at the beginning of the treatment ( $x$ ) gives us the evolutionary potential,  $(5-x) = ep$ .

Observed evolution:  $obsev = fph - iph$ . The observed evolution refers to the evolution that has really occurred. The observed evolution does not have to have the same value as the evolutionary potential. So, the narrative production score a patient has at the final phase of the treatment ( $fph$ ) minus the narrative production score the patient had at the initial phase of the treatment ( $iph$ ) gives us the observed evolution,  $(fph - iph) = observ$ .

Evolution percentage:  $evo\% = obsev * (100/ep)$ . Evolution percentage refers to the percentage of evolution in terms of narrative production found at the end of the treatment process of a given individual. To know the final evolution percentage in terms of narrative production, we multiply the observed evolution (the evolution score that has really occurred) by 100 (considering the individual's evolutionary potential as 100%, meaning the individual's maximum evolution value possible). Then we must divide the given result by the individual's evolutionary potential (the evolution one may accomplish considering the starting score obtained at the beginning of the process and the maximum score one can possibly obtain in terms of narrative production, which is 5). This final result will be the actual evolution percentage of a given individual. This reasoning is expressed by the formula:  $evo\% = obsev * (100/ep)$ .

Narrative change equals the difference ( $Di$ ) between patient classification in the final phase ( $fph$ ) and the baseline obtained from the initial phase observation ( $iph$ ),  $Di = (fph - iph)$ . The maximum amount of change possible for each of the dimensions and subdimensions was 4. In other words, the value assigned to the change,  $Di = (fph - iph)$  corresponds to the amount of change occurring in patients' narrative production during therapy: the difference between the maximum score that can be attributed (5) and the minimum score that was attributed (1).

## Results

Results reveal the existence of statistically significant differences in total narrative change between good and bad outcome cases ( $U = 0.00$ ;  $p = .050$ ). Narrative dimensions and subdimensions were found not to be statistically significant between the two groups. These results are presented in Table 1.

Besides statistical analysis, trends and possible differences between good and bad outcome cases on narrative dimensions and subdimensions were also examined, rather than relying solely on statistically evaluated differences. This allows a better understanding of possible differences. The change values were calculated accordingly to the data analysis procedures explained above.

Evaluation of the total narrative scores revealed higher ratings among the good outcome cases (120) comparatively to the bad outcome cases (96). Although at the beginning of treatment the difference between groups (good and bad outcomes) in terms of narrative production total scores was null, the difference between groups was very significant at the end of treatment (difference of 24 points between groups). Table 2 presents the narrative production total scores in both groups (good and bad outcome groups) through treatment phases in the three narrative dimensions.

Analysis of mean and standard deviations of the total narrative changes (differences from the initial to the final treatment phase total scores) revealed that

Table 1

*Comparison of the Good and Bad Outcome Cases on the Total Narrative Change and on the Narrative Dimensions and Subdimensions*

	Good outcome Cases Mdn (N = 3)	Bad outcome Cases Mdn (N = 3)	U	Z	p
Orientation	2.5	2.5	1.5	-1.5	.114
Structural sequence	4.0	3.0	3.0	-1.0	.317
Evaluative commitment	3.5	3.5	4.5	0.00	1.0
Integration	3.5	3.5	4.5	0.00	1.0
Total structure coherence	4.33	2.67	2.0	-1.124	.261
Objectifying	4.0	3.0	3.0	-.745	.456
Emotional subjectifying	3.5	3.5	4.5	.00	1.0
Cognitive subjectifying	3.67	3.33	4.0	-.258	.796
Metaphorizing	4.17	2.83	2.5	-.943	.346
Total process complexity	4.17	2.83	2.5	-.899	.369
Characters	4.50	2.50	1.5	-1.581	.114
Scenarios	4.50	2.50	1.5	-1.549	.121
Events	4.50	2.50	1.5	-1.581	.114
Themes	4.17	2.83	2.5	-.943	.369
Total content multiplicity	4.33	2.67	2.0	-1.179	.239
Total narrative change	5	2	0.00	-1.964	.050*

\* $p < .050$ .

the narrative production changes were higher among the good outcome group, Change = 0.55 (24.6%) than in the bad outcome group, Change = -0.11 (4.93%).

Evaluation of narrative structural coherence total scores revealed the presence of higher ratings among good outcome cases (42) than among bad outcome cases (37). Analysis of mean and standard deviation of the total narrative structural coherence scores showed that, even though the mean was equivalent in both groups at the beginning of treatment, at the end of treatment the mean of the good outcome group (10.5) was higher than the mean of the bad outcome group (9.25). The difference of means between the final phase and the initial phase was 0.16 in the bad outcome group. In the good outcome group, the difference of means between the final phase and the initial phase was .58. These values indicate that narrative structural coherence change was higher in the good outcome cases (27.6%) than in the bad outcome cases (7.96%). The ratings of the different narrative subdimensions (orientation, structural sequence, evaluative commitment, and integration) were also found to be more characteristic of patients who achieved good outcomes than of those whose outcomes were poor. Integration registered a higher change in cases of good outcomes, Change = 1.3 (49%), but such change was not verifiable among bad outcome cases, (Change = .66 (27.5%). Orientation presented a null change in cases of bad outcomes and a positive change in good outcome cases, Change = .66 (33%). Structural sequence dimension presented a higher change in good outcome cases, Change = .66 (30.4%), than bad outcome cases, Change = -.16 (7.6%).

Change in the narratives revealed quite a different pattern in process complexity and its subdimensions over time in therapy. Poor outcome cases changed in a negative direction from the initial phase to the final phase of the treatment, while good outcome cases tended to increase from the initial to the final phase of the treatment. In general terms, the good outcome cases registered a positive narrative change, Change = .33 (12%), and the bad outcome cases registered a negative change, Change = -.41 (16.9%). The subdimension of metaphorizing was the



**Table 2**  
*Narrative Dimensions and Subdimensions Total Results, Means, and Standard Deviations in the Different Treatment Phases in Good and Bad Outcome Cases*

Narrative dimension	Bad outcome cases					Good outcome cases					
	Initial phase	Middle phase	Final phase	Evolution	Evolution %	Initial phase	Middle phase	Final phase	Evolution	Evolution %	
Structural coherence	Orientation	9	9	9	0	0%	9	9	11	0.66	33%
	Evaluative commitment	9	8	8	-0.33	-16.5%	9	9	10	0.33	16.5%
	Structural sequence	9	10	10	0.16	7.6%	9	10	10	0.66	30.4%
Process complexity	Integration	8	9	10	0.66	27.5%	7	10	11	1.33	49.8%
	Total	35	36	37	0.16	7.96%	35	38	42	0.58	27.6%
	M	8.75	9	9.25			8.5	9.5	10.5		
	SD	0.5	0.81	0.95			1	0.57	0.57		
	Objectifying Emotional subjectifying	7	7	7	0	0%	6	8	7	0.33	11%
Content multiplicity	Emotional subjectifying	9	9	8	-0.33	-16.5%	8	7	8	0	0%
	Cognitive subjectifying	9	7	7	-0.66	-33%	9	11	11	1	33%
	Metaphorizing	6	4	4	-0.66	-22%	4	9	7	1	27.07%
	Total	31	27	26	-0.41	-16.9%	27	32	31	0.33	12%
	M	7.75	6.75	6.5			6.5	8	8.25		
Total narrative dimensions	SD	1.5	1.1	1.3			1.4	0.6	0.4		
	Characters	9	9	8	-0.33	-16.5%	11	13	12	0.33	23.5%
	Scenarios	9	7	9	0	0%	7	13	10	1	37.45%
	Events	9	8	8	-0.33	-16.5%	10	10	12	0.66	39.5%
	Themes	7	9	8	0.33	12.3%	10	11	13	1	59.8%
Total narrative dimensions	Total	34	33	33	-0.08	-3.68%	38	47	47	0.75	39.4%
	M	8.5	8.25	8.25	-0.08	-3.68%	9.5	11.7	11.7	0.75	39.4%
	SD	0.7	0.7	0.3			1.3	1.1	0.9		
	Total	100	96	96	-0.11	-4.93%	100	117	120	0.55	24.6%
	M	33.3	32	32			33.3	39	40		
SD	1.6	3.7	4.5			4.6	6.1	6.1			

particular subdimension that most clearly defined differences between good and poor outcome cases. The good outcome cases changed one point in a positive direction, Change = 1 (27.07%), and the poor outcome cases changed nearly one point in a negative direction, Change =  $-.66$  (–22%). Likewise, the dimension of cognitive subjectifying earned a positive change among good therapeutic outcome cases, Change = .66 (33%), and a negative change, Change =  $-.66$  (–33%), in poor therapeutic outcome cases. Objectifying scores earned a null level of change among bad outcome cases and a positive level of change among good outcome cases, Change = .33 (11%), whereas scores on the emotional subjectifying dimension earned no noticeable change among good outcome cases, Change = 0, but a negative change among poor outcome cases, Change =  $-.33$  (–16.5%).

Evaluation of content multiplicity revealed the existence of higher ratings in good outcome cases in comparison to bad outcome cases. Analysis of the means and standard deviations of the total narrative content multiplicity scores showed that even though the mean was equivalent in both groups at the beginning of treatment, at the end of treatment the mean of the good outcome group, Change = .75 (39.4%), was much higher than the mean of the bad outcome group, Change =  $-.0$  (3.68%). Among the various subscores representing the dimensions of characters, scenarios, events, and themes, the changing rates were consistently more positive among good outcome groups than in poorer outcome groups. The subdimension characters changed to become more positive over time among good outcome cases, Change = .3 (23.5%), and changed to become more negative among poorer outcome cases, Change =  $-.33$  (–16.5%). Scenarios changed for the better among good outcome cases, Change = 1 (37.45%), but failed to change among poor outcome cases. The subdimension events became increasingly positive, Change = .66 (39.5%), among the good outcome cases and became more negative, Change =  $-.33$  (–16.5%) in the poor outcome cases. Themes represented in the narratives positively developed among cases with both good and poor outcomes. The changes were most pronounced, however, among good outcome cases, Change = 1 (59.8%), than among poor bad outcome cases, Change = .33 (12.3%).

### Discussion

In support of our hypothesis, results showed that good outcome cases presented a higher statistically significant global narrative change than poor outcome cases. Besides total narrative change, no further statistically significant differences were found between groups. This fact may be related to the small size of the sample, which can turn out to be an important obstacle for the possibility of finding statistically significant differences in narrative dimensions and subdimensions between good and bad outcome cases. However, in terms of each narrative dimension and subdimension and in terms of therapeutic models, nonstatistical analysis suggests trends and possible differences that justify the development of further studies (with bigger samples) to test these trends and possible differences in statistical terms.

During the therapeutic process, content multiplicity was the dimension for which the highest level of change was obtained, whereas the lower level of change obtained was for process complexity. Changes in patients' narrative structural coherence were found throughout the therapeutic process. Results also suggested a difference between changes obtained in positive and negative/poor therapeutic outcome cases. Integration appeared to be the most discriminative subdimension between positive and negative/poor outcome cases. The structural sequence dimension seemed to be

able to differentiate positive outcome cases (i.e., for which there was a positive change) from negative/poor outcome cases (i.e., for which a negative change took place). These results are congruent with findings from other studies, which separately evaluated the narrative dimensions of structural coherence (McAdams & Janis, 2004), process complexity (Francis & Pennebaker, 1992; Pennebaker, Colder, & Sharp, 1990), and content multiplicity (Deter et al., 2006; Luborsky & Crits-Christopher, 1998).

Patients' narrative production is a result of a multiple variable interaction processes (such as culture, socioeconomic status, developmental level, therapeutic alliance, etc). The size of the sample (6 patients and three therapeutic models) does not allow for controlling over the effects of these variables. In an effort to control for these variables as best as possible, the analysis of the patients' narratives was not based on their initial levels of narrative production, but rather on the evolution showed by the patients during the therapeutic process. This way, if there were very significant individual differences between patients, these differences should have been found on the first evaluation. One explanation for the nonexistence of individual differences between patients in what concerns their narrative production at the beginning of the treatment might be that at the beginning of treatment the depressive symptomatology might have biased the narrative production and diminished the eventual differences that might have existed between patients in terms of narrative production. However, the depressive symptomatology coexisted with the same level of severity in all patients, meaning that it may have similarly interfered in all of them.

An important variable that may have affected the results of this study is the condition's severity. With respect to this question, theoretically, one may consider the hypothesis that higher levels of symptom severity can justify that the therapist and patient dedicate more time and effort to a certain aspect or symptom; consequently, this may interfere (compromise) with the patient's narrative production. On the contrary, patients presenting with less severe symptoms may be more resourceful in terms of narrative production. That is, compared to severely depressed patients, those with milder symptomatology may present an increased ability to access and mobilize psychological processes (such as attention or motivation levels) and this, in turn, may explain the extent to which the latter can attain higher levels and more elaborated forms of narrative production. Although this is an interesting point, it does not seem to explain the existing differences in narrative production. On the one hand, the symptom's severity (as evaluated by levels of depression and substance abuse) of the patients involved in the NIDA project were equivalent. On the other hand, the narrative evaluation instruments assessed dimensions such that differences are not explained by focusing on a specific symptom.

This study emphasizes that a more holistic and ecological approach to discourse and narrative production and change during the therapeutic process is not only possible to achieve, but it is also desirable and necessary to adopt if we are to acquire a better understanding of this complex process. In fact, a key aim of this study was to use instruments to evaluate the narrative and discourse production and change during the therapeutic process, considering the complexity of such phenomenon.

This was the first study where evaluation measures were used to simultaneously assess three narrative dimensions: structural coherence, process complexity, and content diversity. The evaluation measures seem to be sensitive in that they capture the differences between patients and the changes occurring in the same individual

throughout the therapeutic process. However, the essentially qualitative nature of these measures and the scoring methodology used may be difficult to apply in studies using larger samples (i.e., the need for human and economic resources would be heightened given the complexity of the coding procedures for these narrative measures and the use of observational data). More complex coding schemes demand longer periods of time for training and establishment of psychometric properties (e.g., reliability) and the use of observational data is costly, especially if using larger samples (i.e., costs associated with equipment, the transcription and coding process itself, storage, etc.).

Notwithstanding the promising results of this study, they should be interpreted with caution, as these are based on a few number of cases. Other studies are needed, especially studies using larger samples, to ensure the higher reliability and validity of the findings. Nevertheless, the evaluation instruments used here have shown that they are sufficiently reliable and sensitive to capture differences between patients' therapeutic narratives; they can also be useful instruments used independently of therapeutic models.

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