Universidade do Minho
Escola de Psicologia

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Treatment of depression: Empirical evidence from a clinical trial comparing Narrative Therapy with Cognitive-Behavioral Therapy

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Treatment of depression: Empirical evidence from a clinical trial comparing Narrative Therapy with Cognitive-Behavioral Therapy

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Professor Doutor Miguel M. Gonçalves
e co-orientação do
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Dedicated to Nina and Nuno.

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TREATMENT OF DEPRESSION: EMPIRICAL EVIDENCE FROM A CLINICAL TRIAL COMPARING NARRATIVE THERAPY WITH COGNITIVE BEHAVIORAL THERAPY

Abstract

Background: Major depressive disorder (MDD) is a serious problem and research on new interventions is required. White and Epston's (1990) narrative therapy (NT) is a psychotherapeutic approach based on the notion that people construct narratives in order to define themselves and give meaning to their life experiences. MDD is featured by the construction of narratives saturated by negative meanings, such as failures, entrapment and powerlessness, and a hopeless view of the future. The purpose of psychotherapy is to help clients shape new identities and construct stories in a richer and more diverse way. Although familiar amongst clinicians and widely practiced, systematic studies of the efficacy of NT for depression are sparse, especially those using large client samples and quantitative research methods. To our knowledge only one study examined the efficacy of NT and none has compared NT treatment directly to a control group or another intervention in the same clinical setting. On the other hand, cognitive-behavior therapy (CBT) is the most established psychological treatment for depression so far. **Aims:** The primary purpose of this doctoral dissertation is to assess the efficacy of manualized NT for depression and compare it with CBT. Additionally, we aimed to compare the time to improve from depressive symptoms and interpersonal problems during treatments and during follow-up. **Methods:** Ten therapists with different levels of experience and 63 clients diagnosed with mild and moderate MDD took part in this study. Clients were assigned to treatments quasi-randomly. Therapist's adherence to manuals and

competence were assured by weekly supervision and by the completion of a scale by independent judges, after having watched taped sessions. The Beck Depression Inventory-II and Outcome Questionnaire-45.2 were used as outcome measures. **Results:** Both treatments were superior to benchmarked waiting-list control groups in alleviating depressive symptoms for those clients who completed treatment. There is a significant difference favoring CBT when dropouts are included in the analysis. A detailed analysis of the dropout sample confirmed that although treatment assignment did not predict dropout, CBT dropouts had significantly better outcomes than NT dropouts. Also, clients taking medication at intake were 80% less likely to drop out from psychotherapy, compared to those who were not taking medication and clients presenting anxious comorbidity at intake were 82% less likely to drop out compared to those not presenting anxious comorbidity. The follow-up evaluation revealed no differences between treatments and also that half of clients remained free from depressive symptoms after 31 months while the other half still presented depressive symptoms at a dysfunctional range. A survival analytic approach showed that four sessions were necessary for 50% improvement and 16 sessions for 50% recovery, regardless of treatment allocation. Moreover, depressive symptoms were consistently alleviated earlier than interpersonal problems, regardless of treatment assignment. At follow-up, clients keep improving depressive symptoms but not interpersonal problems. **Discussion:** The concept of narrative has gained increasing importance in the fields of psychotherapy theory, research and practice. Data was not consistent enough to fully ascertain the efficacy of NT, but it was shown that when clients completed treatment, NT is a promising treatment for mild and moderate depression. Replications by independent researchers are needed, especially focusing on the prevention of treatment dropout.

TRATAMENTO DA DEPRESSÃO: EVIDÊNCIA EMPÍRICA DE UM ENSAIO CLÍNICO COMPARANDO TERAPIA NARRATIVA E TERAPIA COGNITIVO-COMPORTAMENTAL

Resumo

Introdução: A perturbação depressiva maior (PDM) é um problema de saúde grave, revelando a necessidade de investigação de novas intervenções. A terapia narrativa (TN) de White e Epston (1990) é uma abordagem psicoterapêutica baseada na noção de que as pessoas constroem histórias para se definirem e darem significado às suas experiências de vida. Nesta perspetiva, a PDM evidencia-se pela autoria de narrativas saturadas por significados negativos, tais como fracassos pessoais, impotência e um futuro sem esperança. O objetivo da psicoterapia consiste em ajudar os clientes a construírem novas identidades e narrarem histórias de forma mais complexa e diversificada. Apesar de reconhecida entre clínicos e amplamente utilizada, os estudos sistemáticos sobre a eficácia da TN são escassos, sobretudo estudos com amostras extensas e métodos quantitativos de investigação. Apenas um estudo avaliou a eficácia da TN. Contudo, nenhum estudo comparou diretamente a TN com um grupo controlo ou com outra intervenção no mesmo contexto clínico. Por outro lado, a terapia cognitivo-comportamental (TCC) é o tratamento psicológico mais estabelecido na literatura da depressão. **Objetivos:** O objetivo principal da presente tese de doutoramento é comparar a eficácia dos manuais clínicos da TN e TCC para a depressão. Posteriormente, pretendemos comparar o tempo necessário para atingir uma melhoria clinicamente significativa dos sintomas depressivos e dos problemas interpessoais durante o tratamento e num período prolongado de seguimento. **Métodos:** Participaram dez terapeutas com diferentes níveis de

experiência e 63 clientes diagnosticados com PDM leve e moderada. Os clientes foram alocados às intervenções de forma quase-aleatória. A adesão aos manuais e a competência dos terapeutas no desempenho das intervenções foram asseguradas por meio de supervisão semanal e de uma escala preenchida por observadores externos, após visualizarem sessões gravadas em vídeo. O Inventário de Depressão de Beck-II e o Outcome Questionnaire-45.2 foram usados como medidas de resultados.

Resultados: Ambas abordagens promoveram redução significativa dos sintomas depressivos nos clientes que completaram o tratamento. Contudo, a inclusão dos clientes que abandonaram o tratamento na análise produziu uma diferença significativa a favor da TCC. Apesar da alocação ao tratamento não predizer o abandono, os clientes que abandonaram a TCC obtiveram melhores resultados do que os clientes que abandonaram a TN. A avaliação na fase de seguimento de 31 meses não revelou diferenças entre os tratamentos, mas revelou que metade dos clientes permaneceram sem sintomas depressivos significativos, enquanto que a outra metade ainda apresentava sintomas depressivos clinicamente significativos. Uma análise de sobrevivência revelou que são necessárias 16 sessões para que 50% dos clientes recuperem. Para além disso, os sintomas depressivos diminuem de forma consistentemente mais rápida do que os problemas interpessoais, independentemente do tratamento. Durante a fase de seguimento os sintomas depressivos continuaram a melhorar, o mesmo não se verificando relativamente aos problemas interpessoais.

Discussão: Os dados não foram suficientemente consistentes para demonstrar a eficácia da TN, mas foi constatado que, para os clientes que terminam o tratamento, a TN revela-se promissora para a depressão leve e moderada. São necessárias replicações realizadas por investigadores independentes especialmente centradas na prevenção do abandono do tratamento.

TABLE OF CONTENTS

INTRODUCTION. NARRATIVE THERAPY FOR DEPRESSION AND OUTCOME RESEARCH 21
DEPRESSION 22
Definition 22
Epidemiology of depression 24
Course of depression 24
The impact of depression 25
THE TREATMENT OF DEPRESSION 26
Pharmacotherapy 26
Combined treatment 28
Psychological therapy 29
Evidence-based psychotherapy 30
Efficacious psychotherapies for depression 32
CBT for depression 33
Why still study psychotherapy outcome? 35
NARRATIVE THERAPY FOR DEPRESSION 38
Narrative and depression 39
Narrative therapy for depression 40
Outcome research on Narrative Therapy 45
Possible reasons for scarcity of NT research 45
Available empirical evidence for NT's efficacy 47
INTRODUCING THE CURRENT STUDIES 51
References 55
CHAPTER I. NARRATIVE THERAPY *VS.* COGNITIVE-BEHAVIORAL THERAPY FOR MODERATE DEPRESSION: EMPIRICAL EVIDENCE FROM A CONTROLLED CLINICAL TRIAL 69
Abstract 69
Introduction 69
Methods 72
Participants 72
Clients 72
Therapists 73
Therapists' training 74
Procedures 75
Measures 75
Treatment conditions 78
Adherence to the manual and competence 79
Analyses 80
Intent-to-treat group and missing data 80
Statistical Analysis 81
Results 83
Preliminary analyses 83
Participants' flow 83
Comparison between participants at baseline 84
Number of sessions in each treatment 86
Adherence and competence assessment 87
Influence of medication on outcome 87
Influence of therapist's experience on outcome 87

Symptom reduction during treatment....88
Clinical significance....89
Rate of change across treatment conditions....90
Dropout across treatment conditions....91
Discussion....92
Strengths and limitations....95
Implications of the study....97
References....98
CHAPTER II. TIME TO IMPROVE AND RECOVER FROM DEPRESSIVE SYMPTOMS AND INTERPERSONAL PROBLEMS IN A CLINICAL TRIAL....107
Abstract....107
Introduction....107
Time of improvement within psychotherapeutic treatment....108
Symptomatic *vs*. interpersonal change in psychotherapy....110
Method....113
Clients....113
Therapists....114
Treatment conditions....114
Length of treatment....115
Measures....116
Structured Clinical Interview for DSM-IV....116
Beck Depression Inventory-II (BDI-II; Beck et al., 1996)....116
Outcome Questionnaire-45.2 Interpersonal Relations Subscale (OQ-45.2 IR, Lambert et al., 1996)....117
Analysis....118
Definition of clinical significant change....118
Survival Analysis....118
Effect sizes....119
Results....119
Improvement and recovery on depressive symptoms and interpersonal problems....119
Proportion of clients improving....119
Proportion of clients recovering....119
Differential time effect of treatment group....120
Improvement of depressive vs. interpersonal problems....120
Recovery of depressive symptoms vs. interpersonal problems....121
Time to recovery of depressive symptoms only for those who recovered....122
Effect sizes....122
Discussion....123
Strengths....124
Limitations and future directions....124
Implications....125
References....127
CHAPTER III. PREDICTORS OF DROPOUT IN A CONTROLLED CLINICAL TRIAL OF PSYCHOTHERAPY FOR MODERATE DEPRESSION....135
Abstract....135
Introduction....135
Methods....137
Participants....137

Treatment conditions....138
Measures....139
Definition of dropout....140
Results....141
Attrition along treatment....141
Predicting dropping out using general and clinical characteristics of clients....141
Discussion....144
References....147
CHAPTER IV. DROPOUT OUTCOMES: DOES DROPPING OUT OF PSYCHOTHERAPY MEAN FAILURE?....154
Abstract....154
Introduction....154
Methods....154
Participants....155
Treatment conditions....155
Measures....156
Results....156
Comparing change between NT and CBT dropouts....156
Comparing change between dropouts and completers....157
Comparison at last session attended....157
Comparison at eighth session....157
Comparison at follow-up....157
Clinical significance....158
Discussion....158
References....161
CHAPTER V. LONG-TERM EFFECTS OF PSYCHOTHERAPY FOR MODERATE DEPRESSION: A COMPARATIVE STUDY OF NARRATIVE THERAPY WITH COGNITIVE-BEHAVIORAL THERAPY....165
Abstract....165
Introduction....165
Long-term assessment of psychotherapy outcome....167
Symptomatic *vs.* interpersonal change in depression....168
Research questions....170
Method....170
Participants....170
Procedures....171
Measures....171
Beck Depression Inventory-II....171
Outcome Questionnaire-45.2....172
Treatment conditions....173
Analysis....174
Preliminary analyses....174
Analysis of continuous data....174
Clinical significance analysis....174
Effect sizes....175
Results....175
Preliminary Analyses....176
Differential attrition....176
Pre-treatment differences among NT and CBT....177
Course of symptoms at follow-up and differences across treatments....177

Analysis of variance 177
Clinical significance 178
Comparison of depressive symptoms and interpersonal problems at follow-up 180
Discussion 182
Limitations 184
Strengths 185
Implications of the study 186
References 188
DISCUSSION 199
Summary of results 199
Comparative efficacy of Narrative Therapy and Cognitive-Behavioral Therapy 200
Depressive symptom and interpersonal change in psychotherapy 203
Outcome and prediction of dropouts 205
Narrative Therapy and the evidence-based approach 207
Some thoughts about a future replication 209
Conclusion 215
References 216
APPENDICES 221
Informed consent 223
Dose-response relationship in psychotherapy 224
Table references 225

LIST OF TABLES

1. Clinical and demographic characteristics of the sample at baseline, according to treatment condition 86
2. Intent-to-treat and completer analysis pre- and post-treatment mean scores, standard deviations, and effect sizes for NT and CBT 88
3. Percentage of reliable improvement, movement to functional population, clinically significant change, and reliable deterioration by treatment condition and outcome measure..... 90
4. Pre- to post-treatment effect sizes in each outcome measure 123
5. Attrition along treatment for the whole sample 141
6. Comparison of completers and dropouts according to continuous and discrete variables..... 143
7. Rates of clinical significant change in depressive symptoms (BDI-II) for dropouts and completers on their last attended session and at 31-months follow-up..... 158
8. Proportion of patients remaining well or relapsing over 21 and 31 months follow-up assessments, according to BDI-II, by treatment group 178
9. Proportion of patients remaining well or relapsing over 21 and 31 months follow-up assessments, according to OQ45-IR, by treatment group..... 180
10. Comparison of the proportion of patients remaining well or relapsing over 21 and 31 months follow-up assessments, according to BDI-II and OQ45-IR..... 181
11. Overview on the dose-response relationship in psychotherapy..... 224

LIST OF FIGURES

1. CONSORT flow chart in the clinical trial 84
2. Course of symptom reduction in both treatment conditions on BDI-II and OQ-45.2 91
3. Comparison of Kaplan-Meier survival plots for improving reliably of depressive (BDI-II) and interpersonal problems (OQ-45.2 IR), for the entire sample 121
4. Comparison of Kaplan-Meier survival plots for recovery of depressive (BDI-II) and interpersonal problems (OQ-45.2 IR), for the total sample 122
5. Flow diagram for the clinical trial and follow-up assessments 176
6. Proportions of patients recovering from depressive symptoms and interpersonal problems at post-treatment and follow-ups 182

INTRODUCTION.

NARRATIVE THERAPY FOR DEPRESSION AND OUTCOME RESEARCH

INTRODUCTION. NARRATIVE THERAPY FOR DEPRESSION AND OUTCOME RESEARCH

Depression is a serious emotional problem with high costs for society: hours of work wasted, overload of the general and mental health system (Sava, Yates, Lupu, Szentagotai, & David, 2009) and a high prevalence of suicide among depressed people are some aspects that can be cited (Hollon, Thase, & Markowitz, 2002). Although effective treatments to ameliorate the symptoms exist, almost half of the clients leave untreated for several reasons. Thus, research for alternative treatment approaches and their efficacy is required.

Although widely practiced in several parts of the world, outcome research on Narrative Therapy (NT) for depression is in its infancy (Etchison & Kleist, 2000; Wallis, Burns, & Capdevila, 2011). The present dissertation aims to assess the efficacy of NT to treat depression in adults, when contrasted to Cognitive-Behavioral Therapy (CBT), one of the most tested forms of psychotherapy for depression. We do so through a set of four empirical studies. In this introductory review, we intend to (1) put the empirical studies in the broader context of depression and psychotherapy outcome research, (2) outline the main principles of NT and its potential application to the problem of depression and (3) review the few studies that tested the effects of NT so far.

Before introducing the state-of-the-art of outcome research on NT therapy, we define depression and present the available empirically supported psychotherapies for treating it and on which grounds they were judged to be efficacious. We also make the case of why invest on further research of the outcomes of new treatments for depression.

DEPRESSION

Definition

In this study we use the definition of the fourth edition of the Diagnostic and Statistical Manual[1], which is a diagnostic criteria widely used by clinicians and researchers to classify mental disorders. In this definition what is commonly referred to as depression is called Major Depressive Disorder (MDD). MDD is characterized by the presence of either a depressed mood or a loss of interest or pleasure in almost all daily activities, which previously provided pleasure or joy (i.e., anhedonia), or both, for at least a two-week period. These symptoms are present consistently, during most of the day. The depressed mood is often reported by the person as sadness, constant crying or feelings of emptiness and must also represent a significant change from the person's typical mood. Besides these two essential features, MDD is characterized by the presence of at least four of the following symptoms, also nearly everyday: (1) significant weight loss when not dieting or significant weight gain, or decrease or increase in appetite; (2) insomnia or hypersomnia; (3) psychomotor agitation or retardation; (4) excessive fatigue or loss of energy; (5) feelings of worthlessness or excessive and inappropriate guilt; (6) diminished ability to think or concentrate, or indecisiveness; or (7) recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

[1] Since the fourth edition was the most up-to-date available version of the DSM at the time we begin to select clients for the research, we used this definition to operationalize our study. The fifth edition brought a few changes to the construct, being the more significant the omission of the bereavement as an exclusion criterion for the diagnostic of MDD (see more at American Psychiatric Association, 2013).

Importantly, in order to define MDD the social, occupational, educational or other important functioning of the person's life must also be negatively impaired by the change in mood. There are views that defend that depression, in some degrees, is an adaptive advantage in situations of complex decision-making or abrupt life changes (Andrews & Thomson, 2009). A depressed mood caused by substances (such as drugs, alcohol, medications) or which is part of a general medical condition is not considered to be MDD. In the same way, MDD cannot be diagnosed if a person has a history of manic, hypomanic or mixed episodes (e.g., a bipolar disorder) or if the depressed mood is better accounted for by schizoaffective disorder and is not superimposed on schizophrenia, schizophreniform disorder, delusional disorder or psychotic disorder. Further, the symptoms are not better accounted for by bereavement (i.e., after the loss of a significant other) and the symptoms persist for longer than two months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.

Distinguishing the mood changes between clinically significant degrees of depression[2] (for example, MDD) and those occurring "normally" is not an easy task. Thus, symptoms are viewed as occurring on a continuum of severity (Lewinsohn, Solomon, Seeley, & Zeiss, 2000). To help assessing the clinical significance of MDD we included the score on the Beck Depression Inventory (BDI-II; Beck, Steer, & Brown, 1996) in our evaluation of depression. The BDI-II comprises 21 depressive symptoms and its total score ranges from 0 to 63. It is highly correlated with the aforementioned DSM-IV criteria of MDD (Steer, Ball, Ranieri, & Beck, 1999; Steer, Brown, Beck, & Sanderson, 2001). By comparing the mean scores of a healthy

[2] We use the terms MDD and depression interchangeably along this dissertation.

population with the mean scores of depressed clients[3], it was calculated that a cut-off of 14.29 points on the BDI-II would define a clinical significant severity (Seggar, Lambert, & Hansen, 2002).

Epidemiology of depression

Epidemiological surveys show that 46.4% of the people in the United States have met lifetime criteria for at least one mental disorder. Of those, 20.8% met lifetime criteria for mood disorders and 16.6% have met lifetime criteria for major depressive disorder (Kessler et al., 2005), making it the most prevalent lifetime disorder. Data suggest that adults are the most affected population, with a median age of onset at around 30 years, and an often chronic or recurrent course (Kessler et al., 2005). MDD is more common among women than among men. The risk along lifetime in community samples is between 10 to 15% to women and 5% to 12% for men, and the prevalence ranges from 5 to 9% to women and 2 to 3% to men (Andrade et al., 2003). The absolute prevalence of depression varies substantially across cultures and nations, but the gender difference in depression remains significant across most demographic and cultural groups (Andrade et al., 2003).

Course of depression

The overall mean duration of a depressive episode was estimated in 22.6 weeks (Üstün & Kessler, 2002), but MDD is a largely chronic and recurrent

[3] Along the chapters of this dissertation the word "client" is preferred over the word "patient", which populates a substantial part of the clinical research literature worldwide. This is mainly due to the view that in psychotherapy, the object of this dissertation, the prescriptive function of the psychotherapist is different from most of the health professionals. In this view, the medical doctor has the power and the knowledge to prescribe the medicine the patient needs. Patient in our view is connected to the word patience, which denotes some passivity on the side of the patient. Client on the other hand denotes a more active and democratic attitude. Of course, the medical patient also has to be motivated and we know that this is an important factor for treatment success. But still, the psychotherapy client is expected to be more active than the medical client.

condition. Between 5 to 10% of individuals who fulfill the criteria for a depressive episode still present the same criteria after two or more years (American Psychiatric Association, 2000). Clients with a history of three depressive episodes have 90% of chances of having another depressive episode. In two third of the cases the depressive symptoms will end completely, and on the other third, the depressive symptoms will never cease and. The degree of the symptoms between episodes can vary from none to severe. Moreover, MDD is also resistant to treatment. In a study using long-term long follow-up intervals only 20.4% of depressed inpatients from a psychiatric service recovered after treatment and remained well after 15 years (Brodaty, Luscombe, Peisah, Anstey, & Andrews, 2001).

The impact of depression

MDD is often associated with vast social implications, being the number-one cause of years lived with disability worldwide (Murray & Lopez, 1997; Üstün, Ayuso-Mateos, Chatterji, Mathers, & Murray, 2004). Nearly three fourths of the people with lifetime MDD also meet the criteria for at least one of the other DSM-IV disorders including nearly two thirds with anxiety disorder (Kessler et al., 2003). It is known that depressed people seek significantly more health services, which results in high costs to society (Mariu, Merry, Robinson, & Watson, 2012). Suicide is closely related to depressive symptoms and disorders, and estimates are that depressed individuals attempt half of all suicides. Moreover, 15% of individuals suffering from mood disorders are expected to commit suicide (Hollon et al., 2002). Estimations of economic burden of MDD include direct medical costs (31% of costs), suicide-related mortality costs (7%) and workplace costs (62%; Greenberg et al., 2003).

THE TREATMENT OF DEPRESSION

There is a vast choice of treatments for depression, albeit not all of them are supported by enough empirical evidence. To name a few, light therapy and physical activity are investigated and sometimes prescribed combined with other treatments. In some refractory cases, experimental methods are prescribed such as electro-convulsive therapy, transcranial magnetic stimulation, and vagus nerve stimulation[4]. Below, we will restrict our description to the most commonly used and well-documented treatments for depression, i.e., pharmacotherapy, psychotherapy, and combined treatment. We will focus on the psychotherapeutic treatment of depression, with a special emphasis on Cognitive-Behavioral Therapy (CBT), before we introduce Narrative Therapy for depression.

Pharmacotherapy

MDD is largely considered to be a medical illness (National Institute for Mental Health, n.d.), hence antidepressant medication is the most common treatment for this problem worldwide (for evidence in North America, see Mojtabai & Olfson, 2010; Olfson & Klerman, 1993). Indeed, some of the most influential guidelines for the treatment of depression in primary and secondary health care settings suggest medication as the treatment of choice (e.g., National Institute for Clinical Excellence, 2009; National Institute for Mental Health, n.d.). Thus, the majority of clients who seek help in psychotherapy services had been previously seen by general doctors or psychiatrist to find a solution to their problematic mood. Like psychotherapy, antidepressants are prescribed for any one of three treatment phases of MDD described as acute, continuation, and maintenance treatment (Gitlin, 2009).

[4] For a detailed review of alternative somatic treatments, see Gitlin (2009).

There are different categories of antidepressants. Usually depression is treated with selective serotonin reuptake inhibitors or selective serotonin and norepinephrine reuptake inhibitors, which affect the levels of serotonin and norepinephrine. Moreover there are also tricyclic antidepressants and monoamine oxidase inhibitors (Hollon et al., 2002). Researchers have in several studies compared single drugs with either placebo, or with particular drugs and have generally found that all antidepressant classes, and even specific active agents, are considered equivalent in efficacy, but differ in terms of side effects[5] (Gitlin, 2009; Hollon et al., 2002). Mean pre- post-treatment effect sizes[6] are estimated through meta-analysis to lie between 1.43 and 1.69. It should be taken in consideration that around three thirds of active drug effect is accounted for the inactive placebo effect (Kirsch & Sapirstein, 1998). Fournier et al. (2010) estimated Cohen's *d* effect sizes for the difference between medication and placebo to be less than 0.20 (a standard definition of a small[7] effect) in less severe cases, but the superiority of medications over placebo increases to medium ($d = 0.53$) and large ($d = 0.81$) effect sizes as it increases the degree of severity. Between 30 to 50% of clients will not respond to the first antidepressants of choice, but those clients will often have better outcomes when their medication is changed (Hollon et al., 2002).

Although antidepressant response rates do not differ significantly from psychotherapy in mild and moderate cases (e.g., 36.64% against 36.11%, Demaat et al., 2007; 46.4% against 46.3%, Lam, 2003), antidepressants have the disadvantage of

[5] See Hollon, Thase and Markowitz (2002), for a list of the commonly used antidepressants and the most prominent side effects.

[6] Effect sizes represent a common metric for comparing treatment effects across different measures and are frequently expressed in Cohen's d, which is based on the division of the differences between pre- and post-treatment group means (or between treatment and control groups) by the standard deviation (Hollon et al., 2002).

[7] Effect sizes have been categorized along a continuum of no effect (ES < 0.2), low (0.2 =< ES =<0.5), medium (0.5 =< ES =< 0.8) and high effect (ES >= 0.8) (Cohen, 1988).

consistently showing higher relapse rates after discontinuation, when compared to psychotherapy (e.g., 56% against 26.5%, Demaat, Dekker, Schoevers, & Dejonghe, 2007; 60% against 29.5%, Gloaguen, Cottraux, Cucherat, & Blackburn, 1998; 50% against 33%, Shea et al., 1992). Also, compared to psychotherapy, higher rates of attrition are reported with pharmacotherapy (Cuijpers, van Straten, van Oppen, & Andersson, 2008), especially in outpatient settings (Demaat et al., 2007), which are mostly explained by the side effects at the initial phases of treatment. On the other hand, for more severe forms of MDD, pharmacotherapy tends to work better (Khan, Leventhal, Khan, & Brown, 2002). Also, Cuijpers et al. (2013) conclude pharmacological interventions may be more effective for dysthymia than psychological interventions.

Combined treatment

The rationale for the combination of pharmacotherapy and psychotherapy is based on the assumption that they have different specific mechanisms and thus pharmacotherapy would enhance a rapid alleviation of the client's symptoms and simultaneously psychotherapy would improve social functioning and psychological vulnerability (Thase & Jindal, 2004). Although some clinicians argue that motivation for psychotherapy is reduced when symptoms are alleviated, others also argue that medication is also "a way to hasten recovery and to help patients make better use of psychotherapy" (Thase & Jindal, 2004, p. 744).

In fact, evidence suggests that when antidepressant medication is added to the psychological treatment of depression, this introduces an additional effect compared with only psychological treatment. This additional effect is, however, small on the typical adult outpatient clientele, but larger on specific populations (e.g., older adults,

chronic depression, HIV patients, Cuijpers, van Straten, Warmerdam, & Andersson, 2009). In another meta-analysis comparing psychotherapy for depression alone and psychotherapy plus medication, Thase and Jindal (2004) found that the combined treatment were more effective for more severe cases, but not in less severe cases. At follow-up, no differences between psychotherapy alone and combined treatments were found (Cuijpers et al., 2009).

Psychological therapy

Despite the widespread idea of depression as a medical illness, and the available evidence of its underlying biological characteristics, several models conceptualize depression as a reaction to environmental challenges (Andrews & Thomson, 2009; Hollon et al., 2002). Additionally, there is a growing understanding that environmental and behavioral changes (including changes in language and cognitions) change the biological nature of depression (Eisch & Nestler, 2002; Jeong et al., 2005; Kandel, 1998; Koch, Kell, Hinze-Selch, & Aldenhoff, 2002). It is also often argued that psychotherapy, differently from psychopharmacological interventions, would not only treat the actual symptoms but also help clients develop coping strategies to deal with underlying propensities for symptoms (Beck, Rush, Shaw, & Emery, 1979; Chambless & Hollon, 1998; DeRubeis et al., 2005; Hollon et al., 2005) and have impact of other areas of the clients functioning, such as interpersonal behavior (Barkham, Stiles, & Shapiro, 1993; Kopta, Howard, Lowry, & Beutler, 1994). From a public health perspective, there is evidence suggesting that psychotherapies are more cost-effective than antidepressants (Antonuccio, Thomas, & Danton, 1997; Sava et al., 2009).

Although mediators and mechanisms underlying its effectiveness are largely unknown or at least not consensually defined (Kazdin, 2007), short terms effects of diverse brief outpatient psychotherapies for unipolar depression have been shown consistently in psychotherapy research literature in the last 60 years (Cuijpers, van Straten, Andersson, & van Oppen, 2008; Demaat et al., 2007; Dobson, 1989; Elkin et al., 1989; Hollon & Ponniah, 2010; Lambert & Ogles, 2004; Mazzucchelli, Kane, & Rees, 2009; Westen & Morrison, 2001). Lambert and Ogles (2004) present a series of meta-analysis in which pre-post effect sizes of psychotherapy for unipolar depression in adults range from 0.65 to 2.15. In a meta-analytical benchmark for psychological treatments of depression, it was established that the efficacious treatments show pre-post effect sizes of 1.706 (which designates a high effect) with the BDI-II (Minami, Wampold, Serlin, Kircher, & Brown, 2007). Numerous meta-analytic reviews show that the effects of psychotherapy for depression surpass no-treatment and waiting list controls (Lambert & Ogles, 2004). For a concrete comparison, the aforementioned benchmark Minami et al. (2007) establishes the effect size of 0.371 for natural history of depression (i.e., no-treatment or waiting list control groups).

Evidence-based psychotherapy

In the year of 2012 it was celebrated the 60th anniversary of the publication of Eysenck's psychotherapy outcome review, which claimed that "results and conclusions will no doubt contradict the strong feeling of usefulness and therapeutic success which many psychiatrists and clinical psychologists hold" (Eysenck, 1952, p. 323). According to his data, there was no available evidence to "prove that psychotherapy, Freudian or otherwise, facilitates the recovery of neurotic patients" (p. 322). His provocation is considered a landmark in the modern psychotherapy outcome

research (Orlinsky, Rønnestad, & Willutzki, 2004; Strupp & Howard, 1997), constituting a point from which at least three generations of psychotherapy researchers[8] have departed to test the efficacy of psychotherapy in "facilitating" change.

More recently, responding to political and economical pressures, Division 12 of the American Psychological Association (APA) argued that the survival of clinical psychology, facing the growing recognition of biological psychiatry, depended largely on proving the efficacy of psychotherapies (Task Force on Promotion and Dissemination of Psychological Procedures, 1995). Since then, a prominent line of the contemporary outcome research has emerged based upon the concept of empirically supported treatment (EST), largely inspired in evidence-based medical practices. An EST is defined as a "clearly specified psychological treatment shown to be efficacious in controlled research with a delineated population" (Chambless & Hollon, 1998, p. 7). Based on this definition, to be considered "efficacious" a treatment should show consistent evidence for being superior to pharmacological intervention or psychological placebo or another *bona fide* treatment or at least equivalent to an already established treatment. *Efficacy* in this context refers to the potential of a treatment to "bring about a desired effect" (Cooper, 2008, p. 17) while delivered and assessed in highly controlled environments, largely using Randomized Controlled Trials (RCTs). On contrast, *effectiveness* refers to "the extent to which an intervention, when used under ordinary circumstances, brings about a desired effect" (Cooper, 2008, p. 24). By "ordinary circumstances", we should think of treatments

[8] Strupp and Howard (1997) understand the history of outcome research in three generations according to the research methods employed. In Generation I research did not discriminate specific problems, whereas in Generation II was more specific in operationalizing psychological problems. In Generation III, psychotherapy outcome research was largely influenced by the medical model (for a historical perspective, see Strupp & Howard, 1997).

delivered by professionals in real-life contexts, such as primary and secondary care, public health systems, hospitals, and private practices.

The focus on controlled research implies that these research guidelines (Chambless & Hollon, 1998; Chambless et al., 1998; Task Force on Promotion and Dissemination of Psychological Procedures, 1995) lay strong emphasis on the importance of replication of findings, which should "protect the field from drawing erroneous conclusions based on one aberrant finding" (p. 8). Following the same logic, in order to be considered efficacious, it is suggested that replication studies should be carried out by an independent team of investigators, to ensure further protection against bias of one particular investigator or "reliance on findings that prove unique to a particular setting or group of therapists" (p. 8). Other specific criteria for quality of empirical evidence are (1) that experiments should be conducted with treatment manuals or its equivalent; (2) that the characteristics of the clients should be clearly specified and that (3) clients should be randomly assigned to treatment and control groups. Although there is controversy around those recommendations (Bohart, O'Hara, & Leitner, 1998; Busch, 2011; Elliott, 1998; Luborsky, Rosenthal, et al., 2006; Wampold et al., 1997), they are still the most influential and followed among contemporary researchers, when the issue is the efficacy of a psychological treatment.

Efficacious psychotherapies for depression

Following this line of psychotherapy research, comprehensive reviews for efficacious treatments for mood disorders have been published (e.g., Cuijpers, van Straten, Andersson, et al., 2008; DeRubeis & Crits-Christoph, 1998; Hollon & Ponniah, 2010). Also, the American Psychological Association presents an updated

list of 12 treatments for unipolar depression as having reliable empirical support of their efficacy (Hayes & Strunk, n.d.). These are:

- Behavior Therapy/Behavioral Activation (strong research support)
- Cognitive Therapy (strong research support)
- Cognitive Behavioral Analysis System of Psychotherapy (strong research support)
- Interpersonal Therapy (strong research support)
- Problem-Solving Therapy (strong research support)
- Self-Management/Self-Control Therapy (strong research support)
- Acceptance and Commitment Therapy (modest research support)
- Behavioral Couple Therapy (modest research support)
- Emotion-Focused Therapy (Process-Experiential) (modest research support)
- Reminiscence/Life Review Therapy (modest research support)
- Self-System Therapy (modest research support)
- Short-Term Psychodynamic Therapy (modest research support)

Within this conceptual frame, CBT and its variants is the most researched approach for this problem (Barth et al., 2013; Butler, Chapman, Forman, & Beck, 2006; Gloaguen et al., 1998; Roth & Fonagy, 2005), followed by Interpersonal Psychotherapy (Cuijpers, van Straten, Warmerdam, & Andersson, 2008; Elkin et al., 1989). As an illustration, by the year of 2006, 325 efficacy studies for CBT were counted. Of those, more than 75 tested the effects of CBT on depressed clients (Butler et al., 2006). In the following lines we will present an overview of the classic CBT manual for depression, which was used as a comparison group in our empirical research.

CBT for depression

CBT consists in a structured, present-oriented, and problem focused psychotherapy based on the identification and reframing of negative and dysfunctional thoughts and behaviors (DeRubeis et al., 1990). The treatment is based on the assumption that depressive symptoms are caused by a dysfunctional view of

one's self, of the others and/or of the world. Thus, treatment is aimed at helping the client identify those dysfunctional thoughts and beliefs, understanding how they are connected to the symptoms, and make efforts to change them. The classical research CBT protocol for depression (Beck et al., 1979) comprises of five phases.

In the first phase, the aim is to teach the client about depression, the CBT conceptualization and intervention strategies, and to engage the client as an active partner in therapy. The main strategy at this point is educational. In the next phase, the therapist constructs a case formulation with the aid of the client. This consists in making sense of problems in CBT terms and establishing priorities for the treatment. Thus, therapist and client make a list of problems to be explored, establish priorities and hypothesis about how those problems occur and what maintains them. The formulation is based on the daily records of thoughts and behaviors brought by the client.

Depending on the nature of depression and the case formulation, the next phase, called "behavioral activation phase", focuses mainly on behavioral interventions. The aim is to increase the probability of occurring positive reinforcements and to enhance basic social and problem solving skills. The therapist helps the client to plan more reinforcements, organize daily activities and routines and achieve short-term goals. Even in this behavioral phase, the CBT therapist is attentive to the thoughts that occur simultaneously with the dysfunctional behaviors.

The fourth phase, which is the core of Beck's treatment plan (Beck et al., 1979) constitutes of cognitive interventions. The therapist helps the client to be more self-conscious and critical about his/her own way of thinking about the world, other people and him or herself. To do so, therapist and client develop activities to monitor

and change automatic thoughts and their relationship with dysfunctional emotions and behaviors. The client is also encouraged to make tests of reality of the thoughts and core beliefs to understand the main errors of judgment he/she might be making. The idea is to start understanding the more superficial thoughts and then deepen the understanding to the more crystalized core beliefs or themes that condense these automatic thoughts. The client is constantly encouraged to empirically test the thoughts and beliefs and reappraise them.

Finally, when therapist and client think they have achieved the initial goals, a gradual termination takes place. In this phase it is the therapist's goal to teach the client about relapse prevention and about his/her role as an active self-helper. They can develop together a list of new modified beliefs, a list of rights or a list "red flags" to be used in the future. It is also explored the resources the client has to deal with the new situations that will emerge.

Why still study psychotherapy outcome?

Controlled clinical trials testing the aforementioned treatments show that up to 70% of depressed clients who seek treatment reach satisfactory response with psychotherapy (Beutler et al., 2004; Ogles, Lambert, & Sawyer, 1995; Watson, Gordon, Stermac, Kalogerakos, & Steckley, 2003), and these results are maintained in later follow-ups. Still, knowing that this is an optimistic estimate, in the best-case scenario 30% of the cases are still left untreated. In randomized clinical trials (RCTs) involving psychotherapy about at least 35% to 40% of clients experience no benefit at all and a small group of clients, between 5% and 10%, even deteriorate (Hansen, Lambert, & Forman, 2002). These data are still not taking into account the fact that relapse and recurrence rates are quite high in depression. About 20% of a typical

client group will develop chronic syndromes that persist for two years or longer, even when they have received some kind of treatment (Keller & Boland, 1998). Furthermore, it is often argued that both consumers of mental health services and financing agencies (e.g. public health systems) have the right to know which treatments work and how well they work for a specific psychological problem. Thus, for professional and ethical purposes, outcome research on the effects of treatment is therefore continuously recommended (Kendall, Holmbeck, & Verduin, 2004; Kendall, 1998), especially on the new forms of intervention. This is true especially for NT, which has been empirically supported only by few and largely uncontrolled studies.

Scientifically, a reason for further inquiry on the outcome of psychotherapy is adding empirical knowledge to an old dilemma in psychotherapy research: are all kinds of psychotherapy equally efficacious? One way of answering this challenge is assume that psychotherapies have equivalent effectiveness. Researchers call this hypothesis the Dodo bird verdict (Duncan, 2002; Luborsky, Rosenthal, et al., 2006; Luborsky, Singer, & Luborsky, 1975; Stiles, Shapiro, & Elliott, 1986; Wampold, 2001; Wampold et al., 1997), a metaphor proposed by Rosenzweig (1936) based on the classic “Alice In Wonderland”. In the story, participants run a race, each one in a different pattern of any shape, starting and leaving off whenever they like. In the end, the Dodo Bird declares that “everybody has won, and all must have prizes”. Later Luborsky, Singer, and Luborsky (1975) concluded through meta-analysis that psychotherapies have generally equivalent efficacy and corroborated Rosenzweig's (1936) formulation. Researchers who support this conjecture argue that it is not *what* you do in therapy with the clients, but rather *how* you do it. Most effects of psychological treatments should be caused not by particular techniques, but by

nonspecific factors common to all therapies delivered in good faith (Duncan, 2002; Wampold et al., 1997). Belief in the treatment, a clear rationale explaining why the client has developed the problems, empathy, kindly and unconditional regard and therapeutic alliance between therapist and client constitute some of the common factors of all *bona fide* psychological treatments (Wampold et al., 1997).

Although The Dodo Bird Verdict hypothesis has been empirically supported through meta-analysis studies (Luborsky, Rosenthal, et al., 2006; Luborsky et al., 1975; Smith, Glass, & Miller, 1980; Wampold et al., 1997), contrary evidence suggests the superiority of one psychotherapeutic model over another (Chambless & Hollon, 1998; Chambless et al., 1998; Cuijpers, van Straten, Warmerdam, et al., 2008; Hunsley & Di Giulio, 2002). The most commonly favored approaches are CBT, with a overall mean comparative effect size of about 0.2 in its favor (Dobson, 1989; Gloaguen et al., 1998; Hunsley & Di Giulio, 2002), interpersonal therapy (IPT) for depression (Cuijpers, van Straten, Andersson, et al., 2008), *in vivo* exposure for specific phobias (Choy, Fyer, & Lipsitz, 2007; Cooper, 2008; Lipsitz, Mannuzza, Klein, Ross, & Fyer, 1999) and panic control treatment for panic disorder (Roth & Fonagy, 2005). There are also indications that nondirective supportive therapies are significantly less efficacious than the other treatments (Cuijpers, van Straten, Andersson, et al., 2008).

This dilemma is also referred to as “psychotherapy's equivalence paradox”. It is a paradox because it is assumed that treatments have equivalent outcomes “despite non-equivalent theories and techniques” (Stiles, Barkham, Mellor-Clark, & Connell, 2008, p. 678). The debate is alive because both sides argue that the way in which meta-analysis has been used to address this question has lead to a false, or at least

premature verdict. Proponents of the Dodo Bird also defend that the researchers' allegiance to the treatment model that is being tested influences the outcome in its favor. Indeed, previous research informs us that the correlation of findings with researcher preferences can get up to 0.85 (Luborsky, Diguer, et al., 2006). Once the solution for this debate is mostly inconclusive further psychotherapy outcome research is needed, especially when the researchers controls for the allegiance effect.

NARRATIVE THERAPY FOR DEPRESSION

Having now discussed the mainstream state-of-art of the treatment of depression and the current outcome psychotherapy research paradigm, in this section we will explore the basic assumptions that make Narrative Therapy unique in the treatment of depression.

We should begin by noting that there is a range of definitions for narrative therapies (Wallis et al., 2011). In this dissertation, we restrict the conceptualization and practice of NT as pioneered by Michael White and David Epson in the 1970s and 1980s, also known as re-authoring narrative therapy. This model is theoretically rooted in social constructionism, "a strand of postmodernism that holds that knowledge is constitutive, inter-subjective, and language-based" (da Costa, Nelson, Rudes, & Guterman, 2007, p. 70), that is, it holds the notion that one's narrative repertoire is expanded or constrained by the culture and society one lives in.

NT differentiates itself from the mainstream approach by the critical attitude towards the medical model. Psychotherapeutic models with strong medical influence view the therapeutic success as related to the objective reduction of psychiatric symptoms, or to the modification of dysfunctional behaviors. As opposed to that view, the postmodern constructivist view favors the hermeneutics in psychotherapy

and focuses its attention on the narrative change along the therapeutic process. It is believed that there is no absolute psychological reality and rather, that psychological reality is continuously being constructed in social interactions. In this perspective, narrating life events and the self is a fundamental skill for the survival and adaptation in a social world. People are constantly searching and constructing personal meanings and do so by narrating their experiences. Language is the central process through which psychological development and change occur, being the one an extension of the other. Language and narrative are central not only for one's identity, but also because they connect one individual to the others. Language and narrative define self-positions and constitute the main channel through which power relationships take place (White & Epston, 1990).

Thus, the narrative tradition view defends that the way people narrate their life experiences are fundamental to understand their psychological complaints and to help overcome them (Gonçalves, Matos, & Santos, 2009; Matos, Santos, Gonçalves, & Martins, 2009; White & Epston, 1990) and therapeutic success would be attained when the client leaves therapy narrating his or her existence in a richer, more flexible, more coherent and gratifying ways (White, 2007).

Narrative and depression

Seeing from the lenses of narrative, depression is evidenced by the authorship of narratives saturated by negative meanings of life-experiences, such as failures, entrapment and powerlessness, as well as a future equally negative. The narrative cycle puts the person in a context in his or her power relationships, where he or she believes that this is the only plot, that this is the only possible self.

In fact, empirical findings support that view. For instance, chronically depressed individuals tend to use words with a more negative connotation than do other individuals (Alison & Burgess, 2003; Robertson, Venter, & Botha, 2005) and depressed individuals use more negatively charged words than individuals who were never depressed (Rude, Gortner, & Pennebaker, 2004). In a more narrative-specific study, Robertson et al. (2005) interviewed ten self-identified depressed individuals (five male, five female, ages ranging from 19 to 72 years old), not receiving any kind of psychotherapy. Their answers were analyzed using qualitative analysis and they observed that these people consistently reported negative meanings, not only to their experience with depressed mood, but also to their life experiences in general. Hurtful experiences, such as loss, rejection, or accidents, were normally interpreted as only negative and no positive meanings were attached. Narratives were normally stuck in the past particularly using negative generalizations to articulate their stories. Words such as “always”, “never”, “absolutely”, “totally” were frequently used to describe and explain past and future experiences. The negative events in the past were seen as limiting a hopeless, uncertain and meaningless future. Finally, subjugating narratives from the socio-political context were also seen as limiting their lives. Participants tended to blame the apartheid, religious institutions, gender differences or families to explain their depressed mood and/or problems. Although exceptions emerged, such as the recognition of a skill or strength, they were not enough to form an alternative narrative.

Narrative therapy for depression

Summing up, narrative therapists assumes that reduced and rigidified narratives around the problematic contents (e.g. stories of failure or helplessness)

impose constraints on the way people feel, think and behave, and thus prevent them from experiencing gratifying and diversified ways of life (White & Epston, 1990). In this understanding, psychotherapy has the role of facilitate the separation between depression (or depressive narratives) and the self, helping the clients to build new meanings from their experience (Polkinghorne, 1991). White and Epston (1990) propose the metaphor of authorship for the psychotherapy process. Clients are authors of a book, which is constantly being written, edited, re-written, or in their own words, "with every performance, persons are re-authoring their lives. The evolution of lives is akin to the process of re-authoring, the process of persons' entering into stories, taking them over and making them their own." (White & Epston, 1990, p. 13).

The NT manual developed for this study (Gonçalves & Bento, 2008) was based on the previous works of White (2007; White & Epston, 1990). Essentially, the therapist and the client engage in activities in order to "re-write" the problematic self-narratives. The therapist utilizes a variety of questioning techniques (e.g. deconstruction questions, opening space questions, preference questions, story development questions, meaning questions, and future-centered questions) and practices of validation (e.g. therapeutic letters, therapeutic certificates, and leagues; White, 2007). Strategies are applied according to the therapeutic phase and the clients' response to treatment. The process is organized around three phases: (1) deconstruction phase, (2) reconstruction phase and (3) consolidation and termination phase (Freedman & Combs, 1996), which are going to be described below. It is important to notice that the phases that do not follow necessarily this order and they can even occur simultaneously, according to clients needs at the moment of the treatment and narrative profile.

During the deconstruction phase the central goal is to (a) understand the problem in its context, circumstances, assumptions, effects and influences on the person's life and (b) deconstructing the dominant narrative by finding the subjugated or non-dominant story. The main strategy used at this point of therapy is externalizing conversations (White, 2007), which involve the use of language in a way that detaches (and sometimes even personifies) the problem from the person. This technique is based on the assumption that "the person isn't the problem; the problem is the problem" (Epston, 1993, p. 161). As a clinical example, in one of the cases seen by our therapists, a middle-aged woman, mother of two children, who understood her depressive symptoms as a "parasite", which sucked up all of her energy and brought bad influences to her life. When she named the problem as the "parasite", she was more aware of its influence on her life. This way, instead of being lively, taking responsibility for her life and those around her, considering herself a good mother, treating her employees with respect and empathy; under the influence of the "parasite" she became more dependent on her husband to take actions, with a gloomier, sad and pessimistic view of herself and the world around her. By doing this narrative movement the client could be aware of the "voice" of the "parasite", who gave her orders and thus influenced her mood. She could also be aware of the situations the "parasite's" influence was more likely to occur. Homework assignments were given to intensify the person's awareness of the influence of the problem and the processes by which it maintains a deleterious influence on daily life, like self-observation tasks or letters addressed to the problem or to a significant other, often from an externalizing perspective.

The elaboration of events and meanings outside the scope of the problematic self-narrative is considered to be an important way of improving the flexibility of self-

narratives and promoting narrative change, which in turn has been associated with symptomatic recovery in psychotherapy (Alves, Mendes, Gonçalves, & Neimeyer, 2012; M. M. Gonçalves et al., 2009; M. M. Gonçalves, Mendes, Ribeiro, Angus, & Greenberg, 2010; M. M. Gonçalves, Ribeiro, Mendes, Matos, & Santos, 2011; Matos et al., 2009; Ribeiro & Gonçalves, 2011). Thus, in the reconstruction phase, the main goal is to expand the narrative elaboration of novelties, that is, experiences that fall outside the dominance of the problem-saturated narrative. These new narrative elements, called unique outcomes (White, 2007), are explored, thus facilitating gradually an alternative self-narrative that redefines the relationship of persons with themselves, with their history, and with their significant others. The main strategy used here is the identification and elaboration of the unique outcomes by exploring, for example, how they emerged, what made them possible, what they mean, and what are their implications for the life of the person (White, 2007). The client we have been using as example had feelings of great responsibility with the studies of her son. She used to study with him regularly but felt that this task was overwhelming. The therapist helped her to reflect on her own behavior as a result of the orders of the "parasite", which was constantly trying to convince her that she was a bad mother. Using irony, she was able to ignore the parasite's voice and try to give her son more autonomy in doing the school homeworks. This achievement opened the meanings and feelings associated with this subject to more fulfilling versions of herself as a mother. The therapist explored the outcomes of that event and how it relieved her by adjusting her responsibilities, thus changing the meanings associated with it. She reported feeling much better when she realize that her son was able to do the tasks and still she was around to help, whenever he needed.

In the last phase of the protocol, referred to as the consolidation and termination phase, the goal is to consolidate the alternative self-narrative and to root it in the network of socio-cultural discourses and practices. Strategies used at this point involve the creation of metaphors for the process of change and documenting it. Also, when appropriate, definitional ceremonies (White, 2007) are organized to present the new self-narrative, and the new behaviors, desires, or values, to significant others. These ceremonies promote the experience of recognition and social validation of such self-narrative, contributing to the formation of a system of meanings about the client's identity that is shared with its significant others. In the case we have been mentioning as example, the client built a list along therapy what she referred to as "the new testament". In this document, she reaffirmed positive actions in which she had been engaging and its beneficial outcomes to her life. Also, the client and the therapist wrote a letter to the parasite saying goodbye. In this letter, they acknowledged the presence of the parasite in the client's life, how she managed to recognize its influence in her life and of the ones around her and how she is now ready to live without its influence. Thus, the new narrative meanings are consolidated in the client's experience.

As in the CBT protocol, the quality of the therapeutic relationship is crucial to the successful implementation of the techniques. One difference might be that in the initial phases of CBT treatment the therapist is expected to be more directive and the relationship becomes gradually more horizontal along treatment. On the NT manual the relationship is expected to be horizontal since the first sessions.

Outcome research on Narrative Therapy

Although familiar amongst many clinicians, NT remains a relatively unfamiliar treatment approach for researchers and is often criticized for the lack of clinical and empirical studies to validate its claims (Etchison & Kleist, 2000). Busch (2011) refers to NT as "dissent on the apparent consensus of evaluation" (p. 18) due to the fact that seldom does NT amend itself to evidence-based research. Before we present the available evidence for the efficacy of NT for depression, we will explore why clinician and researchers allied to NT have been resistant to the empirical methods considered as "positivistic".

Possible reasons for scarcity of NT research

It could be argued that the epistemological foundations of NT were built as a reaction against the epistemological and theoretical underpinnings of evidence-based psychotherapy research (Busch, 2011). NT, aligned to postmodernist philosophy (Freedman & Combs, 1996; White & Epston, 1990), emerged as a system that "could challenge modernist assumptions that there can be the discovery and application of universal, authoritative and certain truth claims of human behavior to client experience" (Busch, 2011, p. 1). A constructivist would normally deny the possibility of objectivity, which forms the foundation of quantitative empiricism (Chambless & Hollon, 1998; Kelley, 1998). Reflecting the epistemological abyss between NT and the EST perspectives, NT research methods emphasize a qualitative understanding of one's meaning given to experience (Neimeyer, 1993). In that sense participants and researchers are regarded as co-researchers who together explore the meaning of experience to answer how and why they think and behave as they do. Thus, narrative researchers believe that qualitative approaches are best suited to researching the

effectiveness of NT (Neimeyer, 1993). In the EST approach to psychotherapy research, the primary methods used are quantitative, meanings are not explored and the research design of choice is experimental (Busch, 2011; Task Force on Promotion and Dissemination of Psychological Procedures, 1995).

Another problem is related to the conception of psychopathology. Narrative therapists refuse to impose categories of symptomology or classifications of diagnosis on clients but to map out how the problem influences the person and explore events in which the person resisted or overcame the problem, from the perspective of the client (White & Epston, 1990). In this way the therapist assumes a horizontal attitude when facing the client. In contrast, ESTs emphasizes clinical expertise, uses classificatory language such as "disorder", "clinical problem" and "psychopathology" (Busch, 2011; Task Force on Promotion and Dissemination of Psychological Procedures, 1995) and make use of the established classification of mental disorders, such as the DSM-IV.

Some practical problems have also been barriers to controlled empirical research with NT. It is argued that therapeutic orientations that are less easily operationalized have received less empirical support (Vromans & Schweitzer, 2011). NT may be less amenable to manualization and replication. The reason suggested is that highlighting personal narratives and solutions constructed throughout the relational process means that it is difficult to apply a step-by-step procedure that can easily be replicated and measured (Larner, 2004). Also, it is pointed as a reason for the scarcity of studies the fact that most journal editorial boards are composed of graduates of programs that emphasize quantitative research methods. In this way, journals may be reluctant to accept research using alternative modes of inquiry

(Neimeyer, 1993). Finally, it is also pointed out that the definition of NT and how it is carried out remain unclearly defined, even for narrative therapists themselves, which limits studies of the efficacy of this approach (Wallis, Burns, & Capdevila, 2011). As we have shown in our review in the introduction, studies using the term "narrative therapy" differed substantially from each other.

Available empirical evidence for NT's efficacy

A lot of the knowledge about NT's treatment effectiveness comes from qualitative research (e.g., M. M. Gonçalves, Matos, & Santos, 2009; Matos, Santos, Gonçalves, & Martins, 2009; Moreira, Beutler, & Gonçalves, 2008) and case studies (e.g., Betchley & Falconer, 2002; Cashin, 2008; da Costa, Nelson, Rudes, & Guterman, 2007; Draucker, 1998; Kropf & Tandy, 1998; Nylund, 2002; Palgi & Ben-Ezra, 2010; Rothschild, Brownlee, & Gallant, 2000; Young, 2008), which indeed suggest positive outcomes for a wide range of problems and disorders. Few studies have evaluated the outcomes of narrative interventions applying empirical measures to larger samples in more or less controlled research environments. For instance, one study directed to childhood stealing (Seymour & Epston, 1989) and another one to eating disorders (Weber, Davis, & McPhie, 2006) use larger samples and suggest the efficacy of NT for these problems, but still methods lack in methodological rigor. The problem is that these methods are not congruent with quantitative research and the EST guidelines, as outlined above (Chambless & Hollon, 1998; Task Force on Promotion and Dissemination of Psychological Procedures, 1995). The result is the lack of empirical evidence to support claims of NT's efficacy or effectiveness and that NT researchers and clinicians have been excluded from the mainstream debate in psychotherapy. In this section we are going to present the few controlled studies using

narrative related techniques for treating depression, which suggest that NT may be an effective treatment alternative.

In the first of these studies, Beutler et al. (2003) applied 20 individual psychotherapy sessions of Narrative Cognitive Therapy (NCT; Ó. Gonçalves, 1994) to 11 clients who had comorbid depression and stimulant dependency. The NCT model is a narrative development of cognitive therapy (CT), which emphasized the importance of metaphors and stories in the therapeutic process. The objective of NCT was to "help clients with the construction of more coherent, complex and diverse narratives" (Ó. Gonçalves & Machado, 1999, p. 1183). The clients were randomized to other experimental groups, which were CT for substance abuse (Beck, Wright, Newman, & Liese, 1993) and Prescriptive Therapy (n =11 and 12, respectively). Clients at all treatment groups improved substantially, but the NCT group had the lowest dropout rate. Clinical significant change was attained for the group as whole (it was not calculated individually). Therapeutic gains regarding depression for the NCT group were maintained after 6 months. Although markedly efficacious, a later re-analysis of the data from this study found a superiority of 0.47 (*d*) in the pre-post effect size of CT over NCT (Cuijpers, van Straten, Andersson, et al., 2008).

The second study addressing an NT-related technique for depression assessed the effects of an intervention combining NT with integrative reminiscence (Bohlmeijer, Valenkamp, Westerhof, Smit, & Cuijpers, 2005) - a technique in which elderly are asked to narrate their lives in order to "to create more positive, coherent and meaningful stories by means of reinterpretation, challenging negative views of self and the world and by integrating the event in life-stories with an agentic plot" (Bohlmeijer, Smit, & Cuijpers, 2003, p. 640). The aim of the intervention was to

increase meaning of life in older adults (Bohlmeijer et al., 2005). By meaning of life the authors refer to "the coherent cognitive interpretations of life" and "purposeful motivational directions in life" (Bohlmeijer et al., 2003, p. 639). Using a small group format for delivering the four session narrative intervention they found out that, although the overall meaning of life did not change, there were fewer negative evaluations of self, more positive evaluations of self and participants were more positive about the future. Although no specific data regarding the severity of depression was reported in this study, there is evidence elsewhere showing that the restoration of meaning in life in the elderly predicts a decrease in depressive symptoms (Davis, Wortman, Lehman, & Silver, 2000; Zika & Chamberlain, 1992), which in turn may suggest that a narrative intervention could be effective with depressed clients.

Although showing some clear methodological advantages, such as randomization, the use of other psychotherapeutic interventions as control groups, assessment of participants using a structured clinical interview and a reasonable number of therapists per treatment condition, neither of these studies tests specifically the hypothesis of the efficacy of the NT as proposed by White and Epston (1990) for depression. Firstly, the types of NT applied in both of the aforementioned studies are different in its philosophical roots and techniques from White and Epston's (1990) model in the sense that they focus rather on the narrative content, instead of focusing on the contextual role of the narrative. In NT terms, the aforementioned approaches see the problem as "internalized" in the individual. Secondly, these populations differed from a typical depression sample, which is on average in their mid-thirties, mostly women, presenting comorbid anxiety symptoms and is moderately to severely depressed (Hollon, Shelton, & Loosen, 1991). Beutler et al. (2003) assessed clients

who were comorbid substance abusers ("stimulant-dependent") and the second study (Bohlmeijer et al., 2005) applied the intervention exclusively to older adults, which shows special manifestation of the depressive symptoms.

To the best of our knowledge only one fairly controlled study attempted to assess NT's (White & Epston, 1990) efficacy in the treatment of moderate depression for adults (Vromans & Schweitzer, 2011). With a sample comprised of 47 mildly depressed clients, they found that the NT intervention yield a Cohen's *d* effect size of 1.10 on the intention-to-treat (ITT)[9] analysis, which is a large effect size (Cohen, 1988). For the group who completed the NT intervention (n = 38), effect size was of 1.36. In a clinically significant perspective as proposed by (Jacobson & Truax, 1991) results indicated that 74% of the participants in their study reached a reliable improvement (which means decreasing 8.76 points in the BDI-II) and 61% moved to the functional population (which means moving to less than 14.3 points in the BDI-II). In all, 53% of the sample reached clinical significant change (achieved reliable improvement and moved to the functional population at the same time). These results were comparable to other treatments, as evidenced by benchmark research carried by the authors. Both ITT and completers analysis revealed significant improvements in a measure of interpersonal difficulties, as well. At a 3-months follow-up assessment Vromans & Schweitzer (2011) found that mean BDI-II scores did not change significantly from post-therapy, showing only marginal symptom deterioration between the two time points. They also found that clients maintained gains in interpersonal functioning at 3-months follow-up (showing also only marginal

[9] In line with the Consolidated Standards of Reporting Trials (Moher, Schulz, Altman, & CONSORT Group, 2001) separate intent-to-treat and completers analysis should be carried in order to determine the effect of completion of treatment had on outcome. Including all randomized subjects in the analysis (i.e., treatment dropouts and completers) ensures that the "observed clinical results are valid and applicable to the target patient population" (Shao & Zhong, 2003, p. 2430).

deterioration of interpersonal problems). In the context of the EST movement mentioned above (Chambless & Hollon, 1998; Task Force on Promotion and Dissemination of Psychological Procedures, 1995), this study fulfill some of the criteria for efficacy (e.g., clear specified population, the use of a treatment manual and standardized measures of outcome), but it also showed some major limitations, such as the lack of randomization and a control group.

INTRODUCING THE CURRENT STUDIES

As shown in the previous section, there is evidence suggesting that NT has potential to offer alternative solutions for ameliorating depression but at the same time, narrative therapy researchers have often resisted or have been indifferent in assessing its efficacy. We have also discussed that the available evidence does not fulfill the requirements to claim that NT is an empirically supported intervention. The primary aim of this set of five empirical studies was thus to assess and document the efficacy NT in treating depression in adults, according to the EST research guidelines.

As we saw in our review, the main limitation of Vromans and Schweitzer's (2011) study was not having a control group. Indeed, establishing a waiting list control group and/or administering placebo in controlled clinical trials are expensive and often raise ethical concerns among clinical researchers. In the case of psychotherapy outcome research an additional controversy regards the scientific status of a placebo intervention (Ahn & Wampold, 2001). For that reason, Chambless and Hollon (1998) suggest that comparing outcomes of a new intervention to an empirically supported intervention for the same population is not only a solution, but also a highly recommended design. In that sense, it is a natural choice to use CBT as the comparison group. As also argued earlier in this introduction, CBT for depression

is the psychotherapy that has received most substantial empirical support since its foundation. Thus, this research looked at the differential effects of NT and CBT outpatient treatments for adult depression ($N = 63$; $n_{NT} = 34$, $n_{CBT} = 29$). In this section, we intend to give a brief overview of the five empirical studies that constitute this dissertation and present how they relate to each other.

The main treatment efficacy findings at post-treatment are presented in chapter I, and the main treatment efficacy findings at follow-up are presented in chapter V. In general, hypothesis for our research questions were formulated in the light of the Dodo bird paradigm, presented earlier in this introduction. That means that we expected that both psychotherapies would be equally efficacious in treating MDD. Specifically, at the first study, we expected that within and between-group analysis would demonstrate that (1) clients who have undergone NT would decrease significantly their depressive symptoms; (2) the decrease of depressive symptoms would be similar in both treatment conditions; (3) the dropout rates would be similar in both treatment conditions, (4) the clients of both treatment conditions would change in a similar rate and (5) both treatment conditions would attain similar proportions of improvement and recovery. Due to the recurrent nature of depression, it was crucial to assess whether clients maintain the therapeutic gains after completing therapy. Some evidence suggests that psychotherapy may have a delayed effect on social and interpersonal functioning, hence improvement in interpersonal outcomes may only emerge after treatment has been terminated (e.g., Fairburn et al., 1993, for Interpersonal Therapy). In the last study of this dissertation, we present the assessment of long terms effects of the treatments, hoping that it may shed light and on the actual long-term advantages or disadvantages of choosing one kind of psychotherapy over the other.

Efficacy findings in the study I suggested NT's efficacy for depression, especially for those clients who completed treatment. There were significant differences in symptom reduction on the BDI-II, favoring CBT, when dropouts were included in the analysis (ITT analysis). This finding may suggest that the timing in which the clients recover or improve may differ in both treatments. Thus, on chapter II a dose-response re-analysis of the data using survival analysis shed some light on the question of how long it takes for clients of both treatment conditions to attain significant therapeutic gains.

Interestingly, Vromans and Schweitzer (2011) have found that clients in NT showed only medium effect size on the measure for interpersonal problems, whilst large effect sizes were found on depressive symptoms. This question has echoes in the psychotherapy research literature, which suggests different patterns of change for depressive symptoms and interpersonal problems (Barkham et al., 1996; Barkham, Rees, Stiles, Hardy, & Shapiro, 2002; Barkham et al., 1993; Kopta et al., 1994). This interesting data have caught our attention and we replicated the analysis in our sample, both at post-treatment and at follow-up. The study presented on chapter II assessed whether the speed of change in the interpersonal domain differed from the speed of change of depressive symptoms at post-treatment. On chapter V we assessed clients after 21 and 31 months they finish treatment. One of our questions we had in mind was whether clients had improved in depressive symptoms and interpersonal problems after a long-term follow-up.

The difference found on the ITT analysis and not on the completers analysis suggest that the dropout sample played an important role on the results. Thus on the studies presented on chapters III and IV provide a closer look on the dropout sample.

The study presented on chapter III explores the attrition data aiming to find possible predictors of dropping out of treatments. Although we had some curious results, this analysis was not able to explain the differential effect of CBT and NT treatments. Thus, we explored the outcomes in depressive symptoms and interpersonal problems specifically for the dropout samples of both treatment conditions on the study presented on chapter IV.

Each chapter constitutes a paper that can be read independently. Although this may be useful for researchers interested in specific themes we study, this has the cost of some redundancy in the methods sections throughout this dissertation. As far as we are concerned, this dissertation is innovative in testing the efficacy of a widely practice treatment using a control group. We hope that the present dissertation is a significant step forward for NT and those who practice it and will bring it to a wider public.

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CHAPTER I.

NARRATIVE THERAPY *VS.* COGNITIVE-BEHAVIORAL THERAPY

FOR MODERATE DEPRESSION:

EMPIRICAL EVIDENCE FROM A CONTROLLED CLINICAL TRIAL

CHAPTER I. NARRATIVE THERAPY *VS.* COGNITIVE-BEHAVIORAL THERAPY FOR MODERATE DEPRESSION: EMPIRICAL EVIDENCE FROM A CONTROLLED CLINICAL TRIAL[10]

Abstract

Systematic studies of the efficacy of Narrative Therapy (NT) for depression are sparse. The aim of this study is to evaluate the efficacy of individual NT for moderate depression in adults compared to Cognitive-Behavioral Therapy (CBT). Sixty-three depressed clients were assigned to either NT or CBT. The Beck Depression Inventory-II (BDI-II) and Outcome Questionnaire-45.2 (OQ-45.2) were used as outcome measures. The results revealed a significant symptomatic reduction in both treatments. Group differences favoring CBT were found on the BDI-II, but not on the OQ-45.2. Pre- to post-treatment effect sizes for completers in both groups were superior to benchmarked waiting-list control groups.

Introduction

Depression is among the most common mental health problems for which help is sought (Andrews & Thomson, 2009; Roness, Mykletun, & Dahl, 2005). Despite the fact that 12 treatments for unipolar depression are currently listed as having reliable empirical support (for a complete list, see Hayes & Strunk, n.d.), a considerable proportion of clients leave treatment without substantial gains and/or relapse after treatment. Thus, outcome research with an emphasis on treatment efficacy is recommended (Chambless & Hollon, 1998; Chambless et al., 1998; Kendall, Holmbeck, & Verduin, 2004; Kendall, 1998).

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Narrative Therapy (NT; White & Epston, 1990; NT; White, 2007) is a psychotherapeutic approach based on the notion that people construct narratives to define themselves and give meaning to their daily experiences and life events. Psychological suffering is viewed as a problem-saturated way of constructing life stories and a person's identity. These rigid self-narratives constrain the person's actions, feelings, and thoughts (White, 2007) and obscure life alternatives. The purpose of psychotherapy is to help clients narrate their life stories in richer and more gratifying ways. This view of the human being as a meaning-making agent has had a considerable impact on clinical psychology and psychotherapy in recent years (Angus & McLeod, 2004).

Although widely practiced throughout the world, NT remains underresearched (Busch, 2011; Chenail, DeVicentis, Kiviat, & Somers, 2012; Etchison & Kleist, 2000). Some qualitative process research studies (Matos, Santos, Gonçalves, & Martins, 2009; Moreira, Beutler, & Gonçalves, 2008) and several case studies (Betchley & Falconer, 2002; Cashin, 2008; da Costa, Nelson, Rudes, & Guterman, 2007; Draucker, 1998; Kropf & Tandy, 1998; Nylund, 2002; Palgi & Ben-Ezra, 2010; Rothschild, Brownlee, & Gallant, 2000; Young, 2008) suggest positive outcomes for a wide range of problems and disorders. However, only one of these qualitative studies (Kropf & Tandy, 1998) has addressed the effectiveness of NT for depression, and none have done so in a controlled clinical trial. To the best of our knowledge, only one study tested the efficacy of NT (White & Epston, 1990) in a large sample of adults with moderate depression using a treatment manual. (Vromans & Schweitzer, 2011) found a large pre- to post-treatment effect size (d = 1.36) for those who completed the NT intervention (38 out of the initial 47 clients). Moreover, a clinical significance analysis performed with completers according to Jacobson and Truax's

(1991) criteria indicated that 74% of the participants improved reliably, 61% moved to the functional population range, and 53% recovered. It was also found that NT completers showed significant improvements on a measure of interpersonal difficulties. Intention-to-treat (ITT) analysis obtained a large pre-post effect size (d = 1.10) that was comparable to other treatments. Although this study had methodological strengths, such as the use of a structured interview for diagnostic assessment at pre-treatment, assessment of clinically significant change, and follow-up assessment at three months, it lacked a comparison group.

Because establishing a waiting list control group or administering a placebo in clinical trials is often ethically controversial, Chambless and Hollon (1998) suggested comparison with an empirically supported intervention for the same population. Cognitive-Behavioral Therapy for depression (CBT; Beck, Rush, Shaw, & Emery, 1979) is a strong candidate for a comparison group in the treatment of depression. It has received consistent empirical support since the first study in the 1970s (Rush, Beck, Kovacs, & Hollon, 1977), and it remains one of the best-known psychological treatments for depression (Butler, Chapman, Forman, & Beck, 2006; Cuijpers, van Straten, Andersson, & van Oppen, 2008; DeRubeis & Crits-Christoph, 1998; K. S. Dobson, 1989; Gloaguen, Cottraux, Cucherat, & Blackburn, 1998).

The present study aims to test the efficacy of NT in a comparative controlled trial with CBT as the comparison group and a primary focus on the reduction of depressive symptoms. The secondary aim of this study is to assess the reduction of general psychological distress. Thus, the specific research questions were (1) whether NT is as efficacious as CBT in reducing depressive symptoms in adults; (2) whether clients in the two treatments experience changes at different rates; and (3) whether the

dropout rates differ significantly between the two treatments. It was expected that NT outcomes would be comparable to CBT.

Methods

Participants

Clients

Eligibility criteria were (a) having a diagnosis of Major Depressive Disorder according to the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV; American Psychiatric Association, 2000), (b) being over 18 years old, (c) agreeing to sign an informed consent to treatment, and (d) agreeing to the videotaping of sessions and the completion of research questionnaires[11]. Participants were excluded if they presented (a) any Axis II diagnosis, (b) any other concurrent Axis I disorder that might be a focus of clinical attention (substance-related disorders, sexual disorders, eating disorders), (c) severe suicidal ideation, (d) psychotic symptoms, or (e) bipolar disorder. Clients with anxiety complaints or a secondary anxiety disorder were not excluded if the anxiety was not considered a primary complaint (e.g., panic disorder).

The trial was conducted at a psychology university clinic in the North of Portugal that offered treatment to both the on- and off-campus community. Potential participants were either self-referred or referred by community mental health professionals. Therapy was offered free of charge.

When potential participants sought consultation, they were referred to the screening staff to determine study eligibility. Eligible participants were assigned by

[11] The informed consent signed by the clients and therapists regarding confidentiality and research procedures is attached in the Appendices section.

the clinic secretary to a treatment condition according to their incoming order – one to NT, the next to CBT, and so on. The secretary was unaware of the specific procedures of each treatment. The intake form was given to the therapist, who made contact with the client for a first appointment. The participants were unaware of the treatment modality they would receive.

Therapists

To describe the level of clinical experience, we used the definition proposed by Orlinsky and Rønnestad (2005). The study included six novice therapists (less than 1.5 years of clinical experience), one apprentice therapist (between 1.5 and 3.5 years of clinical experience), and three graduate therapists (between 3.5 and 7 years of clinical experience). Two seasoned therapists (between 15 and 25 years of clinical experience) supervised the study's preparation and implementation, from the elaboration of the NT manual and adaptation of the CBT manual to training and supervision. Some therapists delivered CBT and others delivered NT in a nested design (i.e., they only treated clients in one treatment manual). One supervisor was responsible for the NT group (second author), and the other supervisor was responsible for the CBT group (sixth author). Both had advanced specialized training and extensive clinical and teaching experience with the psychotherapy approach they supervised.

The three graduate therapists (years of experience $_{Mean}$ = 5*; SD*= 0.57) treated 70.8% of the cases, the apprentice therapist (three years of clinical experience) treated 3.1% of the cases, and the six novice therapists (years of experience $_{Mean}$ = 0.33*; SD*= 0.52) treated 26.2% of the cases. The therapists had an average of 1.9 years of experience (*SD* = 2.13). The proportion of cases treated by novice therapists was

significantly larger in the CBT group compared to the NT group [χ^2 (2) = 13.071, p < .002].

All of the therapists were psychologists and graduate students of the Clinical Psychology Program (six at the master's level and four at the PhD level) at the time the trial took place. In Portugal, psychologists complete a five-year program (master's degree), including a one-year clinical internship, which is the minimum training required for supervised practice. Reported years of experience do not include the internship.

Therapists' training

One of the graduate therapists (first author) had previous experience conducting CBT. The other graduate therapist (fifth author) collaborated in the development of the NT treatment manual and had previous experience conducting NT. The other graduate therapist and the apprentice therapist had both theoretical and practical training in NT before joining the project. They all received specific training on the respective treatment manuals from the seasoned therapists. The six novice therapists had theoretical training before joining the project, and they received specific training in the treatment manuals, which consisted of watching videotapes of experienced NT or CBT psychotherapists with depressed clients. They also received close supervision by the two graduate therapists and the two seasoned therapists.

Procedures

Measures

Structured Clinical Interview for DSM-IV - Axis I Disorders, Clinician version (SCID-I; First, Spitzer, Gibbons, & Williams, 2002) *and Structured Clinical Interview for DSM-IV - Axis II Personality Disorders* (SCID-II; First, Gibbon, Spitzer, Williams, & Benjamin, 1997). The SCID-I and SCID-II are the most frequently used diagnostic interviews in research. Training with these clinical interviews consisted of novice therapists watching graduate therapists perform the clinical interviews. These graduate therapists later assisted the novice therapists in their first interviews. The diagnostic decision was discussed in small groups of therapists coordinated by a graduate therapist.

The Graffar Index. Socioeconomic status (SES) was measured with the Graffar index (Graffar, 1956), which is a short scale that takes into account income, level of education, profession, and type of home. It divides the population into five socioeconomic layers. The data are shown using a continuous score ranging from 5 (highest SES) to 25 (lowest SES).

Beck Depression Inventory-II (BDI-II; Beck, Steer, & Brown, 1996). The BDI-II is considered the gold standard measure for all research on depression and was the primary outcome measure in this study. It consists of 21 self-reported items grouped into three subscales: cognitive symptoms, affective symptoms, and somatic symptoms. The total score ranges from 0 to 63. The BDI-II has been shown to have high internal consistency ($\alpha = .91$; Steer, Brown, Beck, & Sanderson, 2001; and $\alpha = .89$ in our sample). It has been translated and validated for the Portuguese population with data similar to the American sample (Campos & B. Gonçalves, 2011; Coelho,

Martins, & Barros, 2002). Because the Portuguese studies did not calculate the Reliable Change Index (RCI; Jacobson & Truax, 1991), normative data gathered from meta-analyses of diverse samples (Seggar, Lambert, & Hansen, 2002) were used to calculate the proportion of clinical change (RCI = 8.46; cut-off score = 14.29).

Outcome Questionnaire (OQ-45.2; Lambert, Burlingame, et al., 1996). The OQ-45.2 is a self-report questionnaire designed to assess clients' progress throughout therapy and its termination. It comprises 45 questions concerning psychological distress and interpersonal relations as well as the social role of the client. The Cronbach's alpha was .93 in various clinical samples (de Jong et al., 2007; Lambert, Burlingame, et al., 1996), and similar reliability was obtained in our sample (α = .89), which is indicative of excellent internal consistency. The RCI calculated for the Portuguese population was 15 points, and the cutoff was 62 points (Machado & Fassnacht, 2014).

Adherence and Competence Scale for Narrative and Cognitive-Behavioral Therapy (ACS-N-CBT; Gonçalves, Bento, Lopes, & Salgado, 2009). This scale was developed specifically for this trial and allows the quality of the sessions to be rated from the videotapes. It consists of five "yes or no" questions concerning general therapeutic attitudes (therapist's empathy, warmth, ability to control the time of session) and ten "never to always" questions (0 to 6 Likert-type scale) concerning the frequency with which the therapist made use of the therapeutic techniques specific to NT and CBT in the particular session. Raters were also asked to use a Likert scale (from 0 to 6) to evaluate the therapists' competence in using each of the specific aforementioned techniques. Thus, this scale yields five scores: (1) the use of general therapeutic attitudes in the session; (2) the frequency with which CBT techniques

were used in the session; (3) the frequency with which NT techniques were used in the session; (4) general psychotherapeutic competence; and (5) competence in using specific therapeutic techniques from CBT and/or NT. The scale developers provided training in this scale with examples of random sessions. Care was taken that the chosen example sessions were not the same as the ones assigned to rating. A manual for the ACS-N-CBT scale containing instructions for each item of the scale and common questions was provided to the raters as support during the rating process.

Assessment procedures

The SCID-I and SCID-II interviews were used in the initial assessment to determine eligibility and were conducted by therapists trained for this purpose. No inter-rater reliability was calculated because one evaluator conducted each interview. Questions about diagnostic criteria were discussed with the supervisors. The SCID-I (First et al., 2002) was also used to gather demographic and clinical information about the participants. The demographic variables assessed were age, gender, relationship status, professional status, and education. The clinical variables assessed were the presence of co-morbidity, medication use at intake, previous hospitalizations, previous suicide attempts, and previous experiences with psychotherapy. To assess the social, occupational, and psychological functioning of the participants, the Global Assessment of Functioning (GAF) scale was used. The BDI-II and OQ-45.2 were used to measure the baseline severity of depressive symptoms and treatment outcomes. BDI-II was defined as the primary outcome measure, and OQ-45.2 was defined as the secondary outcome measure. Questionnaires were given to the participants before the initial session and at every fourth session (i.e., at sessions 1, 4,

8, 12, 16, and 20). The assessment of treatment integrity using the ACS-N-CBT was made after the trial was completed.

Treatment conditions

Treatment in both conditions consisted of 20 sessions of one hour each. Sessions took place weekly from session 1 to 16 and every two weeks from session 17 to 20. Termination occurred at the end of the 20 sessions, as scheduled by the treatment manual (regardless of the clinical status of the client), or at an earlier stage of the treatment manual that was mutually agreed upon between the therapist and client (in cases where the client had reached the therapeutic goals).

Narrative Therapy

NT focuses on the role of narrative processes in the organization of experience, knowledge, and behavior. Problems arise as autobiographical narratives and are restricted to problematic contents, which White and Epston (1990) call "problem saturated narratives". The therapist engages the client in activities to “re-write” self-narratives in a process organized around three phases: a deconstruction phase, a reconstruction phase, and a consolidation and termination phase (Freedman & Combs, 1996). During the deconstruction phase, the central goal is to understand the problem in its context, circumstances, assumptions, effects, and influence on the person’s life in an attempt to separate the problem from the person (mainly using externalization). In the reconstruction phase, the main goal is to expand the narrative elaboration of novelties, or experiences that fall outside the domain of the problem-saturated narrative, gradually facilitating the emergence of an alternative self-narrative. These new narrative elements, called unique outcomes (White, 2007), are explored and contribute to an alternative self-narrative that redefines people’s

relationship with themselves, their history, and their significant others. In the last phase of the protocol, referred to as the consolidation and termination phase, the goal is to consolidate the alternative self-narrative and to root it in the network of socio-cultural discourses and practices.

Following previous criticism on the rigidity of therapeutic manuals (Ablon, Levy, & Katzenstein, 2006; Beutler & Harwood, 2000; Connolly Gibbons, 2003; Kendall, Chu, Gifford, Hayes, & Nauta, 1998; Lester Luborsky, 1993), the NT therapeutic manual was developed to be sensitive to each client's progress during treatment, adjusting specific interventions to the idiosyncratic characteristics of the clients. For the strategies and techniques, we refer the reader to the original unpublished manual (Gonçalves & Bento, 2008, upon request) and to previous work by White (2007; White & Epston, 1990), upon which the manual was based.

Cognitive-Behavioral Therapy

CBT treatment relies on the principle that depressive symptoms are maintained due to a dysfunctional way of interpreting reality. The client is therefore encouraged to attempt new ways of thinking about himself or herself, the world, and/or others and to test these newly reformulated hypotheses in reality. Because the literature about CBT for depression is vast, we refer the reader to the original treatment manual upon which our treatment was based (Beck et al., 1979; Leahy & Holland, 2000).

Adherence to the manual and competence

Therapists chose the model they wanted to use given their prior training or preferences. Treatment integrity was assured through supervision and the assessment

of adherence to the therapeutic manuals from the perspective of external judges. At the beginning of the study, the two graduate psychotherapists received weekly supervision with two seasoned psychotherapists who had extensive experience as supervisors. Later in the study, they helped the graduate psychotherapists (the first and fourth authors) supervise the younger therapists who joined the project. All sessions were videotaped and watched during the supervision meetings so that the supervisors could keep track of adherence to the manual and the quality of the interventions. After the study was completed, videotapes of sessions 4, 8, and 12 of 25% of the randomly selected cases were rated for adherence to the manual by external raters. Each rater rated one case using the ACS-N-CBT scale (Gonçalves, Bento, et al., 2009). The raters (n = 10) were all psychologists and experienced psychotherapists who were familiar with both NT and CBT theory and practice [Mean age = 32.50 (SD = 8.38); Mean years of clinical experience = 7.80 (SD = 5.49)] and were not involved in the trial.

Analyses

Following the Consolidated Standards of Reporting Trials (Moher, Schulz, Altman, & CONSORT Group, 2001), separate intent-to-treat and completer analyses were performed.

Intent-to-treat group and missing data

The intent-to-treat (ITT) analysis included all clients who began treatment. To address the missing data in the case of the clients who left treatment prematurely, the method of carrying the last observation forward (LOCF) was used.

Statistical Analysis

Group differences

The numbers of clients that dropped out of each treatment group were compared using a chi-square test. Other differences between groups on categorical variables were evaluated using chi-square tests. Independent-samples t-tests were used to test the initial differences between the two groups on continuous variables.

Efficacy

Cohen's *d* was computed to express the effect size of the pre- to post-treatment change in each treatment condition. An Analysis of Covariance (ANCOVA) was conducted for each of the outcome measures to test the differences between treatments in reducing depressive symptomatology, with the last observation as the dependent variable, the treatment group as the independent variables, and the first observation of the outcome variable as the covariate.

Clinical significance

To examine the variety of individual responses to treatment conditions, clinical significance was assessed according to Jacobson and Truax's (1991) criteria: (a) the change should be reliable (that is, greater than the RCI for the respective measure) and (b) at the end of the treatment, clients should move from a dysfunctional population range to a range typical of the functional population. We also present the proportion of clients who responded according to the Percentage Improvement method (PI). This method defines treatment response as a pre- to post-treatment change greater than 50% of the client's dysfunctional score. Following recommendations to use the cut-off scores generated from a meta-analysis (Hiller,

Schindler, & Lambert, 2012), for the BDI-II, we used a normative value of 14.29 points to separate the non-clinical and clinical population, as suggested by Seggar et al. (2002). For example, if a client scored 30 at pre-treatment, the number of points to be considered 100% of the change was above 14.29, or 15.71 points. Because 50% of 15.71 is 7.88, any change greater than this value was considered a response for this particular client.

Rate of change

A Hierarchical Linear Model (HLM) analysis was used to assess whether the two treatments, NT and CBT, differed in the pace of symptom reduction over time. The analysis was conducted separately for the BDI-II and the OQ-45.2 scores. All measurements for each subject were used regardless of whether the participants completed treatment or were considered dropouts. At level 1, the within-subject level, we modeled the individual slope and intercept of the outcome measures for each participant over time (reflecting each individual's starting point and rate of change on either the BDI-II or the OQ-45.2). At level 2, the between-subject level, the aforementioned participant-specific parameters (slope and intercept) were modeled using only the group assignment to test whether differences in the rate of change could be predicted by it.

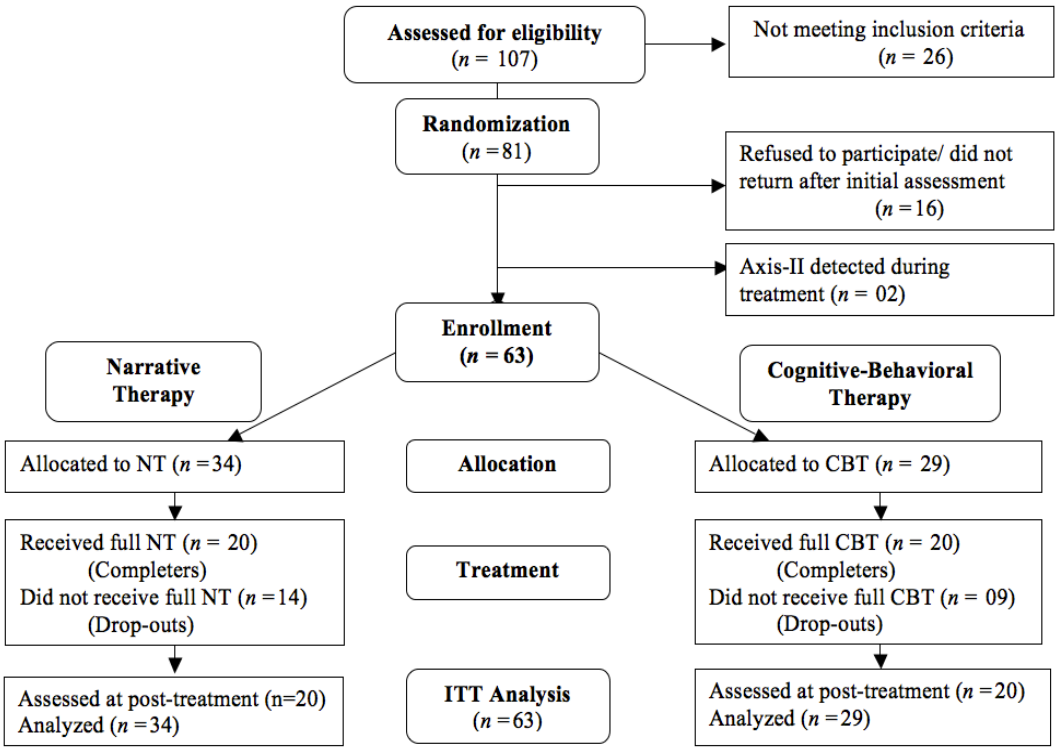
Results

Preliminary analyses

Participants' flow

During the two and a half years it took to complete the trial (from February 2008 to October 2010), 107 people were assessed for eligibility, 26 of whom did not meet the inclusion criteria (see Figure 1). Of the 81 subjects who were assigned to treatments, 16 refused to participate in the study or did not return after the initial assessment, and two were excluded for Axis-II co-morbidity detected during treatment. These clients were referred to more adequate treatment in the clinic. Of the remaining 63 clients, 34 were allocated to NT and 29 to CBT. Of the 34 participants who received NT, 14 dropped out. Of the 29 participants who received CBT, nine dropped out.

Figure 1. *CONSORT flow chart in the clinical trial, having in perspective that it is a really long title and let's see how it goes with the colors*



Note. NT = Narrative Therapy; CBT = Cognitive-behavioral Therapy; ITT = Intend-to-treat

Comparison between participants at baseline

Baseline demographic variables and clinical characteristics for the participants of each treatment condition are presented in table 1 according to the CONSORT statement guidelines (Moher et al., 2001, 2001). No meaningful differences were found between the participants in the two treatment conditions. As shown in table 1, the participants did not differ significantly on any of the demographic variables at the time of intake except for the number of years of education [NT_{Mean} = 14.41 (*SD*=4.07), CBT_{Mean} = 12.03 (*SD*=5.11), $t\,(61) = 2.05$, $p < .044$]. There was also no major group difference (table 1) in any of the clinical variables (global functioning, presence of co-morbidity, intake of medication, previous hospitalizations, previous suicide attempts, and previous experiences with psychotherapy). GAF (DSM-IV; American Psychiatric Association, 2000) was approximately 60 [NT_{Mean} = 58.94 (*SD*=10.87), CBT_{Mean} = 60.90 (*SD*= 10.06), $t\,(61) = -0.73$, $p = .465$], which

corresponds to moderate symptoms and moderate impact on social or occupational functioning. Still regarding initial severity, neither on the BDI-II [NT_{Mean} = 29.08, *SD* = 9.62, CBT_{Mean} = 33.89, *SD* = 11.46; *t* (61) = -1.80, p = 0.075] nor on the OQ-45.2 [NT_{Mean} = 92.14 (*SD* = 15.55), CBT_{Mean} = 97.03 (*SD* = 22.51), *t* (61) = -0.73, *p* = .31] differences were found. Most clients had no comorbid anxiety disorder [NT = 85.3%; CBT = 72.4%, χ^2 (1) = 1.58, *p* = .20] and had never been hospitalized [NT = 94.1%; CBT=82.8%, χ^2 (1) = 2.04, *p* = .15]. In both treatments, a considerable number of clients were taking medication at the beginning of treatment [NT = 64.7%; CBT = 55.2%, χ^2 (1) = 0.59, *p* = .44]. Several clients had previous suicide attempts [NT= 11.8%; CBT = 20.7%, χ^2 (1) = 0.93, *p* = *.33*], and a few had previous experiences with psychotherapy [NT =11.8%; CBT = 13.8%, χ^2 (1) = 0.06, *p* = .81].

Table 1. *Clinical and demographic characteristics of the sample at baseline, according to treatment condition*

Variable		NT (n = 34)		CBT (n=29)			
		M (*SD*)	*n* (%)	*M* (*SD*)	*n* (%)	*t* (61)	x^2 (1)
Age		37.18 (12.72)		33.41 (9.72)		1.30	
Gender	Female		27 (79)		24 (82.8)		0.11
	Male		7 (21)		5 (17.2)		
Education (in years)		14.41 (4.07)		12.03 (5.11)		-2.05*	
SES (Graffar[1])		12.25 (2.75)		12.61 (3.75)		0.54	
Relationship Status	Single		15 (44.1)		12 (41.4)		2.07
	Married		10 (29.4)		11 (37.9)		
	Divorced		7 (20.6)		6 (20.7)		
	Widowed		2 (5.9)		0 (0)		
Professional Status	Employed		14 (41.2)		18 (62.1)		4.8
	Unemployed		10 (29.4)		4 (13.8)		
	Student		8 (23.5)		7 (24.1)		
	Retired		2 (5.9)		0 (0)		
GAF at intake		58.94 (10.87)		60.90 (10.06)		-0.73	
Score BDI-II Session 01		29.08 (9.62)		33.89 (11.4)		-1.80†	
Score OQ.45.2 Session 01		92.14 (15.5)		97.03 (22.5)		-1.01	
Comorbidity at intake (anxiety problems)	No		29 (85.3)		21 (72.4)		1.58
	Yes		5 (14.7)		8 (27.6)		
Psychiatric medication at intake	No		12 (35.3)		13 (44.8)		0.59
	Yes		22 (64.7)		16 (55.2)		
Previous hospitalizations	No		32 (94.1)		24 (82.8)		2.04
	Yes		2 (5.9)		5 (17.2)		
Previous suicide attempts	No		30 (88.2)		23 (79.3)		0.93
	Yes		4 (11.8)		6 (20.7)		
Previous experiences with psychotherapy	No		30 (88.2)		25 (86.2)		0.06
	Yes		4 (11.8)		4 (13.8)		

[1] Graffar is an international classification for socioeconomic status (Graffar, 1956). The higher is the score, the lower the SES. This sample means (NT *M* = 12.2; CBT *M* = 12.6) indicate high SES.

Note. SES = Socioeconomic Status; GAF = Global Assessment of Functioning of the DSM-IV (First et al., 2002); BDI-II = Beck Depression Inventory II; OQ-45.2 = Outcome Questionnaire 45.2

* Indicates statistical significance at $p < .05$; † indicates marginally significant difference at $p < .10$

Number of sessions in each treatment

Of the 40 completers, 24 clients received 20 sessions of treatment, and 16 clients completed treatment between the eighth and nineteenth sessions. NT clients, including dropouts, received an average of 12.94 sessions (*SD* = 7.05), whereas CBT clients received an average of 14.90 sessions (*SD* = 6.48). This difference was not statistically significant [t (61) = -1.13, p = .278.]. Termination occurred either at the end of the treatment manual (20 sessions, n = 24) or at a time that was mutually agreed between the therapist and the client at an earlier stage of the treatment manual (ranging from eight to 19 sessions, n = 16).

Adherence and competence assessment

External raters (n = 16) watched videotapes of sessions four, eight, and 12 of 25% of the cases (n= 16) and rated the sessions using the ACS-N-CBT (Gonçalves, Bento, et al., 2009). As expected, in the NT treatment condition, therapists used significantly more NT techniques than in the CBT treatment condition (U = .500, p < .001). Comparably, in the CBT treatment condition, CBT therapists used significantly more CBT techniques than in the NT treatment condition (U = .00, p < .001). The use of general therapeutic attitudes did not differ across treatments (U = 264, p = .307). General and specific competence rated by external observers did not differ between the two treatments (U = 257.5, p = .692 and U = 206, p = .136, respectively).

Influence of medication on outcome

To determine whether the improvement of clients taking medication differed on the BDI-II compared to clients not taking medication, we used an ANCOVA. The initial BDI-II score was used as the covariate, the final BDI-II score was the dependent variable, and medication at intake was an independent variable. There was no significant effect of medication at intake on the BDI-II [F (1,60) = .14, p = .71]. A similar analysis conducted with the OQ-45.2 also revealed no significant effect for medication at intake [F (1,60) = 1.21, p = .28].

Influence of therapist's experience on outcome

Because the number of clients seen by novice therapists in CBT was significantly higher than the number of clients seen by novice therapists in NT, we tested the effects of the therapist's experience (novice, apprentice, or graduate) on the final score on the BDI-II using an ANCOVA, with the initial BDI-II score as the

covariate. No significant effect was found for therapist experience on the outcome [F (2,59) = 0.78, p = .463].

Symptom reduction during treatment

Pre- to post-treatment means, standard deviations, and effect sizes for both treatment groups are presented in table 2. CBT had higher pre- to post-treatment effect sizes when compared to NT on the BDI-II, both for ITT (d = 1.25 for CBT and d = 0.56 for NT) and completer (d = 1.51 for CBT and d = 0.89 for NT) analysis. For OQ-45.2, CBT and NT pre- to post-treatment effect sizes were very similar (ITT analysis: d = 0.65 for CBT and d = 0.69 for NT; completer analysis: d = 0.91 for CBT and d = 0.84 for NT).

Table 2. *Intent-to-treat and completer analysis pre- and post-treatment mean scores, standard deviations, and effect sizes for NT and CBT*

Measure	Treatment condition					
	NT (n = 34)			CBT (n = 29)		
	Pre Mean (SD)	*Post Mean (SD)*	*d[1] (CI)*	*Pre*	*Post*	*d (CI)*
	Intent-to-treat (LOFC, N = 63)					
BDI-II	29.09 (10)	22.59 (13)	0.56 (0.08 – 1.05)	33.90 (11)	18.90 (13)	1.25 (0.68 – 1.81)
OQ-45.2	92 (16)	75.91 (29,1)	0.69 (0.2 – 1.17)	97 (23)	79.10 (31,3)	0.65 (0.12 – 1.18)
	Completers (N = 40)					
	NT (n = 20)			CBT (n = 20)		
BDI-II	29.4 (10.4)	18.8 (13.2)	0.89 (0.24 – 1.54)	33.5 (9.9)	16.4 (12.6)	1.51 (0.81 – 2.21)
OQ-45.2	94 (17)	71.8 (33.1)	0.84 (0.20 – 1.49)	97.7 (23.2)	72.2 (32.4)	0.91 (0.26 – 1.56)

Note. NT = Narrative Therapy; CBT=Cognitive-Behavioral Therapy; BDI-II = Beck Depression Inventory-II; OQ-45.2 = Outcome Questionnaire 45.2; *SD* = Standard Deviation; LOFC = Last Observation Carried Forward; CI = Confidence interval.

[1] Effect sizes refer to pre-and post-treatment and are categorized along a continuum of "no effect" (ES < 0.2), "small effect" (0.2 =< ES =<0.5), "medium effect" (0.5 =< ES =< 0.8), and "large effect" (ES >= 0.8) (Cohen, 1988).

ANCOVAs comparing the observed post-treatment change with the pre-treatment scores as covariates suggest that both treatment groups showed significant

improvement in all measures for both the ITT (n = 63) and the completer (n = 40) analyses. Comparing CBT and NT, a significant group effect was found for the BDI-II [F (1,60) = 4.16, p = .046] and its somatic dimension [F (1,60) = 4.04, p = .049], but only for the entire ITT sample. No significant group effects for the BDI-II were found for the completer analysis. Additionally, no significant group differences were found for the OQ-45.2 for the ITT analysis [F (1, 60) = 0.15, p = .70] or the completer analysis [F (1, 37) = 0.04, p = .83]. Moreover, separate ANCOVAs were conducted for each of the three subscales of the OQ-45.2, and no difference in the amount of change was found between any groups [for Symptom Distress, F (1,60) = .017, p = .90; for Interpersonal Relatedness, F (1,60) = 0.78, p = .38; and for Social Role Functioning, F (1,60) = 0.073, p = .79].

Clinical significance

Each client's post-treatment score was examined to determine (a) whether it reliably changed, (b) whether it fell below the cutoff scores for the functional distributions (Functional Population, also referred to as remission, Hiller et al., 2012), (c) whether it moved to the functional distribution and improved reliably at the same time (Clinical Significant Change), (d) whether the final score increased more than the RCI for the specific measure (i.e., whether individuals reliably deteriorated during treatment), and (e) whether it decreased by more than 50% of its value on the dysfunctional range of the scale (i.e., whether clients responded). Table 4 shows the results for the ITT and completer analysis separately.

In the completer analysis, the group proportions on the BDI-II were very similar on all of the categories of clinical change (i.e., the proportion of clients who attained reliable improvement (CBT = 75%, NT = 50%; x^2 (1) = 2.667, p = 0.102),

who moved to the functional population (CBT = 50%, NT = 45%; x^2 (1) = 0.1, p = 0.751), or who attained clinically significant change (CBT = 50%, NT = 40%; x^2 (1) = 0.404, p = 0.525). However, in the ITT analysis, the proportion of clients that improved reliably was marginally larger for the CBT group (CBT = 62.1%, NT = 38.2%; x^2 (1) = 3.55, p = 0.059). The proportion of responders (according to the PI method) was significantly larger in the CBT group (CBT = 68.9%, NT = 41.2%; x^2 (1) = 4.865, p = 0.027).

Table 3. *Percentage of reliable improvement, movement to functional population, clinically significant change, and reliable deterioration by treatment condition and outcome measure*

	BDI-II		OQ-45.2	
Type of Change	NT *n* (%)	CBT *n* (%)	NT *n* (%)	CBT *n* (%)
	ITT (*n* = 63)			
Reliable Improvement[a]	13 (38.2)	18 (62.1)[†]	12 (35.3)	14 (48.2)
Functional Population/ Remission[b]	11 (32.4)	12 (41.4)	10 (29.4)	8 (27.6)
Clinical Significant Change[c]	10 (29.4)	12 (41.4)	9 (26.5)	6 (20.7)
Reliable Deterioration[d]	1 (2.9)	0 (0)	1 (2.9)	5 (17.24%)
Response[e]	14 (41.2)	20 (68.9)[*]	14 (41.2)	14 (48.3)
	Completers (n = 40)			
Reliable Improvement	10 (50)	15 (75)	12 (35.3)	11 (38)
Functional Population	9 (45)	10 (50)	9 (45)	7 (35)
Clinical Significant Change	8 (40)	10 (50)	9 (45)	5 (25)
Reliable Deterioration	0 (0)	0 (0)	1 (2,9)	3 (10)
Response	11 (55)	15 (75%)	13 (65)	12 (60)

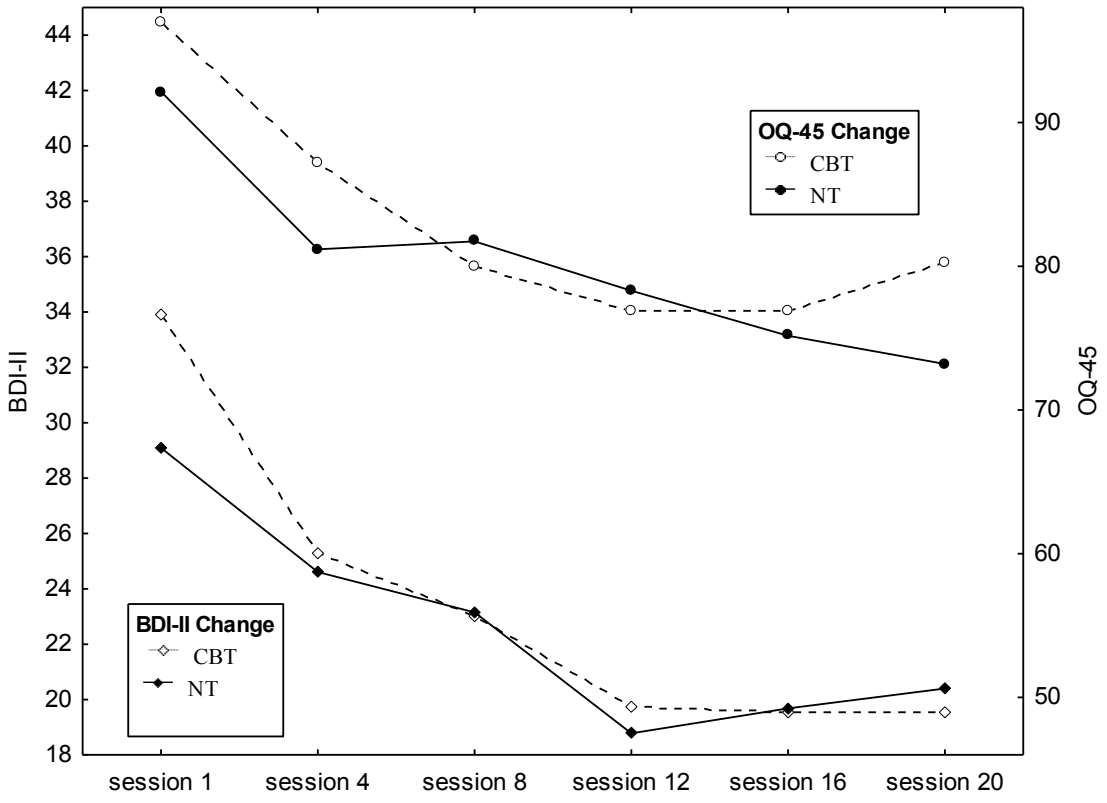
Note. BDI-II = Beck Depression Inventory-II; OQ-45.2 = Outcome Questionnaire-45.2, NT = Narrative Therapy; CBT = Cognitive Behavioral Therapy; ITT = Intend-to-treat; [†] = $p < 10$ and [*] = $p < .05$.
[a] Reliable Improvement = proportion of clients who attained Reliable Improvement (changed more than the Reliable Change Index: for BDI-II = 8.46; for OQ-45.2 = 15); [b] Functional Population/Remission = Proportion of clients who moved into the Functional Population (below the 80th percentile; for BDI-II = 14.29; for OQ-45.2 = 62); [c] Clinical Significant Change = clients who simultaneously showed reliable improvement AND moved into the Functional Population; [d] Proportion of clients who deteriorated reliably (more than Reliable Change Index); [e]Response = change greater than 50% of pre-treatment score, considering the number of points situated on the dysfunctional range of the scale (Percent Improvement Method, Hiller et al., 2012).

Rate of change across treatment conditions

The results from the HLM comparing the rates of change in the two groups indicate that according to the BDI-II, group allocation was not significantly related to

individual growth rates (coefficient of BDI-II for group: $b = 0.283$, $t\ (62) = 1.442$, $p = .154$). This was also the case using the OQ-45.2 (coefficient of OQ-45.2 for group: $b = 0.163$, $t\ (62) = 0.33$, $p = .742$). The rate of symptoms reduction for the BDI-II was 0.84 points per session for the CBT group and 0.56 points for the NT group. For the OQ-45.2, the rate of symptom reduction was 1.17 points per session for the CBT group and 1.01 points for the NT group. Figure 2 illustrates the rate of change for both groups.

Figure 2. *Course of symptom reduction in both treatment conditions on BDI-II and OQ-45.2*



Note. BDI-II = Beck Depression Inventory-II; OQ-45.2 = Outcome Questionnaire-45.2, NT = Narrative Therapy; CBT = Cognitive Behavioral Therapy

Dropout across treatment conditions

Dropout in our study was defined as unilateral termination by the client without the therapist's approval or knowledge (Richmond, 1992) and/or failure to

attend the last scheduled appointment (Hatchett, Han, & Cooker, 2002; Hatchett & Park, 2003). Fourteen clients (41.2%) dropped out in the NT group compared to nine (31%) in the CBT group, but this difference was not statistically significant (Fisher's exact probability = 0.27). The overall dropout rate was 36.50%.

NT and CBT dropouts did not differ on any of the baseline demographic variables (age, gender, relationship status, professional status, years of education, and socioeconomic status) or on clinical baseline variables (severity of depression, presence of co-morbidity, medication at intake, previous hospitalizations, and previous experiences with psychotherapy).

Discussion

The present study aimed to assess the efficacy of NT for major depression in adults, a popular treatment among clinicians that has very little empirical evidence in its favor, compared with CBT. The results showed that by the end of treatment, clients in both treatment groups scored significantly lower on all measures. Although the completer analyses yielded no evidence indicating differential effects or the superiority of either CBT or NT in reducing depressive symptoms (BDI-II) or general psychosocial symptoms and problems (OQ-45.2), surprisingly, when the analysis included dropouts (i.e., ITT analysis), the CBT group showed a significantly larger decrease of depressive symptoms at post-treatment and a significantly larger proportion of treatment responders. This difference may indicate that dropouts in the CBT group have better gains in reducing depressive symptoms than the NT dropouts. One possible clinical explanation for this difference is the inclusion in the CBT manual of a clear and structured behavioral activation module at the beginning of treatment, in which therapists have the opportunity to work exclusively on the

alleviation of depressive symptoms. In contrast, in NT, therapists directly begin to intervene with a focus on the narrative change. NT intervention may require more cognitive resources than some depressive clients have available at the onset of treatment. If this hypothesis is confirmed in future studies of NT, narrative therapists should consider ways to address this problem, including a more supportive module at the beginning of the treatment manual or explaining that the client might feel that his condition is worsening before he begins to get better, as is often the case with antidepressant medication. Warning the client about this effect may change the client's expectation of the course of treatment and thus enhance adherence to it.

The better results on the BDI-II for the ITT sample may not be surprising given that CBT treatment specifically aims to reduce depressive symptoms in the same way that the BDI-II aims to measure depressive symptoms. Future research should consider the use of measures focused on narrative change (e.g., innovative moments; Gonçalves, Matos, & Santos, 2009; Gonçalves, Ribeiro, Mendes, Matos, & Santos, 2011) and outcome measures using independent raters (e.g., the Hamilton-D scale; Fleck, Poirier-Littre, Guelfi, Bourdel, & Loo, 1995) to assess whether NT produces changes that are more consistent with its theoretical background.

An established benchmark for the psychotherapeutic treatment of depression outcomes (Minami, Wampold, Serlin, Kircher, & Brown, 2007) provided parameters for the most efficacious treatments (efficacy benchmark) and parameters for clients who were randomly assigned to the waiting list group control (natural history benchmark). Comparing the natural history benchmark with the pre-post effect size yielded in the ITT analyses ($d = 0.56$) we conclude that there is insufficient evidence to support NT as an efficacious treatment for depression. In contrast, the effect size in

the completer analysis of NT (d = 0.89) is significantly greater than the natural history. Thus, completing NT treatment is reliably better than no treatment. However, even for the completers, the effect size is not large enough to conclude that the treatment is clinically equivalent to the most efficacious treatments in clinical trials. Caution must be taken when comparing our results with this benchmark given that our sample presented higher initial severity at the BDI-II than the sample used to calculate this benchmark (Minami et al., 2007). Benchmarking CBT data against the values provided by Minami et al. (2007) shows that undergoing CBT is clinically superior than no treatment for the more conservative ITT analysis (d = 1.25) and the less conservative completer analysis (d = 1.51). Whereas for the ITT analysis, the effect size is not large enough to state that the CBT group was as effective as the efficacy benchmark, for the completer analysis, it is very likely that the CBT provided in this trial was as effective as any effective treatment.

As mentioned previously, Vromans and Schweitzer (2011) have recently conducted a clinical trial with NT, the only empirical study that is directly comparable to ours. For those who complete treatment, BDI-II pre-post effect sizes are comparable to our findings. However, the ITT pre-post effect size comparison confirms that our sample had poorer improvement. Future studies may clarify this issue, especially given that Vromans and Schweitzer (2011) used a much shorter intervention (eight sessions, compared to 20 sessions in the current study).

The overall dropout rate was 35.5%. Considering the estimate of the weighted mean dropout rate of 19.7% obtained by a meta-analysis including a large number of studies (Swift & Greenberg, 2012), this is a high dropout rate. The considerable number of young therapists in our sample might explain this rate. There is some

evidence suggesting a relationship between the level of the therapist's experience and dropout rates. Trainees who had not yet obtained their degrees have higher dropout rates (27%) than trainees who had already obtained their degrees (17%; Swift & Greenberg, 2012). Similarly, some evidence has shown significantly higher dropout rates in university clinics (Kadera, Lambert, & Andrews, 1996; Swift, Callahan, Heath, Herbert, & Levine, 2010).

One might argue that the fact that our sample included clients on medication may create a bias favoring the efficacy of the treatments. However, the outcomes of clients taking medication and clients not taking medication did not differ. In addition, the proportion of medicated clients was evenly distributed across treatments, which should attenuate any possible bias.

Strengths and limitations

The strengths of the study included the following: (1) the sample size, which satisfied the analysis we applied and is comparable to most studies in the area (Chambless & Hollon, 1998; Kazdin & Bass, 1989); (2) the assessment of clinically significant change; (3) the presentation of the ITT and completer analyses separately adds information on the dropouts during treatment; (4) the use of manualized treatments favors the principle of replicability (Chambless & Hollon, 1998); and (5) the integrity assessment indicates that therapists followed the manual and that they did so with some degree of competence, which increases confidence in the results.

Following the criteria to identify ESTs (Chambless & Hollon, 1998), our study used a controlled clinical trial design to test the efficacy of NT, the therapists followed treatment manuals, and the characteristics of the sample were clearly

specified and thoroughly assessed. Although these characteristics can be regarded as strengths, the question may be raised of the generalizability of the results. The sample included in this trial was very homogeneous and may not be the population normally found in clinical settings (i.e., clients with multiple comorbid Axis I and II conditions). This methodological choice emphasizes the internal validity and sacrifices the external validity of the results (Hansen, Lambert, & Forman, 2002; Lambert & Ogles, 2004).

The current study has other limitations. The diversity in the therapists' level of expertise may have been a confounding variable because many cases were seen by novice therapists and were not evenly distributed in both conditions (the CBT group had significantly more clients seen by novice therapists than the NT group). However, the impact of this limitation on the results is unclear because the level of therapist experience was not related to the outcome, a finding similar to that of other researchers (e.g., Kadera, Lambert, & Andrews, 1996). The fact that the therapists did not see pilot cases before seeing the actual clients for the trial may also be considered a limitation. The nested design used in this study (therapists were divided by treatment group) increases the possibility of therapist effects.

Another limitation was the way the clients were assigned to treatments. Every other patient was assigned to either CBT or NT as they arrived in the clinic. It is not clear how this method may interfere with the results because (a) this method was conducted in a systematic manner by a clinic administrative staff member who was unaware of the research design, and (b) there was most likely not a specific order or pattern in which clients sought treatment. Although this may technically be considered a quasi-random method, it is still worth noting the possibility of bias.

Implications of the study

As discussed, the data were not consistent enough to ascertain the efficacy of Narrative Therapy for moderate depression, especially due to a high number of client dropouts who did not seem to benefit from treatment.

However, when clients completed treatment, it appears to be an effective treatment. Thus, the main conclusion of this study is that additional efficacy studies are needed before NT can be recommended for the treatment of depression.

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CHAPTER II.

TIME TO IMPROVE AND RECOVER FROM DEPRESSIVE SYMPTOMS AND INTERPERSONAL PROBLEMS IN A CLINICAL TRIAL

CHAPTER II. TIME TO IMPROVE AND RECOVER FROM DEPRESSIVE SYMPTOMS AND INTERPERSONAL PROBLEMS IN A CLINICAL TRIAL[12]

Abstract

Results from an earlier clinical trial comparing Narrative Therapy (NT) to Cognitive-Behavioral Therapy (Lopes et al., 2014) suggested that NT is efficacious for depression. However, there were significant differences in symptom reduction on the Beck Depression Inventory-II, favoring cognitive–behavioral therapy, if dropouts were included in the analysis, suggesting that time to recovery or improvement would differ in both treatments. Contrarily, results showed that treatment assignment was not a predictor for differential effect. Using a survival analytic approach it was found that four sessions were necessary for 50% improvement and 16 sessions for 50% recovery. Additionally, depressive symptoms changes occurred significantly faster than interpersonal changes, again regardless of treatment assignment. These results support previous findings of the dose-response literature and of the Phase Model of change, with the advantage of being specific to psychotherapy with depressive clients.

Introduction

Results from an earlier controlled clinical trial comparing Narrative Therapy (NT) with Cognitive-Behavioral Therapy (CBT) for depression (Lopes et al., 2014) showed significant differences in symptom reduction according to the Beck Depression Inventory (BDI-II; Beck, Steer, & Brown, 1996), favoring CBT, but only on the intend-to-treat (ITT) analyses. This finding suggest that although both

[12] This study has been published in the journal Clinical Psychology & Psychotherapy (2013) with the co-authorship of M. M. Gonçalves, D. B. Fassnacht, P. P. Machado, and I. Sousa.

treatments are equally effective for those who complete treatment, the timing in which clients attain reliable improvement may differ in these treatments. Moreover, despite this difference on the BDI-II, no differences (either in the ITT and or the completer samples) were found on the (OQ-45.2; Lambert, Burlingame, et al., 1996), which measures psychological functioning more globally (besides symptoms, it also measures social functioning and interpersonal problems). This raised the question of whether treatments had differential effects on depressive symptoms and interpersonal problems. Thus, this study targets these two issues: the time needed for change in both treatments and the time needed for change depressive symptoms and interpersonal problems, also in both treatments.

Time of improvement within psychotherapeutic treatment[13]

A vast majority of evidence in psychotherapy outcome research points out a positive correlation between the amount of psychotherapy provided and its benefit. In an important meta-analysis Howard, Kopta, Krause and Orlinsky's (1986) assessed 2,431 outpatients. “Dose” was defined as the number of sessions of psychotherapy the client had been exposed to, which is a common unit in across all psychotherapies. “Effect” was defined as the percentage of clients that improved at a certain point of therapy. The results yielded that between 29% and 38% of the clients improved between the first three sessions. Then, half of the clients improved after eight sessions of therapy and 75% of the clients would still respond to psychotherapy after 26 sessions, independently of the ultimate number of treatment sessions. One major limitation of this study is the lack of an operationalized definition of improvement,

[13] A table with an overview of the dose-research literature is attached in the Appendices section.

which relied on therapist and client ratings without using standardized measures of clinical change.

This limitation was addressed by other researchers (Anderson & Lambert, 2001; Hansen et al., 2002; Hansen & Lambert, 2003; Harnett, O'Donovan, & Lambert, 2010; Kadera et al., 1996; Kopta, Howard, Lowry, & Beutler, 1994), who used the clinical significant change criteria (Jacobson and Truax, 1991). According to this method, a client is considered to have "improved" when pre- to post-treatment change is statistically reliable, i.e., change at post-treatment is greater than the standard error of the outcome instrument (also referred to as the Reliable Change Index, RCI). In order to be considered "recovered" the client must improve reliably and the scores should lie within the limits of the functional population. This definition became the most used to assess clinical significant change in psychotherapy research (Bauer, Lambert, & Nielsen, 2004; Ogles, Lunnen, & Bonesteel, 2001).

There seems to be a consensus among psychotherapy researchers that the overall shape of the improvement trajectories reflects rapidly increasing rates in the early stages of treatment (Anderson & Lambert, 2001; Harnett et al., 2010; Howard et al., 1986; Kadera et al., 1996), which progressively slow down as the number of sessions increases, i.e., the greater the doses, the less clients benefit from the treatment (Barkham et al., 1996). However, there seems to be a great discrepancy around the exact doses needed to attain a certain level of clinical significant change, which varies according to the clinical setting and client population. Generally, it has been found that 25% of clients reach clinically significant change between two and eight sessions of psychotherapy, 50% of clients between 8 to 21 sessions and 75% of clients reach clinically significant change with more than 25 sessions (Anderson &

Lambert, 2001; Hansen et al., 2002; Harnett et al., 2010; Howard et al., 1986; Kadera et al., 1996; Kopta et al., 1994; Lambert, 2007). Further investigation about the number of sessions required to attain clinical improvement is thus needed to establish more accurate estimates (Kadera et al., 1996), specially within controlled experimental settings and with homogenous client samples (Anderson & Lambert, 2001).

Symptomatic *vs*. interpersonal change in psychotherapy

Howard, Lueger, Maling and Martinovich (1993) proposed a descriptive model of change in psychotherapy, called the "Phase Model". Change is proposed to occur through the progression across a sequence of three phases that have been labeled remoralization, remediation, and rehabilitation. In the *remoralization* phase the client seeks to enhance subjective well-being through connecting himself or herself to the therapist who help the client getting a feeling of hope that the problematic experience will change. The *remediation* phase targets the alleviation of the client's symptoms and life problems. The *rehabilitation* phase starts at the point where symptomatic distress has abated and the client focus on the patterns of functioning that may have led to the precipitating problems and symptoms. The therapeutic work is then directed to acquire a better mode of functioning, in which, usually, the interpersonal domain is the main focus.

The Phase Model was empirically supported by the results indicating that remoralization preceded remediation, which in turn preceded rehabilitation (Hilsenroth, Ackerman, & Blagys, 2001; Howard et al., 1993; Swift et al., 2010). Consistent with the Phase Model, Kopta et al. (1994) found different patterns of recovery for different clusters of symptoms, with acute distress requiring less time to

recover (five sessions for 50% of the clients) than chronic distress (14 sessions for 50% of the clients). Finally, for the cluster the authors called "characterological symptoms", which consist mainly of interpersonal problems, the required dose increases up to more than 104 sessions for 50% of the clients to recover (Barkham et al., 1996; Kopta et al., 1994).

Two other related researches attempted to study the hypothesis of differential time for improvement and offer empirical support for the Phase Model. Both studies included CBT treatment in the research. In the first study Barkham et al. (1996) assessed 212 psychotherapy clients with a first diagnosis of Major Depressive Disorder (MDD; American Psychiatric Association, 1980) using the BDI (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961) to assess depressive symptoms and the IIP-32 (Horowitz, Alden, Wiggins, & Pincus, 2000; Horowitz, Rosenberg, Baer, Ureño, & Villaseñor, 1988) to assess interpersonal problems. In order to study the dose-effect relation, clients were randomized to four experimental conditions: CBT or Interpersonal Therapy (IT), plus a varying treatment length (eight vs. 16 sessions). Results indicate that there were no differences between the two treatment approaches. However, the recovery rates for depressive symptoms vs. interpersonal problems differed across different durations of treatments: clients who received more therapy (16 sessions) had a significant higher proportion of recovery in the interpersonal problems scale than those clients who only received eight sessions. Moreover, the proportion of clients who achieved recovery on depressive symptoms was significantly lower than the proportion of clients who achieved recovery on the interpersonal level, at all tested durations of treatment.

In the second study, Barkham, Rees, Stiles, Hardy, and Shapiro (2002) used a quasi-experimental design to assess 105 moderately depressed clients assigned to three conditions: a two-, eight- and 16-sessions intervention samples. The results replicated the general trend of the dose-effect research: larger numbers of sessions were associated with a larger proportion of clients recovering. Specifically, and more importantly, the authors revealed that while many clients recovered from depressive symptoms in the three groups, larger proportions of clients recovered in the eight and 16-sessions groups. Alternatively, the proportions of recovered clients according to the IIP-32 were very low in the two- and eight-sessions conditions, but increased in the 16-sessions group.

Up to date, except the earlier mentioned study by Lopes et al. (2014), the clinical trial by Vromans and Schweitzer (2011) remains the only study, to our knowledge, testing the efficacy of NT for depression by using a treatment manual and a reasonable sample size (n = 47). Although no direct comparison between change on depressive symptoms and interpersonal problems was presented, the authors showed stronger effect sizes for depressive symptoms (d = 1.10) compared to interpersonal problems (d = 0.52), indicating that change on depressive symptoms was greater than change on interpersonal problems. Additionally, it was found that while improvements in depressive symptoms were maintained at 3-month follow-up, improvements in interpersonal symptoms were not.

Hence, the main aim of this study is twofold: (1) to investigate the time it takes for depressed clients to attain change, and (2) to assess whether the courses of depressive symptoms and interpersonal problems are different, as proposed previously by Howard, Lueger, Maling and Martinovich (1993). Moreover, as we

have two different treatments we aim to study if these treatments have any differential impact, both on the pace of global change, as on the changes of depressive symptoms, compared to interpersonal problems.

Method

A brief summary of procedures of the clinical trial from which this data is taken will be given. These procedures were described in more details elsewhere (Lopes et al., 2014).

Clients

Sixty-three clients (NT: $n = 34$, CBT: $n = 29$), diagnosed with MDD according to the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV; American Psychiatric Association, 2000), were assigned to a treatment condition, according to their incoming order – one to NT, the next to CBT, and so on. Some clients (20.6%) were included in the sample with a secondary anxiety diagnosis or symptoms. Baseline demographic and clinical characteristics were equivalent for both groups: mean age in the mid-30's ($M = 35.44$, $SD = 11.51$), a majority of female clients (81% female), coming from a middle to high social economic class and mostly single. Global Assessment of Functioning (GAF, American Psychiatric Association, 2000) was on average 60 ($SD = 10$), which corresponds to moderate symptoms and moderate impact on social or occupational functioning. A considerable number of clients were taking psychoactive medication at the beginning of treatment (NT = 64.7%; CBT = 55.2%, $x^2(1) = .59$, $p = .44$).

Therapists

All of the ten therapists were psychologists and had on average 1.9 years of experience (*SD* = 2.13). Weekly supervision, using videotapes of sessions, was provided in order to assure the quality of the interventions and the adherence to the manual. Details of therapists' characteristics and training are given elsewhere (Lopes et al., 2014).

Treatment conditions

The CBT manual used in this clinical trial was based on the typical CBT treatment manual for depression (see e.g. Beck, Rush, Shaw, & Emery, 1979; Fennel, 1997; Leahy & Holland, 2000; Lopes et al., 2014; Rush, Beck, Kovacs, & Hollon, 1977), which relies on the principle that depressive symptoms are maintained due to a dysfunctional way of interpreting reality. The client is therefore encouraged to try new ways of thinking about him or herself, the world and/or others and to test those new reformulated hypothesis in reality. A behavioral activation module precedes the cognitive restructuring phase. Since literature about CBT for depression is vast, we refer the reader to the original treatment manual upon which our treatment was based (Beck et al., 1979; Leahy & Holland, 2000).

NT focuses on the role of narrative processes in the organization of experience, knowledge and behavior. Problems arise as autobiographical narratives that are restricted to problematic contents, which White and Epston (1990) call problem saturated narratives. The purpose of psychotherapy is to help clients shape new identities and narrate stories in richer and more gratifying ways. Thus, the therapist engage the client in activities to “re-write” self-narratives, for instance by

encouraging the externalizing conversations (White, 2007), which involve the use of language in a way that detaches (and sometimes even personifies) the problem from the person. Tasks assignments are suggested to intensify the person's awareness of the influence of the problem and the processes by which it maintains an deleterious influence on daily life, like self-observation tasks or letters addressed to the problem, often from an externalizing perspective. The new alternative narrative elements that arise are called unique outcomes (White, 2007). The therapist helps the client to identify and elaborate unique outcomes by exploring how they emerged, what made them possible, what do they mean for client's life, or what are their implications for the life of the person (White, 2007). For an overview of the psychotherapeutic process and further details of the strategies and techniques we refer the reader to the original unpublished manual (Gonçalves & Bento, 2008, upon request) and to the previous works of White (2007; White & Epston, 1990), upon which the manual was based. Neither of the clinical manuals laid special emphasis on the interpersonal area, but they were flexible enough to deal with interpersonal issues when they were evaluated to be at the core of the client's problem.

Length of treatment

In both conditions, treatment was planned to be 20 weekly 60 minutes sessions. Sessions 1 to 16 were scheduled weekly, whereas sessions 17 to 20, were scheduled every other week. Overall clients received on average 13.8 sessions (SD = 6.8). NT clients received an average 12.94 sessions (SD = 7.05), whereas CBT clients received an average 14.90 sessions (SD = 6.48); $t(61) = -1.13$, $p = .26$. Termination was initiated either after 20 sessions, as scheduled by the treatment manual (regardless of the clinical status of the client), or mutually agreed between therapist

and client at an earlier stage (in case the client has reached the therapeutic goals). Dropout was defined as the unilateral termination by the client without the therapist's approval or knowledge (Richmond, 1992) and/or failure to attend the last scheduled appointment (Hatchett et al., 2002; Hatchett & Park, 2003). Fourteen clients (41.2%) dropped out in the NT group compared to nine (31%) in the CBT group; however, this difference was not statistically significant (Fisher's exact probability = 0.27).

Measures

Structured Clinical Interview for DSM-IV

The SCID-I (First et al., 2002) was used to assess the presence of MDD, the existence of comorbidities, medication use at the onset, previous suicide attempts and comorbidities. Also, to assess the initial severity of participants at pre-treatment the Global Assessment of Functioning scale (GAF, American Psychiatric Association, 2000) was used. SCID-II (First et al., 1997) was used to assess the presence of a personality disorder, which was an exclusion criterion.

Beck Depression Inventory-II (BDI-II; Beck et al., 1996)

The BDI-II was the primary measure of depressive symptoms. It consists of 21 self-report depressive symptoms rated on a 4-point scale ranging from 0 to 3, and total score ranges from 0 to 63. It has been translated and validated with a Portuguese sample (Campos & Gonçalves, 2011; Coelho et al., 2002). The BDI-II total score is considered in the present analyses the measure of acute and chronic distress, as measured by Kopta, Howard, Lowry and Beutler (1994) or an informative measure for the remoralization and remediation phases of psychotherapy, as proposed by Howard et al. (1993).

Outcome Questionnaire-45.2 Interpersonal Relations Subscale (OQ-45.2 IR, Lambert et al., 1996)

The 11 self-report items of OQ-45.2 interpersonal relations (IR) subscale were extracted from the Outcome Questionnaire 45 (OQ-45.2; de Jong et al., 2007; Lambert et al., 1996). I*t* measures a range of interpersonal complaints such as loneliness, conflicts with others, family and marriage problems and sexual life, which are rated on a 5-point *Likert* scale ranging from 0 to 4. Thus, the total score ranges from 0 to 44, where high scores indicate interpersonal problems and low scores indicate satisfaction with interpersonal relations (Lambert, Hansen, et al., 1996). Lambert, Burlingame, et al. (1996) found good internal consistency (α = .74), and test-retest reliability measures (r =.80). Furthermore, Lambert, Burlingame, et al. (1996) indicated that the OQ-45.2 IR correlates significantly with all but two subscales of the Inventory of Interpersonal Problems (IIP, Horowitz, Alden, Wiggins, & Pincus, 2000), the most widely used measure of interpersonal functioning. For a comparison with the results obtained by Kopta et al. (1994) and Barkham et al. (1996), we assume that the OQ-45.2 IR is equivalent to the "characterological" symptoms, which are interpersonal in nature. In the Phase Model, it would reflect the rehabilitation phase (Hilsenroth et al., 2001; Howard et al., 1993; Swift et al., 2010).

Clients were asked the complete both questionnaires every fourth session (i.e., at sessions 1, 4, 8, 12, 16 and 20) and handed to participants before the session took place.

Analysis

Definition of clinical significant change

A standardized definition of clinical change was used (Jacobson & Truax, 1991). The values that determine the threshold for the clinical and non-clinical sample and the RCI are given below. According to norms gathered from meta-analysis (Seggar, Lambert, and Hansen 2002), changes on the BDI-II greater than 8.46 are considered to be a reliable change (i.e., improvement) and if simultaneously the score falls below 14.29, the client is considered as "recovered". Regarding the OQ-45.2 IR, the client is considered dysfunctional when the score is above 14 points. Change is considered reliable (RCI) when a score changes by 8 points or more.

Definition of an event

The event should be a binomial variable that occurs after a period of time, which in this study is defined as recovery and improvement (as described above). A client was only considered as improved and recovered if the status was reached and kept until the last session of treatment (Anderson & Lambert, 2001).

Survival Analysis

A survival analysis of an event implies that the whole sample has been included in the analysis, including those participants who did not reach the event of interest during the observation period. The Kaplan–Meier method (KM; Kaplan & Meier, 1958), a nonparametric technique for analyzing survival data (Harnett et al., 2010; Willett & Singer, 1993), was used for the present analyses. In order to evaluate whether or not KM survival curves were statistically different the log–rank test (Mantel-Cox test) was used.

Effect sizes

Pre- to post-treatment effect sizes (ES) using Cohen's *d* (Cohen, 1988) were calculated for the BDI-II and the OQ-45.2 IR. For a more conservative ES estimate of post-treatment the value of the last observation carried forward (Shao & Zhong, 2003) was used. Paired *t*-tests were applied to evaluate statistical significance of pre- to post-treatment differences on the BDI-II and the OQ-45.2 IR.

Results

One fourth of the ITT sample (23.8%) attended eight sessions or fewer and almost half of the clients (49.2%) attended 16 sessions or more. The mean number of sessions attended was 13.9 sessions ($SD = 6.8$) and the median was 16. Out of the 63 clients of the total sample only two (3%) had scores in the functional range of the BDI-II and seven (11%) had scores in the functional range of the OQ-45.2 IR at pre-treatment. These clients were also included in all analysis.

Improvement and recovery on depressive symptoms and interpersonal problems

Proportion of clients improving

The survival analysis for depressive symptoms (BDI-II) revealed that 49.2% of clients improved, whereas only 15.9% improved in interpersonal problems (OQ-45.2 IR) [$x^2(1) = 15.95$, $p < .001$].

Proportion of clients recovering

Similarly to the improvement rates, significantly more clients recovered from their depressive symptoms (34.9%), when compared to their interpersonal problems (14.3%) [$x^2(1) = 7.23$, $p = .01$].

Differential time effect of treatment group

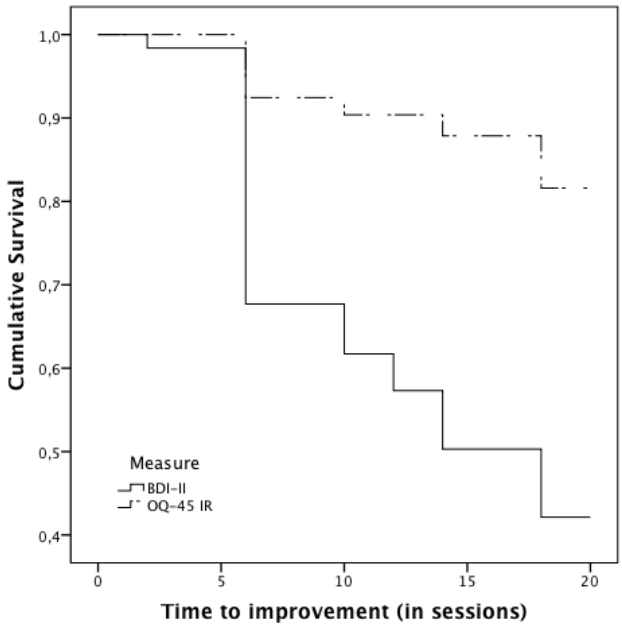
Separate survival analyses were carried out to assess whether time to improvement and recovery of depressive symptoms and interpersonal problems were associated with treatment assignment. Log rank (Mantel-Cox) tests show that neither for the time to improvement [BDI-II: $x^2(1) = 0.7$, $p = .40$; OQ-45.2 IR: $x^2(1) = 0.23$, $p = .63$], nor for the time to recovery [BDI-II: $x^2(1) = 0.06$, $p = .81$; OQ-45.2 IR: $x^2(1) = 0.03$, $p = .87$] the survival curves of the two treatment conditions differ from each other.

Improvement of depressive vs. interpersonal problems

As analyses revealed no significant differences for treatment group regarding time to improvement or recovery in depressive symptoms or interpersonal problems, the total sample ($n = 63$) will be used in the following survival analyses which aim to assess the hypothesis that the change in symptoms occurs faster than the change in interpersonal problems (Barkham et al., 1996, 2002; Howard et al., 1993; Kopta et al., 1994). Thus, figures 1 and 2 compare, respectively, the probability rates of improvement and recovery of depressive symptoms and interpersonal problems for the total sample.

Figure 3 shows the survival curves for improvement of depressive symptoms and interpersonal problems. The curves differ significantly from each other [$x^2(1) = 17.12$, $p < .001$]. Thus, four sessions of psychotherapy are necessary for 25% of the sample to improve from depressive symptoms. Comparatively, more than 20 sessions are necessary for the same 25% of the sample to reach clinical improvement from interpersonal problems. By session 4, only 11.7% of the sample had improved their interpersonal symptoms.

Figure 3. *Comparison of Kaplan-Meier survival plots for improving reliably of depressive (BDI-II) and interpersonal problems (OQ-45.2 IR), for the entire sample*

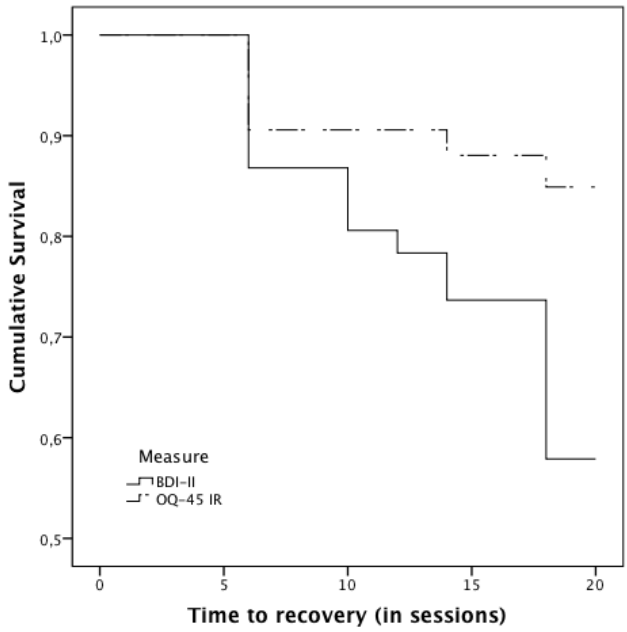


Log Rank (Mantel-Cox): $x^2_{(1)} = 17.12$, $p = .001$.
Note. BDI-II = Beck Depression Inventory; OQ-45.2 IR = Outcome Questionnaire Interpersonal Relations Subscale.

Recovery of depressive symptoms vs. interpersonal problems

In figure 4, the Kaplan-Meier survival curves comparing the probability of recovery for depressive symptoms and interpersonal problems are displayed. The survival curves differ only marginally from each other [$x^2(1) = 6.65$, $p = .10$]. They show the same probability of change in the first sessions, but already on the fourth session the BDI-II curve starts to show a higher probability of improvement per session when compared to the OQ-45.2 IR curve. The differential probability of depressive symptoms and interpersonal problems recovery is clearer by the end of the treatment. At the end of 12 psychotherapy sessions 25% of clients had recovered in their depressive symptoms, whereas only 11.5% had recovered from their interpersonal problems.

Figure 4. *Comparison of Kaplan-Meier survival plots for recovery of depressive (BDI-II) and interpersonal problems (OQ-45.2 IR), for the total sample*



Note. BDI-II = Beck Depression Inventory; OQ-45.2 IR = Outcome Questionnaire Interpersonal Relations Subscale. Log Rank (Mantel-Cox): $x^2_{(1)} = 6.65$, $p = .10$.

Time to recovery of depressive symptoms only for those who recovered

If we considered only clients who recover of depressive symptoms, after four sessions 25% of the clients ($n = 22$) had recovered, while 50% recovered only after 11 sessions.

Effect sizes

Pre to post-treatment effect sizes are an alternative strategy to compare treatment impact on depressive symptoms and interpersonal problems. As table 1 shows, it was found that the pre to post-treatment effect size for the BDI-II for the total sample was $d = 0.79$, whereas for the OQ-45.2 IR it was only $d = 0.34$. Furthermore, the pre to post-treatment effect size was statistically significant for the BDI-II, but only marginally significant for the OQ-45.2 IR (see table 4).

Table 4. *Pre- to post-treatment effect sizes in each outcome measure*

Outcome Measure	Treatment Group	Pre-treatment Mean *(SD)*	Post-treatment Mean *(SD)*	*df*	*t*	*p*	*d*[1]
BDI-II	CBT	33.90 (11)	18.90 (13)	28	6.08	.000	1.25
	NT	29.09 (10)	22.59 (13)	33	3.09	.004	0.56
	Total	31.3 (10.7)	20.9 (13.3)	62	6.19	.000	0.79
OQ-45.2 IR	CBT	21.41 (5.8)	18.06 (7.6)	28	2.37	.025	0.50
	NT	20.70 (5.7)	19.15 (7.7)	33	1.37	.179	0.17
	Total	21.03 (5.73)	18.65 (7.62)	62	2.66	.010	0.34

Note. BDI-II = Beck Depression Inventory-II; OQ-45.2 IR = Outcome Questionnaire Interpersonal Relations Subscale; *SD* = Standard Deviation; *df* = degrees of freedom; *d* = pre- to post-treatment effect size.
[1] Effect sizes have been categorized along a continuum of "small"(0.2 =< ES =<0.5), "medium" (0.5 =< ES =< 0.8) and "large effect" (ES >= 0.8) (Cohen, 1988).

Discussion

The main aim of this study was to test whether time to attain clinically meaningful change was different in Narrative Therapy (NT) and Cognitive-Behavioral Therapy (CBT). Survival analyses indicate that being assigned to either NT or CBT treatment was not associated with the time to improve or recover. This finding is coherent with the Dodo Bird Verdict (L. Luborsky et al., 2006; L. Luborsky, Singer, & Luborsky, 1975; Stiles, Shapiro, & Elliott, 1986; Wampold et al., 1997) a paradigm in psychotherapy theory and research that suggests psychotherapy equivalence of all *bona fide* treatments (Wampold, 2001).

Consistent with the finding that improvement occurs before full recovery (e.g., Kadera et al., 1996; Anderson & Lambert, 2001), it was found that after four sessions 25% of the clients had improved from their depressive symptoms, which is similar to the five sessions for 25% of improvement reported by Anderson and Lambert (2001). These figures are also very similar to those found by Kadera et al. (1996).

To the authors' knowledge, this is the first research studying the Phase Model within a NT setting. The fact that a larger proportion of clients improved and recovered from depressive symptoms than from interpersonal problems yields evidence for the Phase Model for NT and CBT of depression. Additionally, the

calculation of pre- to post-treatment effect sizes highlights that more consistent change on the BDI-II (medium effect size) and only a modest change on the OQ-45.2 IR (small effect size) occurred in both treatments. Moreover, findings from the survival analyses add the information that not only greater change occurs in the symptomatic level, but also that it occurs significantly faster than change in the interpersonal level.

In another study with NT, using a large sample and a standardized treatment procedure, Vromans and Schweitzer (2011) reported similar results. The authors found large pre- to post-treatment effect sizes on depressive symptoms (on the BDI-II) and only medium pre- to post-treatment effect sizes on interpersonal problems (on OQ-45.2 IR). This was also observed in a different study with a sample of clients who underwent psychodynamic psychotherapy of depression (Hilsenroth et al., 2001), which may suggest that the Phase Model might apply to brief psychotherapies for depression in general. However, in order to generalize these findings, further research with other psychotherapy models and settings should be conducted.

Strengths

Strengths of the study to be highlighted are its innovative nature by showing data from a clinical trial of an understudied form of psychotherapy (NT), its specificity to depressed clients, the use of a survival analytic approach and the use of a standardized evaluation of clinical improvement.

Limitations and future directions

The sample of therapists was composed by a considerable number of postgraduate students. It remains unclear to which extent this may have influenced the

results regarding the speed of change. Some evidence suggests that more experienced therapists achieve quicker results than their less experienced colleagues (e.g., Aveline, 2005; Okiishi, Lambert, Nielsen, & Ogles, 2003). Alternatively, there are also studies that found no evidence for differential dose-response curves for professionals and therapists in training (e.g., Hansen & Lambert, 2003; Beutler et al., 2004). In the present study the clinical experience of the therapist was not associated with the speed of recovery and improvement.

Also, this kind of research may confound, the number of psychotherapy sessions one client received with the time elapsed from the first observation to the last. Thus, it should be highlighted that "the effects could reflect merely the passage of time rather than the dose of treatment" (Barkham et al., 2002, p. 472). This limitation may refer to the area of psychotherapy outcome research in general, but has special relevance for the scientific question risen by this study, namely, the time it takes for a client to change.

Future research should assess clients' symptom progress and interpersonal changes at every session during treatment and also evaluate the follow-up period, given the recurrent nature of major depression.

Implications

The dose-response research has steered the political discussion around the number of psychotherapy sessions offered by health agencies (Anderson & Lambert, 2001; Hansen et al., 2002; Harnett et al., 2010; Kadera et al., 1996; Lambert, 2007). One of the arguments is that the number of sessions offered by these agencies is often not informed by empirical research and hence set up arbitrarily. As a consequence it is

argued that public health systems and health insurance companies offer less psychotherapy than what would be necessary for clients to attain significant clinical benefits. Our estimates corroborate the dose found by other researchers that between 8 and 21 sessions of psychotherapy are required for 50% of clients to improve from depressive symptoms. A typical MDD client who recovers does so by session 11.

In that sense, these findings are informative for clinicians to elaborate a more accurate treatment plan and adjust clients and therapists' expectations regarding treatment length. It is suggested that clinicians can reduce dropout rate significantly by informing the clients of the expected length of treatment (Swift & Callahan, 2011). It was also observed that clients who expected to have more psychotherapy sessions in fact end up attending more sessions (Owen, Smith, & Rodolfa, 2009). Moreover, for the few clients who will not recover during brief interventions, and especially for the clients who present strong interpersonal problems at onset, long-term treatment plans should be considered.

These findings yield additional evidence for the Phase Model of change in a sample of depressive clients. No empirical support was found for the claim that CBT produce a more "superficial" symptomatic level (e.g., D. Dobson & Dobson, 2009). In NT and even in stronger interpersonally focused treatments (e.g., IPT; Barkham et al., 1996, 2002), changes in interpersonal problems occur, but rather slow compared to changes in depressive symptoms. Thus, these findings support the idea shared by clinicians that special interventions should be applied at different phases of treatment, with more emphasis laid on symptomatic relief in the early stages of treatment and focusing on interpersonal issues at later stages (Howard et al., 1993).

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CHAPTER III.

PREDICTORS OF DROPOUT IN A CONTROLLED CLINICAL TRIAL OF PSYCHOTHERAPY FOR MODERATE DEPRESSION

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Abstract

Psychotherapy dropout is a major challenge for clinicians. The present study explores potential predictors of dropout in a sample of clients who took part in a controlled clinical trial designed to test the efficacy of Narrative Therapy for major depressive disorder when compared to Cognitive-Behavioural Therapy. The most significant findings were that (1) clients taking medication at intake were 80% less likely to drop out psychotherapy, compared to those who were not taking medication; (2) clients presenting anxious comorbidity at intake were 82% less likely to drop out compared to those not presenting anxious comorbidity; and (3) treatment assignment did not predict dropout. These results suggest that pharmacotherapy and comorbid anxiety symptoms may enhance motivation for depressed clients to make better use of psychotherapy.

Introduction

A high number of psychotherapy clients remain untreated and dropout is one of the main reasons. Mean dropout rate at psychotherapy settings has been found to be 46.86%, ranging from 30 to 60%, (Wierzbicki & Pekarik, 1993). Although a more recent meta-analysis found the mean dropout rate across studies to be reasonably lower (approx. 20%, ranging from 0% to 74.23%, Swift & Greenberg, 2012), the problem still represents a waste of economic and human resources and thus, a challenge for clinicians and psychotherapy researchers.

A few predictors of dropping out have emerged recurrently in research, such as low social economic status (Garfield, 1994; Reis & Brown, 1999), marital status, previous therapy experience (Werner-Wilson & Winter, 2010), low education, younger age (Swift & Greenberg, 2012), race (Lester, Artz, Resick, & Young-Xu, 2010), being female (Shamir, Szor, & Melamed, 2010), suffering from low levels of anxiety and/or depression (Baekeland & Lundwall, 1975), less experience as therapist (Roos & Werbart, 2013; Swift & Greenberg, 2012) and weaker alliance (Sharf, Primavera, & Diener, 2010). Still, most researchers who have investigated psychotherapy dropout agree that there is no clear evidence for a pattern of dropout predictors (Baekeland & Lundwall, 1975; Corning & Malofeeva, 2004; Pina, Silverman, Weems, Kurtines, & Goldman, 2003; Reis & Brown, 1999; Swift & Greenberg, 2012).

Some evidence is found suggesting higher dropout rates for cognitive-behavioural therapy (CBT; Cuijpers, van Straten, Andersson, & van Oppen, 2008), when compared to other psychotherapies for depression, such as nondirective supportive therapy, behavioural activation therapy, psychodynamic therapy, problem-solving therapy, interpersonal psychotherapy and social skills training. On the other hand, it is most common not to find differences between treatment groups (Swift & Greenberg, 2012). To our knowledge there is no research addressing specifically the dropout problem in narrative therapy (NT). In a study conducted to test the efficacy of NT for depression (Vromans & Schweitzer, 2011) it is only presented the completers analysis and no references to the dropout rate are mentioned. Another study on similar forms of NT includes some information about the dropout rates. Using a randomized controlled trial design, Beutler et al. (2003) applied 20 individual sessions of a variant of NT called Narrative Cognitive Therapy (NCT; Ó. Gonçalves, 1994) to clients who

had comorbid depression and stimulant dependency. Dropout in this study was defined as the failing to show up for three consecutive scheduled sessions, which yield an overall dropout rate of 52%. The NCT group had a significantly lower dropout rate if compared to cognitive therapy for substance abuse and prescriptive therapy.

In a controlled clinical trial aimed to test the comparative efficacy of narrative therapy (NT) and cognitive-behavioural therapy (CBT) for moderate adult depression (Lopes et al., 2014) the dropout sample played an important role in the results. They found that although both NT and CBT completers had similar performance in depressive symptoms reduction with outcomes significantly greater than the natural history of depression, when dropouts were included in the analysis pre-post-treatment outcomes for CBT were significantly better. The aim of this study is to explore the attrition data of Lopes et al's (2014) clinical trial by assessing differences between dropouts and completers and potential predictors for dropping out of therapy.

Methods

Participants, therapists, procedures and treatment conditions are described in more details in the original report of the study (Lopes et al., 2014). A brief description is provided here.

Participants

Eighty-one clients diagnosed with moderate Major Depression Disorder (MDD) according to the DSM-IV (American Psychiatric Association, 2000) were selected for the study. Of those, 16 either refused to participate or simply did not show up after the initial assessment (i.e., who we count as “non-engagers”, according

to Huang, Hill, & Gelso, 2013). Two additional clients (one in the CBT and one in the NT group) were excluded due to comorbid personality disorders. A sample of 63 clients was then assigned to either NT or CBT. Clients of both groups showed no significant differences at intake [majorly female (81%), had a mean age of 35.44 years old (*SD* = 11.51), 79.4% had comorbid anxiety as a prominent symptom or a comorbid disorder at intake and 60.3% of them entered treatment taking some kind of psychiatric medication].

Ten therapists, all psychologists, with different levels of experience (*M* =1.9 years of experience, *SD* = 2.13) saw clients individually. According to Orlinsky and Rønnestad's (2005) definition, seven therapists were considered novice or apprentice (i.e., they had between 1.5 and 3.5 years of clinical experience) and three therapists were considered graduate therapists (i.e., they had between 3.5 and 7 years of clinical experience). The seven apprentice and novice therapists treated 29.2% of the cases whereas the three graduate therapists treated 70.8% of the cases.

Treatment conditions

The CBT (Beck, Rush, Shaw, & Emery, 1979) and NT (Lopes et al., 2014; White, 2007) treatment manuals included a total of 20 sessions, being the first 16 sessions weekly and the last four every other week. The interventions made similar requirements on the clients (e.g., completion of forms, in-session assignments, out-of-session assignments). Adherence to the manual and therapist competence were guaranteed through weekly supervision and assessment by external judges using videotapes of sessions and a rating scale developed for this purpose (M. M. Gonçalves, Bento, Lopes, & Salgado, 2009), showing good results (Lopes et al., 2014).

Measures

Structured Clinical Interview for DSM-IV-TR - Axis I Disorders (SCID-I; First, Spitzer, Gibbons, & Williams, 2002). The SCID-I was used in the initial assessment for determining inclusion and exclusion criteria and to gather demographic and clinical information about the participants. Demographic variables assessed were age, gender, level of education, marital status, and employment status. Clinical variables assessed were global assessment of functioning (GAF) at intake, presence of anxious co-morbidity at intake, medication at the intake, prior hospitalizations, prior suicide attempts and prior experience with psychotherapy. GAF scale is divided into 10 equal parts and provides defining clinical characteristics for each 10-point interval. The lowest number represents the "hypothetically sickest individual" (Startup, Jackson, & Bendix, 2002, p. 417) and the highest number represents the "hypothetically healthiest" (p. 417).

Graffar index (Graffar, 1956): a 25-point scale that measures social-economic status (SES), and takes into account income, level of education, profession, and type of housing. Higher scores mean lower SES.

Beck Depression Inventory-II (BDI-II; Beck, Steer, & Brown, 1996). A Portuguese validated version (Campos & Gonçalves, 2011) was used to measure baseline severity of depressive symptoms. It consists of 21 self-report symptoms, each rated on a 4-point scale ranging from 0 to 3, and total score ranges from 0 to 63. The BDI-II was shown to have high internal consistency (α=.91; Steer, Brown, Beck, & Sanderson, 2001; α =.89 in our sample).

Outcome Questionnaire (OQ45.2; Lambert et al., 1996). A Portuguese version (Machado & Fassnacht, 2014) was used to measure general psychological distress. It

comprises 45 questions not only about psychological distress, but also about interpersonal relations and the social role of the patient. Higher scores mean more psychological distress. Cronbach's alpha was 0.93 (de Jong et al., 2007; Lambert et al., 1996).

The interpersonal relations subscale (OQ-45.2 IR) was extracted to measure interpersonal complaints such as loneliness, conflicts with others, family and marriage problems. Lambert, Burlingame, et al. (1996) indicated that the OQ-45.2 IR correlates significantly with the Inventory of Interpersonal Problems (IIP, Horowitz, Alden, Wiggins, & Pincus, 2000).

Working Alliance Inventory, client version (WAI-C; Horvath & Greenberg, 1989). It measures three dimensions of working alliance (goals, tasks and bond) independent of the therapist's theoretical orientation. Higher scores mean better alliance. The Portuguese version of the WAI-C used in this study also shows good levels of internal consistency and reliability (Machado & Horvath, 1999).

Definition of dropout

Dropout in our study has been defined as the unilateral termination by the client without the therapist's approval or knowledge (Hatchett & Park, 2003; Jung, Serralta, Nunes, & Eizirik, 2013; Roos & Werbart, 2013). Therapists informed clients' dropout status in the project according to this definition (Lopes et al., 2014).

Results

Attrition along treatment

To understand at which point in treatment dropout tends to occur, table 5 shows that of the 23 clients who eventually dropped out, almost 50% did so by the end of the 4th session, and most dropouts (91%) left treatment before the 11th session. Mean length of stay in treatment for the dropout group was 6.4 (*SD* = 4.4) and mean length of stay for the completers group was 18.15 (*SD* = 3.23), which represents a statistically significant difference [$t_{(61)} = -12.16$, $p = .0001$].

Table 5. *Attrition along treatment for the whole sample*

Session	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Cumulative %	9	22	35	48	57	57	57	57	74	87	91	91	91	91	96	100

Predicting dropping out using general and clinical characteristics of clients

To predict dropping out, we used clients' general characteristics (age, gender, level of education, socioeconomic status, marital status, and employment status) clients' clinical characteristics (GAF at intake, anxious comorbidity at intake, medication at intake, prior hospitalization, prior suicide attempt, prior experience with psychotherapy and intake scores on the BDI-II, OQ-45 and OQ-45.2 IR), process related variables (treatment group and WAI-C score) and a therapist variable (clinical experience). We compared dropouts and completers on the aforementioned variables using *t* tests and chi square tests, as shown at table 6. Those at least marginally significant entered a logistic regression model predicting dropping out. Only consumption of medication at intake [$\chi^2_{(1)} = 6.794$, $p = .009$] and anxious comorbidity at intake [$\chi^2_{(1)} = 3.153$, $p = .076$] met that criterion.

When those variables we entered in the logistic regression model, we found that they both had independent effect on the odds of dropping out of treatment: clients taking medication at intake were 80% less likely to drop out, compared to those who were not taking medication [*OR* = 0.2 (95% *CI* = 0.063-0.639), *p* = .007]. Clients presenting anxious comorbidity at intake were 82% less likely to drop out compared to those not presenting anxious comorbidity *[OR* = 0.182 (95% *CI* = 0.033-1.016), *p* = .0520].

Table 6. *Comparison of completers and dropouts according to continuous and discrete variables*

	Completers	Dropouts	$t_{(61)}$	*p*
	M (SD)	*M (SD)*		
Age of Client	36.2 (11.6)	34.1 (11.6)	0.684	.497
Education of client (in years)	13.1 (5.3)	13.7 (3.6)	-0.481	.632
Social Economic Status (GRAFFAR)[1]	12.7 (3.4)	11.7 (2.6)	1.107	.273
GAF at the time of the intake	59.1 (11.5)	61.1 (8.4)	-0.713	.478
Total Score BDI-II Session 01	31.5 (10.2)	31.0 (11.7)	0.168	.867
Total Score OQ-45 Session 01	95.9 (20.1)	91.9 (17.2)	0.795	.430
Total Score OQ-45.2 IR Session 01	21.4 (5.7)	20.4 (5.7)	-623	.535
Score WAI-C at session 04	50.9 (5.3)	51.0 (5.0)	-0.071	.944
	n (%)	*n* (%)	$\chi^2_{(1,3)}$	*p*
Treatment assignment				
Narrative Therapy	14 (41.2%)	20 (50%)	0.695	0.404
Cognitive Behavioural Therapy	9 (31%)	20 (50%)		
Level of therapist experience				
Novice	12 (30.0%)	4 (17.4%)	1.308	.520
Apprentice	1 (2.5%)	1 (4.3%)		
Graduate	27 (67.5%)	18 (78.3%)		
Gender of the client				
Female	33 (82.5%)	18 (78.3%)	0.170	.680
Male	7 (17.5%)	5 (21.7%)		
Relationship status				
Married	15 (37.5%)	6 (26.1%)		
Single	17 (42.5%)	10 (43.5%)	3.410	.333
Divorced	6 (15.0%)	7 (30.4%)		
Widowed	2 (5.0%)	0 (0.0%)		
Professional status				
Employed	18 (45.0%)	14 (60.9%)		
Unemployed	12 (30.0%)	2 (8.7%)	3.943	.268
Student	9 (22.5%)	6 (26.1%)		
Retired	1 (2.5%)	1 (4.3%)		
Previous psychotherapy				
No	35 (87.5%)	20 (87.0%)	0.004	.950
Yes	5 (12.5%)	3 (13.0%)		
Previous suicide attempts				
No	35 (87.5%)	18 (78.3%)	0.934	.334
Yes	5 (12.5%)	5 (21.7%)		
Previous hospitalizations				
No	36 (90.0%)	20 (87.0%)	$\chi^2_{(1)} = 0.137$	.711
Yes	4 (10.0%)	3 (13.0%)		
Psychiatric medication at intake				
No	11 (27.5%)	14 (60.9%)	$\chi^2_{(1)} = 6.794$	.009
Yes	29 (72.5%)	9 (39.1%)		
Anxious comorbidity at intake				
No	29 (72.5%)	21 (91.3%)	$\chi^2_{(1)} = 3.153$	.076
Yes	11 (27.5%)	2 (8.7%)		

[1] Graffar is an international classification for socioeconomic status (Graffar, 1956). The higher is the score, the lower the SES. This sample means (NT *M* = 12.2; CBT *M* = 12.6) indicate high SES.

Note. GAF = Global Assessment of Functioning of the DSM-IV (First et al., 2002); BDI-II = Beck Depression Inventory II; OQ-45.2 = Outcome Questionnaire 45.2; OQ-45.2 IR = Outcome Questionnaire 45.2 Interpersonal subscale; WAI-C = Working Alliance Inventory – client version.

Discussion

Of the 23 clients who have dropped out, almost 50% did so by the end of the fourth session, and most dropouts (91%) had already left treatment by the 11th session. Those figures are in line with other reports in psychotherapy research (e.g., Bados, Balaguer, & Saldaña, 2007; Baekeland & Lundwall, 1975; Garfield, 1994). Mean length of stay in treatment for the dropout group is around six sessions, a stage in which a significant improvement is less likely (e.g., Harnett, O'Donovan, & Lambert, 2010; Lopes, Gonçalves, Fassnacht, Machado, & Sousa, 2013).

Demographic variables that usually are found to predict dropping out in the literature (i.e., low SES, low education and being female) were not corroborated by our results. We expected therapeutic alliance and therapist experience to predict dropout, but rather, dropout and completer groups presented similar patterns in these variables. We suspect that this lack of finding has to do with the little variance these variables had in our sample. Treatment group not predicting dropping out is in line with most findings in the premature termination area (see Swift & Greenberg, 2012), although it conflicts with previous findings showing higher dropout rates in CBT therapies when compared to other therapies (Castro et al., 2014; Cuijpers et al., 2008) and lower dropout rates for NT when compared to cognitive therapy (Beutler et al., 2003).

Out of the variables examined, only consumption of medication at intake and anxiety comorbidity at intake had independent effects on the relative risk of dropping out of treatment: both, when present, reduced the odds of dropping out from therapy. This may suggest that higher level of suffering may be a protective factor. In a recent study, Shamir, Szor, and Melamed (2010) also found that clients taking medication

dropped out later. Although "there has been an enduring concern that alleviation of symptoms with medication would reduce the motivation for gaining the understanding or making lifestyle changes needed to bring about a sustainable 'cure'" (Thase & Jindal, 2004, p. 743), clinicians and researchers often recognize that pharmacotherapy is "a way to hasten recovery and to help patients make better use of psychotherapy" (Thase & Jindal, 2004, p. 744). It appears that the alleviation of acute symptoms promoted by medication, helped the clients adhere to psychotherapy and complete treatment. Also, the fact that clients taking medication were enrolled in two treatments, assisted by different mental health professionals (psychiatrist and psychologist) may have enhanced the adherence in the psychotherapeutic treatment and thus, decreased the odds of dropout.

The other prominent predictor for treatment dropout was not having a comorbid anxiety disorder or any comorbid anxiety symptoms at intake. To explain that relationship, we suggest that anxiety symptoms, due to the higher levels of psychological suffering it creates, would increase activity level and enhance motivation to adhere the treatment and complete the intervention. Being one of the main characteristics of MDD the lack of activity, anhedonia and other negative symptoms, it is possible that depressed clients with no comorbid anxiety would have less motivation or even less resources for completing treatment. Few studies endorse this explanation (Baekeland & Lundwall, 1975). For instance, Kendall and Sugarman (1997) found in the context of child psychotherapy that dropouts had lower levels of anxiety compared to clients who completed treatment. On the contrary, more evidence is found linking MDD and comorbid anxiety, either as a comorbid symptom or as a comorbid disorder, with poorer clinical performance. For instance Lenze et al. (2003) conclude that depressed elderly with anxious comorbidity had poorer treatment

outcomes than depressed elderly with no anxious comorbidity. Also, depressed clients with a comorbid anxiety disorder tended to prematurely terminate treatment more frequently than patients with MDD alone (Brown, Schulberg, Madonia, Katherine, & Houck, 1996). Further research is suggested to resolve these conflicting results.

These findings should be read with caution. The sample size of the dropouts group was small and hence generalization of the findings is restricted. Future studies with this sample should favour qualitative designs and should assess dropouts with good and poor clinical outcomes in different process variables along treatment, with emphasis on interactional processes. Ruptures in therapeutic alliance (Coutinho, Ribeiro, Hill, & Safran, 2011; Coutinho, Ribeiro, Sousa, & Safran, 2013) and therapeutic collaboration (E. Ribeiro, Ribeiro, Gonçalves, Horvath, & Stiles, 2013) seem to be critical factors in clients' decisions regarding premature termination. Process variables with focus on the client, such as the development of narrative change and ambivalence (M. M. Gonçalves et al., 2011; A. P. Ribeiro & Gonçalves, 2011) may also help to reveal how clients and therapist get stuck in the problematic narrative, which may be related to treatment dropout.

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CHAPTER IV.

DROPOUT OUTCOMES:

DOES DROPPING OUT OF PSYCHOTHERAPY MEAN FAILURE?

CHAPTER IV. DROPOUT OUTCOMES: DOES DROPPING OUT OF PSYCHOTHERAPY MEAN FAILURE?

Abstract

This study assesses the outcomes of dropout clients of a controlled clinical trial of Narrative Therapy *vs.* Cognitive-Behavioral Therapy for depression. It is shown that (1) CBT dropouts improved significantly more than NT dropouts and (2) dropouts improve less than completers by the last session attended, but keep improving during the follow-up period. Dropouts might improve without therapy, but it takes them longer.

Introduction

A large proportion of psychotherapy clients remain untreated and dropout is usually considered a major responsible, with rates as high as 74.23% (Swift & Greenberg, 2012). In a controlled clinical trial for moderate depression Lopes, Gonçalves, Machado, et al. (2014) found that although narrative therapy (NT) and cognitive-behavioral therapy (CBT) completers had similar outcomes in depressive symptoms reduction (significantly greater than the natural history of depression), when dropouts were included in the analysis CBT outcomes were significantly greater. The purpose of this study is to reanalyze the data to assess potential outcome differences of dropouts by treatment condition and of dropouts and completers.

Methods

Procedures are described in details in the original report (Lopes, Gonçalves, Machado, et al., 2014).

Participants

Eighty-one clients, from 107 screened, were selected to the study. Of those, 16 either refused to participate or did not show up after the initial assessment. These clients were counted as "refusers" (Issakidis & Andrews, 2004) and not included in the analysis. One client in each treatment condition was excluded for comorbid Axis-II disorders. Sixty-three clients (majorly female, had a mean age of 35.44 years old, *SD*= 11.51) diagnosed with moderate Major Depression Disorder (DSM-IV; American Psychiatric Association, 2000) were then assigned to either NT or CBT. Dropouts and completers only differed on the number of clients taking psychiatric medication at intake and number of clients with anxiety comorbidity (Lopes, Gonçalves, Sinai, et al., 2014). Mean length of stay in treatment for the dropout group was 6.4 (*SD* = 4.4) and significantly lower than for the completers group (18.15, *SD* = 3.23) (Lopes, Gonçalves, Sinai, & Machado, 2014). All participants were contacted after 31 months after termination and 42 (66%) returned assessment forms.

Ten therapists, all psychologists, with different levels of experience (1.9 years of experience, *SD*= 2.13) saw clients individually.

Treatment conditions

The CBT (Beck, Rush, Shaw, & Emery, 1979) and NT (White, 2007) treatment manuals included a total of 20 sessions and made similar requirements on the clients (e.g., completion of forms, in- and out-of-session assignments). Adherence to the manual and therapist competence were granted through weekly supervision and assessed from the perspective of external judges using videotapes of sessions and a

rating scale developed (Gonçalves, Bento, Lopes, & Salgado, 2009) for this purpose, showing good results (Lopes, Gonçalves, Machado, et al., 2014).

Measures

Dropout was defined as the unilateral termination by the client without the therapist's approval or knowledge (Hatchett & Park, 2003).

Beck Depression Inventory-II (BDI-II; Beck, Steer, & Brown, 1996; Campos & Gonçalves, 2011) measured severity of depressive symptoms.

Outcome Questionnaire Interpersonal Relations subscale (OQ-45.2 IR; Lambert et al., 1996; Machado & Fassnacht, 2014) measured interpersonal problems such as loneliness, conflicts with others, and family problems.

Results

Comparing change between NT and CBT dropouts

The proportion of clients who dropped out before (Fisher's exact probability= 0.42) or after the fourth session (0.58) did not differ by treatment group. A two (pre- and last session attended) x two (groups) repeated measures ANOVA with the BDI-II scores showed that both groups improved significantly [F (1, 21)= 6.645, p= .018] and CBT dropouts improved significantly more than NT dropouts [F (1,21)= 5.646, p= 0.27]. On the OQ45.2-IR, no significant time effect [F (1,21)= 0.230, p= .636], or time *versus* group interaction were detected [F (1,21)= 1.873, p= .186].

Comparing change between dropouts and completers

Comparison at last session attended

A two (first and last session attended) *x* two (groups) repeated measures ANOVA showed significant time effects [BDI-II: $F(1,61)= 42.990$, $p= .0001$; OQ45.2-IR: $F(1,61)= 8.010$, $p= .006$] and significant time *vs.* group interactions favoring completers [BDI-II: $F(1,61)= 8.404$, $p= .005$; OQ45.2-IR: $F(1,61)= 8.816$, $p= .004$].

Comparison at eighth session

The analysis was repeated with the eighth session as the ending point instead. Missing data of clients dropping out before the eighth session were filled using the Last Observation Carried Forward method (LOCF; Shao & Zhong, 2003). It was found a significant time effect [$F(1,61)= 25.098$, $p= .0001$] and time *vs.* group interaction $F(1,61)= 5.083$, $p= .028$] favoring completers on the BDI-II, but not on the OQ45.2-IR [time: $F(1,61)= 3.390$, $p= .070$, time *vs*. group interaction: $F(1,61)= 3.148$, $p= .081$].

Comparison at follow-up

A two (post-treatment and 31-month follow-up) *x* two (groups) ANOVA showed significant change over time [BDI-II: $F(1,40)= 5.605$, $p= .023$ and OQ45.2-IR: $F(1,40)= 4.89$, $p= .044$]. Dropouts reduced the BDI-II scores significantly more than completers [$F(1,40)= 13.294$, $p= .001$] but not the OQ45.2-IR scores [$F(1,40)= 2.011$, $p= .164$].

Clinical significance

According to Jacobson and Truax (1991) criteria, by the last session attended, dropouts improve [$x^2(1, N= 63)= 7.74, p= .005$] and recover [$x^2(1, N= 63)= 3.75, p= .027$] significantly less than completers (see Table 7). Still, considerable proportions of dropouts improve (43%) after treatment. At 31-months follow-up dropouts recovered significantly more (46% of the retained dropout sample) than completers (18%, $x^2(1, N= 42)= 3.89, p. = .044$).

Table 7. *Rates of clinical significant change in depressive symptoms (BDI-II) for dropouts and completers on their last attended session and at 31-months follow-up*

Type of Change	Dropouts	Completers	$x^2(1)$
At last session attended (N= 63)			
	n = 23	*n* = 40	
Improvement [a]	6 (26%)	25 (62%)	7.74*
Recovery [b]	4 (17%)	18 (45%)	4.89*
Deterioration [c]	1 (4%)	0 (0%)	1.76†
At 31-months follow-up (N= 42)			
	n = 13	*n* = 29	
Maintained Recovery	2 (16%)	10 (34%)	0.14
Recovery at follow-up	6 (46%)	5 (18%)	3.89*
Never recovered	5 (38%)	8 (27%)	0.12
Relapsed at follow-up	0 (0%)	6 (21%)	1.67

Note. BDI-II= Beck Depression Inventory-II. Yates' correction was employed in comparisons containing cells with less than five cases (Preacher, 2001).
[a]Improvement= proportion of clients who changed more than the Reliable Change Index: for BDI-II= 8.46; [b]Recovery= clients who simultaneously improve and move into the functional population; [c]Proportion of clients who deteriorated reliably (more than Reliable Change Index)
*$p < .05$; †$p < . 10$

Discussion

CBT dropouts leave treatment with significantly greater improvements in depressive symptoms than NT dropouts, which corroborates the differential efficacy found by Lopes et al. (2014). This finding was already implicit on the conflicting results between the completers and the intent-to-treat analysis and now it is more evident. We suggest that CBT clients may have profited of the behavior activation (BA) module. NT clients were asked already at initial phases of treatment to perform narrative tasks that required complex cognitive functions, which may have been

demanding for depressed clients. A dismantling study should compare the performance of clients treated with NT preceded by BA with clients treated with NT alone.

Before dropping out 43% of dropouts improve at a clinically significant level, which is in line with the evidence showing that some dropouts report feeling better by the time they decide to leave treatment (e.g., Shamir, Szor, & Melamed, 2010). Still, as it is expected, dropouts show significantly poorer performances in reducing depressive symptoms and interpersonal problems when compared to treatment completers by the last session attended. To control the dose effect, we considered only the eight initial sessions for both groups. In this analysis, completers still had superior outcomes in depressive symptoms reduction but dropouts and completers did not differed in reduction of interpersonal problems. These findings corroborate the phase model (Howard, Lueger, Maling, & Martinovich, 1993) and previous dose-response research, showing that psychotherapy effects in reducing depressive symptoms occur faster than interpersonal problems (e.g., Lopes, Gonçalves, Fassnacht, Machado, & Sousa, 2013).

The improvement of dropouts at follow-up should not be interpreted as an effect of psychotherapy, but rather due to their higher scores by the last session attended. Rather, the fact that dropout clients improve from depressive symptoms before dropping out of treatment (one-fourth at a clinical significant level) and keep improving at follow-up (46% actually recover after 31 months after dropping out of therapy) may shed light on the spontaneous remission of depression. Qualitative interviews with the clients who recovered before dropping and maintained recovery after 31 months would be especially recommended.

The sample size of the dropouts group was small and hence generalization of findings is restricted. Still, these findings should ground clinician's recommendations to potential dropout clients on the beneficial advantages of completing treatment. Dropping out of therapy does not necessarily mean clinical failure. Optimistically, these findings suggest that dropouts will improve even without therapy. Realistically, they suggest that improvements might take longer time to occur, when compared to those who complete treatment.

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CHAPTER V.

LONG-TERM EFFECTS OF PSYCHOTHERAPY FOR MODERATE DEPRESSION: A COMPARATIVE STUDY OF NARRATIVE THERAPY WITH COGNITIVE-BEHAVIORAL THERAPY

CHAPTER V. LONG-TERM EFFECTS OF PSYCHOTHERAPY FOR MODERATE DEPRESSION: A COMPARATIVE STUDY OF NARRATIVE THERAPY WITH COGNITIVE-BEHAVIORAL THERAPY[14]

Abstract

Background: Narrative Therapy (NT) showed promising results in ameliorating depressive symptoms with comparable outcomes to Cognitive-Behavioral Therapy (CBT) when patients completed treatment. *Methods*: Naturalistic prospective follow-up assessment using Beck Depression Inventory-II and Outcome Questionnaire-45.2 Interpersonal Relations Scale were carried out at 21 and 31 months after the last session of treatment. *Results*: At follow-up clients keep improving depressive symptoms, but not interpersonal problems. The odds that a patient remains recovered from depressive symptoms at follow-up are five times higher than the odds of a patient remains recovered in interpersonal problems. In the same direction, the odds of a patient never recovering from interpersonal problems are five times higher than the odds of never recovering from depressive symptoms. *Limitations*: The natural course of depression was not controlled for. Future studies should apply a more regular assessment schedule at follow-up and use control groups. *Conclusions*: For depressed patients with greater interpersonal disabilities longer treatment plans and alternative continuation treatments should be considered.

Introduction

In a comparative short-term efficacy study, Lopes et al. (2014) found that depressed patients who received NT showed significant reduction in depressive

[14] This study has been submitted to the Journal of Affective Disorders and is currently under reviewing process.

symptoms. The authors concluded that for those who completed NT or CBT outcomes were significantly superior than a waiting list benchmark (Minami et al., 2007). A significant difference was found in depressive symptom reduction favoring CBT when all patients, dropouts and completers, were included in the analysis. Although by the end of treatment almost half of all patients fulfilled the criteria for clinical recovery (Jacobson & Truax, 1991), the rest remained unimproved. With this paper, we aim to assess long-term outcomes of NT in comparison to CBT, with special emphasis to the differential course of depressive symptoms and interpersonal problems.

Short-term effects of brief outpatient psychotherapy for unipolar depression have been widely reported in the psychotherapy research literature over the last 60 years (e.g., Cuijpers et al., 2008a; Demaat et al., 2007; Dobson, 1989; Elkin et al., 1989; Gloaguen et al., 1998; Hansen et al., 2002; Hollon and Ponniah, 2010; Lambert and Ogles, 2004) and Cognitive-Behavioral Therapy (CBT) for depression and its variants are well explored (Beck et al., 1979; Butler et al., 2006; Cuijpers, van Straten, Andersson, et al., 2008; Cuijpers, van Straten, Warmerdam, & Andersson, 2008; Gibbons et al., 2010). Despite effective treatments, about 20% of patients (Keller & Boland, 1998) or more (Barkow et al., 2003; Barnhofer, Brennan, Crane, Duggan, & Williams, 2013) develop a chronic form for at least two years. Accordingly, Angst (1992) found that 75% of patients had one or more recurrences of depression on a 10-year follow-up. Chances of having another depressive episode are around 50% higher for those who already had a first major depressive episode (Hollon, Thase, & Markowitz, 2002; Judd et al., 1998) and the more episodes one has experienced, the more likely is reoccurrence or relapse. For instance, chances for a fourth episode can reach 90% for those who have already experienced three previous

ones (American Psychiatric Association, 2000). Given the recurrence and chronicity of MDD, long-term follow-ups should be considered to evaluate the efficacy of a treatment (Chambless & Hollon, 1998; Cooper, 2008; Lambert & Ogles, 2004; Shapiro et al., 1995).

Long-term assessment of psychotherapy outcome

There is vast evidence showing that relapse rates in psychotherapy for depression (mainly with CBT) are significantly lower than with pharmacotherapy (e.g., 26,5% against 56%, Demaat et al., 2007). However, there is a lack of evidence comparing the differential long-term effects of forms of psychological interventions (Cuijpers, van Straten, Andersson, et al., 2008). Although available research suggests that different psychological treatments have equivalent effects over time (Blay et al., 2002; e.g., Deffenbacher, Oetting, Huff, & Thwaites, 1995; Shea et al., 1992), we find some evidence for superiority of some treatments in comparison to others (Ellison, Greenberg, Goldman, & Angus, 2009). For instance, Shapiro et al. (1995) found equivalent outcomes for CBT and psychodynamic-interpersonal psychotherapy at post-treatment but at the one year follow-up assessments, CBT showed significantly better outcomes.

Other conflicting results are found in the study of long-term effects of psychotherapy for depression. On one side we find evidence that follow-up scores are predicted by post-treatment scores (Cooper, 2008; Nicholson & Berman, 1983; Robinson, Berman, & Neimeyer, 1990). In contrast, some studies suggest a delayed response to treatment. For instance, Anderson and Lambert (2001) found that the overall improvement rate increased from 39% at post-treatment to 53% at six-month follow-up. Also, Keller et al. (1992) show that the probability of recovery from

depression was 70% two years after discharge and increased up to 80% three years after discharge. Accordingly, in a research studying longer follow-up period, the recovery rates increased from 20.4% at 15 years after discharge to 32.7% 25 years after discharge (Brodaty, Luscombe, Peisah, Anstey, & Andrews, 2001). Given the inconsistent findings it seems crucial to include outcome follow-up assessments as an essential part of studies on the effectiveness of treatments (Chambless & Hollon, 1998; Cooper, 2008; Lambert & Ogles, 2004).

A major limitation of most long-term effect studies of psychotherapy so far is the limited follow-up interval: often patients are assessed for no longer than a year after treatment (Cooper, 2008; Westen & Morrison, 2001). This trend for relatively short follow-ups is clear in a systematic review of in 53 high-quality comparative outcome studies of psychotherapy for depression (Cuijpers, van Straten, Andersson, et al., 2008). This study revealed a mean follow-up period of 5.6 months (*SD* = 5.1, median = 4 months), and 93.4% of the studies only reported follow-up data for less than 12 months (only one study presented 24-months follow-up data). For NT specifically, it is not different. To the authors' knowledge, the only study that evaluated the effects of NT for depression at follow-up (Vromans & Schweitzer, 2011) did so within a brief follow-up interval (of only three months). Thus, to understand better long-term implications of treatments a longer follow-up period (more than one year) is strongly recommended (Brodaty et al., 2001; Cooper, 2008; Lambert & Ogles, 2004; Lambert, 2007).

Symptomatic *vs.* interpersonal change in depression

Interpersonal impairment is highly associated with depression (Hammen & Brennan, 2002; Hecht, Genzwürker, Helle, & van Calker, 2005; McEvoy, Burgess, &

Nathan, 2013). It is often argued that psychotherapy, differently from psychopharmacological interventions, would not only improve actual symptoms but also help patients to develop strategies to cope with the underlying mechanisms responsible for the maintenance of depressive symptoms (Beck et al., 1979; Chambless & Hollon, 1998; DeRubeis et al., 2005; Hollon et al., 2005) thus affecting other areas of patients' functioning such as interpersonal behavior (Barkham, Stiles, & Shapiro, 1993; Kopta et al., 1994).

Frequently, clinicians observe in their daily practice that symptomatic change occurs faster than changes in interpersonal levels (interpersonal problems, dysfunctional relationship patterns, e.g. Axis-II disorders). Kopta, Howard, Lowry, and Beutler (1994) assessed clinical significant change for different symptom clusters. The authors found that for 50% of patients to recover of symptoms of acute distress, it was necessary five sessions. For the same 50% of patients to recover of chronic distress 14 sessions were necessary. For the characterological symptoms cluster, which described interpersonal problems, it was required more than 104 sessions for 50% of patients to recover, suggesting greater stability. In another study Barkham et al. (2002) assessed 105 moderately depressed patients who were assigned to three treatment conditions differing in the length of therapy, i.e., a two-session, an eight-session and a 16-session intervention condition. Results revealed that while many patients recovered from depressive symptoms, significantly fewer patients recovered from interpersonal problems in all length conditions. Accordingly, within the NT context, it was found that improvement in depressive symptoms occurred significantly faster than in interpersonal problems during treatment (Lopes, Gonçalves, Fassnacht, Machado, & Sousa, 2013).

None of the studies mentioned above show evidence for the differential effect of different psychotherapies on depressive symptoms and interpersonal problems in the long run. Thus, it is our goal to evaluate whether the differential recovery of depressive symptoms and interpersonal problems is maintained or attenuated in a long-term evaluation, and whether these changes are different in CBT when compared to NT.

Research questions

The general purpose of this study is to evaluate long-term effects of NT and CBT and whether the two treatments differ in stability over time. In order to address the gap of evidence mentioned above, specific research questions are (1) whether therapeutic gains maintain over time, at a 21 and 31 months follow-up, i.e., whether patients keep improving, stabilize or relapse, (2) whether the proportions of clinically significant change for depressive symptoms differ from the proportions of clinically significant change in interpersonal problems at long-term follow-up and, (3) whether any of these effects (referred in questions 1 and 2) have a differential outcome according to the model of treatment (NT and CBT) .

Method

Participants

The sample comprised 63 patients diagnosed with Major Depression Disorder (MDD; American Psychiatric Association, 2000) with moderate severity at the onset of the study [Global Assessment of Functioning (GAF, American Psychiatric Association, 2000): $M = 59.84$ ($SD = 10.47$)]. Some patients (20.6%) were included in the sample with a secondary anxiety diagnosis or symptoms. Patients were blindly

assigned according to their incoming order, one to NT (n = 34) and the next to CBT (n = 29) and so on. All baseline demographic and clinical characteristics were equivalent for both groups. Patients were on average 35.44 years old (SD = 11.51), and 81% were female. NT patients received on average 12.94 sessions (SD = 7.05), CBT patients received on average 14.90 sessions (SD = 6.48); $t_{(61)}$ = -1.13, p = .26 (this includes the dropouts).

Ten therapists participated in the study. All of them were psychologists and had on average 1.9 years of experience (SD = 2.13).

Procedures

Patients were contacted for follow-up regardless of how many therapy sessions they had received and regardless of how treatment was terminated. Type of termination was either consentaneously agreed with the therapist (completers) or unilateral from the patient side (dropouts). All patients were contacted through telephone, e-mail or post mail: for the first follow-up at an average of 21.3 months (SD = 7) and for the second follow-up at an average 31.3 months (SD = 9.1). Time elapsed between treatment termination and follow-up assessment did not differ according to treatment groups [21 months: t (33) = 1.34, p = .189; 31 months: t (40) = 1.43, p = .160].

Measures

Beck Depression Inventory-II

BDI-II (Beck et al., 1996) was used to measure depressive symptoms. It is considered the gold standard self-report measure to assess depression for research

purposes (Hatfield & Ogles, 2004). The BDI-II has shown to have high internal consistency (α =.89 in the present ITT sample and α=.91 in Steer, Brown, Beck, & Sanderson, 2001). The measure has been translated and validated to Portuguese populations (Campos & B. Gonçalves, 2011; Coelho, Martins, & Barros, 2002). Since the Portuguese studies did not calculate the Reliable Change Index (RCI; Jacobson & Truax, 1991), normative data gathered from a meta-analysis of diverse samples (Seggar et al., 2002) was used to calculate the proportion of clinical change (RCI, for improvement = 8.46; cut-off score = 14.29).

Outcome Questionnaire-45.2

The OQ-45.2 (Lambert, Burlingame, et al., 1996; Lambert, Hansen, et al., 1996) is a self-report questionnaire designed to assess clients' progress throughout therapy and its termination. The Cronbach's alpha was .93 in various clinical samples (de Jong et al., 2007; Lambert, Burlingame, et al., 1996), and similar reliability was obtained in our sample (α = .89), which is indicative of excellent internal consistency. *For the current analysis, it was used the* 11 self-report items of the Interpersonal Relations subscale (OQ-45.2 IR, Lambert et al., 1996)*, which* aims to assess interpersonal complaints such as loneliness, conflicts with others, family and marriage problems and sexual life. The items are rated on a 5-point Likert scale ranging from 0 (never) to 4 (almost always) providing a total score between 0 and 44 with high scores indicating interpersonal problems (Lambert, Hansen, et al., 1996). Lambert, Burlingame, et al. (1996) found good internal consistency (α =.74), and test-retest reliability (r =.80). Umphress, Lambert, Smart, Barlow and Clouse (1997) reported good concurrent validity for the OQ-45.2 IR subscale. High correlations were found between the OQ-45.2 IR and the Inventory of Interpersonal Problems (IIP; Horowitz

et al., 2000, 1988) a widely used measure of interpersonal functioning. The RCI and the clinical cut-off score (Jacobson & Truax, 1991) for the OQ-45.2 IR were calculated for the Portuguese population (Machado & Fassnacht, 2013). Change is considered reliable when a patient's score changes by at least 8 points and score of above 14 points are considered as dysfunctional.

Treatment conditions

The CBT group followed the CBT treatment manual for depression well described in the literature (Beck et al., 1979; Leahy & Holland, 2000; Rush et al., 1977). The NT treatment manual (Gonçalves & Bento, 2008) was developed specifically for the clinical trial and is based on the work of Michael White (White & Epston, 1990; White, 2007). Adherence to the manual and therapist competence were monitored at weekly supervisions (using videotapes of sessions) and assessed from the perspective of external judges using a scale developed for this purpose (Adherence and Competence Scale for Narrative and Cognitive-Behavioral Therapy [ACS-N-CBT]; Gonçalves, Bento, et al., 2009), showing good results (Lopes et al., 2014).

Patients' and therapists' characteristics, therapists' training, the two treatment manuals and the assessment of adherence and competence are described in details elsewhere (Lopes et al., 2014).

Analysis

Preliminary analyses

Chi-square analyses were used to determine whether return rates (the percentage of questionnaires sent out that were returned) differed by condition, completion of therapy or treatment response. Independent *t*-tests were used to assess pretreatment differences among conditions.

Analysis of continuous data

Repeated-measures analyses of variance (ANOVA) with time as the within-subjects factor and treatment condition as the between-subjects factor were conducted to compare depressive symptoms and interpersonal problems across the two treatment conditions (NT to CBT) at post-treatment, 21 months and 31 months follow-up.

Clinical significance analysis

Individual responses for both treatment conditions at 21 and 31 months after termination of treatment were assessed using the categories maintenance of recovery, relapse at follow-up, recovery at follow-up and maintenance of symptoms using Jacobson and Truax's (1991) criteria, the most widely used method of assessing clinically significant change in psychotherapy research (Bauer et al., 2004; Kendall et al., 2004; Ogles et al., 2001). *Maintenance of recovery* was assigned when a patient's score at follow-up assessments remained below the clinical cut-off in the range typical for a functional population (i.e., 14.29 for BDI-II and 14 for OQ-45.2 IR). *Relapse at follow-up* was assigned for patients who had recovered (i.e., attained clinical significant change) at termination and scored higher than the clinical cut-off (i.e., in the range typical for a dysfunctional population range) at follow-up

assessments. *Recovery at follow-up* was assigned for those patients who had not at post-treatment but did so at follow-up assessments. *Maintenance of symptoms* was assigned for those patients who had not recovered at post-treatment and still not at follow-up. Fisher's exact tests were used to determine between-group association of the clinical categories providing two-tailed *p*-values (Preacher & Briggs, 2001).

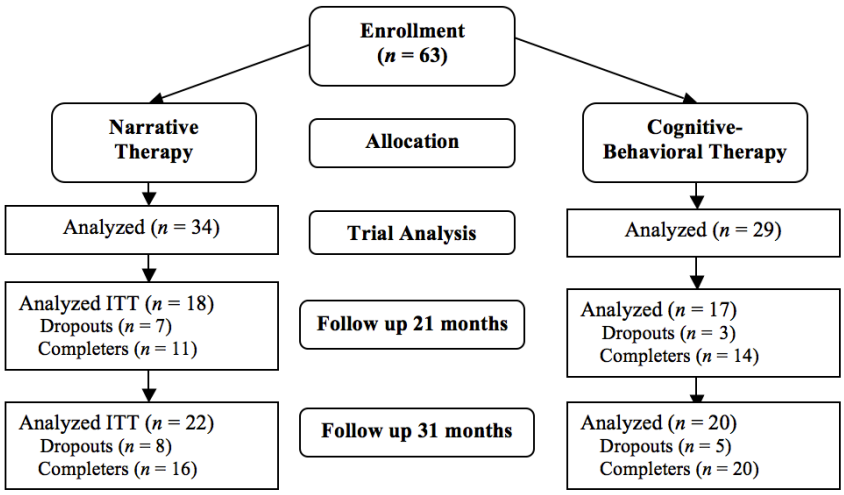
Effect sizes

Effect sizes were expressed in odds ratios, widely used in medical reports to "provide an estimate (with confidence interval) for the relationship between two binary variables" (Bland & Altman, 2000, p. 1468).

Results

Figure 5 describes the flow of participants in the clinical trial: at the 21 months follow-up observation, 35 patients were assessed (10 were dropouts and 25 were completers); at the 31 months follow-up observation 42 patients were assessed (13 dropouts and 29 completers). Reasons for attrition at follow-up were: participants did not reply [$n = 11$ at the 21 months and $n = 5$ at the 31 months follow-up] or had moved away and/or changed phone number [$n = 4$ at the 21 months and 31 months follow-up].

Figure 5. *Flow diagram for the clinical trial and follow-up assessments*



Preliminary Analyses

One "major problem with follow-up designs is that they are particularly susceptible to bias resulting from differential retention" (Chambless & Hollon, 1998, p. 10). To ensure that the present follow-up samples were comparable to the initial sample possible bias due to differential retention was assessed.

Differential attrition

Overall return rates of 55.5% at the 21 months follow-up and of 66.6% at the 31 months follow-up were achieved. A Pearson's chi-square test revealed no differences in return rates between the two treatment conditions [59.9% for NT and 58.6% for CBT at 21 months, $\chi^2(1, N = 63) = 0.20$, $p = .651$; and 64.7% for NT and 69% for CBT at 31 months, $\chi^2(1, N = 63) = 0.13$, $p = .721$]. Also no differential attrition according to recovery status was found: at 21 and 31 months observation return rates for recovered patients were 63.6% and 81.8%, respectively, and for non-recovered patients 51.2% and 58.5% [21 months follow-up: $\chi^2(1, N = 63) = 0.89$, $p = .344$; 31 months follow-up: $\chi^2(1, N = 63) = 3.49$, $p = .062$]. Return rates were not

higher among treatment completers compared to dropouts [21 months follow-up: 62.5% completers *vs.* 43.5% dropouts, $\chi^2(1, N = 63) = 2.14$, $p = .144$; 31 months follow-up: 72.5% completers *vs.* 56.5% dropouts, $\chi^2(1, N = 63) = 1.68$, $p = .195$]. In summary, these findings suggest that the retained follow-up samples were not biased by differential return according to treatment condition, completion of therapy or treatment response.

Pre-treatment differences among NT and CBT

Although the two treatment groups did not show pre-treatment differences in the original study (Lopes et al., 2014), the present retained sample was re-analyzed to check whether long-term findings would not be inadvertently confounded by pre-treatment differences among conditions at follow-up. Independent *t*-tests revealed no significant pretreatment differences across conditions on initial severity [BDI-II: $t(32) = -1.942$, $p = .061$; OQ-45.2 IR: $t(32) = -1.027$, $p = .312$], which supports the idea that this sample is not obviously biased by pre-treatment differences.

Course of symptoms at follow-up and differences across treatments

Analysis of variance

The repeated-measures ANOVA with three time-points (post-treatment, 21 and 31 months follow-up) and treatment condition (NT or CBT) revealed a main effect of time on the BDI-II [$F(2, 64) = 6.15$, $p < .01$], however no interaction effect of time and treatment was found [$F(2,64) = 0.99$, $p. = .379$]. Thus, it seems that patients kept reducing depressive symptoms at follow-ups, regardless of the treatment they were allocated to.

Regarding the interpersonal problems, as measured by the OQ-45.2 IR, the ANOVA revealed neither a main effect of time [$F(2,64) = 2.66$, $p = .077$] nor an interaction effect of treatment and time [$F(2,64) = 0.54$, $p = .585$].

Clinical significance

Course of depressive symptoms at follow-up

Patients' follow-up scores were examined to determine (a) whether the patient *maintained* recovery at follow-up, (b) whether the patient *relapsed* at follow-up, (c) whether the patient *recovered* at follow-up or (d) whether the patient *maintained dysfunctional* at follow-up. Results are presented for depressive symptoms (measured by BDI-II) in Table 8.

Table 8. *Proportion of patients remaining well or relapsing over 21 and 31 months follow-up assessments, according to BDI-II, by treatment group*

	21 months Follow-up ($N = 35$)		Fisher's exact probability	31 months Follow-up ($N = 42$)		Fisher's exact probability
	NT ($n = 18$)	CBT ($n = 17$)		NT ($n = 22$)	CBT ($n = 20$)	
Recovered[1] after treatment	4	7		6	6	
and maintained[2] at follow-up	22%	41%	.29	27%	30%	1
Recovered after treatment and	1	2		1	5	
relapsed[3] at follow-up	6%	12%	.60	5%	25%	.09
Not recovered after treatment	6	5		6	5	
and recovered at follow-up	33%	29%	1	27%	25%	1
Not recover after treatment and	7	3		9	4	
maintained dysfunctional at follow-up	39%	18%	.26	41%	20%	.19

[1] Jacobson & Truax's (1991) clinical significance criteria were used to establish whether a patient has recovered: reliable improvement (BDI-II improvement > 8.46) and decrease into the functional range (BDI-II < 14.29).
[2] Maintenance of recovery: Scores at follow-up assessments stayed in the functional range (BDI-II < 14.29).
[3] Relapse: Scores at follow-up assessments increased into the dysfunctional range (BDI-II > 14.29).
Note. BDI-II = Beck Depression Inventory, NT = Narrative Therapy, CBT = Cognitive-Behavioral Therapy. Percentages refer to patients with follow-up data.

In the NT condition, 22% ($n = 4/18$) of patients kept therapy gains at 21 months and 27% ($n = 6/22$) at 31 months after termination of therapy. In the CBT condition, 41% ($n = 7/17$) of patients kept therapy gains at 21 months and 30% ($n = 6/20$) at 31 months after termination of therapy. Comparing the two conditions, no

significant differences were found (Fisher's exact test: 21 months, $p = .29$; 31 months, $p = 1$).

A small proportion of patients experienced relapses at 21 months follow-up [NT = 6% (1/18) and CBT = 12% (2/17), $p = .60$]; and at 31 months follow-up [NT=5% (1/22) and CBT=25% (5/20)]. Also, a substantial number of patients remained depressed at 21 months [NT = 39% (7/18) and CBT = 18% (3/17), $p = .26$] and at 31 months follow-up assessments [NT = 41% (9/22) and CBT = 20% (4/20), $p = .19$].

An interesting finding is that 33% (6/18) of the NT and 29% (5/17) of the CBT patients had not improved at post-treatment but recovered after 21 months (i.e. 31% of the total sample). However, no differences between the two treatment conditions were found ($p = 1$). At the 31 months follow-up, this proportion of patients was maintained: 27% of the NT (6/22) and 25% of the CBT patients (5/20) who had not recovered during treatment recovered at 31 months after treatment termination (i.e. 26%, of the total sample).

Course of interpersonal problems at follow-up

Rates of patients remaining well or relapsing at 21 or 31 months follow-up assessments in interpersonal problems (measured by the OQ-45.2 IR) are reported in table 9. Again, no differences were found between the two treatment conditions.

Table 9. *Proportion of patients remaining well or relapsing over 21 and 31 months follow-up assessments, according to OQ45-IR, by treatment group*

	21 months Follow-up (N = 35)		Fisher's exact probability	31 months Follow-up (N = 42)		Fisher's exact probability
	NT (n = 18)	CBT (n = 17)		NT (n = 22)	CBT (n = 20)	
Recovered[1] after treatment	1	3		2	1	
and maintained[2] at follow-up	5.5%	18%	.33	9%	5%	1
Recovered after treatment and	2	1		2	2	
relapsed[3] at follow-up	11%	6%	1	9%	10%	1
Not recovered after treatment	1	4		2	5	
and recovered at follow-up	5.5%	23%	.18	9%	25%	.23
Not recover after treatment and	14	9		16	12	
maintained dysfunctional at follow-up	78%	53%	.16	73%	60%	.52

[1] Jacobson & Truax's (1991) clinical significance criteria were used to establish whether a patient has recovered: reliable improvement (BDI-II improvement > 8.46) and decrease into the functional range (BDI-II < 14.29).
[2] Maintenance of recovery: Scores at follow-up assessments stayed in the functional range (BDI-II < 14.29).
[3] Relapse: Scores at follow-up assessments increased into the dysfunctional range (BDI-II > 14.29).
Note. BDI-II = Beck Depression Inventory, NT = Narrative Therapy, CBT = Cognitive-Behavioral Therapy. Percentages refer to patients with follow-up data.

A small proportion of patients (11%; 4/35) had recovered from interpersonal problems at post-treatment and maintained recovered at 21 months follow-up [NT = 5.5% (1/18); CBT = 18% (3/17), p = .33]. At 31 months follow-up, similar proportions of patients (7%; 3/17) remained recovered [NT = 9% (2/22); CBT = 5% (1/20), p = 1]. Also, only a small proportion of patients (9%; 3/35) who were recovered at post-treatment relapsed at 21 months follow-up [NT = 11% (2/18); CBT = 6% (1/17), p = 1], whereas at 31 months follow-up 18% (4/42) experienced a relapse [NT = 9% (2/22); CBT = 10% (2/20), p = 1]. On the other hand, a large proportion of patients [21 months: NT = 78% (14/18); CBT = 53% (9/17), p = .16; and 31 months: NT = 73% (16/22); CBT = 60% (12/20), p = .52] were still considered dysfunctional interpersonally at the follow-up.

Comparison of depressive symptoms and interpersonal problems at follow-up

To compare recovery and relapse rates on depressive symptoms and interpersonal problems odds ratio between recovery and relapse rates are reported (Table 10).

Table 10. *Comparison of the proportion of patients remaining well or relapsing over 21 and 31 months follow-up assessments, according to BDI-II and OQ45-IR*

	21 months Follow-up ($N = 35$)				31 months Follow-up ($N = 42$)			
	BDI-II	OQ-45.2 IR	Odds ratio	95% CI	BDI-II	OQ-45.2 IR	Odds Ratio	95% CI
Recovered[1] after treatment and maintained[2] at follow-up	11 31%	4 11%	3.55	[1.00, 12.55]*	12 29%	3 7%	5.20	[1.34, 20.09]*
Recovered after treatment and relapsed[3] at follow-up	3 9%	3 9%	1.00	[0.18, 5.33]	6 14%	4 10%	1.58	[0.41, 6.08]
Not recovered after treatment and recovered at follow-up	11 31%	5 14%	2.75	[0.84, 8.99]†	11 26%	7 17%	1.77	[0.61, 5.14]
Not recover after treatment and maintained dysfunctional at follow-up	10 29%	23 66%	4.79	[0.08, 0.57]**	13 31%	28 66%	4.5	[0.09, 0.56]**

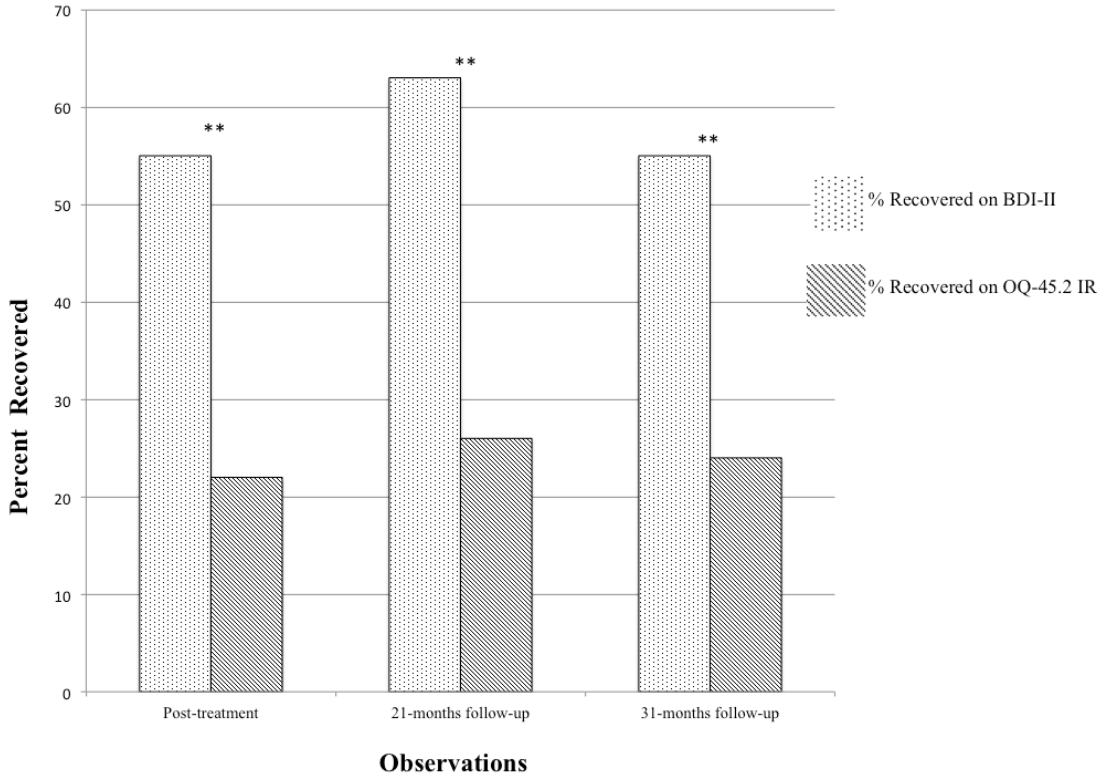
[1] Jacobson & Truax's (1991) clinical significance criteria were used to establish whether a patient has recovered: reliable improvement (BDI-II improvement > 8.46) and decrease into the functional range (BDI-II < 14.29).
[2] Maintenance of recovery: Scores at follow-up assessments stayed in the functional range (BDI-II < 14.29).
[3] Relapse: Scores at follow-up assessments increased into the dysfunctional range (BDI-II > 14.29).
Note. BDI-II = Beck Depression Inventory, NT = Narrative Therapy, CBT = Cognitive-Behavioral Therapy. Percentages refer to patients with follow-up data.
* $p < .05$; *** $p < .001$; † $p < .10$.

A small proportion of patients recovered from interpersonal problems at post-treatment and remained recovered at follow-up [21 months = 11% (4/35); 31 months = 7% (3/42)]. Comparing this to the proportion of patients who remained recovered in depressive symptoms at follow-up significant odds ratios were obtained at both follow-ups observations [21 months: BDI-II = 31% (11/35), OQ-45.2 IR = 11% (4/35); odds ratio = 3.55, $z = 1.97$, $p = 0.049$; 31 months: BDI-II = 29% (12/42); OQ-45.2 IR = 7% (3/42); odds ratio = 5.20, $z = 2.391$, $p = .016$]. Thus, at the 31 month follow-up, patients who had recovered at post-treatment were 5.20 times more likely to remain recovered from depressive symptoms than from interpersonal problems.

Another remarkable finding is the high proportion of patients who had *not* recovered during treatment and *remained dysfunctional* in interpersonal problems [21 months = 66% (23/35); 31 months = 66% (28/42)]. Comparing this with the proportion of patients who had *not* recovered during treatment and *remained dysfunctional* regarding depressive symptoms [21 months: 29% (10/35); 31 months = 31% (13/42)] significant odds ratios were obtained at both follow-up observations.

Hence, at the 21 month follow-up, patients who had not recovered where 4.79 times more likely to remain dysfunctional regarding interpersonal problems compared to depressive symptoms, $z = 3.033$, $p = .0002$; and at the 31 months follow-up, patients who had not recovered where still 4.5 times more likely to remain dysfunctional regarding interpersonal problems compared to depressive symptoms, $z = 3.199$, $p = .001$. Figure 6 compares the proportions of recovered patients on the BDI-II and the OQ-45.2 IR at post-treatment and 21 and 31 months follow-up assessment.

Figure 6. *Proportions of patients recovering from depressive symptoms and interpersonal problems at post-treatment and follow-ups*



Note. BDI-II = Beck Depression Inventory, OQ-45.2 IR = Outcome Questionnaire-45.2 Interpersonal Relations Subscale.
** $p < .01$

Discussion

The aim of this study was to evaluate prospectively a sample of depressed patients who received manualized NT or CBT. For all analyses the allocation to treatment group (i.e., NT or CBT) did not have any impact in all the variables studied.

A case-by-case clinical significance analysis of depressive symptoms reveals that one third of all patients maintained treatment gains at follow-up and very few patients relapse (around 10%). Although almost half of the patients scores in the dysfunctional range at follow-up (either by relapsing or by never recovering), around one third of all patients do recover at follow-up. This latter finding was confirmed by repeated measures ANOVA, which showed that on average patients significantly reduce depressive symptoms from termination of treatment to the follow-ups. The recovery rate for depressive symptoms at follow-up in our study (approximately one third) was superior to earlier studies. For instance, Keller et al. (1992) observed a 21% recovery rate at 24-months follow-up.

An interesting finding is that even in a long-term evaluation, interpersonal problems do seem to be much more resistant to change than depressive symptoms. Only around 10% of patients keep their interpersonal gains at follow-up and only around 15% of patients who did not recover in interpersonal domain during treatment recovered at the follow-up observation. At the same time, a large proportion of patients (around 66%) still reported interpersonal problems (i.e. with scores on the dysfunctional range) at follow-up. This finding is in line with post-treatment outcome of this sample (Lopes et al., 2013) and previous research comparing the course of depressive symptoms and interpersonal problems along treatment (Barkham et al., 1996, 2002, 1993; Hilsenroth et al., 2001; Howard et al., 1993; Kopta et al., 1994; Swift et al., 2010; Vromans & Schweitzer, 2011). Still, this finding is surprising as we expected to detect a delayed effect of treatment on interpersonal problems on the long-term assessment (e.g., Fairburn, Jones, Peveler, Hope, & O'Connor, 1993).

Limitations

Although follow-up studies are an important part of outcome research in psychotherapy they are hard to conduct and difficult to interpret (Chambless & Hollon, 1998). If in psychotherapy research in general it is hard to know what interferes with patient progress, in a long-term follow-up evaluation this problem is even more salient. Keeping this in mind, the results presented are not intended to prove any cause-effect relationship between having undergone psychotherapy and clinical outcomes after 21 or 31 months. This is due to the fact that neither spontaneous remission nor the natural course of depression was controlled for. A control group with patients undergoing an established intervention for relapse depression (e.g., Mindfulness-Based Cognitive Therapy) or with participants who have never been diagnosed with depression could have been used for that purpose. The lack of control groups in long-term outcomes studies is unfortunately the rule and not the exception (Winokur & Tsuang, 1996) and future studies should use such a control group. In addition, continuation of treatment during the follow-up period was not controlled for (medication or alternative treatments, including psychotherapy) limiting the scope of the present results. Another confounding variable might be the chronicity of the depressive symptoms; e.g. we did not separate patients with acute and chronic depression in the present study. As Keller and Shapiro (1982) showed, outcomes for patients with superimposed depression are clearly different from those who have an acute episode alone. This might be an important question for future studies.

Another limitation of this study concerns the form of assessment. We are unable to assess exactly when the patients who relapsed did so. Future designs could employ a more regular assessment schedule (Chambless & Hollon, 1998).

Strengths

As the preliminary analysis shows, the retained sample for the long-term follow-up is representative of the original treatment sample. It also appears that findings are not biased by low or differential return (according to treatment condition, treatment completion and treatment response) or pre-treatment differences among conditions.

Another strength of the study is the length of follow-up that was superior to what is normally observed in the literature. Moreover, the present return rates are similar to other reports in psychotherapy research with shorter follow-up periods (e.g., Barkham, Shapiro, Hardy, & Rees, 1999; Snell, Mallinckrodt, Hill, & Lambert, 2001; Vromans & Schweitzer, 2011). It is also rare to find studies comparing the differential long-term efficacy of psychotherapy models. Furthermore, it is recommended that "the length of the follow-up required is likely to depend on the natural course of the disorder in question and the strength and stability of the treatment effect that is worthy of detection" (Chambless & Hollon, 1998, p. 10). A cornerstone of the studies of natural course of depression, the Collaborative Depression Study (CDS; Katz & Klerman, 1979), has found that by the second year of follow-up, 20% of patients remained ill (Keller, Shapiro, Lavori, & Wolfe, 1982). The same sample of patients was assessed three years later (at five years follow-up) and only 12% of patients remained ill (Keller et al., 1992). Subsequent follow-ups of ten (Mueller et al., 1996) and 15 years (Keller & Boland, 1998) found that 7% and 6% of patients were still ill.

This pattern suggests that recovery rates tend to be greater in the first year of follow-up and stabilize after that. Thus, having almost a three years follow-up period seems to be a reasonable time to describe the course of the disease on a depressed sample.

Finally, it has been pointed out that "psychiatric research emphasizes case-categorization methods designed to identify putatively discrete episodes of disorder, whereas the psychological approach relies solely on parametric analysis of means and continuously distributed scores" (Shapiro et al., 1995, p. 379). Using a stringent definition of recovery and relapse (Jacobson & Truax, 1991), may have added reliability to the results. Using such a method takes into account values of large samples of clinical and community data to establish norms for a functional and dysfunctional range. In addition a parametric analytical approach was used to confirm the results of the clinical analyses.

Implications of the study

Under a clinical perspective, the fact that 1/3 of the patients never recover from depressive symptoms is alarming. It is recommended that the clinical practitioner follow the patients who were treated for depression for a significant period of time bearing in mind that a substantial proportion of them will relapse within the next two years. Relapse prevention approaches, such as Mindfulness-Based Cognitive Therapy, would be thus an option for decreasing relapse rates (Bondolfi et al., 2010; Piet & Hougaard, 2011; Teasdale et al., 2000). Follow-up sessions addressing red flags that might precipitate relapse would also be an option. Also, clinicians should consider longer treatment plans for patients with a longer history of depression. Fava, Rafanelli, Grandi, Conti, and Belluardo (1998) showed that after two years with a CBT maintenance intervention, a considerably greater proportion of

patients remained symptom free (around 75%) compared with regular clinical management (less than 20%).

The present findings highlight the lack of change in the interpersonal related problems with lower rates of recovery in comparison to depressive symptoms. Interpersonal therapy (IPT) has been proved to be efficacious for continuation and maintenance therapy at least at more than monthly "doses" (Hollon et al., 2002). Patients given continuation IPT showed improved social functioning over time, although this effect did not emerge until 8 to 10 months of continuation treatment (Frank & Spanier, 1995; Hollon et al., 2002; Weissman, Klerman, Paykel, Prusoff, & Hanson, 1974). Hence, alternative continuation treatments should be sought for patients with greater interpersonal disabilities.

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DISCUSSION

DISCUSSION

In the last decades, the concept of narrative has gained increasing importance in the fields of psychotherapy theory, research and practice, shedding light on psychological and social processes by which clients construct meaning to their lives (Angus & McLeod, 2004; Gonçalves, Matos, & Santos, 2009; White & Epston, 1990). Despite the growing evidence indicating the relevance of narrative change in psychotherapy and its impact on symptom reduction, narrative therapists and researchers have been reluctant to apply systematic research methods to evaluate their practices, which can be seen by the scarce literature reporting the efficacy of narrative therapy (NT). In this discussion we will reflect upon how future research should look like, based on the potentialities and limitations of our clinical trial. Before doing that, in the lines that follow we will summarize what we see as the main empirical contributions of this dissertation to NT and psychotherapy research in general.

Summary of results

Our general aim was to assess the effects of NT in treating depression in comparison to cognitive-behavioral therapy (CBT), using controlled and quantitative methods of research. For this final reflection, we think it is important to summarize the results of the five studies. For this, we divide our results in three distinctive categories: (1) comparative efficacy of NT and CBT, (2) differential time to improve from depressive symptoms and interpersonal problems and, (3) outcomes and prediction of dropouts.

Comparative efficacy of Narrative Therapy and Cognitive-Behavioral Therapy

As predicted, clients who completed NT and CBT showed similar statistically and clinically significant improvement over time in all measures (chapter I). This result answers positively to our central research question, i.e., whether clients who have undergone NT had a significant symptom reduction. But the conclusion is not that simple. All analyses were conducted twice: a more liberal analysis only with those who completed treatment, and a more conservative analysis with the intent-to-treat (ITT), i.e., including all clients who began treatment in the sample. On the ITT analysis, clients who have undergone NT had significantly worst performances on the BDI-II, compared to clients who have undergone CBT. The evaluation of statistical significance aims to ascertain that chance alone would not explain the results, this could be misleading in informing about the actual clinical relevance of the results (Kendall, Holmbeck, & Verduin, 2004), and thus, clinical significance is an important element in the evaluation of psychotherapy outcome (Ogles, Lunnen, & Bonesteel, 2001; Tingey, Lambert, Burlingame, & Hansen, 1996). Findings in clinical significance analysis corroborated the analysis of variance, i.e., clients of both groups who complete treatments obtained very similar proportions of clinically relevant benefits, regardless of their group allocation (NT or CBT), but on the ITT analysis a higher proportion of CBT clients responded to treatment, when compared to the NT clients, on the BDI-II.

The study of the outcomes of the dropout sample (Chapter IV) showed that CBT dropouts had systematically better outcomes than NT dropouts, which may at least partially explain the CBT superior performance reducing depressive symptoms in this trial. The idea proposed by Reynolds et al. (1996) that some treatments may

require clients to get worse before they get better would probably shed light on the better outcomes of CBT dropouts. Based on the Assimilation Model of psychotherapeutic process (Honos-Webb, Stiles, Greenberg, & Goldman, 1998; Stiles, 2006; Stiles et al., 1990) the idea is that in the experiential psychotherapies (in which NT may be included; Neimeyer, 1993) therapists lay emphasis on the evocation of emotional experiences as critical to the change process. This suggestion found empirical support when the levels of emotional discomfort felt by clients of Psychodynamic Interpersonal Therapy (PIT) were compared to CBT. The authors observed that on PIT clients showed higher levels of discomfort in the initial sessions, in contrast to CBT clients. In their study, they found that later at treatment, these levels converged both to similar lower levels. In the case of our research, the CBT treatment initially focused on behavioral activation and the therapist was very attentive to find and potentiate positive reinforcements in client's environment. We suggest that this strategy might have reduced distress. On the contrary, in the NT manual, it is expected that therapists talk about the problem and map its influence on the client's life already at the initial phases of the treatment, which may bring about negative emotions and may be a difficult task for some clients to undertake. In the same way, differences in the nature of the therapeutic relationship of both treatments might explain the differential effects of CBT on the dropout sample. In the initial phases of CBT treatment the therapist is expected to be more directive and the relationship becomes gradually more horizontal along treatment. This might give some more structure, which depressed clients might need. Differently, in the NT manual the relationship is expected to be more horizontal since the first sessions. This horizontality may have extra costs to the client, especially for those who did not know what to expect of the psychotherapy process. If these ideas were grounded

empirically, narrative therapists would have to think about ways of dealing with clients who appear to be more likely to dropout in the initial phases of treatment. Qualitative research on process variables, especially on narrative change, could help clarify the reasons for the higher benefits of CBT dropouts.

It is also intriguing why we only found differences with the BDI-II. The first explanation to be considered is that BDI-II is the measure developed by the same researchers that developed the CBT method. In that sense, it is easy to think that the measure would suit the intervention. CBT therapists focus a lot on the understanding and reduction of depressive symptoms and that is precisely what BDI-II measures. It is important to consider that the OQ-45.2 has about half of its items related to social role impairments and interpersonal problems, so it is probably less sensitive to detect changes on the depressive symptoms.

Finding the Dodo bird

Along the data analysis we tested exhaustively the potential differences between treatment groups bearing in mind the Dodo Bird Verdict (Luborsky, Rosenthal, et al., 2006; Luborsky, Singer, & Luborsky, 1975; Smith, Glass, & Miller, 1980; Wampold et al., 1997), which predicts that all treatments delivered in good faith will yield similar results. In this sense we were surprised that CBT showed to be superior in reducing depressive symptoms when the dropouts were included in the analysis. Apart from this difference, NT and CBT had similar performances in all other analysis. To begin with, we did not find any evidence pointing to the differential effects on the measure of general psychological distress (OQ-45.2), neither on the ITT or the completer analysis (chapter I). Also, treatment assignment did not predict dropout (chapter III). On the study presented at chapter II, we found that time it took

to improve and/or recover was similar at both groups. Thus, four sessions were necessary for 50% of the sample to improve and 16 sessions were necessary for the same 50% to recover from depressive symptoms. On both NT and CBT treatments, recovery from interpersonal problems happened significantly later, with 20 sessions being necessary for only 25% to improve. Also, results at follow-up revealed that NT and CBT clients had similar improvement and relapse rates at 21 and 31 months after the end of psychotherapy.

These systematical similarities between treatments suggest that, it is premature to ascertain CBT's superiority over NT in treating depression. The discrepancy of findings in the direction of differential effectiveness and findings in the direction of the Dodo Bird hypothesis for itself would justify a replication of this study in alternative clinical settings.

Depressive symptom and interpersonal change in psychotherapy

An interesting and initially unplanned line of investigation has emerged along the data analysis of this dissertation, which also constitutes evidence for treatments' equivalent performances. It refers to an idea raised mainly by the psychodynamic field, which argues that different kinds of psychotherapies would generate change at different symptom clusters (e.g., Kernberg, 1988). According to this perspective, CBT approaches are often regarded as focusing on symptomatic change, rather than on more "profound" or structural change (e.g., Dobson & Dobson, 2009), at the same time as improvement in interpersonal functioning may be considered as one of the major goals in some therapies, such as NT (Reynolds et al., 1996). In fact, it was consistently found that the time to reach a certain level of change (i.e., a 25% or 50% of improvement rate) is significantly shorter for depressive symptoms than for

interpersonal problems, but contrarily to the previous hypothesis, treatment condition to which the clients had been assigned played no role in this differential speed of change. It may not be surprising that effects of brief psychotherapeutic treatments would be greater on the symptomatic than on the interpersonal level. This may be especially the case for treatments focusing on reducing depressive symptoms (such as the present NT and CBT approaches). In fact, it would be particularly awkward if clients improved first on the interpersonal level. Thus, the present finding may reflect that the NT and CBT treatments in this clinical setting worked the way they were intended to do. However, both clinical manuals of depression dealt with interpersonal issues, if they were thought to be important to the maintenance of depression. Howard, Lueger, Maling and Martinovich's (1993) proposed a descriptive model in which change in psychotherapy would proceed in three subsequent phases: (1) remoralization, i.e., improvements on subjectively experienced well-being would precede (2) remediation, i.e., improvements in symptomatology, followed by (3) rehabilitation, i.e., improvements on life functioning, which is associated with interpersonal adaptation. Along with other research reviewed above (Barkham et al., 1996; Barkham, Rees, Stiles, Hardy, & Shapiro, 2002; Howard et al., 1993; Howard, Moras, Brill, Martinovich, & Lutz, 1996; Kopta, Howard, Lowry, & Beutler, 1994) the present results showing that depressive symptoms decreased significantly faster than interpersonal problems corroborates the phase model of psychotherapy change.

It is important to note that results from a similar analysis at the 21- and 31-follow-up evaluation show a similar pattern: interpersonal problems do seem to be much more resistant to change than depressive symptoms, also in the long-term assessment after therapy, similarly for both groups. Generally, clients of both groups keep improving from depressive symptoms at a higher pace than they improve from

interpersonal problems. Analysis of individual trajectories may elucidate how rapid early response (e.g., Comninos & Grenyer, 2007; Greenfield, Gunthert, & Haaga, 2011; Tang & DeRubeis, 1999) can contribute to the overall pattern of change in depressive symptoms. In contrast, it was found that interpersonal mastery predicted early rapid response (Comninos & Grenyer, 2007). Enhanced interpersonal skills are also believed to reduce susceptibility to depression (Howard et al., 1993) and lower levels of interpersonal mastery predict poorer outcomes in psychotherapy for depression (Grenyer & Luborsky, 1996; Grenyer, 2002). Further studies should also consider this inverse relationship.

Outcome and prediction of dropouts

In clinical research, dropout rates are considered to be important measure for treatment efficacy (e.g., Houghton, Curran, & Saxon, 2008) and standard in psychotherapy outcome reports (APA Publications and Communications Board Working Group on Journal Article Reporting Standards, 2008; Moher, Schulz, Altman, & CONSORT Group, 2001). Still, the majority of studies regard the issue of dropout as a secondary theme. Because the dropout sample were determinant in the differences found favoring CBT, we dedicated some time to study this sample separately. On chapter IV, we studied differences in outcomes of dropouts and completers. As expected, completers had consistently greater outcomes than dropouts, by the last session attended. An interesting finding was that dropouts kept on improving at follow-up, even more than treatment completers. It sure sounds odd in a first glance, but we should consider that dropouts had significantly higher scores when they left treatment, thus they had enhanced probability of reducing these scores at follow-up. Still, this finding suggests that psychotherapy is important, but may not

be necessary to for all clients to recover from depression. With psychotherapy clients might take less time and probably also will employ less personal resources to attain significant clinical change.

Another significant contribution of this thesis to the knowledge of the dropout clients, less related to the efficacy, may refer to the prediction of premature termination. In the study presented at chapter III we found that having comorbid anxiety symptoms and taking psychoactive medications at intake were protective factors for treatment completion. Thus, clients taking medication were more likely to stay in treatment, which is contrary to many clinicians' suspicions. Medication may have helped clients managing the symptoms and thus better adhere treatment. Also, clients with comorbid anxiety symptoms were more likely to stay in treatment, which suggest that higher levels of suffering may enhance motivation to stay in psychotherapeutic treatment. Almost half of the clients dropped out by the fourth session and mean length of stay in treatment for the dropout group is around six sessions. This suggests that the issue of treatment abandonment should be addressed in the first sessions.

Many of these findings are not new in psychotherapy research. The main novelty introduced by this dissertation was having NT as one of the experimental conditions. The lack of studies of efficacy and effectiveness of NT is somewhat intriguing, given its popularity among clinicians and theorists. In the next sections, we will discuss what we think the field would gain by continuing the study of NT's efficacy in a experimental manner and how a replication of our study should take in consideration, having in mind our limitations and potentialities.

Narrative Therapy and the evidence-based approach

We are aware of the paradox relationship between NT's epistemological fundaments and empirical research methods. Still, it can also be argued that NT is about promoting diversity and it should also apply for the use of different research methods. We have stated in the introduction reasons for keep doing outcome research in general. We now argue specifically for that the approximation between NT and the empirical supported therapies (EST) methods can be invaluable in promoting further development of NT, the training of new therapists, and also on spreading it and making it better known and accepted within psychotherapy field.

One extreme scenario is that treatments that are not empirically supported may not be funded and their practice may be consequently considered unethical. "Training programs may have to drop 'unsupported' therapies from their postgraduate curricula, and internships that involve the application of such therapies" (Bohart, O'Hara, & Leitner, 1998, p. 141). This could then marginalize some therapies since EST criteria are "inappropriate for therapies whose primary focus is not to 'cure disorder'" (Busch, 2011, p. 3) and subsequently could narrow the availability and choice of psychotherapy.

More research is required on social constructivist, narrative approaches and systemic practices, which are widely used in the United Kingdom (UK), Ireland and elsewhere (Carr, 2009, p. 64). The National Health System of UK, requires that a certain treatment have provided a form of accountability for efficacy, in order to be introduced as a recognized and funded practice (National Institute for Clinical Excellence, 2009). With that being said, public health systems and individual clients are interested in cost-effectiveness. As our data suggest, there is no difference

between treatments regarding the relationship between dose and its effect. Although we have no reason to believe that NT would more costly than CBT, more research is needed because of the differential outcomes of the dropout sample.

Some steps could be taken to bring closer NT and evidence-based psychotherapy research and hence to formalize the clinical perspective and ways of doing that characterize NT. For instance, the NT manual developed for this clinical trial, instead of trying to prescribe therapeutic strategies to each session, constitutes itself as tool-box of ways of behaving, questioning and thinking in sessions typical of narrative therapists.

Although narrative therapists argue that what is called clinical success in NT (i.e., the development of richer and more complex life narratives and a more coherent notion of self), is different from what ESTs define as therapeutic success, we can also look at these two dimensions as complementary. Thus, it is possible to conceive symptomatic change without a substantial narrative change (e.g., Freitas, Batista, & Gonçalves, 2014), in the same way that we can conceive narrative change without a substantial symptomatic change. The evaluation of therapy efficacy through the lenses of symptom reduction does not require at all an evaluation of narrative change. The narrative level of analysis is more complex, but we have accurate tools to measure success based on narrative change (e.g., Boritz, Bryntwick, Angus, Greenberg, & Constantino, 2014; Gonçalves, Ribeiro, Mendes, Matos, & Santos, 2011; Gonçalves, Ribeiro, Stiles, et al., 2011). Attention to the outcomes, as well as process, is important as it allows the identification of 'the active ingredients of psychotherapy and the mechanisms of change' (Kopta et al., 1994, p. 7).

Some thoughts about a future replication

We agree that treatment alternatives to depression should be tested through rigorous research methods. According to EST criteria, "a therapy is considered efficacious and specific, if there is evidence from at least two settings that it is superior to a pill or psychological placebo or another bona fide treatment. If there is evidence from two or more settings that the therapy is superior to no treatment it is considered efficacious. If there is support from one or more studies from just a single setting, the therapy is considered possibly efficacious pending replication" (Hollon & Ponniah, 2010, p. 892). It is suggested "the process of evaluation is not completed even if several studies provide supportive evidence" (Kendall, 1998, p. 3), thus we recommended that further research should be carried, especially through the forms of replications. The studies integrated in this dissertation have different limitations and strengths that have already been acknowledged in the corresponding chapters. Along the following pages, we will reflect upon these limitations and strengths having in perspective a future replication of this study.

Comparative studies are on the top of the hierarchy for studying the efficacy of a new or untested psychological treatment (Chambless & Hollon, 1998). Furthermore, therapists followed treatment manuals and characteristics of the sample were clearly specified and thoroughly assessed. Also, this study was undertaken in very different conditions of the previous study on NT (Vromans & Schweitzer, 2011): in a different clinical setting in a very different cultural context and by an independent research team.

A replication of this experiment would include a more systematic randomization technique. The client allocation consisted on assigning alternatively

each client to one of the treatment conditions, by their incoming order. The secretary who carried out the procedure was unaware of treatment differences and was instructed to do it systematically. Although we assume that there is no specific order in which clients come to a clinic and that the incoming order is *per se* randomized, this method raises controversy among researchers for depending on a professional. Because of that, in future reviews of psychological treatments of depression our study's quality might be rated weaker than if we had used a more impartial computer assisted technique.

Outcomes for clients with superimposed depression are clearly different from those who have an acute episode alone (Keller & Shapiro, 1982). For instance, there is empirical data suggesting that the number of previous depressive episodes predict the likelihood of a new episode. Clients with a history of three episodes have 90% of chances of relapsing (American Psychiatric Association, 2000). We did not separate the clients with acute and chronic depression in our analysis and we probably should have interesting data to look at, if we had done that.

Although the instruments used to assess psychotherapy outcomes can be considered as standard in clinical research, the current evaluation represents only the client's perspective. This is an important perspective, but still results might have been affected if patients' progress were assessed using other perspectives (Barkham et al., 2002). Multiple assessment of client progress along psychotherapy, for instance using the Hamilton Scale and the Global Assessment of Functioning at a regular basis would have increased the reliability of our results. Also, it would have been of some interest to use a measure of client's problems (symptoms and interpersonal problems) on the perspective of a significant other.

In a classical meta-analysis, Nicholson and Berman (1983) have challenged the validity of follow-up assessments claiming that they add little information to post-treatment outcomes and argued that this kind of research would be of little contribution to psychotherapy research and practice. Contrary to that expectation, in the present study we have observed significant improvement in depressive symptoms over time. We agree with the claim that "nonetheless, (…) it is better to collect these data (and to exercise caution in their interpretation) than to not collect them at all" (Chambless & Hollon, 1998, p. 10). Thus, considering the problems generally associated with long-term outcome research and that depression is a chronic illness, it is still recommended that researchers should continuously present follow-up data to the scientific community. A better follow-up evaluation, with more regular observations and controlling for clinically relevant information (such as the intake or not of antidepressants, new psychotherapeutic or psychopharmacological treatment, and suicidal attempts), would have increased the quality of the follow-up information. For instance it would have allowed us to use a survival analytic approach to assess time to improvement, recovery, and relapse at follow-up, as well as time for beginning a new treatment.

In future replications researchers should also be careful and include more experienced therapists. Although no difference was found in our study regarding the amount of change of clients seen by the novice or the graduate therapists, research in therapists variables on treatment outcome are inconclusive about the relationship of years of training on the outcome (Beutler et al., 2004), and there are indications of better outcomes (Beutler et al., 2004) and less dropout rates (Swift & Greenberg, 2012) by more experienced therapists. Also, to control differences in the therapist experience with the manual, it would be recommended that each therapist saw one

pilot case before seeing the actual randomized caseload. These actions would have decreased the therapist effects.

Conclusions based only on the results of controlled clinical trials have well-known limitations. An obvious one is spuriousness of the data. This means that the number of psychotherapy sessions one client received may be confounded with the time it elapsed from the first observation to the last. Thus, it should be alerted that "the effects could reflect merely the passage of time rather than the dose of treatment" (Barkham et al., 2002, p. 472) and causality claims should be made with caution. Since we did not have a waiting list group or a placebo intervention control group, a number of intervenient variables were not controlled, such as engaging in other kind of alternative treatments, engagement in other activities known for being efficacious for depression (e.g., sports), or significant changes in life caused by external factors (e.g. getting a new job or ending a problematic relationship). That is not to mention the potential placebo effect one might get. As we know from the medical research, the expectation of treatment success is responsible for more than half of the actual success. A placebo intervention in psychotherapy is more easily confounded with the actual treatment. To control for this bias, in a future replication, a natural history control group should be considered. A no-treatment control group is ethically questionable, but a waiting-list control group should be a good solution.

A common cited source of suspicion regarding experimental research in clinical settings is referred to as selection bias. Although suggested in the ESTs guidelines that it is important to have a clear specified problem, it is true that controlled clinical trials leave patients with serious comorbidity, such as drug dependence, suicide intentions, or severe personality disorders, out of scope (Demaat,

Dekker, Schoevers, & Dejonghe, 2007). In fact, the majority of suitable patients do not end up in trials as a result of all inclusion and exclusion criteria that have to be met. For example, it was estimated that only 14.5% of eligible depressed patients eventually took part in an specific trial (Keitner, Posternak, & Ryan, 2003). Indeed, we left out clients with more severe forms of anxiety or other impairing Axis-I and II conditions. On the other hand, our sample was not a "pure" depression sample, as those with co-morbid anxiety problems were not excluded from the study. Because depression without co-morbid anxiety is rare and reflects what would be found in the general population (Kessler et al., 2003), it could be argued that our results are in part ecologically valid. Our sample characteristics are comparable to other psychotherapy outcome studies for moderate depression with adults. Hollon, Shelton, and Loosen (1991) determined that "the modal patient was typically female, mid-30s, lower middle to middle class, moderately to severely depressed, and with a history of several previous episodes" (p. 93). This leaves us in good position to compare our findings at least to other controlled clinical trials of depression. Also, the fact that participants' baseline demographic and clinical characteristics are very similar in both treatment groups leaves us in a good position to make group comparisons.

Still regarding participants, the majority of the outcome studies in psychotherapy are limited to the Anglo-Saxon context. In this sense, our study might have contributed to the literature by showing treatment effects in a Portuguese sample, which increase the generalizability of the findings of general psychotherapy efficacy.

Another source of bias is research allegiance, a researcher's preference for a particular treatment, is often suggested to be associated with treatment outcome (Luborsky, Diguer, et al., 2006; Munder, Gerger, Trelle, & Barth, 2011; Munder et

al., 2011). One of the forms of controlling for "the allegiance effect" is including in the clinical trial researchers allied with different traditions in psychotherapy (Munder et al., 2011). If this is indeed an option for reducing the effects of allegiance in the results, we can say that this may be regarded as strength in our study. Researchers overtly allied with NT (M. Gonçalves served as the NT supervisor and T. Bento as researcher and NT therapist) were responsible for the NT treatment. In the same way, researchers overtly allied with CBT (J. Salgado had previous experience as the CBT supervisor and R. Lopes is trained and enrolled to CBT associations and theories) were responsible for the CBT treatment. Furthermore, the team of therapists of both sides got the chance to choose which model they wanted to work with. Hence, we could suggest that they did their best for the treatments they were allied with to have the best performance possible. Matching of therapist orientation and treatment approach may also have washed out the allegiance effect once all of them worked with the model they identified themselves with the most, both theoretically and technically. This is supposedly the more naturalistic option. Researchers who performed most statistical analysis are enrolled with other psychotherapy models rather than NT (R. Lopes, mentioned above, is enrolled with CBT, D. Sinai is enrolled with Interpersonal Therapy, I. Sousa was a statistician with no psychological background). Their mission was to test another treatment (NT), which was not their "own". Another evidence that leads us to believe that allegiance bias was minimized in this study is the fact that the comparison condition has had better results in some analysis. Independent researchers, preferably not enrolled with NT, should carry out future replications.

Conclusion

For CBT practitioners and researchers, this study represents the corroboration of evidence previously found in the literature. In contrast, we believe that NT researchers and clinicians have been excluded of the mainstream debate in psychotherapy for lacking substantial evidence in its favor and this study add to this gap in knowledge.

Along with a previous independent trial (Vromans & Schweitzer, 2011), this set of studies constitutes a meaningful step for the support of the efficacy of NT and its theoretical underpinnings. We showed that NT clients who completed treatment have very similar outcomes of CBT clients, including in the follow-up analysis. Our data were not consistent enough to fully ascertain the efficacy of NT for mild and moderate depression due to a high number of client dropouts who did not seem to benefit a lot from treatment. Still, at this point NT should be considered as a promising alternative for depression and a "possibly efficacious" treatment, according to the EST criteria. We conclude that additional controlled studies from independent research groups are needed, especially focusing on the prevention of treatment drop out.

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APPENDICES

Informed consent

Eu, [nome do cliente] aceito participar na investigação, a decorrer no Serviço de Consulta Psicológica e Desenvolvimento Humano da Universidade do Minho, sobre *Mudança Narrativa em Psicoterapia*, na qual trabalha o psicoterapeuta [nome do terapeuta]. Compreendo que a minha participação é inteiramente voluntária e que posso abandonar ou desistir de participar a qualquer momento, sem que para isso tenha que dar qualquer explicação ou haja qualquer consequência.

Foram-me explicados os seguintes pontos:

- O objectivo da investigação é o de estudar o modo como ocorrem mudanças em psicoterapia e como as pessoas vivem essas mudanças.
- Os procedimentos para a realização do estudo são os seguintes: depois de uma avaliação inicial, responderei a um conjunto de questionários de 4 em 4 sessões. Todas as consultas serão gravadas em vídeo.
- Toda a informação recolhida será tratada de forma confidencial. Apenas os investigadores envolvidos nesse projeto, com consentimento dos responsáveis pela orientação e supervisão, os professores Doutor Miguel Gonçalves e Marlene Matos, terão acesso aos dados. Na publicação de eventuais trabalhos de carácter científico, a minha identidade ficará protegida, não sendo revelado o meu nome nem qualquer característica que me possa identificar diretamente.
- Após a conclusão do projeto, e a meu pedido, ser-me-á facultada uma cópia das conclusões principais do estudo, caso a minha participação neste seja completa.

Compreendo o que este estudo envolve e concordo em participar. Foi-me entregue uma cópia assinada deste formulário de consentimento.

_____ _____

Assinatura Participante Assinatura Investigador

Data _____

Questões adicionais que queira colocar após completar a sua participação, poderão ser colocadas aos professores Doutor Miguel Gonçalves (e-mail: mgoncalves@iep.uminho.pt, telefone: 253 60 4665) e/ou à Dra. Marlene Matos (e-mail: mmatos@iep.uminho.pt, telefone: 253 60 4607), ambos do Departamento de Psicologia do Instituto de Educação e Psicologia da Universidade do Minho.

Dose-response relationship in psychotherapy

Table 11. Overview on the dose-response relationship in psychotherapy

Reference (by year)	Design and Treatment	*n*	Problem	Assessment	# sessions for 25%	# sessions for 50%	# sessions for 75%
Howard et al., 1986	Psychodynamic Interpersonal, routine and trials	2431, Meta-analysis	"Neurotic" (anxiety and depression), few psychotic and personality	1) Objective 2) Subjective		1) Between 8 and 13 sessions 2) Between 4 and 8 sessions	26 sessions
Keller et al., 1992	NIMH-CDS	471	MDD	Research Diagnostic Criteria (RDC) for depression	31% at 8 weeks	54% at 52 weeks (1 year)	70% in 2 years, 80% in 4 years
Kopta et al., 1994	"Time-unlimited therapy", psychodynamic (71%), eclectic (15%), and "other", no behavioral therapies.	685 Adult outpatients	Depression, anxiety, psychosis, personality, etc.	SCL-90 items 1) Acute Distress 2) Chronic Distress 3) Character-ological	-	11th ss (p 187) 1) 5 2) 14 3) >104	58 sessions (p. 187)
Kadera et al., 1996	CBT, Humanistic-Existential, Psychodynamic-interpersonal and integrative-eclectic	Dysfunctional = 45 Functional = 19 Total = 64	Adult, 36% depression and other problems	OQ-45	1) 5 2) 10	1) 10 2) 16	1) 13 2) 25
Barkham et al., 1996	CBT, Interpersonal Therapy	176 (Sheffield) + 36 (NIMH-CDS) Total = 212	Depression 85% DSM-III MDD; mean BDI score for the sample = 24.31 (SD=6.39)	1) Symptoms (BDI-II) 2) Interpersonal problems (IIP-32)	1) 4% CSC before tx 2) IIP-32: 18% recovery	1) BDI-II: 59% recovery 8-session group. In the 16-session treatments 40% recovery after 8 sessions. 2) 40% recovery by 16th session.	1) 72% at the end of the 16-sessions tx
Anderson & Lambert, 2001	Eclectic orientation, routine	Full Sample = 139 Dysfunctional = 53	Mild/moderate problems (relational, depression, anxiety)	OQ-45.2	1) RC/ Full sample: 5 2)CS/Dysfunctional: 8	1) 9 2) 13 3)RC/Dysfunctional: 8 4) RC/Full Sample: 9	1) 17 2) 25
Barkham, Rees, Stiles, Hardy, & Shapiro, 2002	CBT, IPT, clinical trial		Depression	1) Symptoms (BDI-II) 2) Interpersonal problems (IIP-32)	1) 38% at session 2 2) 6% at session 2	1) 56% at session 8 2) 41% at session 8, 56% at session 16	1) 67% at session 16 2)
Hansen & Lambert, 2003	TAU	4,761	Moderate levels of stress and life problems	OQ-45.2		16	
Harnett et al., 2010	TAU	125 adults	Mostly mood, anxiety, or adjustment disorder	OQ-45.2	-	ITT, RC=10 Dysfunctional RC = 8, CS= 14 Functional RC = 13	

Note. MDD = Major Depressive Disorder, KM = Kaplan-Meyer, SA = Survival Analysis, SCL-90 = Symptoms Check-list-90 (Derogatis, 1983), CSC = Clinical Significant Change, RC = Reliable Change , JT = Jacobson and Truax's parameters of clinical change (Jacobson & Truax, 1991), CBT = Cognitive-Behavioral Therapy, OQ-45.2 = Outcome Questionnaire 45.2 (Lambert et al., 1998), DSM-III = Diagnostic and Statistical Manual of Mental Disorders, third edition (American Psychiatric Association, 1980), BDI = Beck Depression Inventory , BDI-II = Beck Depression Inventory-II (Beck et al., 1996), DSM-IV = (American Psychiatric Association, 2000), IIP-32 = Inventory of Interpersonal Problems-32 (Horowitz et al., 2000), SOS = Schwartz Outcome Scale (Blais et al., 1999), HMO = Health Maintenance Organization, CMH = Community mental health service

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