Universidade do Minho
Escola de Psicologia

João Carlos Batista Silva

Change of Self-Narratives in Depression: Core Conflictual Relationship Theme and Innovative Moments

março de 2016

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Tese de Doutoramento em Psicologia Aplicada

Trabalho efetuado sob a orientação do
Professor Doutor Mário Miguel Osório Gonçalves

março de 2016

DECLARAÇÃO

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Título da tese de doutoramento: Change of Self-Narratives in Depression: Core Conflictual Relationship Theme and Innovative Moments

Orientador: Professor Doutor Mário Miguel Osório Gonçalves

Ano de conclusão: 2016

Curso: Programa Doutoral em Psicologia Aplicada

Universidade do Minho, 29/ MARÇO /2016

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STATEMENT OF INTEGRITY

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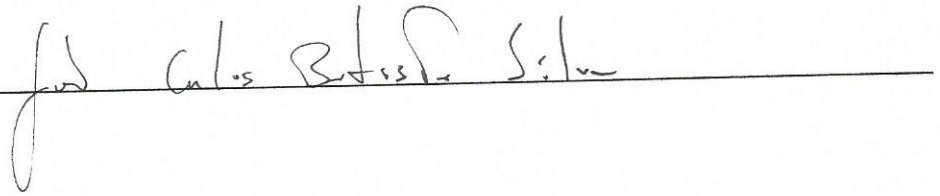
Signature: 

ACKNOWLEDGEMENTS

I would like to thank to all those that directly or indirectly contributed to the concretization of this dissertation. First of all, I would like to show my appreciation towards my supervisor, Dr. Miguel Gonçalves, for his endless support. Dr. Miguel Gonçalves manages to combine the rigor and demand implied in doing a Doctoral dissertation with the support and enthusiasm to go through the required tasks. Secondly, I would like to thank my research group. Working on a group where working together and helping each other are central to the *modus operandi* certainly makes the job less difficult. I would especially like to thank Pablo Fernandes-Navarro, for his friendship, willingness to help and all the insights in the long talks about my work; Joana Silva, Sara Freitas, Daniela Alves and Anabela Machado for their collaboration in coding the sessions; and Inês Mendes, Rodrigo Lopes, João Oliveira, António Ribeiro, Tiago Bento and the remaining colleagues for their support and discussions of my work in the research group meetings. I would also like to express a special gratitude to Dr. Paulo Machado, for his discussion of my work during the Doctoral program, to Dr. Inês Sousa, for her work in the statistical analysis, Dr. Tilman Habermas and his research group, for the wonderful stay in Frankfurt, Dr. Paul Crits-Christoph for his help with the CCRT doubts and Dr. Les Greenberg and Dra. Lynne Angus for allowing me to use to sample of York I study.

Finally, I would like to thank to my family, my wife and my friends for all the support, encouraging words and patient along these years of work. A special gratitude to Inês Batista Gomes, Florinda Gomes, Sónia Sousa, Patrícia Baptista, André Guerra, Maria Jorge Branco, Carla Tiago, João Filipe, Nuno Pires, Jorge Oliveira, Ana Clément, André Coelho, Susana Sousa, Bruno Branco, Luís Troufa and so many more that I am not recalling right now! A special thanks for my cats, for the feline companion in the long hours of work.

A presente tese de doutoramento beneficious do apoio da Fundação para a Ciência e Tecnologia (FCT) através da bolsa de Doutoramento Individual SFRH/BD/77324/2011.

CHANGE OF SELF-NARRATIVES IN DEPRESSION: CORE CONFLICTUAL RELATIONSHIP THEME AND INNOVATIVE MOMENTS

ABSTRACT

This dissertation explores the role of narrative changes in psychotherapy. Narratives guide the interpretation of experiences through a set of implicit assumptions and rules. From these, the set of rules that guide interpersonal interactions, termed relational schemas, are particularly significant. Relational schemas of persons with psychological disorders tend to be highly rigid. This implies that their interpretation of experience do not encompass the diversity of life events thus becoming maladaptive. The Core Conflictual Relationship Theme (CCRT) is a method developed to identify recurrent patterns of interpersonal interactions, describing relational schemas through three components: client's wishes and needs (W), the responses of the others to these needs (RO), and the responses of the self (RS). The rigidity of relational schemas is measured through the pervasiveness (dominance of a specific W, a specific RO and a specific RS), dispersion (the spread of all rated W, all RO and all RS) and valence (proportion of positive RO and RS). Research with this method has shown that symptoms recovery is associated with a more flexible (i.e. less pervasive or more disperse) CCRT and more positive RO and RS. Structures like relational schemas constitute the macro-narrative level of analysis. On the other hand, the moment-to-moment experiences constitute the micro-narrative level. It is proposed that change in macro-narratives in psychotherapy occur through the elaboration of micro-narrative events. While the CCRT represents the macro-narrative level, Innovative Moments (IMs), referring to experiences outside the maladaptive rules and assumptions, represents the micro-narrative level. IMs may allow the reorganization of an alternative macro-narrative, fostering a more flexible and satisfactory way of interpreting experiences. IMs can be organized in two levels: low-level IMs and high-level IMs. Low-level IMs create distance from the problematic macro-narrative, while high-level IMs are centered on the expansion of an alternative macro-narrative. Research with the Innovative Moments Coding System (IMCS) showed that recovered clients presented more IMs than unchanged ones. Moreover, high-level IMs differentiate recovered from unchanged clients and predicted the decrease of symptoms. Despite the body of research on clients' narratives in psychotherapy, the association between different narrative levels has rarely been studied. This dissertation addresses this gap, analyzing possible associations between the micro-narrative level, the macro-narrative level and the

psychotherapy outcome. The sample (N=22) used in these studies was constituted by clients diagnosed with major depressive disorder followed in brief psychotherapy (10 clients in narrative therapy, six in cognitive-behavior and six in emotion-focused therapy). This dissertation combined quantitative and qualitative designs in order to grasp the complexity of the phenomena. The first study explored the association between relational schemas, assessed with the CCRT, and psychotherapy outcome in the described sample (N=22). The results showed that recovery was associated with less RO and RS rigidity. The RO and RS valence was also more positive in recovered clients at the end of psychotherapy. These results reinforced the notion that relational schemas changes are a key ingredient to psychotherapeutic recovery. The second study explored the association between macro- and micro-narrative levels, assessed with the CCRT and IMCS (Innovative Moments Coding System) in the same sample (N=22). Results showed that high-level IMs significantly predicted RO and RS dispersion and the CCRT components' pervasiveness. These results demonstrated that the elaboration of micro-narrative events outside the problematic view (i.e. IMs) were significant predictors of changes in the macro-narrative structures (i.e. relational schemas). The third study compared two recovered cases from the cognitive-behavior therapy subsample. Although both clients were recovered, only one presented narrative changes in macro- and micro-narrative levels (assessed with the CCRT and the IMCS respectively). This client maintained symptoms recovery in the follow-ups whereas the client with only symptomatic recovery (and no narrative change) showed a relapse in the follow-ups. This study highlighted the importance of narrative transformation in psychotherapy change. The contribution of this dissertation to the field of psychotherapy research can be summed up in three points. Firstly, it showed that relational schemas are open to change in brief psychotherapy models. Secondly, it demonstrated that the IMs, events occurring in the psychotherapeutic conversation, are predictors of changes in relational schemas. Finally, this work highlighted the importance of narrative changes in psychotherapy recovery and maintenance of gains.

MUDANÇA DAS AUTONARRATIVAS NA DEPRESSÃO: *CORE CONFLICTUAL RELATIONSHIP THEME* E MOMENTOS DE INOVAÇÃO

RESUMO

Esta dissertação explora o papel que as mudanças narrativas têm em psicoterapia. As narrativas guiam a interpretação da experiência através de um conjunto de regras e premissas implícitas. Destas, o conjunto de regras que orientam as interações interpessoais, os esquemas relacionais, são particularmente significativas. Os esquemas relacionais de pessoas com perturbação psicológica tendem a ser extremamente rígidos, conduzindo a uma interpretação da experiência que não abrange a variedade dos eventos de vida, tornando-se desadaptativa. O *Core Conflictual Relationship Theme* (CCRT) é um método desenvolvido para identificar os padrões recorrentes de interação interpessoal, descrevendo os esquemas relacionais através de três componentes: os desejos e necessidades do cliente (W), as respostas dos outros a estes desejos (RO) e as respostas do *self* (RS). A rigidez dos esquemas relacionais é medida pela dominância (combinação dos W, RO e RS mais frequentes), dispersão (a distribuição de todos os W, todos os RO e todos os RS) e a valência (a proporção de RO e RS positivas). Vários estudos têm demonstrado que a melhoria nos sintomas de uma perturbação psicológica está associada a um CCRT mais flexível (i.e. menos dominante e mais disperso) e a RO e RS mais positivas. Estruturas como os esquemas relacionais constituem o nível macro-narrativo. Tem sido proposto que as mudanças nas macro-narrativas em psicoterapia ocorrem através da elaboração de eventos micro-narrativos. Enquanto o CCRT representa o nível macro-narrativo, os Momentos de Inovação (MIs), referindo-se a experiências não abrangidas pelas regras e premissas desadaptativas, representam o nível micro-narrativo. Através da promoção de uma forma mais flexível e satisfatória de interpretar a experiência, os MIs podem possibilitar a organização de uma macro-narrativa alternativa. São organizados em dois níveis: MIs elementares e MIs elaborados. Os MIs elementares permitem ao cliente distanciar-se da macro-narrativa problemática, enquanto os MIs elaborados centram-se na expansão da macro-narrativa alternativa. A investigação com o Sistema de Codificação dos Momentos de Inovação (SCMI) tem mostrado que clientes com sucesso terapêutico apresentam mais MIs durante as sessões de psicoterapia quando comparados com clientes com insucesso terapêutico. Além disso, a produção de MIs elaborados prediz a diminuição de sintomas. Embora vários estudos abordem o papel das narrativas em psicoterapia, a associação entre diferentes

níveis narrativas raramente tem sido estudada. Assim, esta dissertação tem como principal objetivo analisar as possíveis associações entre o nível micro-narrativo, o nível macro-narrativo e o resultado da psicoterapia. A amostra (N=22) usada nestes estudos foi constituída por clientes diagnosticados com perturbação depressiva *major* acompanhados em psicoterapia breve (10 em terapia narrativa, seis em terapia cognitivo-comportamental e seis em terapia focada-nas-emoções). No primeiro estudo analisou-se a associação entre os esquemas relacionais, avaliados com o CCRT, e o resultado terapêutico na amostra referida. Os resultados evidenciaram uma associação significativa entre o sucesso terapêutico e a rigidez das RO e das RS. A valência destes componentes (RO e RS) foi também significativamente mais positiva nos clientes com sucesso terapêutico. Estes resultados reforçaram a noção que a mudança dos esquemas relacionais é um ingrediente do sucesso psicoterapêutico. No segundo estudo analisou-se a associação entre os níveis micro- e macro-narrativos, avaliados com o CCRT e o IMCS na mesma amostra. Os resultados demonstraram que os MIs elaborados são preditores da dispersão das RO e RS e da dominância de todos os componentes do CCRT. A elaboração dos eventos micro-narrativos não abrangidos pela perspetiva problemática (os MIs) foi desta forma preditora das mudanças em estruturas macro-narrativas (os esquemas relacionais).No terceiro estudo compararam-se dois casos de sucesso terapêutico da sub-amostra de terapia cognitivo-comportamental. Apesar de ambas as clientes terem obtido sucesso terapêutico, apenas uma apresentou mudanças narrativas nos níveis macro- e micro-narrativos (medidos com o CCRT e o IMCS, respetivamente). Esta cliente manteve os ganhos terapêuticos nas sessões de acompanhamento enquanto a cliente que apresentou apenas melhoria de sintomas (sem mudanças narrativas) teve uma recaída nessas sessões. Este estudo realçou a importância da mudança narrativa no resultado terapêutico. Esta dissertação apresenta três contributos para o campo da investigação em psicoterapia. Em primeiro lugar, demonstrou que os esquemas relacionais podem ser alterados em modelos de psicoterapia breve. Em segundo lugar, este trabalho apresentou evidências que os MIs são preditores das mudanças nos esquemas relacionais. Finalmente, realçou a importância das mudanças narrativas no resultado da psicoterapia na manutenção dos ganhos terapêuticos.

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INTRODUCTION

INTRODUCTION

Sou o intervalo entre o meu desejo

e aquilo que os desejos dos outros fizeram de mim.[1]

Álvaro de Campos

Interpersonal difficulties are an important aspect of psychological distress. In several disorders, such as mood and personality disorders, interpersonal patterns have a crucial role (e.g Dimaggio, Montano, Popolo & Salvatore, 2015; Horowitz & Strack, 2011; Vanheule, Desmet, Rosseel & Meganck, 2006). Interpersonal patterns influence psychopathology through its content (e.g. a rejecting representation of others), but also through its *rigidity*. In fact, different psychotherapy models share the idea that rigid sets of expectations and interpretations of interpersonal interactions relate to the onset and maintenance of psychopathology (e.g. Dimaggio et al., 2015; Luborksy, 1998a). When interpersonal patterns become too rigid they will not capture all the diversity of interpersonal life, leading the person to be stuck on a repetitive and unsatisfactory pattern (e.g. Luborsky, 1998a), thus becoming maladaptive. As such, rigidity of interpersonal scripts or schemas is associated with higher symptom severity in several disorders (Albani et al., 1999; Cierpka et al. 1998).

Implicit rules and assumptions that persons use to interpret experiences guide interpersonal interactions (e.g. Baldwin, 1992). Such rules are conceptualized as being stored in scripts, schemas or self-narratives, constituting the macro-narrative level (Angus & Hardtke, 1994). The set of narratives constituting the macro-narrative level establish the characteristic range of emotions and goals (Neimeyer, 2004), structure experience and direct action (Angus, Levitt & Hardtke, 1999). The macro-narrative level encompasses the person's identity stories (Laitila, Aaltonen, Wahlström & Angus, 2005), thus constituting a relatively stable way of constructing the self, relating with others and the world (Angus, Levitt & Hardtke, 1999).

In psychotherapy, the change of maladaptive schemas (or scripts) is associated with symptom recovery (e.g. Angus et al., 1999; Demorest, 2013). These changes in the macro-narrative level are supposed to operate also at the micro-narrative level of discrete events (Gonçalves, Korman & Angus, 2002). Micro-narrative level corresponds to the narrative organization of the moment-to-moment experiences (Angus & Hardtke, 1994). Macro-narratives connect and give meaning to events, that is, the micro-narrative level (Gonçalves et al., 2002).

[1] *I am the interval between my wish and what the others' wishes made of me.*

Concomitantly, macro-narratives develop and change through the integration of new micro-narrative events (Gonçalves et al., 2002). Considering that macro-narratives function as a whole (like a *gestalt*), micro-narratives influence is not only synchronic but also diachronic. In other words, the micro-narrative events that may bring change to macro-narratives influence not only the interpretation of current events but also the past and future ones (Wahlström, 2006).

Our research group have been working with the concept of Innovative Moments (IMs), which are exceptions to the maladaptive macro-narratives associated with clients' psychological problems. The IMs are identified in the therapeutic conversation, thus an element of micro-narrative level. Empirical studies showed that the IMs distinguish recovered and unchanged clients in psychotherapy (e.g. Gonçalves, Ribeiro, Silva, Mendes & Sousa, 2015). However, the possible association between IMs and changes in broader, more stable macro-narratives has not been studied yet.

In this work, the change in relational schemas was explored with the Core Conflictual Relationship Theme (Luborsky, 1998b) in a sample of clients diagnosed with Major Depression Disorder according to the DSM-IV-TR (American Psychiatric Association, 2002). Moreover, the association between changes in relational schemas (macro-narratives) and IMs (micro-narratives) emergence was also studied.

THE MACRO-NARRATIVE LEVEL: SCRIPTS AND SELF-NARRATIVES

In recent decades, several fields of psychology studied the ways people organize their experiences in narrative accounts of themselves, others and the world. In fact, this theme has guided research in areas such as social psychology (e.g. Baldwin, 1992), personality (e.g. McAdams, 2001), psychotherapy (e.g. Neimeyer & Raskin, 2000), developmental psychology (Habermas & Bluck, 2001), among others. This view considers that narrative processes construct the self, allowing persons to make sense of their life experiences (e.g. Angus & McLeod, 2004; Sarbin, 1986; Singer, 2005). The role of clients' narratives in psychopathology and psychotherapy has been studied using different approaches and methods. We may broadly consider two major fields of psychotherapy research using the concept of narrative: the characteristics of narratives associated with psychopathology and recovery in psychotherapy and the way that psychotherapeutic conversation promotes changes in maladaptive narratives. This section briefly analyzes the research in the first field.

The concept of script has been one of the integrating notions in the study of persons' narratives (e.g. Demorest, 2013; Singer, 2004). According to Tomkins (1979), the self is organized around emotionally significant experiences, referred to as scenes. Similar events form scripts, that is, the implicit rules that guide the anticipation and interpretation of life experiences (Demorest, 2013). The person is regarded a dramaturge, constructing her life story by connecting different scenes in scripts (Carlsson & Carlsson, 1984). In fact, a sense of personal authorship emerges from the assemblage of recurrent or similar themes into scripts (Gonçalves et al., 2002; Guidano, 1991). With the increasing interest in the study of narratives, concepts similar to scripts have been developed (Singer, 2004).

The concept of self-narrative (Angus et al., 1999; Gergen & Gergen, 1988) is akin to the concept of script. Like the scripts, self-narratives organize events diachronically, linking the lived past, the present and the possible future in a coherent way (Angus & McLeod, 2004). Self-narratives also contain sets of assumptions, rules and expectations that constrains the interpretation of events (Freedman & Combs, 1996). One main difference between these concepts is the importance of culture in the construction of self-narratives as they are considered to be highly influenced by the cultural milieu (Bruner; 1990; McAdams, 2001) whereas in scripts the emphasis is placed in early and significant relationships (e.g. Demorest, 2013). However, despite this and other differences, persons' narratives (conceived either as scripts or self-narratives) allow the integration and linking of distinct events, in order to make sense of the multiplicity of experiences (Dimaggio et al., 2003; MacAdams, 2001).

Macro-narratives characteristics have been linked with wellbeing (e.g. MacAdams, Reynolds, Lewis, Patten & Bowman, 2001; Pennebaker, 1993) and psychopathology (e.g. Lysaker, Davis, Eckert, Strasburger, Hunter & Buck, 2005). Coherence and flexibility are key features of macro-narratives studied in psychotherapy research (Adler, Wagner & McAdams, 2007; Gonçalves et al., 2002). Whereas coherence refers to the ability of weaving together similar events, thus achieving a sense of self-continuity (Baerger & MacAdams, 1999), flexibility concerns the variety of experiences, behaviors and interpretations available in the persons' narratives (Gonçalves et al., 2002). In fact, the development of a psychological disorder has been associated either with an excessively rigid set of narratives or with its fragmentation (Dimaggio, Hermans & Lysaker, 2010). In other words, psychopathology can be conceived as an excessively coherent and inflexible set of narratives driving events interpretation, or on the contrary, a lack of coherence, in which narratives lose their ability to organize and confer meaning to the events.

This work focuses on the first possibility, that of how psychopathology is associated with macro-narratives that are too rigid and inflexible. The hypothesis that some psychological disorders are linked to the existence of too rigid or narrow ways of interpreting experience has been proposed in different psychotherapeutic theories, like cognitive (Safran & Muran, 2000; Young, 1999), psychodynamic (Luborsky, 1998a), experiential (Angus & Greenberg, 2011) or narrative (White & Epston, 1990). The excess of coherence in persons' narratives can be maladaptive by imposing the same patterns of interpretation and reaction to life events and by limiting the events included in clients' narratives (Dimaggio, 2006; Gonçalves, Matos, & Santos, 2009; Neimeyer, 2000). In other words, when macro-narratives are too rigid the interpretation of events will be recurrent. Furthermore, experiences that are incongruent or challenge those narratives' assumptions will be excluded from the person's field of interpretation (Freedman & Combs, 1996).

The association between changes in macro-narratives and psychotherapeutic recovery and general wellbeing has been demonstrated in several contexts (e.g. Adler, 2012; Baerger & McAdams, 1999; Lysaker, Lancaster & Lysaker, 2003; Pennebaker, 1993). In psychotherapy research, recovery from symptoms relates to an increase of flexibility and adequate levels of coherence in the macro-narrative level. In fact, symptom improvement has been associated with less use of maladaptive scripts (e.g. Siegel & Demorest, 2010), early maladaptive schemas modification (e.g. Nordahl, Holthe & Haugum, 2005), and self-narratives change (e.g. Dimaggio et al., 2015; Lysaker, Ringer, Maxwell, McGuire & Lecomte, 2010). The change of clients' narratives in psychotherapy has also been associated with the integration of negative experiences (Angus & Kagan, 2013). Moreover, when these efforts of coherence, flexibility and integration are successful, the client's agency and metacognitive abilities are enhanced (Dimaggio, Salvatore, Azzara & Catania, 2003), leading to more flexible narratives and more satisfying interpersonal relationships. In fact, clients' narratives about psychotherapy showed an association between recovery and the telling of stories of personal growth, with a strong focus on agency (Adler, Skalina & MacAdams, 2008).

Given the centrality of interpersonal relationships and affect in scripts (Singer, Blagov, Berry & Oost, 2013), schemas (Muran, 2002; Young, 1990) and self-narratives (Angus & Greenberg, 2011) several authors (e.g. Baldwin, 1992; Demorest, 2013; Dimaggio et al., 2015; Horowitz, 1989) have highlighted the role of interpersonal scripts or relational schemas in the organization of the self. As relational schemas is a trans-theoretical construct (Žvelc, 2009),

allowing for efforts of theoretical integration in psychotherapy research, it will be used in this dissertation to characterize the macro-narrative level.

Relational Narratives

Relational schemas are internalized models of relationships that shape the persons interpretation, behavior and expectations regarding interpersonal encounters (Baldwin, 1992; Safran & Muran, 2000). Relational schemas are defined as having a representation of the self, a representation of the other, and an interpersonal script that links self and other (Baldwin, 1992; Waldinger et al., 2002). These models or structures represent regularities in patterns of interpersonal relatedness, functioning as cognitive maps, orienting the person through the social world (Baldwin, 1992), having a strong impact in the experience of the self in relationships (Žvelc, 2009). In fact, considering that significant others representations are laden with affect, they have a pervasive role in shaping interpretations and defining emotional responses in most social encounters (Andersen & Chen, 2002). Relational schemas are thus considered a core element of the self, deeply influencing interpersonal behavior (Andersen & Chen, 2002).

Relational schemas have shown associations with psychopathology and wellbeing similar to those previously mentioned. More specifically, psychopathology has been related to the existence of highly stereotyped and maladaptive patterns of interpersonal behavior in most of psychotherapy models (e.g. Anstadt, Merten, Ullrich & Krause, 1997; Gross, Stasch, Schmal, Hillenbrand & Cierpka, 1998). The existence of a rigid set of relational schemas limits the way in which the person interacts with others and how he or she interprets the information from social encounters. Moreover, this limitation in the person's repertoire can lead to others to react in restricted ways that may be negatively interpreted by the client contributing to maintain the maladaptive patterns (Cierpka et al., 1998; Gross et al., 2007). Relational patterns in clinical populations are thus generally viewed as lacking variability (or flexibility) and having a level of rigidity that turns them maladaptive (e.g. Luborsky, Barber & Diguer, 1992).

Likewise, non-clinical populations showed a more varied set of relational schemas (Cierpka et al., 1998), which are elicited according to the situations' demands (Crits-Christoph, Demorest, Muenz & Baranackie, 1994). Furthermore, recovered psychotherapy clients tend to present more flexible and more satisfying relational schemas (Crits-Christoph & Luborsky, 1998; Demorest, 2013; Leising et al., 2003). Another factor taken into account in the change of relational schemas has been the therapeutic alliance between client and therapist (Safran &

Muran, 1990). In fact, a large strand of psychotherapy research has dedicated to the study of the relationship between clients and therapists. Although not being the focus of the present work, acknowledging the importance of therapeutic alliance as one of the common factors of change (e.g. Castonguay, Constantino, & Holtforth, 2006; Horvath, Del Re, Flückiger & Symonds, 2011), reinforces the significance of relational aspects in psychotherapy.

Different methods were develop to analyze relational schemas' repetitive patterns in psychotherapy. Some of the most common are the Core Conflictual Relationship Theme (CCRT; Luborsky, 1977), the Structural Analysis of Social Behavior (SASB; Benjamin, 1974), the Quantitative Assessment of Interpersonal Themes (QUAINT; Crits-Christoph, Demorest & Connolly, 1990) or the Role-Relationship Models Configuration (Horowitz et al., 1991). The CCRT (Luborsky, 1977; 1998a) was the first method developed to analyze client's narrations of interpersonal interactions. Moreover, the CCRT presents adequate psychometric properties (Slonim, Shefler, Gvirsman & Tishby, 2011) and its application has received strong validation throughout the years (e.g. Crits-Christoph & Luborsky, 1998; Slonim et al., 2011).

Departing from the narratives about relationships that clients tell in psychotherapy, it describes the recurrent patterns of interpersonal behavior (Luborsky, 1998b). Originated in a psychodynamic framework this method emphasizes the identification of transference from the client´s narration (Luborsky, 1998a). However, the relational patterns (or schemas) identified by CCRT can be seen as ways of giving meaning to experience (McLeod, 2004). This means that the CCRT identifies narratives with a stereotyped structure that function as a template to interpret experience (e.g. Demorest, Crits-Christoph, Hatch & Luborsky, 1999). Thus, despite its psychodynamic formulation, the CCRT is mainly a content analysis method, permitting the systematic analysis of the macro-narrative level, independently of the context (clinical or non-clinical) or the population (children, adolescents, adults). In psychotherapy research the CCRT has been widely used to study the relational narratives of clients with different disorders, like drug dependency (Ciaglia, 2012), eating disorders (Sharp, 2000), mood disorders (Crits-Christoph & Luborsky, 1998; Vanheule et al., 2006) and personality disorders (Chance, Bakeman, Kaslow, Farber & Burge-Callaway, 2000; Drapeau, Perry & Körner, 2012).

Most of the research with the CCRT developed within psychodynamic therapy. To our knowledge, only two studies analyzed other psychotherapy models (Crits-Christoph, et al., 1999; Crits-Christoph et al., 1990). The first study (Crits-Christoph, et al., 1999) showed that cognitive therapy had less relational narratives than interpersonal therapy. The second study (Crits-

Christoph, Demorest, Muenz & Baranackie, 1990), comparing dynamic therapy with cognitive therapy, found an association between the rigidity of themes and the duration of treatment, independently of the treatment model. The CCRT was the selected method to analyze the relational schemas in the present work, considering its strong validity, widespread use and the lack of systematic analysis with brief psychotherapy models outside the psychodynamic framework.

The Core Conflictual Relationship Theme

The CCRT unit of analysis is the relationship episode, defined as a discrete narration describing interactions between the client and others, including him/herself and the therapist (Luborsky, 1998b). The CCRT is defined through three main components, inferred from the relational narratives: the person's Wishes, needs and intentions (W), the Response of the Other (RO) to the wishes, and finally the Response of the Self (RS) to the fulfillment or not of the wishes. The RO and RS can be positive if they facilitate the wishes' satisfaction or negative if they frustrate them (Luborsky, 1998b).

There are several measures of relational schemas' rigidity that can be used with the CCRT method (McCarthy, Gibbons & Barber, 2008). The most common is pervasiveness, defined as the most frequent combination of its three components (Crits-Christoph & Luborsky, 1998). That is, the most frequent W, RO and RS of a client constitute her or his relational schema. A highly pervasive CCRT implies that the client uses the same categories of W, RO and RS to interpret most of the relational encounters. On the other hand, a less pervasive CCRT is more flexible and contains less repetitive patterns of interpersonal interactions, thus less conflicts between the client's W, RO and RS (Crits-Christoph & Luborsky, 1998). As an example, the pervasiveness of W may be defined by 60% identification of *to be loved and understood*, considering the total amount of wishes (100%) in all the episodes.

Another measure of rigidity is dispersion, defined as the discrepancy between the observed frequency distribution of the components and the frequency distribution that has the maximum amount of spread given the total components rated (McCarthy et al., 2008). In other words, dispersion takes into account not only the most frequent W, RO and RS but all the categories rated in the client's narrative. Considering the W component as example, this means that all W identified are considered and dispersion refers to the maximum spread of those W.

Whereas pervasiveness allows the identification of the most common categories, dispersion is a structural measure, informing also about the spread of all identified W, RO and RS. Let us consider as illustration of the difference between pervasiveness and dispersion two hypothetical clients with the same W (*to be loved and understood*) present in 60% of the relational episodes, which means that this W is the most pervasive (i.e. the most frequent). However, one of the clients hypothetically had only another W in the remaining 40% of the relational episodes and the other had four categories (each with 10%). In this made-up situation, despite having the same pervasiveness, the second client would have a higher dispersion.

Another important CCRT measure is the valence of responses (of others and of self), that can be positive (e.g. *self-confident*), when the client does not expect an interference with wish actualization; or negative (e.g. *helpless*), when such interference is perceived or anticipated (Ciaglia, 2010). In clinical populations relational schemas valence tends to be overly negative (e.g. Albani et al., 1999; Luborsky et al., 1992).

The association of changes in CCRT and symptoms severity and/or improvement has received a good degree of validation from numerous studies (e.g. Cierpka et al., 1998; Crits-Christoph & Luborsky, 1998; McMullen & Conway, 1997; Slonim et al.2011), although other studies have not found these associations (Lunnen, Ogles, Anderson & Barnes, 2006). Symptoms severity has been associated to a more pervasive CCRT at psychotherapy onset (Crits-Christoph & Luborsky, 1998). Cierpka et al. (1998), comparing a non-clinical with two clinical samples, showed that the non-clinical sample CCRT was less rigid (more disperse). Furthermore, symptoms severity was also related to CCRT valence, with clients with more symptoms presenting more negative views of the self and others (Albani et al., 1999).

On the other hand, changes in relational schemas are associated with a decreased manifestation of the maladaptive theme present at the beginning of therapy and an increase in the positive responses of others and of self (Crits-Christoph & Luborsky, 1998). Crits-Christoph and Luborsky (1998) reported an association between the decrease in pervasiveness of negative RS and the increase of positive RO and RS with symptom improvement. This study was conducted with a sample of 33 subjects with different diagnoses, being the most frequent dysthymic disorder, generalized anxiety disorder and schizoid personality disorder. Slonim et al. (2011) obtained a similar result with a sample of 72 adolescents, where recovery related to changes in rigidity at the level of the RO and RS.

Wilczek, Weinryb, Barber, Gustavsson and Åsberg (2004) studied the change of relational schemas after a long-term dynamic psychotherapy, with a mean duration of 3 years, on a sample of 34 clients. Despite not finding a systematic association between symptoms and CCRT changes, at the end of psychotherapy clients showed a more flexible CCRT pattern on all components except negative RS (Wilczek et al., 2004). Although Crits-Christoph and Luborsky (1998) argued that the W component seemed quite stable while the response components are more open to change, in the Wilczek et al. (2004) study the W component also presented changes at the end of therapy. In sum, higher flexibility of interpersonal pattern (especially the RO and RS components), either measured by pervasiveness or dispersion, and a positive valence of the response components seems related with better wellbeing and improvement of symptoms.

Finally, considering possible mechanisms of change of the relational schemas, Grenyer (2002) associated it with the increase of mastery. Self-knowledge and self-control are the main elements of mastery of interpersonal relationships, which supposedly develop progressively throughout psychotherapy (Grenyer, 1996). In this view, clients' self-control increases with the emergence of new ways of reacting to others, more adaptive and satisfactory, accompanied by client's ability to self-understanding and developing adaptive perspectives (Grenyer, 2002). On a study with 41 clients, Grenyer and Luborsky (1996) found a significant association between the increase of mastery and the decrease of symptoms. Moreover, the changes in mastery also related to the changes in the RS component (Grenyer & Luborsky, 1996). These results showed that even if the W and RO components are relatively stable at the end of therapy, clients might display a more adaptive set of responses (Ceustermont, 2012). Nonetheless, these findings were obtained with psychodynamic therapy, precluding its generalization to other theoretical frameworks. At the same time, mastery was measured in the same narratives used to identify the CCRT (Grenyer & Luborsky, 1996), which means that other significant micro-events outside these extracts of the transcripts were not considered. The next section explores alternative measures of these micro-events in psychotherapy.

THE MICRO-NARRATIVE LEVEL: INNOVATIVE MOMENTS

As mentioned, in psychopathology macro-narratives are frequently maladaptive, burdening clients with a narrow and dissatisfactory view of themselves, the others and the world. According to Frank (Frank & Frank, 1991), the role of psychotherapy is to help clients change the maladaptive framework (which is akin to our proposal of macro-narrative level) that constrains

their lives and causes suffering and demoralization. In this sense, we may assume that psychotherapy values the micro-narrative events that disconfirm or challenge the maladaptive framework. Despite focusing on behavior, cognitive, emotional or interpersonal modification, psychotherapeutic techniques such as behavior activation, cognitive restructuring, externalization or chair work actively aim to provide clients with experiences (and/or interpretations) that question the maladaptive macro-narrative's rules and assumptions (Gonçalves et al., 2015). Thus, changes in the micro-narrative level, occurring throughout psychotherapy, are considered to foster macro-narratives changes in order to turn them less maladaptive (Gonçalves et al., 2002; Žvelc, 2009). In other words, the micro-narrative level can organize into an alternative, more satisfying set of narratives, fostering enough change in the macro-narratives to turn them more flexible, acknowledging the different aspects of the self in the interpretation of experience (Dimaggio & Stiles, 2007). Furthermore, micro-narrative changes in psychotherapy would be traceable before having an impact in the macro-narrative level.

The study of micro-narrative changes in psychotherapy has been diverse, focusing in the events that can lead to symptoms recovery and macro-narratives changes. Some systems of analysis focus on the linguistic interactions between client and therapist, like the Therapeutic Cycles Model (TCM; Mergenthaler, 1996). TCM focuses on affective and cognitive processes to identify key moments (cycles) in psychotherapy conversation (Mergenthaler, 1996). Other systems, like the Metacognition Assessment Scale (MAS; Semerari et al., 2003), address the disruptions of client's narratives and how psychotherapy fosters narrative's transformation, mainly with personality disorders (e.g. Dimaggio, 2011).

Some systems of analysis explore the associations of narrative's change with other related processes. One example is the Narrative-Emotion Process Coding System (NEPCS; Angus et al., 2013), that analyzes the role of emotion in narrative processes. The Assimilation of Problematic Experiences Scale (APES; Stiles et al., 1990) uses the notion of voice instead of schema (Stiles, 2001) to refer to problematic experiences. In this view, psychotherapy helps the clients to assimilate problematic experiences into their narratives through a developmental sequence of recognizing, formulating, understanding and possibly solving those experiences (Stiles, 2001). Finally, the Innovative Moments Coding System (IMCS; Gonçalves, Ribeiro, Mendes, Matos & Santos, 2011) tracks the emergence of narrative novelties, the meanings and behaviors outside the maladaptive macro-narratives' rules and assumptions (Gonçalves et al., 2015). Innovative Moments (IMs) are identified on the micro-narrative level, understood as

narrative markers of meaning transformation (Gonçalves et al., 2015). IMs are all the experiences challenging the maladaptive macro-narratives, creating the opportunity for the development of alternative, more flexible views of the self and the world (Gonçalves et al., 2012).

Research on the influence of the micro-narrative level on relational schemas has been scarce and the existent studies were mostly rooted on psychodynamic theories, like the aforementioned study of mastery (e.g. Grenyer & Luborsky, 1996). The present work addresses this gap, by analyzing whether IMs (micro-narrative level), evaluated with the IMCS, are related to changes in the relational schemas (macro-narrative level), assessed with the CCRT.

Innovative Moments Coding System

The IMCS (Gonçalves et al., 2011; Gonçalves, Matos & Santos, 2009) was developed to study how IMs contribute to clients' narrative and symptomatic change. The IMCS considers the existence of different types of IMs (see Table 4 for the detailed description of each IM type), reflecting the notion that micro-narrative events leading to broader changes are multifaceted (e.g. behaviors, thoughts, attitudes, etc.). Besides considering the heterogeneity of narrative exceptions, the IMCS also recognizes that these may present different potential in fostering alternative interpretative frameworks (Cunha, Gonçalves, Valsiner, Mendes & Ribeiro, 2012; Montesano, Gonçalves & Feixas, 2015). Therefore, the IMs can be further discriminated into low-level IMs and high-level IMs. Low-level IMs, despite being important in mobilizing the client to change, through the expression of intentions and new understanding of the problem's rules and effects, do not allow, by themselves, the development of alternative macro-narrative rules and assumptions. High-level IMs on the other hand, are centered on change, on the recognition, elaboration and expansion of more flexible and satisfactory macro-narratives.

The high-level IMs encompass several processes by which the transformation of the macro-narrative can occur (Mendes et al., 2011; Gonçalves & Silva, 2014). In fact, these IMs allow clients to elaborate and develop different views of themselves, by articulating contrasts (when clients identify *what* changed on their perspective), processes, strategies (when clients elaborate on the *how* or *why* they changed), and agentive stances (of assertiveness and empowerment). Therefore, the high-level IMs seem to pinpoint mechanisms of change akin to mastery, insight or metacognition, fostering a greater flexibility and integration of the self (Gonçalves & Ribeiro, 2012). Moreover, the articulation of contrasts between alternative and

maladaptive meanings and behaviors in high-level IMs permits a sense of self-continuity (Gonçalves & Ribeiro, 2012).

Empirical research with the IMCS has consistently shown that recovered clients' sessions present more IMs than those of unchanged clients. These results have been found in different psychotherapy models, such as constructivist grief therapy (Alves et al., 2014), client-centred therapy (Gonçalves et al., 2012), narrative therapy (Gonçalves et al., 2015), cognitive-behavior therapy (Gonçalves, Silva, Ribeiro, Batista & Sousa, 2016), and emotion-focused therapy (Mendes et al., 2010). Recovered clients also presented significantly more high level IMs (e.g. Gonçalves et al., 2015; Montesano et al., 2015) and more recently, Gonçalves et al. (2015, 2016) showed that high level IMs predicted symptom improvement in the following session, on a sample of narrative therapy and on a sample of cognitive-behavior therapy. These results are in accordance with the notion that narrative changes may be a mechanism of therapeutic change and not merely a reflection, or a byproduct, of that change (Angus & Kagan, 2013).

Despite the body of evidence pointing to the strong association between the IMs emergence and therapy outcome, the impact of the IMs on the macro-narrative level has not been studied empirically. Thus, in this dissertation we study if the micro-narrative changes, tracked by the IMs, are experiences that may facilitate the modification of macro-narrative structures like the relational schemas.

INTRODUCING THE CURRENT STUDIES

This dissertation explores the role of micro- and macro-narrative levels in psychotherapy and its interaction in brief psychotherapy for depression.

The first study explored the association between changes in relational schemas, assessed with the CCRT, and psychotherapy outcome. This study analyzed a sample of clients diagnosed with major depression disorder according to the DSM-IV-TR (American Psychiatric Association, 2002) who went through brief psychotherapy. To test the use of the concept of relational schemas and the CCRT method in different therapy models, the sample of this study was composed of three subsamples: 10 clients followed in narrative therapy, six in cognitive-behavior therapy and six in emotion-focused therapy. Dispersion and valence of relational schemas were analyzed, taking in account their evolution throughout psychotherapy. This study can be included in what Elliot (2010) designated a quantitative process-outcome design in

change process research. In fact, this study investigated the association of changes in relational schemas with outcome.

The second study explored the possible association between the macro-narrative changes, described in the second study, and the micro-narrative level. The sample of this study was identical to that of the second one, with 22 clients diagnosed with major depression disorder. In this study, the IMs were divided into low- and high-level (as previously described) and used as predictors for the changes in dispersion, pervasiveness and valence in the relational schemas. This study combined a quantitative process-outcome with a significant events approach, as described by Elliot (2010). Besides associating several narrative changes to outcome, it used the IMs as significant events occurring throughout psychotherapy sessions to predict the changes in relational schemas. Moreover, it tested if the low-level IMs and high-level IMs had different predictive power of relational schemas change.

Finally, the third study intended to deepen the analysis of the relation between micro-narrative and macro-narrative levels by means of case studies. Stiles (2007) emphasized the importance of case studies as a possibility for theory building, by testing the premises of a theory or adding innovative features. Qualitative methods usually underlie this approach, providing an in-depth understanding the studied phenomena (Stiles, 2007). Therefore, the third study compared two recovered cases with symptom improvement (i.e. recovered cases), studying their macro- (CCRT) and micro-narrative (IMs) changes. Both clients were treated in a brief psychotherapy with a cognitive-behavior therapy manual and attained the criteria of recovery: cut-off and Reliable Change Index (Jacobson & Truax, 1991), in both the BDI-II (Beck, Steer & Brown, 1996) and the OQ-45.2 (Lambert et al., 1996; Portuguese version adapted by Machado & Klein, 2006). In one case both micro-narrative (assessed with the IMCS) and the macro-narrative (measured with the CCRT) levels presented the expected changes, that is, a profile with increasing IMs and higher flexibility of relational schemas, whereas in the other case these narrative changes were not observed. Moreover, the case that presented narrative transformation showed a maintenance of therapeutic gains in the follow-ups, while the case without narrative changes presented a relapse in the follow-ups. Thus, this study highlights the importance of narrative transformation, both at micro and macro level, in symptoms recovery and its maintenance.

The studies included in this dissertation followed a scaffolding logic. This means that the results, reflections and interpretations of one study were the departing point for the following. Moreover, the theoretical integration effort also became more central in the process of writing,

which is reflected in the slightly different elaborations of concepts presented in the studies. At the same time, there are some redundancies in the studies, considering that the same sample was used in the quantitative and in the qualitative analysis and that the studies were submitted as independent studies.

CHAPTER ONE

CHANGES IN RELATIONAL SCHEMAS IN THREE BRIEF PSYCHOTHERAPIES FOR DEPRESSION

CHAPTER ONE

CHANGES IN RELATIONAL SCHEMAS IN THREE BRIEF PSYCHOTHERAPIES FOR DEPRESSION[2]

Abstract

Objectives: This study analyzed the changes in relational patterns of clients in brief psychotherapy for depression and its relation to outcome. Change in the client's deeper relational schemas has been associated with successful psychotherapy and maintenance of therapeutic gains. In this study, we analyzed whether clients developed less rigid relational schemas at the end of psychotherapy. **Method:** The Core Conflictual Relationship Theme (CCRT) assessed the evolution of relational schemas. The sample was composed of 22 clients diagnosed with major depression disorder followed in cognitive-behavioral therapy (N=6), emotion-focused therapy (N=6) and narrative therapy (N=10). **Results:** At the end of psychotherapy, recovered clients' relational patterns were less rigid and more positive in two of the three CCRT components: Response of Other and Response of the Self. In the unchanged clients, no changes were found in these components. The Wishes component was less rigid at the end of psychotherapy regardless of the outcome. **Discussion:** The results of this study support the idea changes in relational schemas is associated with recovery in brief psychotherapy. Thus, promoting changes in relational schemas can be an important factor in recovery from major depressive disorder.

Introduction

In this study, we examined the evolution of relational patterns in three different models of psychotherapy. The idea that previous interpersonal experiences can be organized as schemas or scripts has been widely suggested in several fields of psychology (e.g., Balwin, 1992; Horowitz, 1989; Safran, 1990). Relational schemas are internalized models of relationships shaping a person's interpretation, behavior and expectations regarding interpersonal encounters (Baldwin, 1992; Safran & Muran, 2000). As models or structures, these schemas represent regularities in patterns of interpersonal relatedness, functioning as cognitive maps, orienting the person through the social world (Baldwin, 1992). These structures are usually defined as having a representation of the self, a representation of the other, and an interpersonal script that links self and other

[2] This study was submitted to *Journal of Consulting and Clinical Psychology* with the following authors: J. Batista, D. Alves, J. Silva, S. Freitas, A. Machado, I. Sousa, & M. M. Gonçalves.

(Baldwin, 1992; Waldinger et al., 2002). Relational schemas include the affective responses and wishes of the actors (Waldinger et al., 2002).

According to Andersen and Chen (2002), significant others' representations are laden with affect, playing a pervasive role in shaping interpretations and defining emotional responses in most social encounters. These mental representations of interpersonal relationships guide expectations and behavior in social situations (Baldwin, 1992; Demorest, Crits-Christoph, Hatch & Luborsky, 1999), influencing our sense of self and of others (Andersen & Chen, 2002; Žvelc, 2009).

Several authors have recognized the importance of relational schemas in psychology and psychotherapy over the past decades (e.g., Baldwin, 1992; Singer & Salovey, 1991). Rigid and stereotyped relational schemas have been identified and associated with the existence of psychological disorders (e.g., Cierpka et al., 1998; Demorest, 2013). This notion of relational rigidity is not only present in psychodynamic and interpersonal conceptualizations (e.g., Benjamin, 2000) but also in other psychotherapeutic approaches, such as cognitive, narrative or existential approaches (e.g., Gonçalves, Matos & Santos, 2009; Dimaggio, Montano, Popolo & Salvatore, 2015). Moreover, research has shown that successful psychotherapy is associated with relational schemas' increase in flexibility and adaptability (e.g., Crits-Christoph & Luborsky, 1998; Leising et al., 2003; Slonim, Shefler, Gvirsman & Tishby, 2011). However, despite the potential of this concept, it has not been systematically addressed in psychotherapy research (Demorest, 2013; Žvelc, 2009).

Luborsky (1998a) developed one of the first and most reliable attempts to analyze the narratives about relationships that clients communicate in psychotherapy, the Core Conflictual Relationship Theme (CCRT). Despite the psychodynamic background, the patterns (or schemas) identified by the CCRT can be viewed as broader ways of constructing meaning for relational experiences (McLeod, 2004), that is, scripts with a narrative stereotyped structure that functions as a template for interpreting relational experiences (e.g., Demorest et al., 1999). The CCRT allows the identification of relational schemas, independently of the context (e.g., clinical, non-clinical), and the model of psychotherapy that is used. In this study, we used this method to track changes in the relational schemas of three different brief psychotherapies for depression (emotion-focused therapy; narrative therapy; and cognitive-behavior therapy).

Relational Narratives

According to Luborsky, Barber and Diguer (1992), relational narratives that clients share during sessions reflect their deeper relationship schemas, functioning as a stable template in interpersonal contexts. The CCRT unit of analysis is the relationship episode, defined as a discrete narration describing interactions between the client and others, including him/herself and the therapist (Luborsky, 1998b). The CCRT is defined through three main components: the person's Wishes, needs and intentions (W); the Response from Other to the wishes (RO); and the Response of the Self to the fulfillment (or not) of the wishes (RS).

Pervasiveness is a measure of the degree to which a relational schema repeats itself, defined as the most frequent combination of its components (Crits-Christoph & Luborsky, 1998). A less pervasive CCRT is more flexible and contains less frequent conflicts between the client's wishes and the responses of others and of the self (Crits-Christoph & Luborsky, 1998). For instance, in the study by Crits-Christoph and Luborsky (1998), the negative RO decreased from 40.7% to 28.5% from the initial to the final sessions. Thus, the most frequent negative RO was present in 40.7% of the relational episodes in the initial sessions but only 28.5% of the relational episodes in the final sessions included this response.

Despite being the most frequently analyzed dimension of the CCRT, pervasiveness is not the only way to study relational schema rigidity. Dispersion is an alternative measure (Cierpka et al., 1998; McCarthy, Gibbons & Barber, 2008). Dispersion represents the discrepancy between the observed frequency distribution of the components (W, RO and RS) and the frequency distribution that has the maximum amount of spread given the total components rated (McCarthy et al., 2008). Thus, dispersion is the spread of the distribution of the CCRT components taking into account all the W, RO and RS rated (McCarthy at al., 2008). Whereas the pervasiveness measure only considers the most frequent category (e.g., the W *to be loved and understood*), the dispersion measure considers all the components' categories (see Table 2 in the Methods section) and their relative distribution (the frequency of each category). Thus, dispersion takes into account the maximum dispersion of the component and the total number of categories rated for that component.

Slonim et al. (2011) considered that this measure provides an indication of the narrowness or wideness of range of the CCRT components. Because dispersion takes into account the frequency of all categories, it seems a more accurate measure of the rigidity of

clients' narratives. Moreover, dispersion allows for the study of the structural aspect of the CCRT, without being particularly dependent on the categories' content.

Another important measure of the CCRT is the response (of others and of self) valence, which can be positive (e.g., *self-confident*) or negative (e.g., *helpless*), depending on the relationship to wish fulfillment (Luborsky, 1998b). This measure indicates how clients evaluate their and others ways of acting and whether they feel their wishes and needs are being fulfilled. In clinical populations, relational schema valence tends to be overly negative (e.g., Grenyer & Luborsky, 1996).

Research with the CCRT

The association of changes in the CCRT and symptom severity and/or improvement has received a good degree of validation from numerous studies (e.g., Cierpka et al., 1998; Crits-Christoph & Luborsky, 1998; Slonim et al., 2011). The change in relational schemas was empirically associated with decreased manifestation of the maladaptive theme present at the beginning of psychotherapy and an increase in the positive RO and RS (Crits-Christoph & Luborsky, 1998).

More specifically, Crits-Christoph and Luborsky (1998), in a study conducted with a sample of 33 patients with different diagnoses (the most frequent being dysthymic disorder, generalized anxiety disorder and schizoid personality disorder), reported an association between a decrease in pervasiveness of negative RS and an increase of positive RO and RS with symptom improvement. Slonim et al. (2011) obtained a similar result among a sample of 72 adolescents, in which recovery related to changes in rigidity (measured by dispersion) on RO and RS components. Cierpka et al. (1998) found an association between a more rigid CCRT and symptom severity in comparing a non-clinical control group and two clinical groups with a total sample of 80 subjects. Symptom recovery has been consistently related to a decrease in the rigidity of the CCRT components and to a more positive valence in patients with drug abuse (Ciaglia, 2010) and mood disorders (Crits-Christoph & Luborsky, 1998) and in adolescent patients (Slonim et al., 2011).

In a different study, Wilczek, Weinryb, Barber, Gustavsson and Åsberg (2004) analyzed the changes in relational schemas after long-term dynamic psychotherapy (mean duration of 3 years). Considering three CCRT measures (pervasiveness, dispersion and valence), and despite not having found associations between those measures and symptom measures, this study

provides an interesting description of changes in components. In fact, relational patterns at the end of psychotherapy were significantly less pervasive (all components), whereas only the RO component showed an increase in dispersion. The RS and RO valences were also significantly more positive than at the beginning of psychotherapy. In sum, most research on the CCRT suggests that more severely impaired patients present less flexible relational patterns (Cierpka et al., 1998) and have more negative RO and RS (Albani et al., 1999). Thus, lower rigidity of interpersonal pattern, measured by either pervasiveness or dispersion, and a positive valence of the response components appears to be related to a better wellbeing and improvement in symptoms.

However, most of these studies involving clinical samples used psychodynamic therapies. To the best of our knowledge, only two studies analyzed other psychotherapy models (Crits-Christoph, et al., 1999; Crits-Christoph, Demorest, Muenz & Baranackie, 1990). The first study (Crits-Christoph, et al., 1999) showed that cognitive therapy had less relational narratives than interpersonal therapy. The second study (Crits-Christoph, et al., 1990), which compared dynamic therapy with cognitive therapy, found an association between the pervasiveness of themes and the length of treatment, independently of the treatment model.

Moreover, most of the samples used in these studies featured clients with mixed diagnoses (e.g., Cierpka et al., 1998; Crits-Christoph & Luborsky, 1998; Vanheule, Desmet, Rosseel & Meganck, 2006), which may have complicated the identification of clear patterns of relational schemas associated with specific diagnostic entities. Finally, the studies that associated changes in relational schema with symptom improvement only had two points of assessment with the CCRT, at the beginning and at the end of treatment. Thus, there is no information about the evolution of the relational schemas throughout treatment.

The Present Study

This study analyzed whether changes in relational schemas are also identifiable in brief therapeutic models outside the psychodynamic tradition. Therefore, one of our questions is whether changes in relational patterns are associated with symptom improvement, regardless of the therapeutic model used. Although using three different therapies, all the clients in this study had a common diagnosis of major depressive disorder. At the same time, the introduction of a middle point of assessment of the relational schemas allowed for a richer analysis of the evolution of relational schemas. In sum, this study had two main objectives: to analyze whether

there were changes in relational patterns of rigidity and valence from the beginning to the end of brief therapy and to determine whether the changes in the relational patterns were associated with symptom evolution.

Method

Sample

The sample for this study was composed of 22 clients diagnosed with major depressive disorder (MDD). There were three treatments in this sample: emotion-focused therapy (EFT), cognitive-behavior therapy (CBT) and narrative therapy (NT). In these subsamples, the maximum duration of the treatment protocol was 20 sessions. Whereas the EFT clients had weekly sessions, the CBT and NT clients had biweekly sessions after session 16. The clients consented to participating in the original studies from each subsample derived (see Greenberg & Watson, 1998; Lopes et al. 2014 for further details).

Sample selection. The EFT subsample was derived from the York I Depression Study (Greenberg & Watson, 1998), comparing the effectiveness of EFT (also referred as process experiential) with client-centered therapy (CCT). The clients were diagnosed with MDD according to the DSM-III-R (American Psychiatric Association, 1987), based on the Structured Clinical Interviews for DSM-III-R Disorders (SCID; Spitzer, Williams, Gibbon & First, 1989). Exclusion criteria were the occurrence of an ongoing treatment, either psychotherapy or pharmacology, and diagnoses of an eating disorder, antisocial or borderline personality disorder, or a bipolar or psychotic disorder. In that study, 34 clients constituted the final sample, 17 in each condition. The six clients in this group (three recovered and three unchanged) were selected for intensive process analyses, taking into account the psychotherapy outcome measured by the BDI cut-off and a reliable change index (RCI; Jacobson & Truax, 1991) calculation. The CBT and NT subsamples were part of a controlled trial comparing treatment effectiveness (Lopes et al., 2014). The clients in this study were diagnosed with MDD according to the DSM-IV-TR (American Psychiatric Association, 2002), based on the Structured Clinical Interviews for DSM-IV-TR Axis I Disorders (SCID-I; First, Spitzer, Gibbon & Williams, 2002). Exclusion criteria were the occurrence of other Axis I diagnoses (including anxiety disorders as main diagnoses) and any Axis II diagnoses. The final sample of that study featured 63 clients, 34 in the NT condition and 29 in the CBT condition. Considering the BDI-II cut-off and the RCI (Jacobson & Truax, 1991) for that measure, the completers (20 in each subsample) were classified as either unchanged or

recovered. The current subsamples of six CBT clients (three unchanged and three recovered) and 10 NT clients (five unchanged and five recovered) were randomly selected from the completers.

Sample description. The EFT subsample was composed of four women and two men ranging in age from 27 to 63 years (M = 45.50, SD = 13.78). Three of the clients were married, two had divorced and remarried and one was divorced. With respect to educational level, one of the clients had received education beyond grade 6, two had graduated high school and three of them had a university degree.

The CBT subsample was composed of five women and one man ranging in age from 24 to 46 years (M = 34.50, SD = 8.50). At the time of psychotherapy, two clients were single, three were married and one was divorced. These clients had between 9 and 16 years of formal education (M = 14.17, SD = 2.71). In terms of occupational status, three clients were employed, two were students and one was unemployed.

Finally, the NT subsample was composed of seven women and three men ranging in age from 22 to 64 years (M = 41.00, SD = 14.97). Four clients were single (although one was in a long-term relationship), three were married, two were divorced and one was widowed. The clients of this subset had between 9 and 24 years of formal education (M = 13.90, SD = 5.07). In terms of occupational status, four of the clients were unemployed, two were employed, two were students and one was retired.

Therapists

Among the therapists of the EFT group, four were female and one was male. These therapists had different levels of education; they ranged from advanced PhD students in clinical psychology to PhD clinical psychologists. The therapists received training over a 24-week period (eight weeks for CCT and the rest for experiential techniques) according to the manual devised for the study (Greenberg, Rice, & Elliot, 1993). Therapists were supervised as they treated a pilot client before the study. Adherence was rated based on 20 minutes of four sessions for each client. Session two was always rated, and three other sessions that were randomly selected were also rated.

The CBT and NT subsamples had only one therapist for each treatment. The therapist of the CBT group was a male PhD student with five years of previous clinical experience. He already had experience with CBT and received training on a manual based on the Beck, Rush, Shaw and Emery (1979) and Leahy and Holland (2000) models of CBT treatment. A more experienced

therapist also supervised this therapist. The application of an adherence scale, in each of four sessions, ensured that the treatment complied with the model (see Lopes et al., 2014 for further details).

The therapist of the NT group was a male PhD student with seven years of experience as psychotherapist. He had three years of experience in NT and received training on a manual based on the White and Epston (1990) model of NT. A more experienced therapist also supervised this therapist. The application of an adherence scale, in each of four sessions, ensured that the treatment complied with the model. Each therapist chose his preferred model (CBT or NT) as a way of controlling therapist allegiance.

Treatments

Emotion-focused therapy. The manual used in the EFT subsample departed from the CCT basis of empathic working alliance with the addition of process directive, experiential interventions (Greenberg et al., 1993). This model views psychological problems as dysfunctions in emotion processing and regulation (Elliott, Watson, Goldman, & Greenberg, 2004). Psychotherapy is considered a way for clients to access their emotion schemes in a secure environment, striving for more complete emotional processing (Greenberg et al., 1993). After three sessions focused on the establishment of therapeutic alliance, experiential and gestalt interventions were used to foster the dysfunctional emotion schemes activation and restructuring (Greenberg et al., 1993).

Cognitive-behavior therapy. The manual used on the CBT subsample followed Beck's treatment protocol for depression (Beck et al., 1979). The CBT protocol involved five phases: psychoeducation, case formulation, behavioral activation, cognitive restructuring and termination (Beck et al., 1979; Lopes et al., 2014). Psychoeducation consisted in explaining to the client the aims of psychotherapy and the manner in which dysfunctional patterns are organized (the treatment rationale). The second phase was the application of CBT concepts to the client's situation, establishing treatment priorities and working hypotheses. The third phase addressed more behavioral strategies (e.g., reinforcement, problem-solving skills), whereas the fourth phase targeted dysfunctional beliefs and thoughts, serving as the main phase of the manual (Beck et al., 1979). Finally, the termination phase was set to prepare the client for the end of treatment, in particular, dealing with relapse prevention.

Narrative therapy. A manual based on the work of Michael White (2007; White & Epston, 1990) was constructed to guide this intervention. From this perspective, psychological problems are caused by unsatisfactory or rigid, problem-saturated life narratives (White & Epston, 1990). According to White and Epston (1990), not all life events integrate a life narrative, opening the way for new narrative possibilities by developing the meanings outside the problematic self-narrative that brought the client to psychotherapy. NT develops in three phases: deconstruction, reconstruction and consolidation (Freedman & Combs, 1996). The deconstruction phase targets the understanding of the problem as detached from the client, mainly through externalizing conversation (White, 2007). The reconstruction phase revolves around the identification and elaboration of unique outcomes (i.e., events outside the domination of the problematic self-narrative). Finally, the consolidation phase consists of the expansion and search for audiences for emerging alternative plots (White, 2007).

Measures

Outcome measure. The common outcome measure in the three subsamples was the Beck Depression Inventory (BDI, Beck, Steer & Carbin, 1988; BDI-II, Beck, Steer & Brown, 1996), applied at pre- and post-test. This inventory is composed of 21 items that evaluate depressive symptoms. The items are rated on a four-point Likert scale (0-3), and the total score ranges between 0 and 63 points. Higher values in the BDI and the BDI-II correspond to higher depressive symptomatology. Clients were considered unchanged if they did not meet the double criteria of the BDI cut-off (11.08 in BDI and 14.29 in BDI-II) and the RCI. Table 1 presents the range, mean (M) and standard deviation (SD) of BDI and BDI-II scores at pre- and post-test.

Table 1
BDI and BDI-II results from the three subsamples

	Range			Mean (Standard Deviation)		
	Pre-test	Post-test (unchanged)	Post-test (recovered)	Pre-test	Post-test (unchanged)	Post-test (recovered)
CBT	16-44	18-34	1-8	30.67 (9.14)	25.33 (6.60)	4.67 (2.87)
EFT	15-35	13-22	3-5	25.33 (6.18)	17.67 (3.68)	4.00 (0.82)
NT	17-48	20-45	2-7	29.70 (9.09)	31.40 (8.11)	4.00 (2.10)

Note. EFT results refer to BDI scores; CBT and NT results refer to BDI-II scores.

Relational schemas. The Core Conflictual Relationship Theme method (Luborsky, 1998b) was used to assess clients' relational schemas. The CCRT is a content analysis system that identifies relationship episodes narrated by the client during psychotherapy and distinguishes three components (W, RO, RS) in each relational episode. After the initial coding, the components are converted to the standard categories (see Table 2) proposed by Barber, Crits-Christoph and Luborsky (1998). Higher pervasiveness, lower dispersion and a negative valence of the components are indicative of a more rigid and less adaptive relational schema.

Table 2
Standard categories of the CCRT components (Edition 3)

CCRT components	Standard categories
Wishes	1. To assert self & be independent
	2. To oppose, hurt & control others
	3. To be controlled, hurt & not responsible
	4. To be distant & avoid conflicts
	5. To be close & accepting
	6. To be loved & understood
	7. To feel good & comfortable
	8. To achieve & help others
Responses of Other	1. Strong
	2. Controlling
	3. Upset
	4. Bad
	5. Rejecting & opposing
	6. Helpful
	7. Likes me
	8. Understanding
Responses of Self	1. Helpful
	2. Unreceptive
	3. Respected & accepted
	4. Oppose & hurt others
	5. Self-controlled & self-confident
	6. Helpless
	7. Disappointed & depressed
	8. Anxious & ashamed

Note. Adapted from Barber, Crits-Christoph & Luborsky, 1998.

Procedures

CCRT components identification. We used transcripts of the sessions to identify relational episodes, as proposed by Luborsky (1998b). Two sessions from the beginning, two from the middle and two from the end of psychotherapy were analyzed. The use of two sessions of each psychotherapy phase ensured the minimum of 10 relational episodes required to identify the CCRT. Following Albani et al. (1999), we considered all the relational episodes in the sessions,

not only the minimum number. The initial sessions were always the second and the third; the middle sessions were defined arithmetically (dividing the total amount of sessions by two), and the final sessions were the two before the last one.

Five independent raters coded the CCRT working in pairs in which one of the elements was constant. The main coder was a PhD student and the other coders were two PhD students, a master student and two psychologists with a PhD. Before coding, all the judges completed CCRT training that included extensive reading of the Luborsky (1998b) guidelines and exercises with several clinical sessions to adequately locate relational narratives and identify the CCRT components. The training was considered successful when a percentage of agreement greater than 90% for the identification of relational narratives and an intraclass correlation (ICC) for the components definition higher than .80 were reached. for component definition were obtained. Additionally, the main coder had the help of Dr. Paul Crits-Christoph in resolving initial doubts in coding. All of the judges involved were unaware of the therapeutic outcome of the cases.

The CCRT coding followed the procedures described by Luborsky (1998b). First, two judges independently identified the relational episodes and then met to decide which episodes were to be coded. This decision was based on an episode's degree of completeness, which was rated on a scale from 1 to 5 with a cut-off at 2.5. Next, the judges identified the components and converted them to one of the standard W, RO and RS categories shown in Table 2, based on their proximity to it.

CCRT measures calculation. To calculate the dispersion of each component, we used the dispersion index derived from Gini's concentration measure C (Cierpka et al., 1998). The formula for calculating dispersion is as follows (Cierpka et al., 1998):

$$\text{Dispersion} = \frac{\text{C} = 1 - \text{Sum of squared relative frequencies of coding in each cluster (for W, RO or RS)}}{C_{max} = \text{Maximum value of C for a given number of codings (for W, RO or RS)}} = \frac{C}{C_{max}}$$

The computation of the maximum value of C (C_{max}) followed the formulas described by Cierpka et al. (1998). The dispersion score ranges from 0 (all responses are in the same category; there is no dispersion) and 1 (the responses are distributed over the maximum dispersion possible). Although the dispersion score ranges from 0 to 1, this measure cannot be considered a proportion of a total, but an index. The discrepancy between the observed and maximum spread distributions indicates the level of dispersion of the CCRT component

(MacCarthy et al, 2008). According to Cierpka et al. (1998), the higher the dispersion score the more flexible the relational pattern is, whereas lower scores indicate that the pattern is highly rigidified.

The calculation of pervasiveness took into account the frequency of each category and the total number of relational episodes in each psychotherapy phase. The pervasiveness score is a proportion of the frequency of a component's given category over the total number of relational episodes (Crits-Christoph & Luborsky, 1998). Positive and negative responses were defined following the proposal of Wilczek et al. (2004). Instead of deciding whether each RO and RS was positive or negative (the procedure used by Crits-Christoph & Luborsky, 1998), some categories were considered to be positive and the others negative. Therefore, the RO categories 1 (*strong*), 6 (*helpful*), 7 (*likes me*), and 8 (*understanding*) and the RS categories 1 (*helpful*), 3 (*respected and accepted*), and 5 (*self-controlled and self-confident*) were considered positive. The remaining RO and RS categories were considered negative. The valence analysis used the sum of all the positive RO pervasiveness categories and all the positive RS pervasiveness categories. Because there are no neutral categories, the sum of the positive and negative responses is always 100%. Pervasiveness and dispersion were calculated for each component of the CCRT (W, RO, RS), whereas valence was calculated for RO and RS.

Statistical analysis. Positive RO pervasiveness and positive RS pervasiveness (valence) were compared in the recovered and the unchanged groups using unpaired two-tailed *t* tests. These tests compared the groups' means at the beginning, the middle and the end of psychotherapy. Although many studies that have used the CCRT (e.g., Cierpka et al., 1998; Crits-Christoph & Luborsky, 1998) have analyzed the data obtained by ANOVA, we opted for a generalized linear mixed model (GLMM) for the analysis of dispersion because it allows for a better analysis of unbalanced data and takes into account subject-specific random effects. In this study, we considered a GLMM model with the CCRT components' dispersion (Gini dispersion score for W, RO, RS) as response variables. Psychotherapy phase, the outcome, and the interaction between outcome and psychotherapy phase were the explanatory variables.

Considering the response as a dispersion score with a value between 0 and 1 we treated this as a random variable with a beta distribution. We were therefore interested in making inferences based on model parameters of the expected value of the distribution E[Y].case of a binary response variable 0/1 that corresponds to the non-occurrence of a CCRT category or the occurrence of that category (e.g., the RS *helpless*). We treated this variable as a random variable

with a Bernoulli distribution and were interested in inferring the probability parameter associated with this distribution. The parameters were incorporated into the model through linear regression of the explanatory variables. The introduction of a random effect allowed each client to have a common component in all of her or his sessions. Thus, we could decompose the total variability in the data into between- and within-subject variability.

Results

Inter-rater Agreement

Two reliability indexes were calculated, a percentage of agreement for the identification of the relational episodes and an ICC for the identification of the CCRT components. The percentage of agreement for the relational episodes of the 22 cases was 93.5%. The ICC was .89 for W, .92 for RO and .93 for RS.

CCRT Descriptive Results

This section presents the descriptive results obtained for the CCRT coding in the three subsamples. The mean number of relational episodes was similar from one psychotherapy to the other, ranging from 7 to 10 relational episodes for each session. Table 3 presents the pervasiveness of the most common CCRT components considering the psychotherapy outcome.

Table 3

Most pervasive CCRT components in the three psychotherapy phases

	Most pervasive component	Initial phase	Middle phase	Final phase
Recovered Group	To be loved and understood (W).....	40%	40%	34%
	Reject and oppose (NRO).....	54%	45%	35%
	Understanding (PRO).....	8%	-	16%
	Helpful (PRO).....	-	9%	-
	Depressed and disappointed (NRS).....	58%	36%	21%
	Comfortable and accepted (PRS).....	4%	16%	29%
Unchanged Group	To be loved and understood (W).....	39%	51%	45%
	Reject and oppose (NRO).....	57%	59%	64%
	Understanding (PRO).....	6%	-	6%
	Helpful (PRO).....	-	9%	-
	Depressed and disappointed (NRS).....	58%	43%	53%
	Comfortable and accepted (PRS).....	5%	12%	15%

Note. W, Wishes; NRO, Negative Response of Other; PRO, Positive Response of Other; NRS, Negative Response of the Self; PRS, Positive Response of the Self.

As reported in other studies involving depressed clients (e.g., Vanheule et al., 2006; Crits-Christoph & Luborsky, 1998), the most pervasive CCRT components were quite stable throughout psychotherapy. RS was the only component with a change in the most frequent category at the end of therapy in the recovered group, with the positive RS (PRS) becoming the most frequent category.

Changes in CCRT Components across Phases

As previously described, a GLMM model was computed to determine whether the CCRT components dispersion changed over time (considering three phases) and according to outcome. For the W component, there were no significant differences between recovered and unchanged clients (Figure 1).

Figure 1. Wishes dispersion predicted by outcome

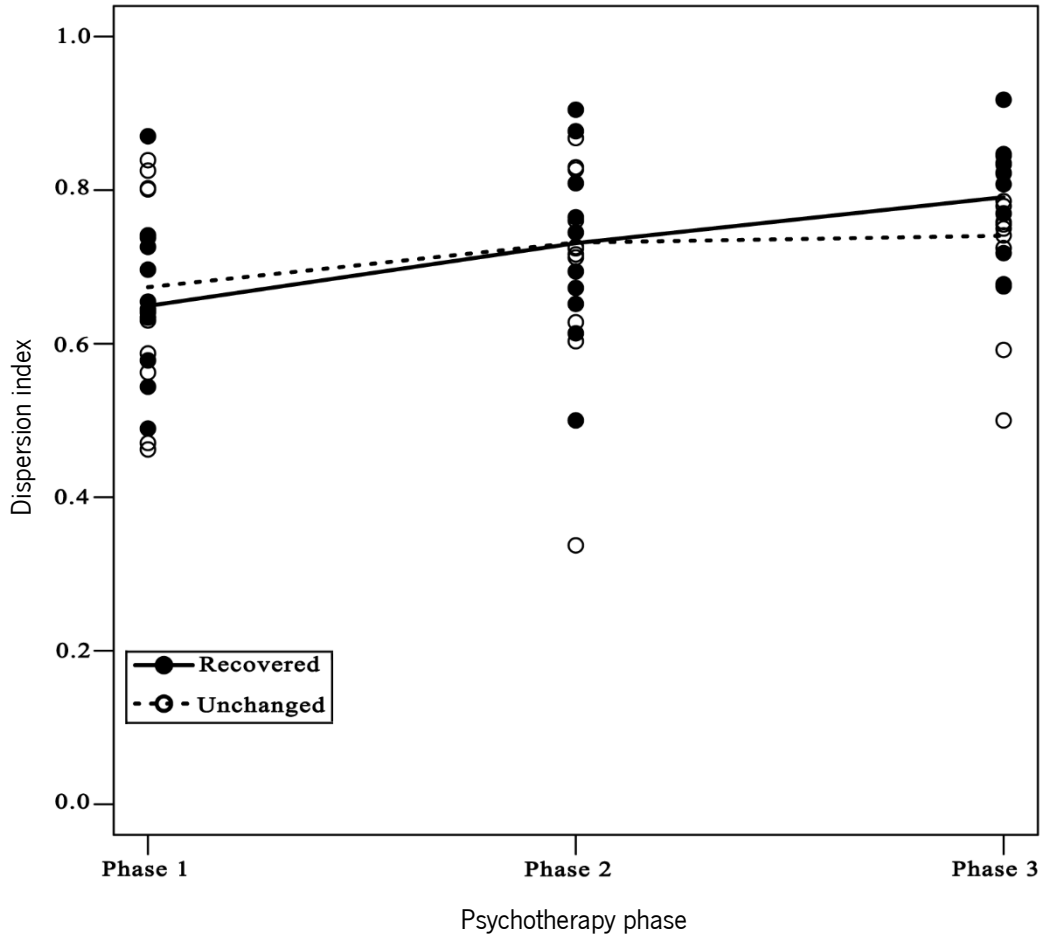

Figure 1. Evolution of W component throughout the three phases of psychotherapy, initial (Phase 1), intermediate (Phase 2) and final (Phase 3). The *x* axis shows the dispersion index, ranging from 0 to 1. Points represent clients, divided according to the outcome (recovered vs unchanged).

Nonetheless, this component's dispersion increased significantly in the final phase for all clients (β= 0.46, *t*= 3.68, R^2_{adj}= .49, p = .00059), indicating that the W became less rigid regardless of psychotherapy outcome.

For the RO component, there was a significant increase in the dispersion of recovered clients at the end of psychotherapy (β= 0.91, *t*= 2.88, R^2_{adj} = .42, p=.0058). This component became less rigid but only among the recovered clients (Figure 2).

Figure 2. Responses of Other dispersion predicted by outcome

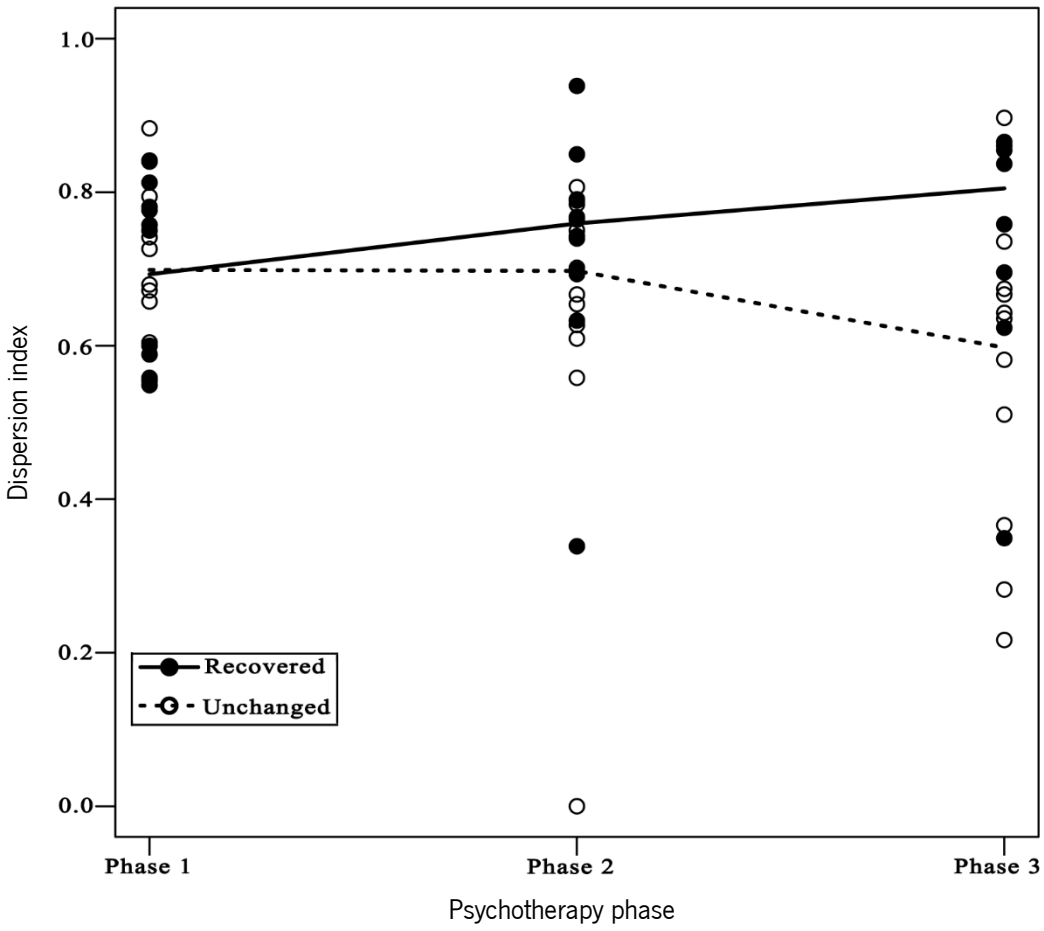

Figure 2. Evolution of RO component throughout the three phases of psychotherapy, initial (Phase 1), intermediate (Phase 2) and final (Phase 3). The *x* axis shows the dispersion index, ranging from 0 to 1. Points represent clients, divided according to the outcome (recovered vs unchanged).

The RS dispersion showed a similar pattern, with differences between the groups only in the final phase (β= 0.81, *t*= 3.02, R^2=.54, p=.0039), indicating that the recovered clients ended psychotherapy with less rigidity on this component (Figure 3).

With respect to valence, the two-tailed unpaired *t* test showed no differences between recovered and unchanged clients in the initial and middle phases of psychotherapy. In the final phase of psychotherapy, there was a difference between the outcome groups on the valence of

both RO, $t(20) = -3.59$, p=.002, and RS, $t(20) = -9.05$, p<.001. With respect to both variables, the recovered clients presented significantly higher positive responses than the unchanged ones.

Figure 3. Responses of the Self dispersion predicted by outcome

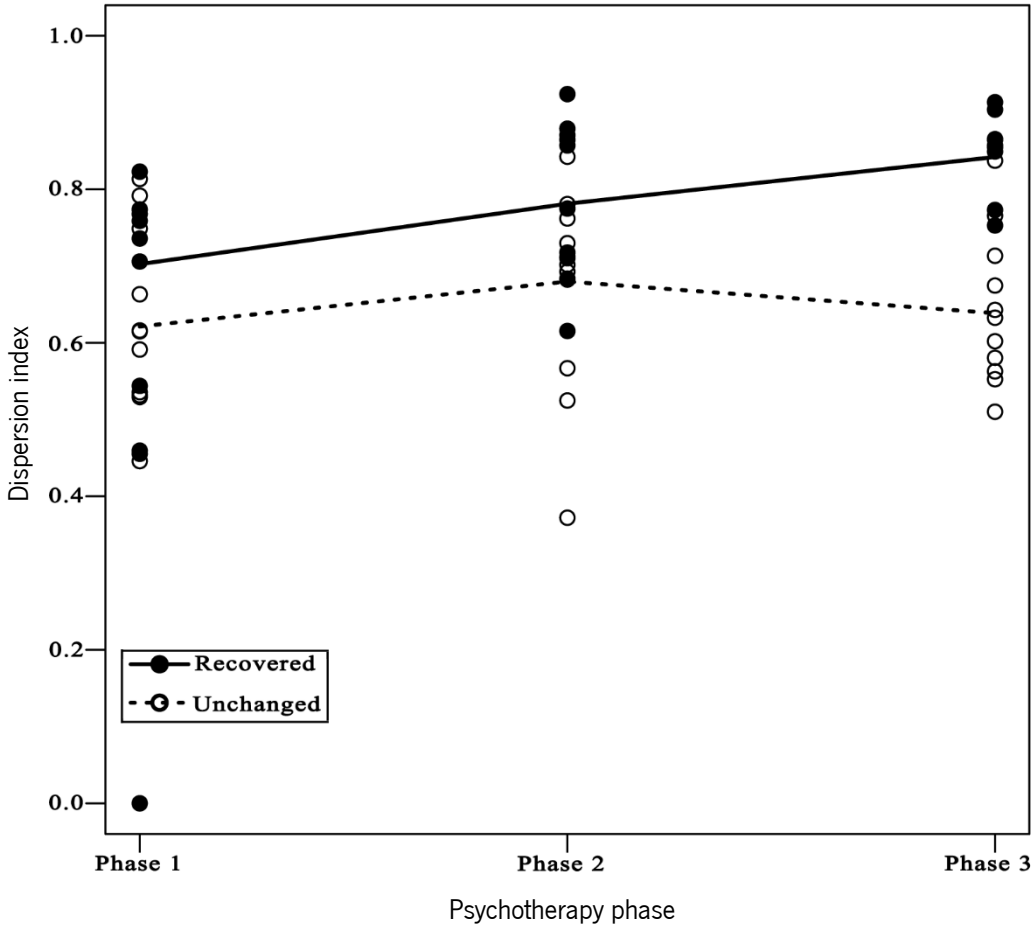

Figure 3. Evolution of RS component throughout the three phases of psychotherapy, initial (Phase 1), intermediate (Phase 2) and final (Phase 3). The *x* axis shows the dispersion index, ranging from 0 to 1. Points represent clients, divided according to the outcome (recovered vs unchanged).

Discussion

The results of this study support the applicability of the CCRT method in brief therapies outside a psychodynamic theoretical framework. In fact, these results confirmed previous findings obtained with the CCRT: Successful psychotherapy was significantly associated with a decrease in rigidity (measured by dispersion) and with a more positive response valence at the end of psychotherapy. One innovative feature of this study was the use of an intermediate point of assessment. This made it possible to analyze the evolution of client's CCRT, which is not possible with only two assessments (at the beginning and at the end of psychotherapy). Nevertheless, significant changes in rigidity only occurred in the final phase of psychotherapy. This finding may

be due to the claim that relational schemas are relatively stable structures (e.g., Luborsky, 1998a) and therefore changes will take some time to be traceable.

The W component was more flexible at the end of psychotherapy, regardless of the outcome. Although some studies (Crits-Christoph & Luborsky, 1998; Slonim et al., 2011) have described this component as relatively stable, others have reported changes in its rigidity after psychotherapy (Wilczek et al., 2004). We can interpret this result as one of the possible effects of psychotherapy; clients tend to describe interactions with others guided by a more varied set of needs and intentions, despite their symptom evolution. Some unchanged clients may increase their W flexibility despite maintaining their responses rigid and negative; that is, despite presenting a wider set of needs and intentions, clients continue to regard them as unfulfilled.

Similarly to other studies (e.g., Crits-Christoph & Luborsky, 1998; Slonim et al., 2011), differences between the outcome groups were found in the response components. The RO was more disperse and positive in the recovered clients at the end of psychotherapy, showing that others' behavior was interpreted in a more flexible and positive way than at the beginning. This result confirms that this component at the end of psychotherapy is frequently more positive and flexible than at the beginning (e.g., Crits-Christoph & Luborsky, 1998; Slonim et al., 2011; Wilczeck et al., 2004).

Changes in the RS are also in line with previous findings (e.g., Crits-Christoph & Luborsky, 1998; Slonim et al., 2011), confirming the general observation that it is the component most open to change (Grenyer & Luborsky, 1996). In fact, the most frequent RS changed from a negative to a positive category in the recovered group. One of the explanations for the adaptive changes in the RS component has been clients' increase in interpersonal mastery (Greyner & Luborsky, 1996). Self-knowledge and self-control are the main elements of mastery of interpersonal relationships, which supposedly develop throughout psychotherapy (Grenyer, 1996). In this view, clients' self-control increases with the emergence of new ways of reacting to others, becoming more adaptive and satisfactory. Moreover, as suggested by Grenyer (1996), relations with others should improve with increased mastery.

A common question regarding changes in clients' deeper schemas is whether these changes are a mechanism of change or an outcome of psychotherapy itself. Whereas some authors (Crits-Christoph & Luborsky, 1998) considered interpersonal changes as a curative factor, others (e.g., Wilczek, Weinryb, Barber, Gustavsson & Åsberg, 2000) questioned this assertion, arguing that these changes may be a consequence of symptom recovery or an

unrelated phenomenon. However, most studies involving the CCRT have used psychodynamic models, in which these interpersonal changes are a focus of psychotherapy. Using models that are not psychodynamic oriented, our results show a strong predictive relationship between symptom recovery and a decrease in relational schema rigidity. These results reinforce the notion that these factors are closely related, regardless of the psychotherapy model used. Thus, whether the increase in interpersonal flexibility is considered a curative factor or not, this flexibility appears to be an indicator of recovery from depressive symptomatology.

Limitations and Implications

A methodological limitation of this study was the use of the BDI in one subsample and the use of the BDI-II on the others as an outcome measure, which may threaten internal validity. Another limitation is the sample size. Given the small size of the sample, the results may be caused by other factors associated with brief therapies. Dispersion is likely a better measure of schema rigidity but clearly has its own limitations. It has been argued (Wiczek et al., 2004) that dispersion is less sensitive to changes in the CCRT components, thus not able to detect subtle changes.

An alternative interpretation of our findings could be that clients who were feeling better at the end of psychotherapy wanted to share with the therapist more stories of positive interactions, whereas clients who still felt depressed wanted to indicate to their therapists how their lives had not changed at all. This response could be an effect of brief therapies not present in longer treatments. However, what each person chooses to narrate in each context is likely relevant to that person's account of the self (Bruner, 1986). Therefore, this selection can be interpreted as a subjective way of displaying the current relational schemas guiding the client's interactions.

Relational variables have been considered mediators in depression (e.g., Vanheule et al., 2006), which emphasizes the importance of addressing these factors in psychotherapy. Our results reinforced the association between the increased flexibility of relational schemas and recovery in psychotherapy. Thus, promoting changes in the relational schemas, in the way clients think about themselves and others, and in the needs they are expressing in those interactions can effectively change the way they feel and behave (Žvelc, 2009).

Acknowledgments

We are very grateful to Dr. Paul Cris-Cristoph for assisting us in the coding of the CCRT. We are also very grateful to Dr. Les Greenberg and Dra. Lynne Angus for allowing us to use the York I sample.

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CHAPTER TWO

DOES NARRATIVE INNOVATION PREDICT CHANGES IN RELATIONAL SCHEMAS?

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Abstract

Objectives: Changes in clients' relational schemas have been associated with recovery in psychotherapy. However, the mechanisms that facilitate these changes are not fully understood. This study investigated whether exceptions to clients' maladaptive framework of meaning, i.e., innovative moments (IMs) predicted changes in relational schemas. **Method:** The Core Conflictual Relationship Theme (CCRT) was used to assess relational schemas. IMs were evaluated using the Innovative Moments Coding System. The sample included 22 clients suffering from major depressive disorder. **Results:** High-level IMs, which are more developed IMs, were significant predictors of changes in CCRT dispersion and pervasiveness. This prediction was more robust for the components of CCRT responses (Responses of Other and Responses of the Self). **Discussion:** This study demonstrated that the emergence of meanings that challenge clients' maladaptive framework of meaning predict changes in relational schemas. These results reinforced the notion that changes in clients' micro-narratives (i.e. IMs) have an impact on more stable structures of the self, the relational schemas.

Introduction

Most psychotherapy models have acknowledged the significance of maladaptive relational patterns in psychological problems (Demorest, 2013; Gross, Stasch, Schmal, Hillenbrand & Cierpka, 2007; Muran, 2002). Relational patterns are part of the structures (conceived as scripts, schemas or self-narratives) that guide an individual's attribution of meaning to an experience (e.g., Demorest, 2013; McAdams, 2001). Scholars have proposed that the concept of relational schemas designate the structures individuals use to interpret interpersonal experiences (Leising et al., 2003; Muran, 2002; Žvelc, 2009). Relational schemas are internalized models of relationships that shape a person's interpretations, behaviors and expectations in interpersonal encounters (Baldwin, 1992; Muran, 2002). Although centered on interpersonal events, relational schemas are crucial in shaping the self (Andersen & Chen, 2002). Given that relational schemas act as subjective rules for interpreting emotionally

[3] This study was submitted to *Psychotherapy Research* with the following authors: J. Batista, J. Silva, S. Freitas, D. Alves, A. Machado, I. Sousa, P. Fernández-Navarro M. M. & Gonçalves.

significant experiences (Demorest, Popovska & Dobova, 2012), the study of such schemas is central to understanding how individuals change over the course of psychotherapy (Demorest, Crits-Christoph, Hatch & Luborsky, 1999).

In clinical populations, relational schemas are typically overly rigid and recurrent, allowing only a narrow interpretation of relational experiences, thus becoming maladaptive (Dimaggio & Stiles, 2007; Leising et al., 2003). In fact, in various psychotherapeutic approaches, relational rigidity is associated with psychopathology (Benjamin, Wamboldt, & Critchfield, 2006; Dimaggio, Montano, Popolo & Salvatore, 2015; McCullough, Schramm, & Penberthy, 2015). By contrast, an increase in the flexibility and adaptability of relational schemas has been associated with symptoms improvement in psychotherapy and wellbeing (Cierpka et al., 1998; Crits-Christoph & Luborsky, 1998).

To clarify the aim of this research, we distinguish between micro- and macro-narratives. At the macro-narrative level, relational schemas can be conceived as structuring experience, directing action (Angus, Levitt & Hardtke, 1999), and encompassing the client's identity stories (Laitila, Aaltone, Wahlström & Angus, 2005). Accordingly, the single episodes emerging in psychotherapy conversations are at the micro-narrative level, creating the narrative organization of the person's moment-to-moment experiences (Angus & Hardtke, 1994). With this distinction in mind, we expected changes at the micro-narrative level to be evident before they could have an impact on the macro-narrative level. Research on the micro-narrative level's influence on the macro-narrative has been scarce. In an attempt to address this gap, this article studied whether innovative moments (IMs) (Gonçalves et al., 2011), occurring in the micro-narrative level, can predict changes in the broader, macro-narrative level.

Relational Schemas

The Core Conflictual Relationship Theme (CCRT) (Luborsky, 1998a) was one of the first measures developed to study relational scripts or schemas. Thus, it can be considered a measure of the macro-narrative level. Departing from narratives about relationships that clients tell in psychotherapy, it identifies recurrent patterns of interpersonal behavior (Luborsky, 1998a). As one of the "most psychometrically sophisticated clinician-based methods for assessing central relationship patterns" (Slonim, Shefler, Gvirsman & Tishby, 2011, p. 686), the CCRT has received strong validation (e.g. Crits-Christoph & Luborsky, 1998).

The CCRT characterizes relational schemas by identifying three components: 1) Wishes, needs and intentions (W), referring to the wishes expressed in an interpersonal encounter; 2) the Responses of Other (RO), which describes the perceived reaction of the other person(s) interacting with the individual; and 3) the Responses of the Self (RS), referring to the individual's response to that interaction. The CCRT unit of analysis is the relational episode, discrete narrations that describes interactions between the client and others, including the self and the therapist (Luborsky, 1998b).

The rigidity of the CCRT has been measured using several methods, including *pervasiveness*, *valence* and *dispersion* (McCarthy, Gibbons & Barber, 2008). *Pervasiveness* refers to the frequency of a given component in the client's relational episodes (Crits-Christoph & Luborsky, 1998) measuring the dominance of a specific component. For instance, at the beginning of treatment, 70% of the individual's W could be *to be loved and understood*. By the end of treatment, this percentage could be reduced to 30%, hence being less dominant. *Valence* assesses whether the RO and RS are positive (e.g., *self-confident*), when client does not expect an interference with wish actualization, or negative (e.g., *helpless*), when interference is perceived or anticipated (Ciaglia, 2010). *Dispersion* measures the spread of the distribution of the CCRT components (Cierpka et al, 1998). It represents the discrepancy between the observed frequency distribution of each component and the frequency distribution that has the maximum amount of spread given the total number of categories rated in each component (McCarthy et al, 2008). Thus, it is possible to compute the dispersion of each of the CCRT components considering their distribution in all relational episodes.

Numerous studies have validated the association between changes in the CCRT and clients improvement in psychotherapy (e.g., Cierpka et al., 1998; Crits-Christoph & Luborsky, 1998; McMullen & Conway, 1997; Slonim et al., 2011). The change in relational schemas was empirically associated with a decrease in the maladaptive theme present at the beginning of therapy and an increase in the positive RO and RS (Crits-Christoph & Luborsky, 1998). Most CCRT research has suggested that more severely impaired clients present less flexible relational patterns (Cierpka et al, 1998) and that the their RO and RS are more negative (Albani et al., 1999). At the same time, symptoms recovery has been consistently related to increased flexibility of the CCRT components and a more positive valence in clients suffering from drug abuse (Ciaglia, 2010) or mood disorders (Crits-Christoph & Luborsky, 1998) and adolescents (Slonim et al., 2011). In our analysis of a sample undergoing brief therapy for depression (Batista et al.,

2016), the dispersion of RO and of RS increased significantly for the recovered clients, suggesting an increase in flexibility at the end of therapy. The valence of RO and RS also became more positive in recovered clients but not on unchanged clients. Thus, greater flexibility of the clients' interpersonal pattern and a positive valence of the responses seem to be related to wellbeing and improvement in symptoms.

Despite these results, changes in the CCRT or other similar methods (e.g., QUAINT; Crits-Christoph, Demorest & Connoly, 1990) were not empirically related to change processes occurring in therapeutic sessions. One exception was the study of Grenyer and Luborsky (1996), which showed an association between changes in the CCRT and an increased sense of mastery. Grenyer (1996) defined mastery as the development of self-control and self-understanding in the context of interpersonal relationships. However, this concept was associated with psychodynamic therapy, hindering its usage in other theoretical frameworks. Furthermore, mastery was measured in the same narratives used to identify the CCRT (Grenyer & Luborsky, 1996). Therefore, the study did not analyzed other potentially significant micro-events in the change of relational schemas.

Narrative Innovations

Gonçalves, Ribeiro, Mendes, Matos and Santos (2011) developed the concept of IMs, defined as exceptions to the maladaptive framework of meaning (Frank & Frank, 1991; Gonçalves, Ribeiro, Silva, Mendes & Sousa, 2015). The concept of a framework of meaning is akin to the concept of a macro-narrative. The rationale of this model is that the maladaptive macro-narratives that prompted the client to begin psychotherapy are revised in the therapeutic conversation (and the client's daily life) as IMs are produced. Thus, IMs are identified at the micro-narrative level as narrative markers of meaning transformation (Gonçalves et al., 2015) that challenge and eventually lead to a transformation of the macro-narratives. Gonçalves et al. (2011) identified seven types of IMs (see Table 1), each with a different relevance in the change process.

For this study, we separated these IMs into two major categories (see also Cunha, Gonçalves, Valsiner, Mendes & Ribeiro, 2012; Montesano, Gonçalves & Feixas, 2015): low-level and high-level IMs. Low-level IMs mobilize clients to change by expressing intentions, critiques and understanding the rules and effects of the problems. However, by themselves, they do not allow the development of an alternative macro-narrative. By contrast, high-level IMs are centered

on change and the recognition, elaboration and expansion of more flexible and satisfactory meanings. These IMs encompass several processes from which the transformation of the macro-narrative can result (Mendes et al., 2011; Gonçalves & Silva, 2014).

Table 1
Innovative Moments categories

TYPES OF IMS	SUBTYPES	DEFINITION	EXAMPLES (Maladaptive self-narrative: depression)
LOW-LEVEL IMS (Creating distance from the problem)	Action I	Performed and intended actions to overcome the problem	C: Yesterday, I went to the cinema for the first time in months!
	Reflection I	New understandings of the problem	C: I realize that what I was doing was just not humanly possible because I was pushing myself and I never allowed myself any free time, uh, to myself ... and it's more natural and more healthy to let some of these extra activities go...
	Protest I	Objecting the problem and its assumptions	C: What am I becoming after all? Is this where I'll be getting to? Am I going to stagnate here!?
HIGH-LEVEL IMS (Centered on change)	Performing change (Action II)	Generalizations about the future and other life dimensions of good outcomes (performed or projected actions)	T: You seem to have so many projects for the future now! C: Yes, you're right. I want to do all the things that were impossible for me to do while I was dominated by depression. I want to work again and to have the time to enjoy my life with my children. I want to have friends again. The loss of all the friendships of the past is something that still hurts me really deeply.
	Reflection II	Contrasting self (what changed?) OR self-transformation processes (how/why change occurred?)	C: I feel positive and strong. It's okay to ask for these things [her needs], it's a new part of me, so I'm not going to turn it down.
	Protest II	Assertiveness and empowerment	C: I am an adult and I am responsible for my life, and, and, I want to acknowledge these feelings, and I´m going to let them out! I want to experience life, I want to grow, and it feels good to be in charge of my own life.
	Reconcep-tualization	Moments distanced from the experience (meta-positions) where the self is repositioned outside the problematic experience AND understands the processes involved in this transformation	C: I feel differently nowadays. I don't worry about what others think about what I'm saying. I discovered that I need to respect my needs and opinions, even if other people disagree with me. Before, to protect myself from disagreeing with others, I was always in conflict with myself – thinking one thing, saying another. When is the disagreement with others worse than this internal fighting?

Empirical research using the The Innovative Moments Coding System (IMCS) consistently showed that recovered clients present more IMs than those of unchanged clients in different psychotherapy models, such as constructivist grief therapy (Alves et al., 2014), client-centered therapy (CCT) (Gonçalves et al., 2012), narrative therapy (NT) (Gonçalves et al., 2015), cognitive-behavior therapy (CBT) (Gonçalves, Silva, Ribeiro, Batista & Sousa 2016), and emotion-focused therapy (EFT) (Mendes et al., 2010). Recovered clients also presented significantly more high-level IMs (Gonçalves et al., 2015; Montesano et al., 2015). More recently, Gonçalves et al. (2015, 2016) showed that in a sample of patients receiving CBT, high-level IMs predicted symptom improvement in the following session and that in a sample undergoing NT, a type of high-level IMs (reconceptualization) predicted improvement. These results are in accordance with the notion that narrative changes can be a mechanism of therapeutic change rather than merely a reflection of that change (Angus & Kagan, 2013).

Despite the body of evidence that points to a strong association between the emergence of IMs and therapy outcomes, the impact of IMs on the macro-narrative level has not been empirically studied. Along these lines, we hypothesize that micro-narrative changes tracked by IMs are experiences that may facilitate the modification of macro-narrative structures, including the relational schemas.

The Present Study

With this study, we aimed to test whether there is a relationship between the micro-narrative level (assessed with IMs) and the macro-narrative level (assessed with the CCRT) in a sample of clients receiving brief therapy for depression. As referred, the analysis of the CCRT dispersion and valence showed that recovered clients' relational schemas became less rigid and more positive in this sample (Batista et al. 2016). Additionally, previous studies using the same sample showed that the emergence of IMs was related to therapeutic outcomes (Mendes et al., 2010) and the improvement of symptoms (Gonçalves et al., 2015).

Therefore, we studied whether micro-narrative changes (IMs) can predict changes in macro-narratives (CCRT) given that both variables are related to symptom change. Thus, we tested the following hypothesis: as IMs increase over the course of treatment, they predict changes in the client's CCRT. Moreover, we expected high-level IMs to be better predictors of the changes in relational schemas than low-level IMs. This hypothesis accounted for the differential predictive value of low- and high-level IMs shown in previous studies. In other words, this study

will allow answering the question whether micro-narrative innovations have significant impact in broader, more stable macro-narratives.

Method

Sample

The study sample was composed of 22 clients who were diagnosed with major depressive disorder (MDD) and undergoing one of three treatments: EFT, NT, or CBT. For these subsamples, the maximum duration of the treatment protocol was 20 sessions. The clients consented to participating in the original studies from each subsample derived (see Greenberg & Watson, 1998; Lopes et al. 2014 for further details).

Sample selection. The EFT subsample was derived from the York I Depression Study (Greenberg & Watson, 1998), which compared the effectiveness of EFT and CCT. The clients had a diagnosis of MDD according to the DSM-III-R (American Psychiatric Association, 1987) and based on the Structured Clinical Interviews for DSM-III-R Disorders (SCID) (Spitzer, Williams, Gibbon & First, 1989). The final sample of that study was comprised of 34 clients, with 17 in each condition. The clients in this subsample (three recovered and three unchanged) were selected for intensive process analyses taking into account therapy outcome, measured by the Beck Depression Inventory (BDI, Beck, Steer & Carbin, 1988) cut-off and calculation of a reliable change index (RCI) (Jacobson & Truax, 1991).

The CBT and NT subsamples were part of a controlled trial comparing treatment effectiveness (Lopes et al., 2014). The clients in this study were diagnosed with MDD according to the DSM-IV-TR (American Psychiatric Association, 2002) and based on the Structured Clinical Interviews for DSM-IV-TR Axis I Disorders (SCID-I) (First, Spitzer, Gibbon & Williams, 2002). Considering the Beck Depression Inventory (BDI-II; Beck, Steer & Brown, 1996) cut-off and the RCI (Jacobson & Truax, 1991) for that measure, the completers (20 in each group) were classified as either unchanged or recovered. The current subsamples of six CBT clients (three unchanged and three recovered) and 10 NT clients (five unchanged and five recovered) were randomly selected from the completers.

Sample description. The EFT subsample was composed of four women and two men, with age ranging from 27 to 63 years (M = 45.50, SD = 13.78). Three of the clients were married, two were divorced but remarried, and one was divorced. Regarding their level of

education, one of the clients had completed grade 6, two had graduated high school, and three had enrolled in or graduated from university.

The CBT subsample was composed of five women and one man, and their ages ranged from 24 to 46 years (M = 34.50, SD = 8.50). Two clients were single at the time they began therapy, three were married, and one was divorced. These clients had between 9 and 16 years of formal education (M = 14.17, SD = 2.71). Professionally, three clients were employed, two were students, and one was unemployed.

The NT subsample was composed of seven women and three men, whose ages ranged from 22 to 64 years (M = 41.00, SD = 14.97). Four clients were single (although one was in a long-term relationship), three were married, two were divorced, and one was widowed. The clients in this subset had between 9 and 24 years of formal education (M = 13.90, SD = 5.07). Professionally, three of the clients were unemployed, three were employed, two were students, and one was retired.

Therapists

For the EFT subsample, four of the therapists were female and one was male. These therapists had different levels of education; they ranged from advanced PhD students in clinical psychology to PhD clinical psychologists. The therapists received a 24-week training (eight weeks for CCT and the remaining weeks for experiential techniques) according to a manual devised for the study (Greenberg, Rice, & Elliot, 1993). Prior to the study, therapists were supervised with a pilot client. Adherence to the model was rated based on 20 minutes of four sessions with each client. Session two was always rated, while the other three sessions were randomly selected (see Greenberg & Watson, 1998 for further details).

The therapist of the CBT subsample was a male PhD student with five years of previous clinical experience. Although he had experience with CBT, he received training on a manual based on the Beck, Rush, Shaw and Emery (1979) and Leahy and Holland (2000) models of CBT treatments. A more experienced therapist supervised this therapist. An adherence scale was applied to each of the four sessions to ensure that the treatment complied with the model (see Lopes et al., 2014 for further details).

The therapist of the NT subsample was a male PhD student with seven years of experience as a psychotherapist. He had three years of experience providing NT and received training on a manual based on the White and Epston (1990) model of NT. A more experienced

therapist also supervised this therapist. An adherence scale was also applied to each of these four sessions (see Lopes et al., 2014 for further details). To control the therapists' allegiance, this study allowed each therapist to choose his or her preferred model (CBT or NT).

Treatments

The protocol used in the EFT subsample departed from the CCT approach of forming an empathic working alliance with added process directive, experiential interventions (Greenberg et al., 1993). This model views psychological problems as dysfunctions in emotion processing and regulation (Elliott, Watson, Goldman, & Greenberg, 2004). Therapy is viewed as a tool that helps clients access their emotion schemes in a secure environment while striving for more complete and adaptive emotional processing (Greenberg et al., 1993).

The manual used for the CBT subsample was mainly based on Beck's treatment protocol for depression (Beck et al., 1979). This perspective maintains that the client's symptoms are a result of the activation of negative cognitive patterns, which represent dysfunctional ways of interpreting the self and the world (Beck, 1967). Therapy, aims to help clients find new, more adaptive ways of interpreting experiences (Beck, 1967).

A NT intervention manual was constructed based on the work of Michael White (2007; White & Epston, 1990). From this perspective, psychological problems are due to unsatisfactory, rigid, and/or problem-saturated life narratives (White & Epston, 1990). According to White and Epston (1990), not all life events integrate a life narrative, creating possibilities for a new narrative to be established by developing the events that occur outside the problematic life story.

Measures

Beck Depression Inventory. The common outcome measure in the three subsamples was the BDI (BDI, Beck, Steer & Garbin, 1988; BDI-II, Beck, Steer & Brown, 1996), which was applied at both the pre- and post-test. The BDI-II was used in the CBT and NT subsamples. The BDI was used in the EFT subsample because that data of this sample were collected before the BDI-II was published. This inventory was composed of 21 items that evaluated depressive symptoms. The items were rated on a four-point Likert scale (0-3), and the total score ranged between 0 and 63 points. Higher BDI and the BDI-II values corresponded to greater depressive symptomatology.

Innovative Moments Coding System. The IMCS (Gonçalves et al., 2011) is a coding system that divides observed IMs into seven categories, which are organized into two major groups: high-level and low-level IMs. This study used the IMCS to assess the micro-narrative level. A higher proportion of IMs was associated with a higher presence of alternative experiences to the maladaptive framework of meaning. Moreover, a higher proportion of high-level IMs was associated with the narrative innovations typical in recovered cases. Studies using the IMCS (e.g. Gonçalves et al., 2012; Matos, Santos, Gonçalves & Martins, 2009; Mendes et al., 2010) have produced inter-rater agreements ranging between 0.86 and 0.97.

Core Conflictual Relationship Theme. The CCRT method (Luborsky, 1998a) was used to assess clients' relational schemas (i.e. macro-narratives). The CCRT is a content analysis system that identifies relationship episodes narrated by the client during therapy and distinguishes the three components (Wishes/Needs, Responses of Other, Responses of Self) of each relational episode. After the initial coding, the components were converted to the standard categories (Table 2), as proposed by Barber, Crits-Christoph and Luborsky (1998). A higher pervasiveness, lower dispersion, and negative valence of the components indicate a more rigid and less adaptive relational schema.

Table 2
Standard categories of the CCRT components (Edition 3)

	CCRT components		
	Wishes	Responses of Other	Responses of Self
Standard categories	1. To assert self & be independent 2. To oppose, hurt & control others 3. To be controlled, hurt & not responsible 4. To be distant & avoid conflicts 5. To be close & accepting 6. To be loved & understood 7. To feel good & comfortable 8. To achieve & help others	1. Strong 2. Controlling 3. Upset 4. Bad 5. Rejecting & opposing 6. Helpful 7. Likes me 8. Understanding	1. Helpful 2. Unreceptive 3. Respected & accepted 4. Oppose & hurt others 5. Self-controlled & self-confident 6. Helpless 7. Disappointed & depressed 8. Anxious & ashamed

Note. Adapted from Barber, Crits-Christoph & Luborsky, 1998.

Procedures

Innovative Moments identification. The coding of IMs followed the procedures described by Gonçalves et al. (2011). After receiving training in the IMCS, five judges (working in pairs) viewed the video recordings or read the transcripts of the initial sessions and reached a mutual

agreement on the main features of the client's maladaptive framework of meaning. Then, working with transcripts of the sessions, they independently coded the IMs in all psychotherapy sessions, defined the exceptions to the maladaptive framework, tracked their proportion (that is, the proportion of text involved in their descriptions), and identified the type of IM. When disagreement occurred, a final consensus was reached between the judges with the help of an external auditor with IMCS experience. The judges were unaware of the therapeutic outcomes of the cases. In the EFT subsample, the main judge coded 100% of the sessions, and the other judge coded 50%. In the CBT and NT subsamples, both judges coded all sessions. The IMs were coded prior to this study; this coding is documented in other studies (Gonçalves et al., 2015; Gonçalves et al., 2016; Mendes et al., 2010).

The most common measure of IMs is the proportion, defined as the length of each IM in the transcript. Thus, the proportion was calculated by dividing the number of words related to each IM by the total number of words in that session. The therapist's statements were also included in the IM given the co-constructed nature of micro-narrative innovation (Angus, Levitt & Hardtke, 1999; Gonçalves et al., 2015).

Innovative Moments Coding System reliability. Two reliability indexes were calculated in previous studies: percentage of agreement of the IM identification and Cohen's k for agreement on the IM types. In the EFT subsample, the agreement on IM identification was 88.7% and Cohen's k was .86 (Mendes et al., 2010). In the CBT subsample, agreement on IM identification was 90% and Cohen's k was .94 (Gonçalves et al., 2016). Finally, in the NT subsample, agreement on IM identification was 89.9% and Cohen's k was .91 (Gonçalves et al., 2015). All these agreements were based on the independent codings of two coders.

CCRT components identification. We used transcripts of the sessions to identify the relational episodes, as proposed by Luborsky (1998b). Two sessions from the beginning, two from the middle, and two from the end of therapy were analyzed. The initial sessions were always the second and the third sessions; the middle sessions were defined arithmetically by dividing the total number of sessions by two; and the final sessions were the two that occurred before the final session. Following Albani et al. (1999), we considered all the relational episodes in the sessions rather than solely the minimum number of 10 suggested by Luborsky (1998b). This method increased the number of narratives that were analyzed to define each client's relational schema.

Five independent judges coded the CCRT, working in pairs in which one of the elements was constant. Prior to coding, all judges completed a CCRT training that included extensive reading of guidelines from Luborsky and Crits-Christoph (1998) and exercises with several clinical sessions. All judges were unaware of the therapeutic outcome of the cases.

The CCRT coding followed the procedures described by Luborsky (1998) and were described in detail in our previous article (Batista et al., 2016). First, two judges independently identified the relationship episodes and decided which episodes to code. This decision was based on an episode's degree of completeness, which was rated on a scale from 1 to 5, with a cut-off of 2.5. Next, the judges identified the components and converted them into the standard eight categories based on their proximity.

CCRT measures calculation. To calculate the dispersion of each component, we used the dispersion index derived from Gini's concentration measure C (Cierpka et al, 1998). The formula used to calculate dispersion is as follows (Cierpka et al, 1998):

$$\text{Dispersion} = \frac{\begin{array}{c}C = 1 - \text{Sum of squared relative frequencies} \\ \text{of codes in each cluster (for W, RO or RS)}\end{array}}{\begin{array}{c}C_{max} = \text{Maximum value of C for a given} \\ \text{number of codes (for W, RO or RS)}\end{array}} = \frac{C}{C_{max}}$$

The computation of the maximum value of C (C_{max}) for a given number of codes (for W, RO or RS) followed the formulas described by Cierpka et al. (1998). The discrepancy between the observed and maximum spread distributions represented the level of dispersion of the CCRT component (MacCarthy et al, 2008). According to Cierpka et al. (1998), the higher the dispersion score the more flexible the relational pattern is, whereas lower scores indicate that the pattern is highly rigidified. The calculation of pervasiveness took into account the frequency of each category and the total number of relational episodes in each therapy phase. The pervasiveness score was the proportion of the frequency of a component's given category over the total number of relational episodes (Crits-Christoph & Luborsky, 1998).

Statistical analysis. To study the association between the progression of IMs and CCRT dispersion, we conducted a two-stage statistical analysis using a mixed model. The advantage of using a mixed model in the analysis is that these models allow measurements of one subject to be correlated while keeping measurements of different subjects independent.

In the first stage of the analysis, we modeled IMs using a generalized linear mixed model (GLMM) and assumed that the response variable had a binomial distribution. That is, we modeled the probability of an IM occurrence. These models allow analyzing unbalanced data

while taking into account subject-specific characteristics. In this case, two components of random effects were included in the model: a subject-specific intercept (starting point) and a subject-specific slope (progression). In the second stage of the analysis, we used a GLMM to model the dispersion score (a value between 0 and 1) assuming a beta distribution for the response variable. Moreover, the model in the second stage included the predicted subject-specific values for the random effects (intercept and slope) obtained in the first stage as independent variables (explanatory variables). With this strategy, we inferred about the subject-specific characteristics of IM progression on the subject dispersion score.

The association between the progression of the IMs and pervasiveness was studied using the same two-stage statistical analysis. The only difference was that in the second stage of the analysis, we modeled pervasiveness, that is a proportion, also using a GLMM with a binomial distribution for the response variable. With this strategy, we made inferences about the subject-specific characteristics of IM progression on subject pervasiveness.

Results

Inter-rater Agreement

Two reliability indexes were calculated: a percentage of agreement on the identification of relational episodes and an ICC for the identification of the CCRT components. The percentage of agreement for the relational episodes was 93.5%. The ICC was .89 for W, .92 for RO, and .93 for RS. These values are high, reflecting an adequate agreement level.

IMs Predicting CCRT Dispersion

This analysis used the final dispersion scores of the CCRT components (W, RO, RS) as the response variable and the proportions of IMs as the explanatory variables. As mentioned, the IM profile was operationalized by considering two components of the random effects, a subject-specific intercept (starting point) and a subject-specific slope (progression). The starting point variable referred to the IM proportion in the first psychotherapy session. The progression variable referred to the proportion slope of IMs throughout the treatment. The IMs profile was also tested considering low-level IMs and high-level IMs. With this method, the subject-specific variables (starting point of low- and high-level IMs and their progression) were used to predict the response variable, i.e., the dispersion of CCRT components (W, RO, and RS). The results of these analyses are described in detail below and summarized in Table 3.

Table 3

IM variables predicting the dispersion of the CCRT components

Models and effects	Estimate	*SE*	*z*	*P*
Wishes				
Low-level IM intercept	0.31	0.21	1.43	0.17
Low-level IM slope	1.13	3.10	0.36	0.72
High-level IM intercept	0.11	0.09	1.18	0.25
High-level IM slope	1.99	1.44	1.38	0.18
Responses of Other				
Low-level IM intercept	0.59	0.36	1.67	0.11
Low-level IM slope	1.86	5.38	0.35	0.73
High-level IM intercept	0.37	0.15	2.41	**0.03**
High-level IM slope	3.34	2.29	1.46	0.16
Responses of the Self				
Low-level IM intercept	0.46	0.27	1.73	0.10
Low-level IM slope	5.85	4.20	1.39	0.18
High-level IM intercept	0.29	0.11	2.74	**0.01**
High-level IM slope	5.00	1.79	2.79	**0.01**

None of the IM variables (high-level or low-level IMs) predicted the final dispersion of W. Concerning the RO, the starting point of high-level IMs (p = .027) predicted the final dispersion of this component. In other words, a higher proportion of high-level IMs in the first session predicted a higher RO dispersion at the end of therapy, explaining 25% of the variance of that variable (R^2_{adj} = .25). However, the progression of IMs was not a significant predictor of RO dispersion. Regarding the RS variable, as shown in Table 3, the proportion of high-level IMs at the starting point (p = .013) and its progression (p = .012) were significant predictors of RS dispersion. This component was predicted by not only the proportion of high-level IMs in the first session but also the progression of this variable, explaining 37% of the variance in RS dispersion (R^2_{adj} = .37). Thus, a higher initial proportion of high-level IMs and its increase during psychotherapy significantly predicted higher RS dispersion.

IMs Predicting CCRT Pervasiveness

This analysis used the final pervasiveness score of the most frequent CCRT components as the response variable and the IMs profiles as explanatory variables. As described, the IM

profile was operationalized by considering two components of the random effects, a subject-specific intercept (starting point) and a subject-specific slope (progression). We tested five models to examine low- and high-level IMs starting points and progressions: (1) the most frequent W (*to be loved and understood*), (2) the most frequent Negative RO (*opposing and rejecting*), (3) the most frequent Positive RO (*understanding*), (4) the most frequent Negative RS (*depressed and disappointed*), and (5) the most frequent Positive RS *(accepted and comfortable*) (Table 4).

Table 4

IM variables predicting the pervasiveness of the CCRT components

Models and effects	Estimate	*SE*	*z*	*p*
Wish 6 (*to be loved and understood)*				
Low-level IM intercept	-0.67	0.25	-2.68	**0.007**
Low-level IM slope	2.64	3.95	0.67	0.50
High-level IM intercept	-0.45	0.10	-4.38	**<0.001**
High-level IM slope	-6.19	1.93	-3.20	**0.001**
Negative Responses of Other 5 *(opposing and rejecting)*				
Low-level IM intercept	-0.74	0.25	-2.97	**0.003**
Low-level IM slope	1.17	3.90	0.30	0.76
High-level IM intercept	-0.54	0.11	-4.87	**<0.001**
High-level IM slope	-3.54	1.66	-2.13	**0.03**
Positive Responses of Other 8 *(understanding)*				
Low-level IM intercept	0.37	0.42	0.88	0.38
Low-level IM slope	0.13	6.38	0.02	0.984
High-level IM intercept	0.62	0.22	2.82	**0.005**
High-level IM slope	7.41	2.57	2.89	**0.003**
Negative Responses of the Self 7 *(depressed and disappointed)*				
Low-level IM intercept	-0.35	0.24	-1.49	0.14
Low-level IM slope	0.99	3.74	0.27	0.79
High-level IM intercept	-0.32	0.10	-3.23	**0.001**
High-level IM slope	-5.38	1.76	-3.06	**0.002**
Positive Responses of the Self 3 *(comfortable and accepted)*				
Low-level IM intercept	0.59	0.36	1.64	0.10
Low-level IM slope	-5.54	5.22	-1.06	0.29
High-level IM intercept	0.88	0.20	4.30	**<0.001**
High-level IM slope	11.20	2.26	4.96	**<0.001**

The starting point of low-level IMs ($p = .007$) and high-level IMs ($p < .001$) significantly predicted the final pervasiveness of W. Moreover, the progression of high level IMs ($p= .001$) was also a significant predictor of W pervasiveness. These relationships were negative, indicating that a higher proportion of IMs (both low- and high-level IMs) at the starting point and the progression of high-level IMs were associated with lower pervasiveness of the final W. This model explained 40% of the variance ($R^2_{adj} = .40$).

Regarding RO, low-level IMs ($p = .02$) and high-level IMs ($p < .001$) during the first session also predicted Negative RO (NRO) pervasiveness. Moreover, the progression of high-level IMs ($p = .03$) was also a significant predictor of the pervasiveness of this component. As expected, as the initial proportion of IMs increased, the NRO pervasiveness in the final sessions decreased. Similarly, an increase in high-level IMs throughout therapy predicted lower pervasiveness of this component. This model explained 35% of the variance ($R^2_{adj} = .35$). The starting point ($p = .005$) and progression ($p = .003$) of high-level IMs predicted the final pervasiveness of Positive RO (PRO). As expected, as the initial proportion and progression of IMs increased, this component's pervasiveness increased. This model explained 41% of the variance ($R^2_{adj} = .41$).

Regarding the RS, the initial proportion ($p = .001$) and progression ($p = .002$) of high-level IMs predicted the Negative RS (NRS). As expected, as the initial proportion of IMs increased, the NRS pervasiveness in the final sessions decreased. Likewise, an increase in high-level IMs throughout therapy predicted lower pervasiveness of this component. The model explained 18% of the variance ($R^2_{adj} = .18$). Finally, both the starting point ($p < .001$) and progression ($p < .001$) of high-level IMs predicted the Positive RS (PRS) pervasiveness in the expected direction. A higher initial proportion of high-level IMs and an increase in this variable throughout psychotherapy predicted higher PRS pervasiveness. This model explained 46% ($R^2_{adj} = .46$) of PRS variance.

Discussion

In this article, we tested whether the micro-narrative level, measured using the IMCS, is an adequate predictor of macro-narrative changes, as assessed by the CCRT. Emerging in the therapeutic conversation, IMs have been described as processes of therapeutic change (e.g., Gonçalves et al., 2015) that impact a client's self-narratives (e.g., Alves et al., 2014; Mendes et al., 2010). However, prior to this study, IMs were not empirically associated with changes in broader stable structures, such as relational schemas.

The results showed that high-level IMs were the main predictors of changes in relational schemas, either measure with dispersion or pervasiveness. Moreover, all the observed relationships occurred in the expected directions. Using dispersion as a response variable, initial high-level IMs predicted higher RO dispersion. This variable's starting point and increasing progression also predicted higher RS dispersion. These results confirmed the previous notion that the emergence of IMs, particularly higher-level IMs, is related to the transformation and increased flexibility of clients' macro-narratives. In terms of dispersion, the only component not predicted by IMs was W. Another relevant finding is that low-level IMs were not significant predictors of the dispersion of any CCRT components.

Regarding pervasiveness, starting point and progression of high-level IMs significantly predicted the pervasiveness of all tested CCRT components (W, NRO, PRO, NRS and PRS). Low-level IMs at the initial point also predicted changes in W and NRO. In the literature, changes in the RO and RS have been associated with successful psychotherapy more often than changes in W (e.g., Crits-Cristoph & Luborsky, 1998; Slonim et al., 2011). Furthermore, in our previous research (Batista et al., 2016), both the dispersion and valence of RO and RS distinguished recovered from unchanged clients, whereas those of the W component did not. Interestingly, despite the absence of a relationship between IMs and the final W dispersion, IMs predicted the final W pervasiveness. In other words, the most frequent W was not as pervasive at the end of psychotherapy, indicating that clients with more IMs also presented a more flexible W at the end of therapy.

Along these lines, Wilczeck, Weinryb, Barber, Gustavsson and Åsberg (2004) suggested that, as a measure of rigidity, dispersion may be more precise but also less sensible than other measures, such as pervasiveness, because this measure takes into account the whole structure of the relational schemas (McCarthy et al., 2008). Of course, this reduced sensibility may also be understood as an indication of a deeper change in the relational schemas (Wilczeck et al., 2004). The results of this study support these claims, as IMs were better predictors of the pervasiveness of CCRT components than the dispersion of these components.

As previously discussed, the mechanisms by which relational schemas change have not been frequently addressed in psychotherapy research. Grenyer and Luborsky (1996) proposed that these changes are due to an increase in clients' sense of mastery, defined as emotional self-control and self-understanding (Grenyer, 1996). This concept can be associated with the development of insight in psychotherapy. Insight is defined as a conscious meaning shift that

involves new connections (Castonguay & Hill, 2007) and is considered a common element of recovery in psychotherapy (e.g., McAleavey & Castonguay, 2014). Increased mastery can also be associated with clients' increased self-observation and greater metacognitive awareness (Badgio, Halperin & Barber, 1999; Dimaggio, Hermans & Lysaker, 2010).

In sum, changes in clients' relational schemas have been explained by the development of a more flexible and integrated view of the self and others. In previous studies (e.g., Alves et al., 2014; Gonçalves et al., 2015; Mendes et al., 2011), IMs were considered to foster alternative frameworks of meaning relative to the initial maladaptive framework that created psychological difficulties. Moreover, in those studies, high-level IMs were clearly associated with clients' ability to elaborate and develop different views of themselves at the micro-narrative level of the psychotherapeutic conversation. Thus, the results of the present study are in line with previous findings, considering that high level IMs were the main predictors of relational schemas. We may find adaptive contrasts (when clients identify *what* changed according to their perspective), processes of change or strategies associated with improvement (when clients elaborate on the *how* or *why* they changed), and agentive stances (regarding assertiveness and empowerment) in high-level IMs.

By tracking contrasts between the maladaptive framework of meaning and the alternative patterns, high-level IMs foster a sense of self-continuity (Cunha et al., 2012; Gonçalves & Ribeiro, 2012) and allow the more adaptive forms to be integrated into the client's set of macro-narratives. Additionally, the identification of the strategies and processes that the client associates with his or her changes promotes the client's access to a self-observing, metacognitive perspective associated with self-understanding and psychotherapy recovery (e.g., Dimaggio & Stiles, 2007). Moreover, high-level IMs are also expressions of a greater sense of agency, which has been associated with recovery in various psychotherapy models (Williams & Levitt, 2007). Therefore, high-level IMs seem to pinpoint mechanisms of change akin to mastery, insight and metacognition, fostering a greater flexibility and integration of the self (Gonçalves & Ribeiro, 2012).

In this article, we have shown a strong association between changes in relational schemas and the evolution of IMs, particularly high-level IMs. We speculate that the dimensions of previously discussed high-level IMs (e.g., contrast, process, agentive position) are key elements of psychotherapy recovery. We also argue that these dimensions of high-level IMs can be viewed as mechanisms of change that have significant impacts on stable structures of the self, such as

those captured by the CCRT, being potential indicators of narrative reconstruction (Montesano et al., 2015). This hypothesis has been recently tested on samples undergoing NT (Gonçalves et al., 2015) and CBT (Gonçalves et al., 2016). In both studies, the changes in symptomatic measures were predicted by the high-level IMs in the previous session. Thus, IMs seem to function as elements that promote symptom improvement.

Limitations

A methodological limitation of this study is that the BDI was used as the outcome measure in one subsample and the BDI-II was used in the other two samples, potentially threatening internal validity. The difference in the number of therapists providing treatment in the subsamples can also be considered a limitation. Specifically, for the CBT and NT subsamples, only one therapist provided treatment, whereas the EFT sample had five therapists. Another limitation is the sample size. Given the small size of the sample, the generalizability of the results is limited.

Despite our efforts to articulate the association between the micro- and macro-narrative levels, it can still be argued that these levels could be unrelated. Considering that IMs are not necessarily related to relational contents, changes in relational schemas could be due to other factors that are unconnected with the phenomena tracked by IMs. However, the identified associations are congruent with theoretical expectations, and the models explained a considerable amount of variance. Moreover, the mechanisms of change presented in the IMs are similar to those that other studies and authors considered therapeutic (Badgio, Halperin & Barber, 1999; Dimaggio, Hermans & Lysaker, 2010; Grenyer & Luborsky, 1996).

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CHAPTER THREE

NARRATIVE AND CLINICAL CHANGE IN CBT: COMPARISON OF TWO RECOVERED CASES

CHAPTER THREE

NARRATIVE AND CLINICAL CHANGE IN CBT: A COMPARISON OF TWO RECOVERED CASES[4]

Abstract

Psychotherapy research suggests that therapeutic change is associated with the emergence and development of innovative moments (IMs), i.e. exceptions to the problematic self-narrative that brought the client to therapy. This study compares two recovered cases of major depression, according to symptom measures, that presented contrasting profiles of evolution of IMs: one typical of successful therapy (*Barbara*), and another typical of unsuccessful therapy (*Claudia*). The Core Conflictual Relationship Theme (CCRT) was used to study narrative change independently of the Innovative Moments Coding System (IMCS). The results suggest a high congruence between the IMCS and the CCRT profiles. While *Barbara* presented changes in the IMCS and the CCRT in a similar way, *Claudia*'s self-narratives (IMs and CCRT), despite symptom change, did not change. The results are discussed considering the importance of narrative changes in recovery from depression and the maintenance of therapeutic gains.

Introduction

Several scholars and researchers have proposed that meaning is constructed through narrative processes that allow a person to make sense of their life experiences (e.g. Angus & McLeod, 2004; Sarbin, 1986; Singer, 2005). According to this perspective, in psychopathology, problematic self-narratives block the healthy diversity of meanings and experiences (Dimaggio, 2006; Gonçalves, Matos, & Santos, 2009; Neimeyer, 2000). Thus, the elaboration of events outside the scope of the problematic self-narrative, that is, the occurrence of exceptions, is considered to be an important process of improving the flexibility of self-narratives, which has also been associated with change in psychotherapy (Alves, Mendes, Gonçalves & Neimeyer, 2012; Angus & Greenberg, 2011; Polkinghorne, 2004). To evaluate the process of narrative change in psychotherapy, Gonçalves, Ribeiro, Mendes, Matos and Santos (2011) developed the Innovative Moments Coding System (IMCS), which identifies exceptions to the problematic self-narrative experienced by clients throughout treatment, called Innovative Moments (IMs). IMs are

[4] This study was accepted for publication in the *Journal of Constructivist Psychology* with the following authors: M. M. Gonçalves, J. Batista, & S. Freitas.

categorized into five types: action, reflection, protest, reconceptualization and performing change, as illustrated in Table 1.

Table 1
Innovative Moments categories

Types of IMs	Contents
Action Actions or specific behaviours against the problem(s).	New coping behaviours facing obstacles Effective resolution of unsolved problem(s) Active exploration of solutions Strategies implemented to overcome the problem
Reflection Thinking processes that indicate the understanding of something new that creates a change in the problematic pattern (e.g., thoughts, intentions, interrogations, and doubts).	Comprehension – reconsidering causes of problems and/or awareness of their effects New problem(s) formulations Adaptive self-instructions and thoughts Intention to fight problem(s') demands, references of self-worth and/or feelings of well-being Therapeutic process – reflecting about the therapeutic process Change process – considering the process to overcome the problem(s); references of self-worth and/or feelings of well-being (as consequences of change). New positions – references to new/emergent identity versions in the face of the problem(s).
Protest Moments of critique, which involve some kind of confrontation (directed at others or versions of oneself); it could be planned or actual behaviours, thoughts, or/and feelings	Position of critique in relation to the problem(s) or/and the others who support it. The other could be an internalised other or facet of oneself. Positions of assertiveness and empowerment Repositioning oneself towards the problem(s).
Reconceptualization Process description, at a meta-cognitive level (the client not only manifests thoughts and behaviours outside the problematic narrative, but also understands the processes that are involved in it).	Reconceptualization always involves two dimensions: A. Description of the shift between two positions (past and present). B. The process underlying this transformation.
Performing Change References to new aims, experiences, activities, or projects, anticipated or in action, as consequences of change.	Generalisation to the future and other life dimensions of good outcomes Problematic experience as a resource for new situations Investment in new projects as a result of the process of change Investment in new relationships as a result of the process of change New skills unrelated to the problem Re-emergence of neglected or forgotten self-versions

Note. Innovative Moments Coding System (Gonçalves et al., 2011). Adapted with permission.

Using the data from several studies that employed the IMCS (Gonçalves et al., 2012; Gonçalves, Mendes, Ribeiro, Angus & Greenberg, 2010; Mendes et al., 2010; Ribeiro, Gonçalves,

& Ribeiro, 2009; Santos, Gonçalves, & Matos, 2010; Santos, Gonçalves, Matos, & Salvatore, 2009) and analyzing different samples (e.g. major depression, victims of intimate violence), in different therapeutic modalities (e.g. emotion focused therapy, narrative therapy), a heuristic model of narrative change in psychotherapy was developed (Gonçalves et al., 2009; Matos, Santos, Gonçalves, & Martins, 2009). According to this model, action, reflection and protest IMs are the first types of innovation to occur among recovered cases, representing the first signs of alternative experiences. Reconceptualization IMs appear later in the treatment, facilitating the emergence of a position of authorship, as it is composed of two interrelated dimensions: a contrast between a problematic past and an emerging alternative present; and an identification of the change processes involved in that contrast. Performing change IMs involve new experiences projected in the future, allowing the expansion of the change process. In unchanged cases, reconceptualization and performing change IMs are rarely found, or have a very low presence. Moreover, the global proportion of IMs has been found to be consistently higher in recovered than in unchanged cases.

Narratives may be conceived at different levels of organization, from the conversational layer (IMs in the therapeutic conversation), to the intermediate level of self-narratives (a story told in therapy), and to the highest level of life stories and culturally shaped narratives (Angus, Levitt & Hardtke, 1999; Gergen & Gergen, 1997). According to this framework, IMs (i.e. micro-narrative changes) are the building blocks of new self-narratives (i.e. macro-narrative changes), and those self-narratives are the building blocks of a life story.

In the present article, our aim is to study the association between the first two layers of narrative organization (i.e. micro and macro-narrative changes) and their relationship with symptom change. While the micro-narrative evolution was tracked through the IMCS, the macro-narrative changes were identified using the Core Conflictual Relationship Theme method (CCRT) (Luborsky, 1998). The CCRT analyzes the relational patterns, relatively stable throughout life (Luborsky, 1998), which operate as templates or scripts (e.g. Demorest Crits-Christoph, Hatch, & Luborsky, 1999) driving people's interactions with others. As such the CCRT gives us an access to the macro-narrative level. Importantly, research both with the IMCS and the CCRT suggests that change in narratives, assessed through the IMCS or the CCRT, is closely associated with changes in symptoms (e.g. Crits-Christoph & Luborsky, 1998; Gonçalves et al., 2011).

Relational Narratives: The Core Conflictual Relationship Theme Method

According to Luborsky, Barber and Diguer (1992), relational narratives reflect the client's deeper relationship patterns. Luborsky (1998) developed the CCRT to derive these relational patterns from the stories that clients tell during psychotherapy. The CCRT unit of analysis is therefore the relational episode, defined as a discrete narration describing interactions between the client and others, including the *self* and the therapist (Luborsky, 1998). The CCRT is defined by the combination of the most frequent of three components: Wishes (wishes, intentions or desires of the client in the described interaction), Response of Other (others' perceived or expected reaction to his/her wishes) and Response of Self (client's reaction to others' responses and the satisfaction, or not, of his/her wishes).

The CCRT method allows the identification of the pervasiveness of the relational patterns (Crits-Christoph & Luborsky, 1998), which is defined as the frequency of a given component in the client's relational episodes. According to Crits-Christoph and Luborsky (1998), a CCRT with less pervasiveness is more flexible and contains less frequent and repetitive conflicts between the client's Wishes, the Responses of Other and the Responses of Self. Another central CCRT dimension is the Responses' (of Other and of Self) valence, which can be positive (e.g. *self-confident*), when the client does not expect or perceives an interference with wish actualization, or negative (e.g. *helpless*), when such interference is perceived or anticipated (Ciaglia, 2010).

Luborsky et al. (1992) argued that in successful psychotherapy changes in the Responses of Other and of the Self are more common than changes in Wishes. Thus, a successful transformation of the CCRT present at the beginning of therapy is achieved by a decrease in negative responses and an increase in positive responses (of Other and of Self) (Crits-Christoph & Luborsky, 1998; McMullen & Conway, 1997). Several studies (e.g. Bressi et al., 2000; Cierpka et al., 1998) have further suggested that these indicators are associated with symptomatic improvement. Despite its psychodynamic origins, the CCRT method has been applied to analyze several therapeutic modalities, such as interpersonal (Crits-Christoph et al., 1999), psychodynamic (Crits-Christoph & Luborsky, 1998) and cognitive (Crits-Christoph, Demorest, Muenz & Baranackie, 1994). Interestingly, Crits-Christoph, Demorest, Muenz and Baranackie (1994) showed that the pervasiveness of themes was not different in cognitive and dynamic therapy, and that the individual differences found in the CCRT were significantly associated with treatment length but not with its modality. These studies suggest that the CCRT framework can be applied to study therapy modalities in which interpersonal change is not a

focus of the treatment, nor in which the CCRT is used as a therapeutic tool. This was also what occurred in the present study, in which a cognitive-behavior therapy (CBT) protocol was followed.

Narrative Change in Psychotherapy

The claim that narrative changes are related to symptomatic recovery in psychotherapy and general wellbeing has received a strong body of evidence in the last decades (e.g. Adler, 2012; Baerger & McAdams, 1999; Lysaker, Lancaster & Lysaker, 2003; Pennebaker, 1993). Recently, Angus and Kagan (2013) argue that the narration, understanding and integration of self-narratives may be the key to an adaptive identity and flexible view of the self. Reinforcing this view, the impact of processes of narrative change has not only been shown on mood disorders such as depression (e.g. Mendes et al., 2010; Gonçalves, Ribeiro, Silva, Mendes & Sousa, 2015), and in grief therapy (Neimeyer, Herrero & Botella, 2006), but also on schizophrenia (Lysaker, Ringer, Maxwell, McGuire & Lecomte, 2010), and personality disorders (Dimaggio, Montano, Popolo & Salvatore, 2015).

More specifically, Lysaker et al (2010) found that aspects of client narratives were associated with the quality and quantity of social relationships. The dimensions of social worth and agency of the narratives were the most associated with the social relationship's quality. The authors considered therefore that their results are consistent with the notion that changes in personal narratives are an important domain of recovery in schizophrenia. Using a similar approach, Dimaggio et al (2015) consider the change of narrative styles to be at the core of personality disorder therapy. Accordingly, changes in interpersonal schemas are central, as these involve rigid and dysfunctional interpretations that prevent alternative views of others and the self. These authors not only consider the importance of factors such as metacognition, agency and narrative integration but also the role of interpersonal schemas. These schemas are subjective representations of interactions with others, guided by the person's wishes and expectations, generating rigid and dysfunctional interpretations that prevent alternative views (Dimaggio et al, 2015). Similarly to the CCRT framework, these schemas lead clients to rigid and stereotyped interpretations of interpersonal interactions.

The change of clients' narratives in psychotherapy has also been operationalized as an improvement in coherence (Neimeyer, Herrero & Botella, 2006) and in the integration of negative experiences (Angus & Kagan, 2013). Moreover, when this effort of coherence and integration is successful, the client's agency and metacognitive abilities are enhanced (Dimaggio,

Salvatore, Azzara & Catania, 2003), leading to more flexible self-narratives and more satisfying interpersonal relationships. Ultimately, the change of clients' narratives can have an impact on the deeper maladaptive schemas (Young, 1999), or interpersonal patterns (Crits-Christoph & Luborsky, 1998). Psychotherapy can thus be considered a form of rewriting the client's self-narratives (Dimaggio, Salvatore, Azzara & Catania, 2003). In this sense, change in clients' narratives is considered as a factor not only associated with recovery but also with the maintenance of therapeutic gains (Angus & Kagan, 2013).

Despite analyzing different narrative levels, we expect that the more flexible and integrated are the micro-narrative changes (IMs), the more impact they will have on the client's relational patterns (Core Conflictual Relationship Theme). More specifically, we expect that the deeper narrative changes will be associated with a higher proportion of complex IMs (reconceptualization and performing change) and a more flexible (less pervasive) and a more positive interpersonal pattern identified by the CCRT. Moreover, when there are more narrative changes (both at micro and macro levels) the more stable and pronounced will be the changes in the symptomatic measures.

The Present Study

In this study we selected from a sample of CBT patients (Lopes et al., 2014) two contrasting cases: a recovered case in which reliable symptom change occurred with the expected IMs pattern (typical case), and a case in which reliable symptom changes occurred without significant IMs changes (atypical case). Narrative micro-changes (IMs) were compared with narrative macro-changes (CCRT) to explore whether in the atypical case a broader narrative change occurred without the corresponding IM changes (an anomalous finding) or whether changes in symptoms occurred without significant narrative transformations (both at the level of IMs and the level of CCRT). We hypothesize that the patterns of IMs and the CCRT are congruent in both cases. That is, we expect that in the atypical case a pre-post change in symptoms has occurred without significant narrative changes, both at the level of the IMs and at the level of the CCRT. On the contrary, we expect that in the typical case pre-post changes are congruent, at the level of narrative change (IMs and CCRT) and at the level of symptom change. Moreover, if changes in IMs and the CCRT are congruent, an important question is if the atypical case has a less stable change than the typical one.

Method

Clients

Both clients were diagnosed with major depressive disorder at axis I according to the DSM-IV-TR (American Psychological Association [APA], 2002), without any comorbidity on axis II. Although not having an axis II diagnosis, *Claudia* presented traits of dependent and avoidant personality, while *Barbara* did not present any axis II traits. More specifically, *Claudia* presented 3 traits of personality disorders. According to Dimaggio et al. (2013), who considered 5 groups of personality disorders traits (0-4, 5-9, 10-14, 20 or more), both clients are in the first of the considered groups, although *Claudia* showed more traits than *Barbara*. These cases were selected from a sample composed of 10 patients (5 recovered and 5 unchanged), chosen for process research, who were part of a larger controlled clinical trial (Lopes et al., 2014). Both cases were recovered, according to the reliable change index criteria (RCI, Jacobson & Truax, 1991) of the Beck Depression Inventory (BDI-II, Beck, Steer & Brown, 1996; more on this below).

Claudia is the only recovered case of the CBT subsample without significant narrative changes (according to the IMCS). This is why we chose *Claudia*, since she is the only case studied so far who has pre-post clinical significant changes, without the corresponding pattern of IM changes. *Barbara* was randomly chosen from the other typical cases, in which symptom change and IM changes co-occurred as expected. Both names are fictional in order to maintain the clients' confidentiality.

At the time of therapy, *Claudia* was a divorced 39 year-old, living with her 9 year-old daughter. Although she was a teacher, she was on sick leave because of repeated lateness and absences, a situation that lasted until the end of therapy. *Claudia*'s problematic self-narrative was characterized by her inability to comply with working hours and task dispersion, both exacerbated by a perceived difficulty in defining priorities. Combined with reported concentration and memory difficulties, these characteristics resulted in repeated incidents of procrastination and task avoidance. Finally, the client also reported difficulties in maintaining intimate relationships and feelings of loneliness.

At the time of therapy, *Barbara* was a divorced 26-year old, living with her parents. She had finished her university course and was looking for a job. During the period of therapy she had several part-time professional experiences despite not finding a full-time job. *Barbara*'s problematic self-narrative was heavily marked by her recent divorce that was still unresolved due to litigation concerning asset sharing with her husband. This situation was causing several

interpersonal conflicts, with her ex-husband, his family and her own family, that she viewed as very stressful. Encompassing these recent events was *Barbara*'s general lack of assertiveness and empowerment associated with an overvaluation of other people's opinions. Finally, she also reported deep fears of trusting other people again (especially men, since her ex-husband abused her psychologically) and the need to reorganize her life.

Treatment and Therapist

Both clients agreed to participate in a controlled clinical trial (Lopes et al., 2014) that compared the effects of Narrative Therapy (White & Epston, 1990) and Cognitive-Behavioral Therapy (CBT; Beck, Rush, Shaw & Emery, 1979). They were informed about the study's goals and signed an informed consent form. Both clients were assigned to undergo a CBT protocol for depression of 20 sessions; *Claudia* attended 19 sessions, while *Barbara* completed 20. All sessions were videotaped.

The therapist was a male doctoral student in clinical psychology with five years of clinical experience and was supervised by a more experienced therapist, with over 15 years of clinical experience and wide experience as a clinical supervisor. The weekly supervision was the common criterion used with these two cases, to ensure that the treatment complied with the model (see Lopes et al., 2014 for further details about the clinical trial).

Researchers

The IMs coding was performed by two judges, both doctoral students with over one year of clinical experience, after completing the IMCS training. This coding was done previously to this study (Gonçalves et al., 2015). The training comprised of the completion of three workbooks in which the judges had to identify the IMs and IM types in clinical vignettes. Then, the judges coded a sample of full therapeutic sessions. The training was successfully completed when each judge obtained a Cohen's kappa higher than .70.

The CCRT coding was done by a doctoral student (with 8 years of clinical experience), who also coded the IMs, and a masters student (with one year of clinical experience). Prior to the coding, both judges also completed a CCRT training that included extensive reading of Luborsky and Crits-Christoph's (1998) guidelines and examples of several clinical sessions to adequately locate relational narratives and identify the CCRT components. The training was considered successfully completed when a percentage of agreement for the relational narratives

identification higher than 90% and an intraclass correlation (ICC) for the components definition higher than .80 were reached. Despite the fact that there was a common judge in both codings, these were conducted with a time lapse of two years, the systems have different approaches to coding, and the reliability was high in both, which reduced the possibility of bias. Finally, all the judges involved were unaware of the clients' outcomes and the purpose of the study.

Measures

Structured Clinical Interviews for DSM-IV-TR Axis I Disorders (SCID-I; First, Spitzer, Gibbon & Williams, 2002) **and Axis II Disorders** (SCID-II; First, Gibbon, Spitzer, Williams & Benjamin, 1997). The SCID-I and II are structured clinical interviews based on the diagnostic criteria of the DSM-IV-TR (APA, 2002), which evaluates clients' axis I and II symptoms. They were administered during a pre-therapy evaluation session.

Beck Depression Inventory (BDI-II; Beck, Steer & Brown, 1996; Portuguese version adapted by Coelho, Martins & Barros, 2002). This inventory is composed of 21 items that evaluate depressive symptoms and was administered every fourth session and in the follow-up sessions (18 and 30 months after therapy). The items are rated on a four-point Likert scale (0-3), and the total score ranges between 0 and 63 points. Higher values in the BDI-II correspond to higher depressive symptomatology. The inventory has a high internal consistency of .91 (Steer, Brown, Beck & Sanderson, 2001). The cut-off for significant depressive symptoms is 14.29 and the reliable change index (RCI; Jacobson & Truax, 1991), indicating clinically significant change, is 8.46 (Seggar, Lambert and Hansen, 2002).

Outcome Questionnaire (OQ-45.2; Lambert et al, 1996; Portuguese version adapted by Machado & Klein, 2006). This 45-item questionnaire is divided into 3 subscales (symptomatic, interpersonal and social) and assesses clinical progress. It was administered every fourth session and at the two follow-up sessions (18 and 30 months after therapy). The items are rated on a five-point Likert scale (0-4), and the total score ranges between 0 and 180 points. Higher values in the OQ-45.2 correspond to higher general psychological distress. The questionnaire has good test-retest reliability (.84) and a high internal consistency (.93; Lambert et al., 1996). The Portuguese version (Machado & Fassnacht, 2014; Machado & Klein, 2006) used in this study has a high internal consistency, with a cut-off score of 62 and a RCI (Jacobson & Truax, 1991) of 18.

Innovative Moments Coding System (IMCS; Gonçalves et al., 2011). The IMCS is a coding system that divides observed IMs into five categories. A higher proportion (in previous articles this proportion was termed salience) of IMs is associated with a higher presence of alternative experiences to the problematic self-narrative. A higher proportion of reconceptualization and performing change IMs is associated with the narrative innovations typical of recovered cases. Studies that have used the IMCS (Gonçalves et al., 2012; Matos et al., 2009; Mendes et al., 2010) produced inter-judge agreements that ranged between .86 and .97.

Core Conflictual Relationship Theme (CCRT; Luborsky & Crits-Christoph, 1998; translated by Batista, Alves, Freitas & Machado, 2012). The CCRT is a content analysis system that identifies relationship episodes narrated by the client during therapy and distinguishes the three components (Wishes/Needs, Response of Other, Response of Self) of each relational episode. After the initial coding, the components are converted to the standard categories proposed by Barber, Crits-Christoph and Luborsky (1998). A higher pervasiveness and a negative valence of the components are indicative of more rigid and less adaptive relational patterns.

Procedures

Innovative Moments Coding System. As previously mentioned the IMs were coded before this study (Gonçalves et al., 2015). Here we summarize the main procedures of the coding process. After receiving training in the IMCS, two judges viewed the video recordings of the initial sessions and reached a mutual agreement on the main features of the client's problematic self-narrative. Then, working with transcripts of the sessions, they independently coded the IMs, defined as novelty elements (exceptions to the problematic self-narrative), tracked their proportion (that is, proportion of text involved in their description and/or elaboration), and identified their type. The reliability was based on the initial (independent) coding of the sessions. In this study, reliability on IM identification was 85.9% for *Claudia* and 95.7% for *Barbara*. The reliability of IM types was calculated through Cohen's kappa and was .97 for *Claudia* and .92 for *Barbara*. When disagreement occurred, the final coding was the result of consensus between the judges, with the help of an external auditor with IMCS experience.

Core Conflictual Relationship Theme. Two judges independently coded the CCRT. In order to track the existence of changes in the relational patterns throughout therapy, the CCRT method was applied at three temporal moments: the beginning, middle and end of therapy. Two sessions from the initial (2nd and 3rd), two from the middle (10th and 11th) and two (three for

Claudia) from the final phase of therapy (18th and 19th in *Barbara* and 16th, 17th and 18th in *Claudia*) were selected and coded. It was necessary to analyze three sessions from the final phase of *Claudia*'s treatment to ensure that a minimum of 10 relational episodes were used to define the CCRT, as suggested by Luborsky (1998).

The CCRT coding followed the procedures described by Luborsky (1998). First, the relationship episodes were identified independently by the two judges, who then met to decide which episodes were to be coded. This decision was based on an episode's degree of completeness, which was rated on a scale from 1 to 5 with a cut-off at 2.5. Next, the components were identified and converted into one of the standard eight categories based on their proximity to it. These categories, listed in Table 2, constitute clusters theoretically derived from empirical research with the CCRT (Barber, Crits-Christoph & Luborsky, 1998).

Table 2
Standard categories of the CCRT components (Edition 3)

CCRT components	Standard categories
Wishes	1. To assert self & be independent
	2. To oppose, hurt & control others
	3. To be controlled, hurt & not responsible
	4. To be distant & avoid conflicts
	5. To be close & accepting
	6. To be loved & understood
	7. To feel good & comfortable
	8. To achieve & help others
Responses of Other	1. Strong
	2. Controlling
	3. Upset
	4. Bad
	5. Rejecting & opposing
	6. Helpful
	7. Likes me
	8. Understanding
Responses of Self	1. Helpful
	2. Unreceptive
	3. Respected & accepted
	4. Oppose & hurt others
	5. Self-controlled & self-confident
	6. Helpless
	7. Disappointed & depressed
	8. Anxious & ashamed

Note. Adapted from Barber, Crits-Christoph & Luborsky, 1998.

The responses' valence was analyzed according to the procedures described by Wilczek, Weinryb, Barber, Gustavsson and Åsberg (2004). Instead of deciding whether a response is

positive or negative, it was assumed that Response of Other clusters 1 (*strong*), 6 (*helpful*), 7 (*likes me*) and 8 (*understanding*), and Response of Self clusters 1 (*helpful*), 3 (*respected and accepted*) and 5 (*self-controlled and self-confident*) are positive and all others are negative. Since there are no neutral categories the sum of positive and negative responses is always 100%. Agreement on the identification of relationship episodes was 88% in both cases. ICC for the identification of Wishes, Response of Other and Response of Self was respectively .90, .89 and .89 for *Claudia,* and .96, .93 and .98 for *Barbara*.

Results

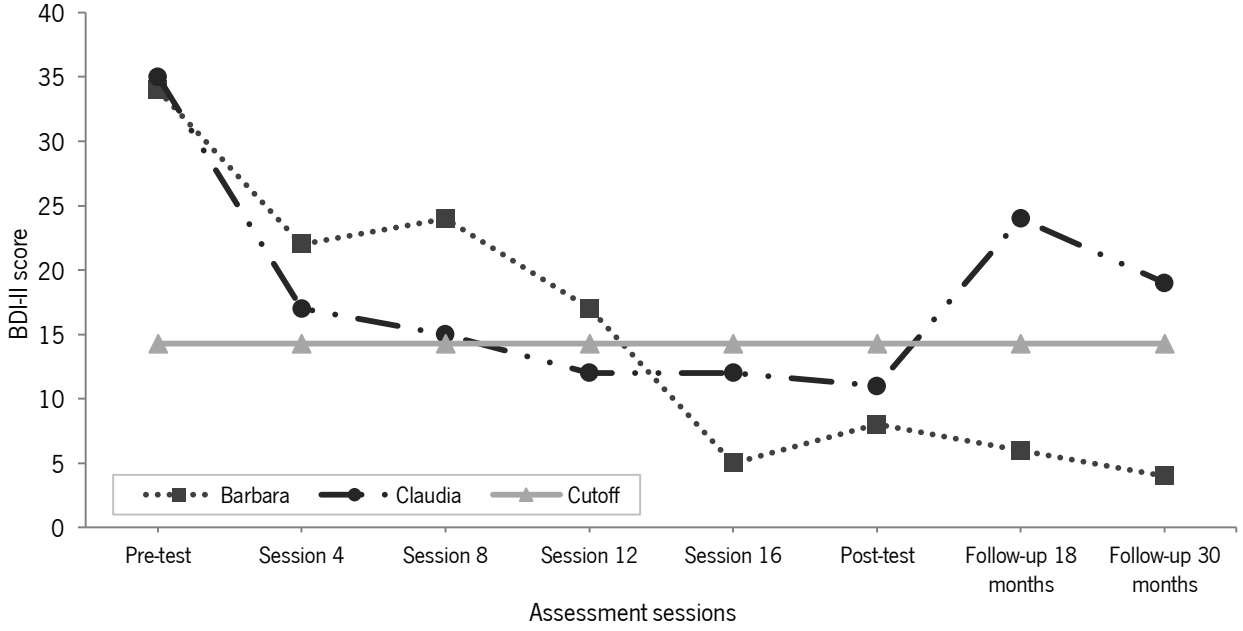
Given the criteria for case selection described above, the results of the BDI-II and of the IMs are the expected ones. As stated above, we selected *Claudia* as she was the only case studied so far with the IMCS with incongruent results: she was recovered according to the BDI-II, but unchanged according to the IMCS. As with all the other typical recovered cases, *Barbara*'s BDI-II and IMCS results are congruent, that is, she has a profile of a recovered case according to the IMCS and she is also a recovered case according to the reliable change index on the BDI-II. We present first the results of the BDI-II and of the IMCS, and then the CCRT to compare the narrative changes in the IMCS with the narrative changes in the CCRT. We finalize the results sections with the evolution of the OQ-45.2 subscales in order to have a more fine-grained analysis of the changes in both clients.

Symptom Evaluation on BDI-II

The BDI-II results (Figure 1) indicated that clinical recovery had occurred between pre and post-therapy in both cases, suggesting that the therapeutic changes were clinically reliable and that at the end of treatment the clients scored within the range of a functional population (Jacobson & Truax, 1991). This evolution of the BDI-II scores was what leads us to consider these cases as recovered.

However, the clients were also evaluated at 18 and 30 month follow-up. During this period, *Claudia*'s (the atypical case) depressive symptoms slid back within the range of the clinical population (i.e., above 14.29 points), indicating a relapse. On the other hand, *Barbara*'s scores maintained the decreasing tendency, continuing to be within the range of the functional population.

Figure 1. Clients' BDI-II score evolution



Innovative Moments (IMs)

The main results of the IMCS are shown in Table 3.

Table 3
IMCS results

IMs/ Client	Overall	Action	Reflection	Protest	Reconcep-tualization	Performing Change
Barbara	28.58%	0.52%	18.13%	4.07%	3.23%	2.58%
Claudia	8.99%	0.99%	7.60%	0.05%	0.34%	0.00%

Whereas *Barbara* presented an overall proportion of IMs throughout the treatment of 28.58%, *Claudia*'s overall results only reached 8.99%. The IM type with the highest proportion in both cases was reflection. *Barbara´* s profile exhibited a higher diversity of IMs (with only action being residual) than *Claudia*, who had no performing change IMs and a residual proportion of action, protest and reconceptualization IMs.

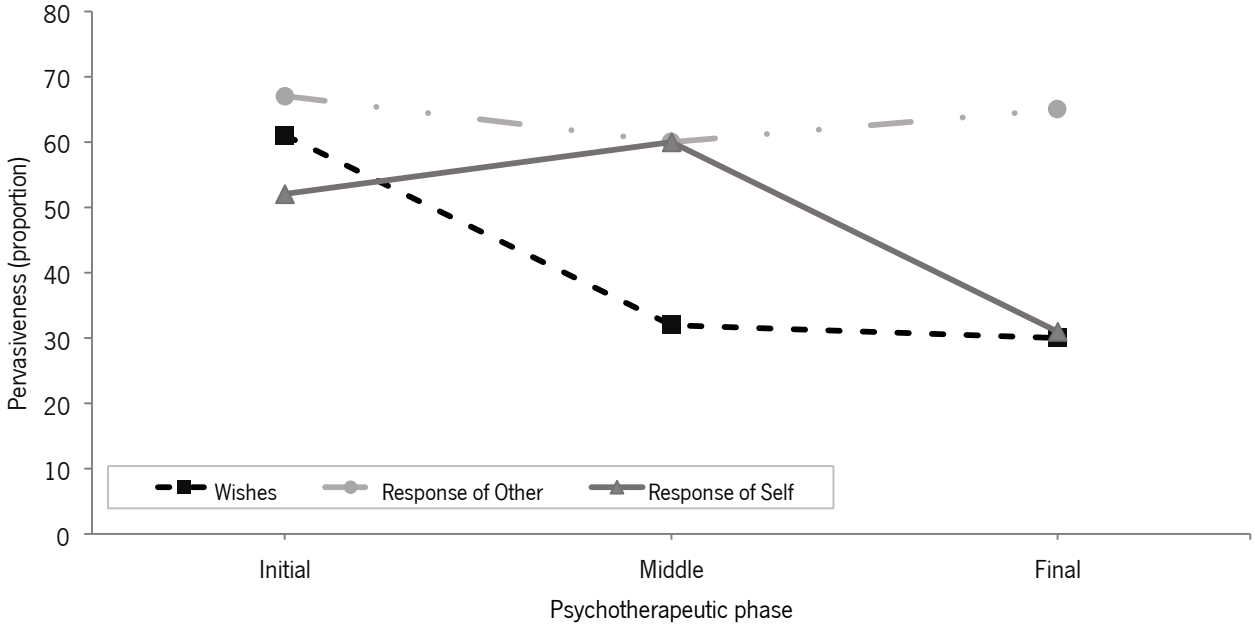
In sum, despite the fact that both cases were recovered cases according to the BDI-II, it is clear that their narrative innovation profiles were very distinct. While *Barbara* presented a typical profile of a recovered case, with an overall proportion of IMs of around 30% and all types of IMs (with reconceptualization and performing change appearing from the middle to the end of therapy), in *Claudia*'s profile there was a low IM diversity and low overall proportion. According to

the innovative moments model, this profile is typical of an unchanged case (e.g., Gonçalves Matos & Santos, 2009; Gonçalves et al., 2012; Mendes et al., 2010), since the two main features congruent with an unchanged case are (1) a low IM diversity across sessions (with some of them rare or even absent), and (2) a very low (if any) proportion of reconceptualization.

Core Conflictual Relationship Theme (CCRT)

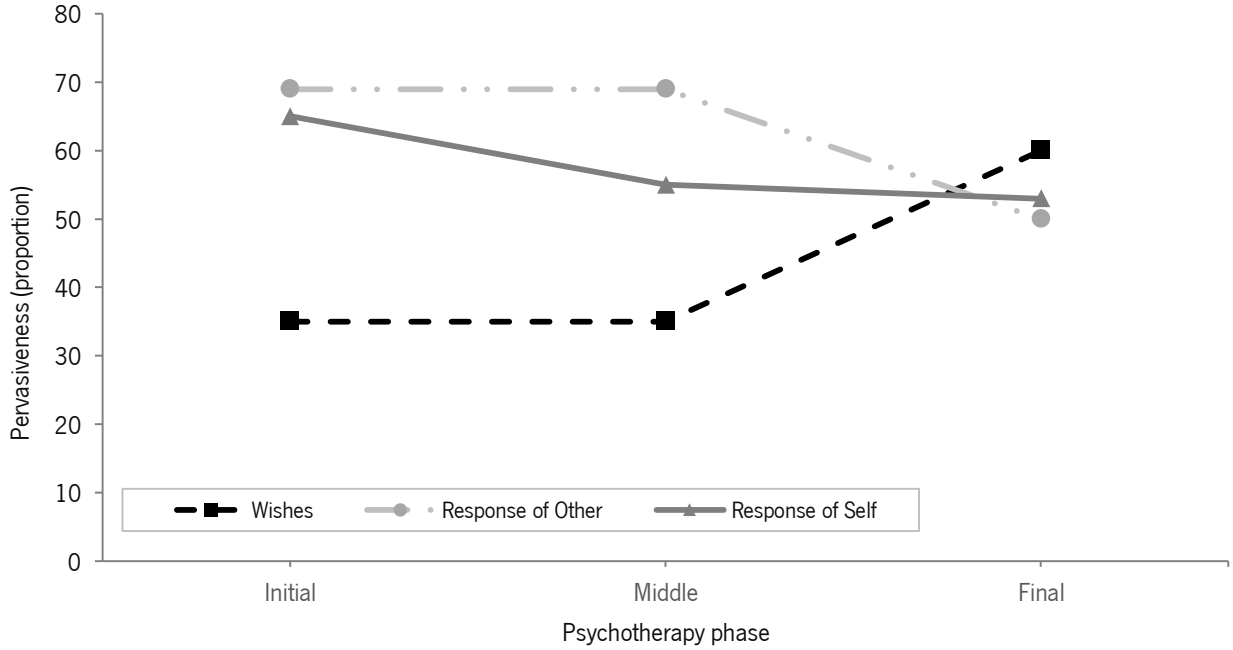
The results of CCRT pervasiveness are shown in Figures 2 and 3. The profiles of both clients are very different on the Wishes and on the Response of Self components, being more similar in the Responses of Other.

Figure 2. *Barbara*'s CCRT components pervasiveness



Considering the Wishes component we can see how it had opposite tendencies in these clients. *Barbara*'s dominant Wishes evolved from *to be loved and understood* in the initial sessions, to the self-oriented wish *to assert self and be independent* in the middle phase, and to *to be loved and understood* again in the final phase, but with a decrease in its pervasiveness (61 to 30%). *Claudia*'s Wishes, on the other hand, were more flexible in the initial and middle sessions (with two categories equally as most frequent, *to be loved and understood* and *to achieve and help others,* with 35% of pervasiveness) and became more pervasive in the final phase of therapy, *to achieve and help others* being the most prevalent wish in 60% of the relational episodes.

Figure 3. Claudia's CCRT components pervasiveness



The Response of Other component presented a stable pattern throughout therapy in both clients, *rejection and opposition* being the most pervasive category in all therapy phases. The response component valences of the Response of Others were also not very different between clients. *Barbara*'s positive Response of Other was very low in the initial sessions (10%), increasing in the middle sessions (27%), and dropping in the final sessions (17%). On the other hand, *Claudia*'s positive Response of Other was similar in the initial and middle sessions (23% and 21% respectively), and had a small increase in the final sessions (30%).

Contrarily to the similarity of the Response of Other in both cases, the Response of Self component depicts different profiles between the cases. The *helpless* category, which includes reactions of insecurity, ambivalence or dependency, was the most pervasive in *Barbara*'s initial and middle sessions (with 52% and 65% respectively), but in the final sessions there was not only a more flexible Response of Self (31% of the relational episodes), but also a change in the most frequent category, that became *self-controlled and self-confident*; a category composed of positive reactions. On the other hand, *helpless* was *Claudia*'s most pervasive Response of Self throughout therapy, with a slight decrease of its presence in relational episodes from the initial (65%) to the middle (55%) and the final (53%) sessions. These differences are also reflected at the level of this component's valence. Thus, *Barbara*'s positive Response of Self showed an increase from the initial (13%) to the middle (23%), becoming very high in the final sessions (61%); while *Claudia*'s

showed a slight increase throughout therapy, from 12% in the initial, 15% in the middle, to 27% in the final sessions.

OQ-45.2 Subscales

The results of OQ-45.2 subscales are presented in Figures 4 and 5. *Claudia* (the atypical case) showed a clinically meaningful evolution on the symptom subscale, as her score decreased from 65 to 39, exceeding the 12 points needed for a reliable change. However, the scores on the interpersonal and social subscales did not reach the reliable cut-off requirement (8 and 7 points, respectively), decreasing from 23 to 16 on the first subscale and from 16 to 11 on the second subscale. *Barbara*, on the other hand, showed a dramatic evolution on the symptom subscale (from 54 to 7), also reaching the reliable cut-off requirement in the interpersonal and social subscales (from 21 to 3 and from 20 to 1 respectively).

Figure 4. *Barbara*'s OQ-45.2 sub-scales scores evolution

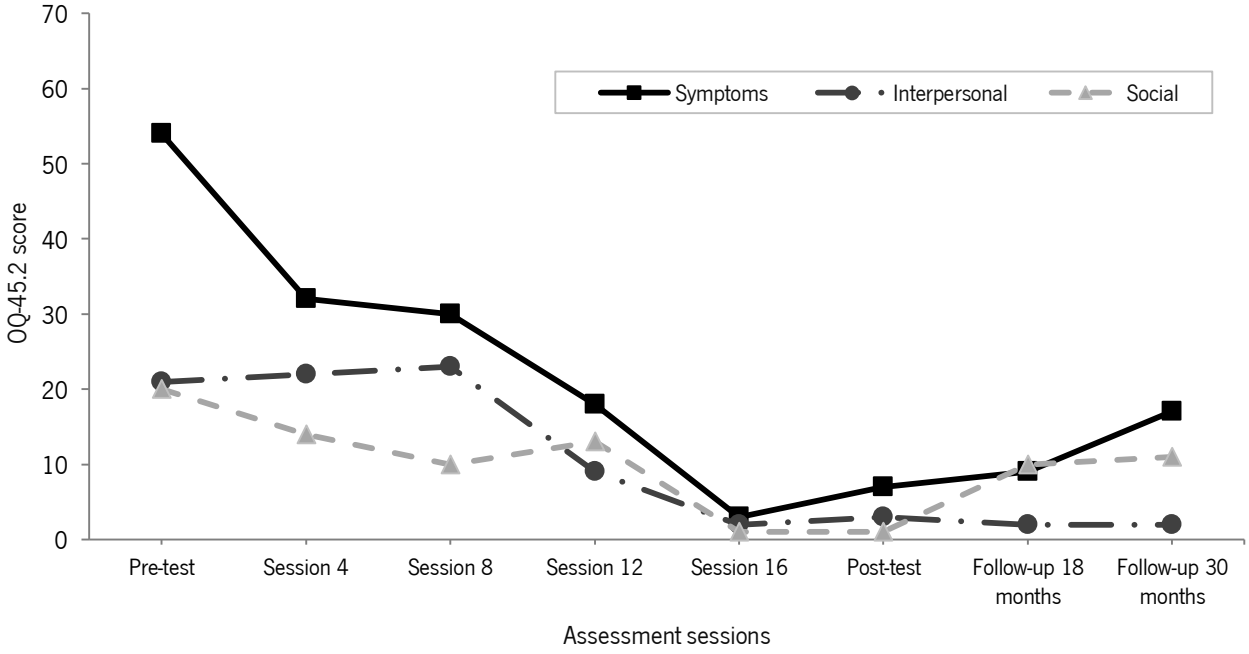
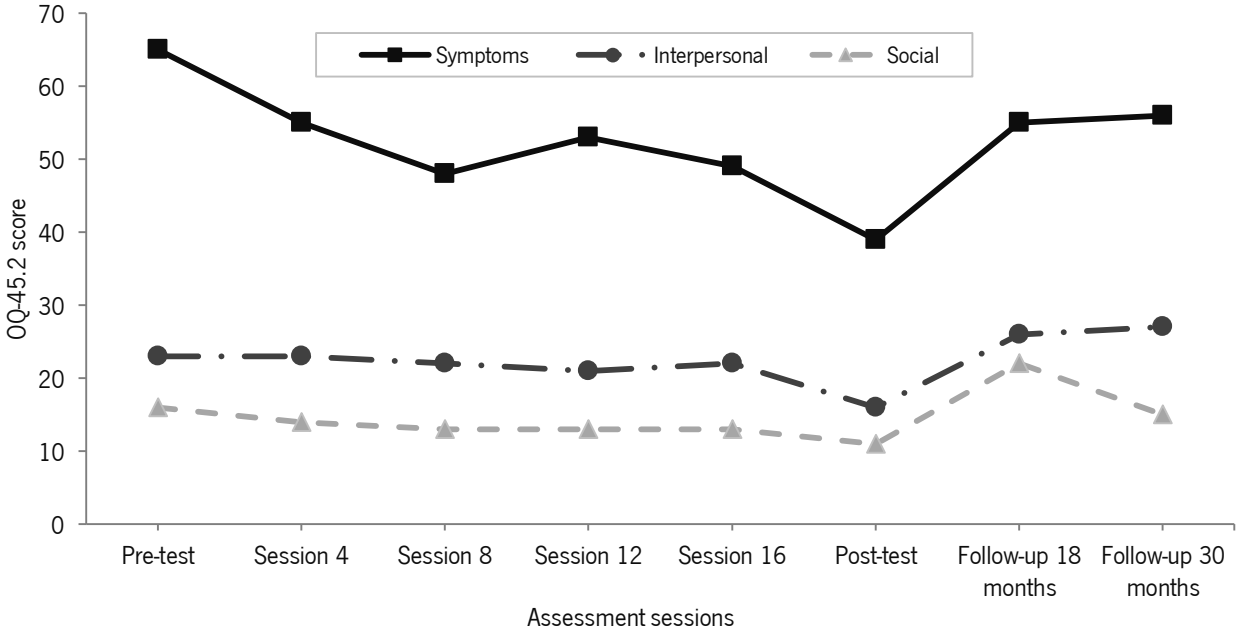


Figure 5. *Claudia*'s OQ-45.2 sub-scales scores evolution



Discussion

This paper aimed to compare two cases in which symptom recovery was associated with different IM profiles: one typical (*Barbara*) and one atypical case (*Claudia*). The CCRT method was used to determine whether there were changes in the broader self-narratives in both cases, congruent with the symptomatic changes, or if the pattern of the CCRT was congruent with the IMCS results. If the CCRT and the IMCS were congruent we would expect the occurrence of narrative changes in the typical, but not in the atypical case. In other words, we explored if *Claudia* (the atypical case) had significant changes in her self-narratives that were not detected by the IMCS, but were detected with the CCRT, which would be an anomalous finding; or if she had recovered from the depressive symptoms without a deeper narrative transformation. This was done comparing *Claudia* to another case, *Barbara*, who presented a typical IMCS recovered case profile, congruent with the changes in symptoms.

The CCRT results indicated that these cases had a different evolution in their relationship patterns, supporting our expectation that changes in IMCS and in the CCRT are consistent. Whereas *Barbara*'s results showed more flexible Wishes and Response of Self components, *Claudia*'s Wishes pervasiveness was higher in the final sessions and her Response of Self was less flexible than *Barbara*'s. Moreover, considering the valence of the relationship patterns, it is clear that *Barbara*'s Response of Self became positive (and the most frequent category), while this did not happen with *Claudia*. *Claudia* had just a slight increase in Response of Self positive

valence, continuing to respond to her interpersonal events mostly with reactions of incapacity, insecurity and ambivalence (that constituted 73% of her responses). Despite the difficulty of making comparisons between cases with the CCRT, previous research has consistently shown that the decrease of Response of Other and Response of Self pervasiveness, and increase of positive valence are strongly associated with a decreased symptom severity (Cierpka et al., 1998) and a successful therapeutic outcome (Crits-Christoph & Luborsky, 1998; Grenyer and Luborsky, 1996). A more flexible and positive Response of Self has also been related to an increased sense of mastery (Grenyer & Luborsky, 1996), i.e., the client's ability to deal with interpersonal distress and conflicts. Finally, Cierpka et al. (1998) also found an association between less pervasive Wishes and higher well-being.

All these findings from previous research suggest that *Barbara* achieved a more flexible and positive interpersonal pattern than *Claudia,* consistently with Luborsky and Crits-Christoph's (1998) theoretical model underlying the CCRT, in which the maladaptive relationship episodes should decrease during therapy, resulting in a more functioning central pattern. This assertion is substantiated by the clients' OQ.45.2 subscales: whereas *Barbara* reaches a clinically significant change on all the subscales, *Claudia* only reaches significant change on the symptom subscale. Thus, *Claudia* did not reach meaningful changes in her deeper patterns, including the interpersonal milieu.

Thus, the IMCS results were congruent with the clients' interpersonal pattern changes, as detected by the CCRT. Whereas in *Claudia's* sessions the identified IMs were less diverse and less frequent than are typically observed in recovered cases, *Barbara* presented a higher IMs diversity and frequency, alongside with a higher proportion of reconceptualization and performing change IMs, all features of recovered cases (e.g. Gonçalves et al, 2011). We suggest that in *Barbara*'s case the narrative innovation fostered by these more complex IMs (reconceptualization and performing change) led to new ways of interpreting and reacting to events (including to interpersonal ones), which in turn are reflected in the changes of interpersonal patterns (evaluated by the CCRT).

Although belonging to different theoretical frameworks, the results from the IMCS and the CCRT were highly convergent. In fact, both systems managed to distinguish a case (*Claudia*) that despite achieving an adequate level of symptom functioning, most likely did not reach a stable and deeper change from a case (*Barbara*) that seems to have reached it, showing more elements of a narrative transformation. These transformation involved new forms of interpreting events and

interacting with herself and others. We can speculate if these narrative changes are a mechanism of change or a consequence of the recovery of this client. In a recent study, the IMs predicted symptom improvement in the following session (Gonçalves et al, 2015) in a sample of narrative therapy. These results are in accordance with the notion that narrative changes can be a mechanism of therapeutic change (Angus & Kagan, 2013).

The absence of significant narrative transformation in *Claudia*, both at the level of the micro (IMCS), as well the level of macro-narrative (CCRT), probably had an impact at the follow-ups. We speculate that it is the absence of deeper narrative transformation during treatment that leads to a relapse in *Claudia*, as assessed by the BDI-II. On the contrary, *Barbara,* who had a significant transformation in her self-narratives (at the level of IMs and the CCRT), maintained her gains. Despite the fact that *Claudia*'s relapse could be due to external, unknown factors, we speculate that without significant changes at the self-narrative level, the risk of relapse is significantly higher, as occurred in this case. Further research could assess whether self-narrative changes in fact predict relapse at follow-up, as we are suggesting, which would be of great importance both from a theoretical as well from a clinical perspective.

An alternative explanation for the difference of CCRT changes in both cases could be that while *Barbara*'s problems were mainly interpersonal, *Claudia*'s had to do more with her own ability to cope with responsibilities and the fulfilment of her obligations. Therefore, while *Barbara*'s therapeutic gains would reflect more plainly in her interpersonal patterns, *Claudia*'s would not. This alternative explanation would also be congruent with the lack of changes reflected in the IMCS. However, and following Luborsky's (1998) claim that therapeutic progress will always be reflected in clients' interpersonal patterns to some extent, even if *Claudia*'s problems had a less interpersonal nature, she would have achieved more mastery of her difficulties that would be more evident in her interactions with others, which should be reflected in the CCRT (and in the IMCS).

Another alternative interpretation is to claim that CBT therapeutic work was not expected to produce a change in the interpersonal problems, as identified by the CCRT. However, at least one previous study does not support this idea: Crits-Christoph (1998) reported, in a comparison of cognitive therapy and interpersonal therapy, that in the former the therapist would adjust therapeutic work to the client's needs, which is reflected in the interpersonal patterns. Our own results are congruent with this interpretation from Crits-Christoph, as *Barbara*, following the same

therapeutic manual as *Claudia,* presented changes in the CCRT that are in line with previous literature.

Finally, another factor to be considered is the difference in the personality disorder traits. Recent studies (Dimaggio et al., 2013; Verheul, Bartak & Widiger, 2007; Wilberg, Hummelen, Pedersen & Karterud, 2008) have shown some evidence that the amount of personality disorder traits is a better predictor of outcome than the criteria of presence or absence of a personality disorder. Dimaggio et al. (2013) showed a significant association between increase in personality disorder traits and interpersonal problems as well as symptom severity. However, and in line with Verheul et al. (2007), the authors consider a cut-off of 5 personality disorders traits. This means that the associations found are only significant above that cut-off. So, although *Claudia* presented more traits than *Barbara*, they are both bellow the referred threshold, and can be considered pure axis I clients (Dimaggio et al, 2013).

Limitations and Implications

Due to its exploratory nature, this study has several limitations that need to be addressed in forthcoming research. Despite being just a comparison between two cases, which limits the possibility of generalization, this study examines what seems to be a finding that contradicts the theory. This, ultimately, may help refine the theory, as suggested by Stiles (2005, 2009) in his proposal for theory-building case studies. Finally, the narrative analyses used only sessions transcripts, which means that the results are dependent on the content of those sessions. An interesting alternative could be using narratives collected at both pre; and post-therapy which could allow a more rigorous assessment of change in self-narratives.

Having these limitations in mind, the findings in these cases need to be replicated in other cases and samples, as this study also addresses an important question that has been challenging researchers in psychotherapy for at least 50 years (see Strupp, 1963/2013): what do therapists and researchers mean when they refer to recovery or improvement? The field of psychotherapy outcome research has generally accepted the idea that outcomes should be measured at the symptom level (often with self-report measures). However, as Hill, Chui and Baumann (2013) have recently emphasized, measuring outcomes solely at this elementary level may overlook the complexities of psychotherapeutic change. The present study contributes to this discussion by emphasizing the importance of measuring self-narrative change in psychotherapy. Thus, two interesting questions for the future are whether measuring self-narrative change could

be a more robust predictor of reliable change than the amelioration of symptoms and whether this narrative change could also be an important factor in preventing relapse.

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CONCLUSION

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As human beings, we live by and in the stories we tell about ourselves, the others and the world around us (Bruner, 1990). Creating narrative accounts about our experiences is a way of giving meaning to experiences and achieve coherence (McLeod, 2004). Narratives are thus meaning structures, organizing events and human action (Polkinghorne, 1988). Underlying the narratives we create are our intentions, interpretations, emotions and evaluations (e.g. Botella, 2001). Thus, the narration of life events implies a selective process, with some experiences remaining outside these narrative accounts (Freedman & Combs, 1996). This selection ensures the stability of the self and its coherence (McAdams, 2001). Similar experiences associate to form rules and assumptions that will guide the interpretation of experience, giving meaning to the person's life (Gonçalves, Korman & Angus, 2002). The organized set of these abstracted experiences (schematized in implicit rules and assumptions) constitute the macro-narrative level (Angus, Levitt & Hardtke, 1999). Functioning as a whole (Polkinghorne, 1991), the macro-narratives imbue the person with a sense of self-continuity and purpose. A healthy narrative organization encompasses the diversity of life experiences in a coherent yet flexible way (e.g. Gonçalves et al., 2002; McAdams, 2001). Despite the stability of narratives, they are open to change, by the elaboration of these experiences outside our normal way of interpretation (e.g. Gonçalves et al., 2002; Gonçalves, Ribeiro, Mendes, Matos & Santos, 2011).

As referred throughout this dissertation, persons with psychological disorders present narratives highly rigid, fragmented or disconnected (Dimaggio, Hermans & Lysaker, 2010). Psychotherapy involves the efforts of exploration, elaboration and change of clients' narratives (Angus et al., 1999). Departing from this assumption, our research group has been studying how this process of narrative transformation is unfolded throughout psychotherapy (e.g. Gonçalves et al., 2011). The research with the IMs has shown that is possible to identify these narrative exceptions in different psychotherapy models (e.g. Alves et al., 2014; Gonçalves, 2015; 2016; Mendes et al., 2010), using the Innovative Moments Coding System (IMCS; Gonçalves et al., 2011). Moreover, IMs differentiated recovered from unchanged cases and a particular developmental emergence pattern of IMs was described as characteristic of successful psychotherapy. Despite this, the impact of IMs on broader, more stable narratives have been assumed in previous research, although not empirically demonstrated to this date. Therefore, a

main goal of this dissertation was to study if the IMs, conceived as micro-narrative events, would have a significant impact on macro-narratives.

The assessment of macro-narratives was done with the Core Conflictual Relationship Theme (CCRT; Luborsky, 1998b). Both systems of analysis used in this work (the CCRT and the IMCS) are primarily interested in the clients' narratives and their association with psychopathology and recovery in psychotherapy, although focusing in different phenomena related to the micro- and macro-narrative levels. This dissertation presented several studies exploring two notions: 1) Change of clients' narratives is a crucial aspect in psychotherapy, and 2) Narrrative changes can operate at different yet connected levels. The following sections summarize the main findings of these studies considering these two aspects.

The Importance of Narrative Transformation

The first contribution of this dissertation to the field of psychotherapy research is not a new one. In fact, the transformation of clients' maladaptive narratives in psychotherapy has been systematically studied in the past decades (e.g. Adler, Wagner & McAdams, 2008; Angus et al., 1999; Lysaker et al., 2005).

The first chapter presented a quantitative process-outcome study (Elliot, 2011), associating a key process in psychotherapy, the changes in relational schemas, with the outcome. The sample used in this study was constituted by 22 clients followed in one of three brief psychotherapy models: emotion-focused therapy (EFT), cognitive-behavior therapy (CBT) and narrative therapy (NT). Clients were diagnosed with major depressive disorder (MDD) according to the DSM-III-R (American Psychiatric Association, 1987) or the DSM-IV-TR (American Psychiatric Association, 2002). The results of this study supported the applicability of the CCRT method in brief therapies outside a psychodynamic theoretical framework. In fact, these results confirmed previous findings obtained with the CCRT: Successful psychotherapy was significantly associated with a decrease in rigidity (measured by dispersion) and with a more positive response valence at the end of psychotherapy.

One innovative feature of this study was the use of an intermediate point of assessment. This made it possible to analyze the evolution of client's relational narratives, which is not possible with only two assessments (at the beginning and at the end of psychotherapy). This way, a longitudinal statistical model was used (generalized linear mixed model, GLMM) instead of the usual ANOVA design. That means that instead of comparing the initial and final CCRT results the

GLMM allowed the modeling of the three points of assessment. The results from this study confirmed that changes in the CCRT occurred only in the final phase. Thus, we can consider that these structures are in fact stable (Luborsky, 1998a), taking some time to integrate changes in interpersonal interactions.

The W component was more flexible at the end of therapy regardless of the outcome. We interpreted this finding as a possible effect of undergoing psychotherapy. In fact, Cierpka et al. (1998) showed that the W was the CCRT component that distinguished clinical and non-clinical populations. Thus, we considered that undergoing psychotherapy may have helped clients to have a more flexible set of intentions in interpersonal interactions, despite the interpretation of responses of others and of the self continued to be rigid and negative.

Similarly to other studies (e.g., Crits-Christoph & Luborsky, 1998; Slonim, Shefler, Gvirsman, & Tishby, 2011), differences between the outcome groups were found in the response components. The RO was more disperse and positive in the recovered clients at the end of psychotherapy, showing that others' behavior was interpreted in a more flexible and positive way than at the beginning. This result confirms the previous finding that this component at the end of psychotherapy is frequently more positive and flexible than at the beginning (e.g., Crits-Christoph & Luborsky, 1998; Slonim et al., 2011; Wilczek, Weinryb, Barber, Gustavsson & Åsberg, 2004). Changes in the RS are also in line with previous findings (e.g., Crits-Christoph & Luborsky, 1998; Slonim et al., 2011), confirming the general observation that it is the component most open to change (e.g., Crits-Christoph & Luborsky, 1998; Grenyer & Luborsky, 1996). In fact, this was the only component for which the most frequent category changed from a negative (*depressed and disappointed*) to a positive category (*comfortable and accepted*) in the recovered group.

The third chapter presented a study comparing two cases from the cognitive-behavior subsample in which symptom recovery was associated with different profiles of narrative changes. Both clients were diagnosed with major depressive disorder (MDD) according to the DSM-IV-TR (American Psychiatric Association, 2002) and followed in CBT for 20 sessions. Whereas one case (*Barbara*) showed the expected narrative changes in recovered clients, the other (*Claudia*) did not present those changes. The CCRT results indicated that these cases had a different evolution in their relational schemas. As mentioned, successful psychotherapy is associated with a decrease in CCRT's components rigidity (e.g. Crits-Christoph & Luborsky, 1998; Wilczeck et al., 2004). Considering these pattern of changes in the CCRT it was possible to consider that *Barbara* showed the expected profile in the CCRT. By contrast, *Claudia* showed

only minimal changes in her relational schemas at the end of psychotherapy. This assertion was substantiated by the clients' OQ-45.2 subscales: whereas *Barbara* reaches a clinically significant change on all the subscales, *Claudia* only reaches significant change on the symptom subscale.

The IMCS results were congruent with the clients' relational schemas evolution. One important conclusion of this study was the congruency between the CCRT and IMCS results. Considering that one of the studied cases was an anomalous finding in the IMs research (a recovered case without the expected IM profile) this convergence was quite relevant. It showed that the lack of narrative elaboration (IMs) throughout psychotherapy was reflected in minimal changes in the client's relational schemas. On the other case, in which the symptom recovery was accompanied by the expected profile of narrative elaboration (IMs) in the sessions, the CCRT presented changes that were more pronounced. Thus, the two measures showed a better convergence than each of them with the symptoms measure (the BDI-II). Besides the importance of this congruence for the forthcoming studies, this result allowed us to reflect on the way that recovery from psychological disorders is measured in psychotherapy research. In fact, *Claudia*'s clinical results showed that a client may be considered recovered in self-report measures, such as the BDI-II, without reaching a deeper transformation in the macro-narratives structures, such as the relational schemas. The results from clients' follow-ups reinforced this conclusion. Whereas *Barbara* maintained her gains in the follow-ups, *Claudia* presented a relapse in the depressive symptomatology in both moments. Despite considering that this relapse could have occurred due to unknown factors, we interpreted this finding as evidence that narrative transformation can be a protective factor to clients' future relapses. Of course, this interpretation needs further research, but at the current moment our research group is studying precisely how narrative change can be a protector ingredient of further relapse in depression.

The results of the first study replicated the major findings of research with the CCRT on a sample of brief psychotherapy. At the same time, these two studies fulfilled the initial purpose, to show the importance of promoting changes in the relational schemas, regardless of the psychotherapeutic model used and present a case study (in this instance a case comparison) of the IMCS and CCRT association.

The Connection between Narrative Levels

A second contribution of this dissertation focused on the largely unexplored connection between different narrative levels. The research on the importance of narratives presents a wide

variety of focus, from the moment-to-moment interactions (e.g. Avdi & Georgaca, 2009) to life stories (e.g. McAdams et al., 2006). This heterogeneity reflects the potential of the concept to encompass several levels of life events organization but it may also lead to a fragmented body of research. Thus, in chapter two of this dissertation we addressed this gap by studying in which ways the micro-narrative events may have a significant impact in the broader macro-narrative structures. As Gonçalves et al. (2002) considered, micro-narratives changes should be evident before macro-narratives are able to change. Thus, a study was designed using the IMs as predictors of relational schemas change. The IMCS was used to track the emergence of micro-narrative changes and the macro-narratives changes were assessed with the CCRT. Prior to this study, neither the IMs were empirically associated with macro-narratives nor the CCRT with micro-narratives events, except for the research with the concept of mastery (Ceustermont, 2012; Grenyer & Luborsky, 1996). This study used the same sample referred before, of 22 clients diagnosed with MDD.

The results of this study confirmed that high-level IMs were the main predictors of changes in relational schemas, either measure with dispersion or pervasiveness. This can be considered a main contribution of this dissertation, that the occurrence of micro-narrative events outside the scope of maladaptive framework of meaning, mainly the high-level IMs, are significant predictors of the macro-narratives at the end of psychotherapy. Moreover, the high-level IMs identify several processes (contrast, process, agentive position) that are akin to other mechanisms of change proposed in psychotherapy research. As referred, the mechanisms by which relational schemas change have not been frequently addressed in psychotherapy research. Grenyer and Luborsky (1996) proposed that these changes are due to an increase in clients' sense of mastery, defined as emotional self-control and self-understanding (Grenyer, 1996). This concept can be associated with the development of insight (Castonguay & Hill, 2007), self-reflecting (e.g. Dimaggio, Hermans & Lysaker, 2010) or metacognitive awareness (Badgio, Halperin & Barber, 1999) in psychotherapy. In other words, all these processes are associated with the increase of self-understanding and self-reflecting, processes that allow the further integration of different aspects of the self (Dimaggio et al., 2010).

Limitations and Future Directions

The specific limitations of the studies were addressed in the respective chapters. The common limitations of these studies will be summed up in this section. A frequent limitation of

studies, using time consuming systems of analysis such as the IMCS or the CCRT, is the sample size. The transcription and analysis of the data limit the amount of selected cases, which in turn limits the generalization of the results. Another limitation of the presented studies is the fact that both the CBT and NT subsamples only had one therapist, which could create some unacknowledged effect in these subsamples. The therapist role in changing the relational schemas and elaborating the IMs was also not studied. Although the relational episodes identified to code the CCRT include those with the therapists, this specific subset of data was not analyzed, due to time constraints. Thus, it is not possible to tell if the negotiation of psychotherapeutic relationship (identified in the relational episodes) played a role in the studied phenomena.

Another limitation of the studies that integrate this dissertation is the exclusive focus on the psychotherapy sessions. The use of interviews at pre- and post-test could have enriched the analysis, allowing either the exploration of significant events for the client (e.g. with the change interview, Elliot, Slatick & Urman, 2001) or an assessment of macro-narratives in a more formal way. We also only tested our hypothesis on a single disorder, major depressive disorder. Despite the homogeneity of the results, that allow a rigorous characterization of this psychopathological entity, it would be enriching to have another set of clients to test our assumptions. Finally, another limitation was the use of different outcome measures. The EFT subsample was assessed with the BDI and not the BDI-II because at the time of the study it was the only available version of this measure.

At the end of this work, it is also possible to identify future research directions departing from our results and limitations. One challenge to future research projects on this field is the use of less time consuming designs, in order to include a higher number of participants.

Another future direction is the exploration of the role of narrative changes (either at micro- and macro-narrative levels) in the maintenance of psychotherapeutic gains and relapse prevention. At the same time, the use of the IMs as a psychotherapeutic resource should also be addressed. If the IMs are predictors of relational schemas' change and in turn, these are a key element of recovery, psychotherapists could benefit from learning how to identify potential IMs and elaborate them according to their theoretical background.

Another issue that should be addressed in future studies using the IMCS is the applicability of this system to disorders characterized differently than the ones studied so far. I am referring especially to disorders where the clients narratives are fragmented or disconnected (Dimaggio, Hermans & Lysaker, 2010), like posttraumatic stress disorder or personality

disorders. At the same time, it would also be relevant to explore how these relational events are incorporated and changed in the IMs. In fact, departing from this dissertation a case study is being developed to explore how the relational themes emerge in the IMs and what is their progression throughout psychotherapy, and their relation with the CCRT. Finally, these studies results reinforced the view that relational events are at the core of the way we interpret our life experiences, not in a deterministic way but rather giving the tone to the narrative construction of the self.

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