

# Therapist's theoretical orientation and patients' narrative production. Rogers, Lazarus, Shostrom and Cathy revisited

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## ABSTRACT

This study aimed to explore the influence of the therapist's theoretical orientation on patient's narrative production. Cathy's therapeutic narratives with Carl Rogers, Arnold Lazarus and Everett Shostrom were analyzed in terms of three narrative dimensions: structural coherence, process complexity and content multiplicity. Results showed statistically significant differences in scores of Cathy's total narrative production depending on the therapist she was interacting with. Process complexity was the only narrative dimension that registered statistically significant differences between the three therapists. Comparison between the three therapists showed statistically significant differences between Rogers and Shostrom but neither between Rogers and Lazarus nor between Lazarus and Shostrom. Cathy's highest narrative production scores were obtained with Carl Rogers. Results suggest that the therapist's theoretical orientation influences the patient's narrative production in psychotherapy.

*Key words:* narrative production, psychotherapy process research, therapist theoretical orientation, therapist factors.

## RESUMEN

Este estudio tiene como objetivo explorar la influencia de la orientación teórica del terapeuta sobre la producción narrativa del paciente. La narrativa terapéutica de Cathy con Carl Rogers, Arnold Lazarus and Everett Shostrom fue analizada en términos de tres dimensiones narrativas: coherencia estructural, complejidad del proceso y multiplicidad del contenido. Los resultados muestran diferencias significativas en la producción narrativa total de Cathy obtenida con cada uno de los terapeutas. La complejidad del proceso registró diferencias estadísticas significativas entre los tres terapeutas solamente en la dimensión narrativa. La comparación entre los tres terapeutas mostró diferencias estadísticamente significativas entre Rogers y Shostrom pero no entre Rogers and Lazarus ni entre Lazarus and Shostrom. La puntuación más alta en la producción narrativa de Cathy fue obtenida con Carl Rogers. Los resultados sugieren que la orientación teórica del terapeuta influye en la producción narrativa en psicoterapia.

*Palabras clave:* producción narrativa, proceso de investigación en psicoterapia, orientación teórica del terapeuta, factores del terapeuta.

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The concept of narrative is being increasingly acknowledged as a way to develop a more integrated understanding of the psychological functions. In fact, the narrative emerged as a transtheoretical concept (Moreira, Beutler, & Gonçalves, 2008), including a significant diversity of authors from diverse theoretical orientations, such as psychodynamic (e.g. Book, 2004), experiential (e.g. Greenberg & Angus, 2004), cognitive (e.g. Gonçalves, Henriques, & Machado, 2004) and familiar models (e.g. Anderson & Goolishian, 1992). Several authors have maintained that the narrative is characterized by the way an individual uses their language on the interconnection of the various psychological processes, such as memory, emotion, perception, meanings and narrative functions (Bruner, 2004; Gonçalves, Henriques, & Machado, 2004; Neimeyer, 1995; Nye, 1994; Polkinghorne, 2004; Russell & Bryant, 2004; Russell & Wandrei, 1996; White, 2004).

Recent studies showed that patient's narrative change during psychotherapy is related to therapeutic outcomes (e.g. Deter, Llewellyn, Hardy, Barkham, & Stiles, 2006; Moreira, Beutler, & Gonçalves, 2008). Differences between patients' total narrative production were found at the end of the therapeutic process of patients treated with cognitive, prescriptive and narrative therapies. Good outcome cases presented a higher statistically significant total narrative change than poor outcome cases (Moreira, Beutler, & Gonçalves, 2008).

Other studies on the language processes in psychotherapy have focused on the understanding of the role of the verbal response modes in the therapeutic process. Research has shown that therapists' theoretical orientation influences their attitudes (e.g. Elliot, Hill, Stiles, Friedlander, Mahrer, & Margison, 1987). Studies that have explored how the same patient responded, in terms of verbal response modes, to two different approaches found that the therapists' response modes were marked different one from another, and that were congruent with the therapist theoretical orientation. Besides, clients' verbal response modes were also found to be different accordingly to the therapists' response modes (e.g. Stiles, Shapiro, & Firth-Cozens, 1988).

Although research has shown that the theoretical orientation influences the verbal response modes, both of the therapist and the patient, little is still known about the influence that the therapist's theoretical orientation has on the patient's narrative production.

Therefore, it would be very valuable to explore how the therapist's theoretical orientation influences the patients' narrative production. An ideal methodology to achieve this goal would be to compare the same patient's narratives when interacting with different therapists.

Videotapes produced by Everett L. Shostrom (1966) showing different therapists conducting a therapeutic session with the same client, became classic instruments in psychotherapy process research, due to the possibility of comparing the same patient in interaction with different therapists. These videos have inspired researchers from different theoretical orientations and domains to develop several studies, with the purpose of reaching a better understanding of the therapeutic process. Examples of such studies include analysis of therapist responses (Zimmer & Pepyne, 1971); content analysis (Zimmer & Cowles, 1972); differential perceptions of therapist's behaviour (Barak & Dell, 1977; Barak & Lacross, 1975; LaCrosse & Barak, 1976); therapist's response category system (Hill, Thames, & Rardin, 1979); comparison of the stylistic complexity

of the language of therapist and client (Meara, Shannon, & Pepinsky, 1979); analysis of the interaction processes between client and therapist (Dolliver, Williams, & Gold, 1980); evaluation of the semantic communication and counselling expectations (Meara, Pepinsky, Shannon, & Murray, 1981); analysis of counselors' responses by observers (Gustavson, Cundick, & Lambert, 1981); analysis of the use and convergence of neuro-linguistic programming representational system (Mercier & Johnson, 1984); analysis of client-therapist complementarity (Kiesler, Goldston, & Chesley, 1988); analysis of subjectivity in therapeutic speech (Essig & Russel, 1990); analysis of the therapist's verbal behaviour (Weinrach, 1990); analysis of counselors' responses (Bohart, 1991); analysis of transference and countertransference (Weinrach, 1991); an analysis of patterns of verbal language between Rogers and Gloria (Wickman, 2000); an analysis of how Rogers enacted client-centered conversation with Gloria (Wickman & Campbell, 2003).

The main limitation of these studies relies on the fact that they have focused on specific aspects of the language (e.g., grammatical elements, verbs, themes, response modes), and not on the evaluation of the way the different elements contribute to the patient's narrative coherence, complexity and diversity. This tendency may be explained by the difficulty to conceptualize and operate the language process and its several components in an integrating and comprehensive concept capable of including a greater variety of elements associated with language production (the construction of meanings, the interpretation of events, the interaction and the linguistic expression).

Recently, new methodologies for the evaluation of the different dimensions of patients' narratives have been developed. These assessment instruments have been considered to be adjusted for the evaluation of the different dimensions of the narrative (e.g. Gonçalves, Henriques, Alves, & Soares, 2002; Moreira, Beulter, & Gonçalves, 2008).

The goal of this study was to explore trends and possible differences found in a previous pilot study and to investigate the influence of the therapist's theoretical orientation on the patient narrative production, evaluating narratives in the three narrative dimensions that traditionally have been evaluated separately in patient's narratives (structure, process and content). The hypothesis of this study was that Cathy would present statistically significant differences on her narrative production, depending on the therapist she was interacting with.

## METHOD

### *Participants*

The participant of the study is Cathy, a client interacting with Carl Rogers, Arnold Lazarus and Everett Shostrom, from the videotapes produced by Everett L. Shostrom (1966). The object of our study is Cathy's narratives produced upon the interaction with each therapist. Carl Rogers (Client Centered therapy), Arnold Lazarus (Multimodal therapy) and Everett Shostrom (Actualizing therapy) are the therapists and the founders of the relevant therapeutic models (Shostrom, 1966).

*The Therapists*

*Rogers and the Client-Centered Therapy.* Client-centered therapy suggests that every human being has the potential for self-actualization, as long as the conditions for self-actualization are provided. The necessary and sufficient self-actualization conditions (genuineness, unconditional positive regard and accurate empathy) are contained within the therapeutic relationship. The aim of client-centered therapy is to promote these conditions in the client. The client-centered therapist emphasizes the client's subjective experience, in an acceptance rather than judgement attitude. The therapist genuinely accepts the clients' experiences and point of view. Change occurs when the subjective experience of both patient and therapist promotes the patient's self-actualization. It is expected that the therapist will facilitate the exploration and organization of psychological processes, whilst promoting the client's narrative production.

*Lazarus and the Multimodal Therapy.* Accordingly to Lazarus, human beings are the product of a complex interplay of genetic, social, learning, physical factors and history. This interplay of factors justify that individuals are primarily to representation of stimuli rather than to the stimuli itself. Both personality and psychological disturbances are products of the dynamic relations between multiple factors. Thus, analysis of psychological maladjustment must be made from a comprehensive perspective. Similarly, therapeutic change depends on the comprehensive use of techniques that covers the multiple human functioning domains. The emphasis of the multimodal therapy is the delivering of multiple techniques that should cover the functioning domains needing for intervention. The therapeutic relation is an important instrument, but as an instrument its main goal is to facilitate the techniques' implementation. Unlike Rogers, Lazarus does not share the idea that genuine empathy, therapist congruence and positive regard are the necessary and sufficient conditions for therapeutic change. Accordingly to Lazarus, the therapeutic relationship should obey the universal principals of individual differences. Therefore, the therapeutic relationship must be tailored accordingly to each patient's needs. The therapist's role is characterized by selecting and delivering the therapist's posture and therapeutic techniques accordingly to the patient's characteristics and needs. It is expected that Lazarus will use a variety of techniques, accordingly to the patients' needs (including behavioral, cognitive, psychodynamic, client-centered, etc.) (Lazarus, 1989). Lazarus attitude is expected to be more focused on the techniques and it wouldn't be expected that he would dedicate many efforts on the patient's narrative production promotion.

*Shostrom and the Actualizing Therapy.* Actualizing therapy refers to a therapeutic approach that is assumed by its founder (Shostrom) as being an integrative approach, integrating contributions from different therapeutic models. Assuming that human beings are complex beings, actualizing therapy addresses their multiple dimensions (body, mind and feelings). Each and every human beings needs to have trust in themselves in order to be able to concretize his or her natural tendency: the actualization. Energy released from core conflicts becomes immediately available for growth and creative living (Shostrom & Montgomery, 2001). Psychopathology and psychological disturbances is understood in terms of limited or distorted attempts to actualize, i.e. "when individuals

aren't able to deal with daily life challenges with creative self-expression, interpersonal effectiveness, commitment to values, and choice of one's mission in life" (Shostrom & Montgomery, 2001, p.1). The psychotherapy process consists in promoting individuals' actualizing process. By other words, the therapeutic process goal is to help the patient in replacing survival tactics with actualizing growth responses. The actualizing process, then, consists in aiding the person to become aware of core pain, to express feelings that have being rigidly held back, to experiment with actualizing behaviors, body awareness, and feelings expression on the four polarities, to develop a sense of core trust in being oneself and to use newfound energies for effective and satisfying living. The actualizing process goes through a process that may be facilitated by the use of techniques that are therapeutic tools for facilitating awareness and change such as reflection of feeling, reflection of experience, therapist self-disclosure, interpretation, body awareness and value clarification. As the founders suggest, Actualizing therapy incorporates a creative synthesis from many schools of theory and practice in psychotherapy (Shostrom & Montgomery, 2001), what turns the Actualizing therapy in an eclectic and integrative therapeutic modality. It is expected that Shostrom shares the perspective of Rogers about the need for the individuals' actualization and growth. Although Rogers and Shostrom share the same theoretical point of view of the need of actualization, they tend to use different methods to promote it. Rogers does it primarily based on the therapeutic relationship and the way therapeutic relation gives the patient the necessary but sufficient conditions for their self-actualizing. On the other hand, Shostrom does it making use of techniques of different theoretical models.

In what concerns the three therapists' attitude, it is expected that Rogers will be the one that highlights the importance of the clients' own perspective and client's own potential towards the self-actualizing process (the therapist should only make sure that the therapeutic relationship is given the necessary but sufficient conditions to the individual's self-actualization). Shostrom shares the Rogerian perspective of the individuals' actualization, but he would be more instrumental, implementing techniques from different theoretical models. Lazarus is eclectic like Shostrom, but does not share the emphasis in the actualizing process.

Theoretically, it is expected from Rogers' attitude to be more focused on clients' own exploration and integration oriented, and Lazarus to be the most technique oriented. It is expected from Shostrom's to be more oriented to help Cathy person to become aware of core pain, to express feelings, to experiment with actualizing behaviors, body awareness, and feelings expression on the four polarities. By attempting this, it is expected from Shostrom to be the one more focused on specific topics (such as emotion, sensations, body experiences, etc.).

### *Instruments*

The instruments used to assess each narrative dimension were The Narrative Structural Coherence Coding System, The Process Complexity Coding System and The Content Multiplicity Coding System.

*The Narrative Structural Coherence Coding System* (Gonçalves, Henriques, & Cardoso, 2001) assesses narrative structural coherence, focusing on the way in which different aspects of experience relate to one another, engendering a feeling coherent with one's self. This measure is based on the narrative structure models proposed by Labov and colleagues (Labov & Waletzky, 1967). Structural coherence is assessed according to four subdimensions. Orientation refers to information about the characters and the social context, time and space, and personal characteristics that influence behaviour. Structural sequence is a subdimension that refers to a series of events that are defined by the temporal sequence of an experience at the precise moment it had occurred. Evaluative commitment refers to the degree of the narrator's involvement or dramatic behaviour with the narrative. Integration evaluates and measures the degree of diffusion or integration among various elements or stories in order to produce a meaning that binds the elements or stories together (Gonçalves, Henriques, & Cardoso, 2001). Each dimension is coded using a five point, anchored Likert scale (1= absent or vague; 2= little; 3= moderate; 4= high; 5= very much). The Narrative Structural Coherence Coding System presents a high level of inter-observer fidelity (i.e., 96%) and internal consistency ( $\alpha$  values between .79 and .92) (Gonçalves, Henriques, Alves, & Soares, 2002).

*The Narrative Process Complexity Coding System* (Gonçalves, Henriques, Alves, & Rocha, 2001) assesses narrative process complexity. Process complexity refers to the initial degree of the individual's openness to experience, as shown by the quality, variety and complexity of the narrative process, which is evident at the sensorial, emotional, and cognitive levels and in narrative meanings. Narrative process complexity is assessed according to four subdimensions. Objectifying refers to the presence in the narrative of several sensorial experience elements (e.g. vision, audition, smell, taste and physical sensations). Emotional subjectifying refers to the degree to which the narrative presents various emotional experiences. Cognitive subjectifying concerns the degree to which the client includes and integrates in his or her narrative several elements of his or her cognitive experience. Metaphorizing refers to the range of meta-cognitive elements and meanings present in the narrative (Gonçalves, Henriques, Alves, & Rocha, 2001). Each subdimension is coded using a five point anchored Likert scale (1= absent or vague; 2= little; 3= moderate; 4= high; 5= very much). The Narrative Process Complexity Coding System presents high levels of fidelity among inter-observers (i.e., 89%), and internal consistence ( $\alpha$  values between .66 and .87) (Gonçalves *et al.*, 2002).

*The Narrative Content Multiplicity Coding System* (Gonçalves, Henriques, Soares, & Monteiro, 2001) assesses the degree to which the individual's narratives are characterized by diverse content. Narrative content multiplicity is assessed according to four subdimensions. Subdimension themes concerns the diversity and multiplicity of themes present in the narrative. Events subdimension refers to the diversity and multiplicity of events. Scenario analyses the diversity and multiplicity of scenarios. Characters subdimension evaluates the diversity and multiplicity of characters (Gonçalves, Henriques, Soares, & Monteiro, 2001). Each subdimension is coded, using a five point anchored Likert scale (1= absent or vague; 2= little; 3= moderate; 4= high; 5= very much). The

Narrative Content Multiplicity Coding System presents high levels of inter-observers fidelity (i.e., 94%) and internal consistence ( $\alpha$  values between .86 and .90) (Gonçalves *et al.*, 2002).

Methodological issues in terms of reducing complex interaction phenomena by using anchored, five point Likert scale coding procedures for the evaluation of narrative production in psychotherapy were considered. Although this methodology may reduce complex interaction processes, it was chosen due to the fact that it was the best methodology available for the evaluation of narrative dimensions and subdimensions. In fact, other authors being aware of these methodological limitations recognize that, despite these, there are benefits in using methodologies based on taxonomies and categories. Several studies using these methodologies (as rating scales) have been developed, providing interesting findings and important clues both in the study domain and the study methodology (e.g. Elliot *et al.*, 1987).

### *Procedures*

The therapeutic sessions (the object of analysis of the present study) were transcribed and then coded independently by two pairs of judges according to an inter-judge agreement, for each narrative dimension (structural coherence, process complexity and content multiplicity).

The unit of analysis was the whole session. Therefore, for each narrative subdimension, judges read the entire session transcript and then gave a single, global score for each subdimension.

Each dimension was rated by separate teams of judges (i.e. each narrative was evaluated for the structural dimension by a team of judges, process complexity by another team of judges content multiplicity was rated by another different team of judges).

The judges were psychologists that had 30 hours of training in each coding system. After the initial training, in which the judges were introduced to the coding concepts and methodology, ten therapeutic sessions were evaluated, as a training technique. Ten more therapeutic sessions were distributed and rated in order to evaluate fidelity between judges. Only when the inter-judges agreement was equal or superior to 80% was the pair of judges allowed to initiate the coding of the sessions used in this study. Narratives were then coded by pairs of similarly trained judges presenting high levels of agreement (reliability of rating on the actual sample was superior to 80% agreement). The different therapist-client dyads were evaluated by the same pairs of raters.

### *Data Analysis Procedures*

A statistical analysis of the differences between Cathy's narratives with the three therapists was performed using the binomial expansion test, in order to evaluate how many of the differences between Cathy's narratives with each therapist (Rogers, Shostrom and Lazarus) are in the predicted direction, and if this number of differences is greater than chance. The binomial expansion is a nonparametric test that can be used to calculate the probability of obtaining the observed results by chance. By other

words, the binomial expansion determines the probability of obtaining X outcomes in one category and Y outcomes in the other category. The binomial expansion answers the question "given  $n$  events, what is the probability of obtaining X successes and Y failures by chance?" (Chynweth, Blankinship, & Parker, 1986, p.1). The binomial expansion requires the definition of two categories. The categories used in this study were the existence of differences between Cathy's narratives with Rogers, Lazarus and Shostrom (category 1) and the non existence of differences between Cathy's narratives with Rogers, Lazarus and Shostrom (category 2). Events ( $n$ ) were the total number of comparisons between the therapists in each subdimension. Therefore, the number of comparisons between two therapists in terms of specific narrative dimensions is 4 (the number of subdimensions that are included in each subdimension).

In order to calculate the probability of obtaining differences between the therapists in a given subdimension, the number of events will be 3 (the number of comparisons made between the therapists for a given subdimension). For example, in order to calculate the probability of obtaining differences between the three therapists by chance in the objectifying subdimension, one must consider the total number of events (i.e. comparisons), which are 3: the result of the comparison between Rogers and Lazarus, the result of the comparison between Rogers and Shostrom, and the result of the comparison between Lazarus and Shostrom. Again, consider the case of objectifying. The difference between Cathy's score with Lazarus and Rogers is 0; the difference between Rogers and Shostrom is 1; and the difference between Lazarus and Shostrom is 1. Then, the probability of obtaining differences by change is calculated considering the total number of events ( $n= 3$ ) and the number of reversals ( $r= 1$ ), the probability of obtaining these observed differences by change is .5, which means that we must reject the hypothesis of the existence of statistically significant differences between therapist in what concerns objectifying subdimension. This reasoning is applied to every subdimension. In order to calculate the differences between therapists, not in one subdimension but in a dimension (which is the sum of four subdimensions), the number of events will be the number of the subdimensions (4) multiplied for 3 (the number of comparisons between therapists). The  $n$  would be 12 and  $R$  will be the number of events that did not registered a difference in each comparison. For the total narrative score, the number of events will be the number of subdimensions (12) multiplied by 3 (the number of comparisons) ( $n= 32$ ). The number of reversals is the number of events that did not registered a difference in each comparison.

Comparing differences between two therapists. For a given dimension (which is the sum of four subdimensions) one must consider the  $n$  the total number of events a comparison occurs (for each dimension, it occurs 4 comparisons) ( $n= 4$ ). If the number of reversals is 1, then the probability of obtaining those differences chance is .312, for a  $n= 4$  and a  $r= 1$ , meaning that we can not accept the hypothesis that those differences are statistically significant. For example, in the objectifying subdimension, events ( $n$ ) are the number of times that a comparison between Cathy's narrative with Rogers and Shostrom and Lazarus is made. By other words, if Cathy has a objectifying subdimension score of 2 with Rogers, 1 with Shostrom, and 1 with Lazarus, we will have two events,  $n= 2$  (comparison between Rogers and Shostrom, and difference between Rogers



and Lazarus) and one reversal,  $r= 1$  (no difference between Shostrom and Lazarus), meaning that this result is not statistically significant.

The use of the binomial expansion test was performed as follows:

1. The binomial (the establishment of the two categories) was defined along with the expected direction of the comparison. Category 1 was defined as being the expected direction: the existence of differences from the comparison of Cathy's scores obtained with different therapists. Category 2, or reversal ( $r$ ) was defined as the non existence of differences between the scores obtained with Cathy with different therapists, which is not in the expected direction. For example, the narrative score on a given subdimension in Cathy's narrative with Rogers differs from Cathy's narrative on the same subdimension with Lazarus. If these two scores are different, it would be considered as a category 1 event. If these two scores are not different, it would be considered as a category 2 event, or a reversal ( $r$ ).
2. Each event was evaluated and labelled as category 1 or as category 2 ( $r$ ).
3. Cathy's scores with each one of the three therapists were compared to one another, for each narrative subdimension.
4. Narrative dimensions are calculated by summing the total of events of the four subdimensions.
5. The sum of the events of each one of the binomial allows the calculation of the total of events that were labelled as being category 1 or category 2 were used to calculate the probability of those events be obtaining by change.
6. The probability of obtaining the observed results by change was calculated using the following formula adapted from Kolstoe (1973), which has being widely used on research in psychology and education:

$$p = \sum_{r=0}^r \binom{n}{r(n-r)} (.5^n)$$

Additional analysis were conducted to better understand possible differences and to explore possible trends. The maximum rating for the difference in scores for each of the dimensions and subdimensions was four (4) -the difference between the maximum score which can be attributed (5) and the minimum score which can be attributed (1). Calculation of the percentage in differences of narrative dimensions and subdimensions scores obtained by Cathy with each one of the therapists was calculated as follows. The maximum score Cathy could obtain with each therapist was 5 and the minimum score was 1. The maximum difference rating Cathy could obtain with the three therapists was 4, i.e. the difference between the maximum score of 5 that she could obtain with therapist A and the minimum score of 1 she could obtain with therapist B. The percentage of the difference score obtained between two therapists was calculated via conversion of the difference percentage score. That is, the maximum difference score (5-1= 4) corresponds to 100%. The values of each difference score are calculated using a simple rule in which the maximum difference score ( $md= 4$ ) corresponds to 100% and this allows calculation of the percentage of the existing difference ( $ed$ ). The difference in percentage score obtained with therapist A comparatively with the score obtained with therapist B is calculated using the following formula:  $ed100/md$  ( $md= 4$ ).

## RESULTS

For the total narrative score, results revealed statistically significant differences between the three therapists ( $p= .032$ ). The difference between Cathy's narrative scores obtained with Rogers and Shostrom presented statistically significant differences ( $p= .03$ ), but no differences statistically significant were found between Cathy's narrative scores with Rogers and Lazarus neither between Lazarus and Shostrom. Table 1 presents the scores of Cathy's narratives with Rogers, Lazarus and Shostrom.

When comparing dimensions, only process complexity dimension registered statistically significant differences between the three therapists ( $p= .019$ ). All narrative subdimensions were found not to be statistically significant between the three therapists. Table 2 describes these data.

Besides statistical analysis, trends and possible differences on Cathy's scores accordingly to the therapist she was interacting with were also explored, rather than relying only on statistically significant differences. This allows a better understanding of possible differences, and was justified to the small  $n$  of the sample. This analysis was performed accordingly to the data analysis procedures explained above.

The difference between the average score of Cathy's narrative obtained with Rogers compared with the average scores obtained with Lazarus and with Shostrom is half a point (12.5%), while the average score of Cathy's narrative between Lazarus and Shostrom is the same.

*Table 1.* Scores of Cathy's narratives with Rogers, Lazarus and Shostrom.

Dimension	Sub dimension	Rogers	Lazarus	Shostrom
Structural Coherence	Orientation	3	2	2
	E. Commitment	4	4	5
	Str. Sequence	4	3	3
	Integration	5	4	4
	Total	16	13	14
	Mean	4	3,25	3,5
	<i>SD</i>	0,81	0,95	1,29
Process Complexity	Objectifying	1	1	3
	E. Subjectifying	3	2	4
	C. Subjectifying	3	3	2
	Metaphorizing	5	4	3
	Total	12	10	12
	Mean	3	2,5	3
	<i>SD</i>	1,63	1,29	0,81
Content Multiplicity	Characters	3	2	2
	Scenarios	2	2	1
	Events	3	3	1
	Themes	2	2	2
	Total	10	9	6
	Mean	2,5	2,25	1,5
	<i>SD</i>	0,57	0,5	0,57
Total narrative production	Total	38	32	32
	Mean	3,16	2,66	2,66
	<i>SD</i>	1,19	0,98	1,23

Table 2. Comparison of the narrative scores of Cathy's interaction with Rogers, Shostrom and Lazarus, using the Binomial Expansion test.

Narrative dimensions and subdimensions		Rogers	Rogers	Lazarus	Differences between the three therapists		
		/v/ Lazarus	/v/ Shostrom	/v/ Shostrom	N	R	p
Structural Coherence	Orientation	1	1	0	3	1	.500
	E. Commitment	0	1	1	3	1	.500
	Str. Sequence	1	1	0	3	1	.500
	Integration	1	1	0	3	1	.500
	N	4	4	4	12	4	.194
	R	1	0	3			
	p	.312	.063	.937			
Process Complexity	Objectifying	0	1	1	3	1	.500
	E.Subjectifying	1	1	1	3	0	.125
	C.Subjectifying	0	1	1	3	1	.500
	Metaphorizing	1	1	1	3	0	.125
	N	4	4	4	12	2	.019*
	R	2	0	0			
	p	.687	.063	.063			
Content Multiplicity	Characters	1	1	0	3	1	.500
	Scenarios	0	1	1	3	1	.500
	Events	0	1	1	3	1	.500
	Themes	0	0	0	3	3	1
	N	4	4	4	12	6	.612
	R	3	1	2			
	p	.937	.312	.687			
Total narrative scores	N	12	12	12	36	12	.032*
	R	6	1	5			
	p	.612	.003*	.387			

\*  $p \leq .05$

Table 3 presents the results for the difference in percentage scores for each of the narrative dimensions and subdimensions between the three therapists.

Cathy's scores with Rogers were the highest in the three narrative dimensions, followed by scores with Shostrom in the structural coherence and in the process complexity), whereas in content multiplicity was followed by Lazarus scores. Cathy presented the highest narrative score ( $T= 3.16$ ) with Carl Rogers and a similar score with Lazarus and Shostrom ( $T= 2.66$ ) Structural coherence was the dimension that presented the most differences between therapists. Cathy's narrative score with Lazarus ( $T= 3.25$ ) was below the one obtained with Rogers (.75 points lower, meaning less 18.75%). In orientation, Cathy's narrative with Rogers received a higher score ( $T= 3$ ) than Cathy's narrative with Shostrom and Lazarus, who got the same score ( $T= 2.25\%$  lower than the score obtained with Rogers). Cathy's narrative with Shostrom received the highest score ( $T= 5$ ). In fact, this was the only sub dimension where Cathy's narrative with Shostrom received the maximum score, which was 25% higher than the score obtained in this subdimension by both Cathy's narrative with Rogers and with Lazarus. Regarding structural sequence subdimension, Lazarus and Shostrom presented the same score ( $T= 4$ ), one point (25%) lower than that presented by Cathy's narrative with Rogers. In integration, Cathy's narrative with Rogers received the highest score ( $T= 5$ ), while Cathy's narrative with Lazarus and Cathy's narrative with Shostrom were one point lower ( $T= 4$ , meaning 25% lower).

Table 3. Comparison of percentages between Rogers, Lazarus and Shostrom in Cathys' narrative production.

Dimension	Sub dimension	Rogers		Lazarus		Shostrom	
		/v/	/v/	/v/	/v/	/v/	/v/
		Lazarus	Shostrom	Rogers	Shostrom	Rogers	Lazarus
Structural Coherence	Orientation	-1 (-25%)	1 (25%)	-1 (-25%)	0 (0%)	-1 (-25%)	0 (0%)
	E. Commitment	0 (0%)	-1 (-25%)	0 (0%)	-1 (-25%)	1 (25%)	1 (25%)
	Str. Sequence	1 (25%)	1 (25%)	-1 (-25%)	0 (0%)	-1 (-25%)	0 (0%)
	Integration	1 (25%)	1 (25%)	-1 (-25%)	0 (0%)	-1 (-25%)	0 (0%)
	Total	0.75 (18.75%)	0.50 (12.5%)	-0.75 (-18.75%)	-0.25 (-6.25%)	-0.50 (-12.5%)	0.25 (6.25%)
	Process Complexity	Objectifying	0 (0%)	-2 (-50%)	0 (0%)	-2 (-50%)	2 (50%)
E. Subjectifying		1 (25%)	-1 (-25%)	-1 (-25%)	-2 (-50%)	1 (25%)	2 (50%)
C. Subjectifying		0 (0%)	1 (25%)	0 (0%)	1 (25%)	-1 (-25%)	-1 (-25%)
Metaphorizing		1 (25%)	2 (50%)	-1 (-25%)	1 (25%)	-2 (-50%)	-1 (-25%)
Total		0.5 (12.5%)	0 (0%)	-0.5 (-12.5%)	-0.5 (-12.5%)	0 (0%)	0.5 (12.5%)
Content Multiplicity		Characters	1 (25%)	1 (25%)	-1 (-25%)	0 (0%)	-1 (-25%)
	Scenarios	0 (0%)	1 (25%)	0 (0%)	1 (25%)	-1 (-25%)	-1 (-25%)
	Events	0 (0%)	2 (50%)	0 (0%)	-2 (-50%)	-2 (-50%)	-2 (-50%)
	Themes	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
	Total	0.25 (6.25%)	1 (25%)	-0.25 (-6.25%)	0.75 (18.75%)	-1 (-25%)	-0.75 (-18.75%)
Total narrative production		0.50 (12.5%)	0.50 (12.5%)	-0.50 (-12.5%)	0 (0%)	-0.50 (-12.5%)	0 (0%)

Process complexity was the narrative dimension where the differences in Cathy's narratives with the three therapists were less marked. In fact, Cathy's narrative with Rogers and with Shostrom obtained the same score ( $T=3$ ), half a point higher than that obtained with Lazarus ( $T=2.5$ ). The subdimensions of process complexity showed quite different scores in Cathy's narratives with each therapist. Objectifying showed the lowest score ( $T=1$ ) in Cathy's narratives with Rogers and Lazarus, while with Shostrom it got a higher score ( $T=3$ ), which means that Cathy's narrative production scores in terms of objectifying with Shostrom was 50% higher than the scores obtained with both Rogers and Shostrom. Regarding emotional subjectifying, the score of Cathy's narrative with Shostrom was the highest one ( $T=4$ ), followed by Cathy's narrative with Rogers ( $T=3$ ) and finally, by Cathy's narrative with Lazarus ( $T=2$ ). Cathy's narratives with Rogers and Lazarus got the same score ( $T=3$ ) in the cognitive subjectifying subdimension, 25% higher than that of Cathy's narrative with Shostrom ( $T=2$ ). In metaphorizing, Cathy's narrative with Rogers received the highest score ( $T=5$ ), while Cathy's narrative with Lazarus was one point lower ( $T=4$ ), and Cathy's narrative with Shostrom was two points lower ( $T=3$ ). This reveals a marked difference between Cathy's narratives with

the 3 therapists, namely between that with Rogers and that with Shostrom (50% higher than Shostrom, and 25% higher than Lazarus).

Finally, content multiplicity was the dimension presenting the lowest scores, regardless of the therapist. Cathy's narrative with Rogers was once again the narrative that achieved the highest score ( $T= 2.5$ ), followed by Cathy's narrative with Lazarus ( $T= 2.25$ ) and finally, Cathy's narrative with Shostrom ( $T= 1.5$ ). The difference score between Cathy's narrative with Rogers and the difference score with Shostrom was of one point (25% higher), while the difference score between Cathy's narrative with Rogers and that with Lazarus was somewhat lower (.25, that is 6.25% lower).

In characters sub dimension, Cathy's narrative with Rogers received a higher score ( $T= 3$ ) than Cathy's narrative with Shostrom and Lazarus, who got the same score ( $T= 2$ , 25% lower than the score obtained with Rogers).

Scenarios subdimension got the lowest score ( $T= 1$ ) in Cathy's narrative with Shostrom. Cathy's narrative score with Rogers and Lazarus ( $T= 2$ ) was twice the one obtained with Shostrom. Regarding the events subdimension, there was a marked difference between Cathy's narrative score with Rogers and Lazarus which registered the same value ( $T= 3$ ) and Cathy's narrative scores with Shostrom ( $T= 1$ ), meaning that scores obtained with Shostrom were 50% lower than the scores obtained with the other two therapists. The themes subdimension did not differentiate Cathy's narratives with the three therapists, as it was given the same score in the three narratives ( $T= 2$ ).

It is worth noting that Cathy's narrative with Rogers received a higher score than Cathy's narrative with the two therapists in structural coherence and content multiplicity dimensions and in the process complexity received also a higher score than Lazarus, but this time, presenting the same score obtained by Cathy's narrative with Shostrom. As regards narrative sub dimensions, Cathy's narrative with Rogers registered higher scores than Cathy's narratives with the other two therapists in orientation, structural sequence, integration cognitive subjectifying, metaphorizing, characters and scenarios. Cathy's narrative with Rogers did not registered highest scores than the other therapists in the case of the evaluative commitment, objectifying and emotional subjectifying, which was obtained by Cathy's narrative with Shostrom. By contrast, Cathy's narrative with Rogers only got the lowest score ( $T= 1$ ) in the objectifying subdimension, which was the same score obtained by Lazarus. Cathy's narrative with Lazarus never achieved a higher score than the other two therapists in any subdimension.

## DISCUSSION

Results showed the existence of statistically significant differences on Cathy's total narrative scores, depending on the therapist she was interacting with, as suggested by our hypothesis. Comparing therapist to therapist, statistically significant differences were also found between Cathy's total narrative scores when interacting with Rogers and when she was interacting with Shostrom. Process complexity was the only dimension that registered statistically significant differences between the three therapists. The other two narrative dimensions (structural coherence and content multiplicity) and all narrative subdimensions were found not to be statistically significant between the three therapists.

The fact that different therapists may promote a differential narrative production in the same patient may be explained in light of the therapist's theoretical orientations. In fact, the way each therapist interacted with Cathy was dependent on their theoretical orientation, which naturally interfered with their therapeutic attitudes. Each therapist and every therapist's attitudes becomes in a stimuli to the patient narrative production.

As pointed out earlier, Rogers' attitude throughout the session was characterized by empathy and unconditional acceptance. The unconditional acceptance and empathy of Rogers, valuing Cathy's subjective experience, accepting her point of view, facilitated the narrative production or the organization of psychological processes. Although Rogers and Shostrom share the same point of view of the need of actualization, they tend to use different methods to promote it. Rogers does it primarily based on the therapeutic relationship and by constructing a therapeutic relation that gives the patient the necessary but sufficient conditions for his or her self-actualization. On the other hand, Shostrom promotes the patient self-actualization by implementing a variety of techniques from different theoretical models. The attitude of Rogers offering unconditional acceptance and empathy provides the patient with the opportunity of exploring the different psychological processes in a relatively secure way, which may encourage the patient to explore, to access and to organize his or her different psychological processes. Putting the client in touch with their body experiences, promoting body, emotional, and values awareness, Shostrom implements a therapeutic attitude characterized by a constricted orientation towards specific stimuli considered by the therapist as important to the patient be confronted to. Therefore, the patients may not feel free nor have the opportunity to access to different psychological processes in the same degree as the presence of an attitude of unconditional acceptance would allow them to do. This unconditional acceptance attitude may justify that the process complexity is the only narrative dimension that presents statistically significant differences on Cathy's narrative production between the three therapists. Cathy obtained with Shostrom the higher rates of objectifying and emotional subjectifying, the two narrative subdimensions more linked to the sensory (objectifying) and emotional (emotional subjectifying) elements of the narrative. This may be understood with the attitude of Shostrom of promoting that the patient be confronted with his or her body, resulting on a more incisive narrative production on specific topics such as the body experiences (objectifying) elements and information or stimuli and its integration on the psychological processes (objectifying and emotional subjectifying). The theoretical orientation may help to explain the statistically significant differences found between Cathy's narratives with Rogers and Shostrom. In fact, the Rogerian unconditional acceptance may promote that patient explore different psychological processes throughout the narrative production whilst the attitude of Shostrom is more oriented to certain psychological processes (such sensory, emotions, etc), which does not facilitate the same attitude of exploration which reflects on the narrative production. Lazarus attitude is eclectic like Shostrom, but he does not share the emphasis in the actualizing process. This can explain the reason that Lazarus, although eclectic technique-oriented (as Shostrom) does not emphasizes the clients contact with the body, emotions and values, which may help to understand that there no statistically significant differences were found between Cathy's narratives with Shostrom and with Lazarus.

A recent study that evaluated narrative change in psychotherapy in patients with comorbidity of depression and drug abuse, using the same evaluation instruments used in the present study, found statistically significant differences in narrative change during the therapeutic process between good and bad outcome cases in cognitive, narrative and prescriptive therapies (Moreira, Beutler, & Gonçalves, 2008). It would be very valuable to explore as to whether the differences found in Cathy's narratives accordingly to the therapist she was interacting with, suggesting that the therapist theoretical orientation impacts on the patients narrative production, would be also found in studies using samples from clinical settings, as the study presented above.

Studies that explored the influence of the therapist's theoretical orientation on the verbal response modes found that therapists differ systematically in their verbal interventions, even when they implement a manualized treatment (Stiles, Shapiro, & Firth-Cozens, 1989). By other words, therapists' verbal interventions variance was explained by the therapists' personal variables, and not only by the therapists' theoretical orientation. Other studies found that the theoretical orientation of the therapist and the therapeutic goals and intents has a statistically significant impact on the patients' Verbal Response Modes (Stiles, Shapiro, & Firth-Cozens, 1988). Verbal response modes seemed, then, to be influenced by the therapist personal characteristics. These results emerged from studies focused on the language processes in psychotherapy which are congruent with several various studies that suggest that, for certain dependent variables, a significant proportion the therapeutic outcomes variance is due to the therapist (e.g. Caroll, Connors, Cooney *et al.*, 1988; Crits-Christoph *et al.*, 1991, Luborsky, McLellan, Diguer *et al.* 1997).

Regardless of this study's results, it remains unclear as to whether the differences found on Cathy's narratives are explained by the therapist theoretical orientation, by the therapists' personal characteristics or by the interaction between both of them. Future studies that address this question are needed.

Although the findings of this study seem promising, they should be viewed with caution as generalisations to clinical populations can't be made. Notwithstanding this limitation, this is a study that has important implications for psychotherapy process research. Similarly to prior investigations using videos produced by Shostrom, the findings of this study reinforce the need for further research, namely studies of clinical samples focusing on patients' narrative production in psychotherapy.

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