THE STORY-TELLER, THE STORY AND CHANGE: A NARRATIVE EXPLORATION OF OUTCOME IN BRIEF EXPERIENTIAL TREATMENTS FOR DEPRESSION

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A dissertation submitted to the Faculty of Graduate Studies
in partial fulfilment of the requirements
for the degree of

DOCTOR OF PHILOSOPHY

Graduate Programme in Psychology
York University
Toronto, Ontario

March, 2007

Library and Archives Canada

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395 Wellington Street
Ottawa ON K1A 0N4
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395, rue Wellington
Ottawa ON K1A 0N4
Canada

Your file Votre référence
ISBN: 978-0-494-29328-7
Our file Notre référence
ISBN: 978-0-494-29328-7

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Abstract

Although conceptualizing clinical phenomena in terms of "narrative" has come under the purview of investigators in the psychotherapy research field, few have developed research agendas that include assessing treatment outcome from a narrative approach. Fuelled by the notion that the stories people tell about themselves are essential threads in the fabric of their self-identities, this study presents the first comprehensive investigation of participant post-treatment and follow-up change applying the Narrative Assessment Interview (NAI; Hardtke & Angus, 1998) and it illustrats the rich and meaningful material gleaned from a triangulated methodology.

The NAI was developed for this study to provide a heuristic method to investigate the impact of psychotherapy treatment over time on clients' self-perception and on the aspects of self they wished to change in treatment, as illustrated by their stories. The NAI was administered at baseline, post-treatment and again 6-months following treatment to a sample of 20 participants who took part in a brief-experiential treatment program for depression.

Comparative post-treatment analyses of participants' baseline NAI profiles indicated that the recovered group differed from the non-recovered group along the dimensions of self-perception, treatment goals in terms of desires for self-change, and degree of convergence between how they viewed themselves and how they perceived they were viewed by others. Analyses of participants' post-treatment and follow-up self-stories indicated differing patterns of autobiographical memory subtypes. Results also strongly suggested that those participants who recovered from their depression were able to

solidify gains made in treatment in their stories of change, thereby suggesting that the ability to generate alternative stories may indeed be an important marker of client change and treatment efficacy.

Qualitative analyses of the NAIs of two participants with contrasting outcomes highlighted the value of using a pluralistic approach in the investigation of the clients' experience of change, as well as illustrating the potential utility of the NAI as a tool for both researchers and clinicians.

Dedication

This work is dedicated to my partner, Sharon Armstrong, whose support nurtured this work to completion and with whom I write my story.

Acknowledgements

I was fortunate to have had a dissertation committee composed of three highly skilled academics, whose work has distinguished them within the psychotherapy research community. First, I would like to express my appreciation to my academic supervisor Dr. Lynne Angus, whose style of supervision created an environment in which I had the space to develop my own ideas. Second, I would like to thank Dr. David Rennie, who took an interest in my professional development throughout my time in graduate school. Last, and by no means least, I would like to extend my gratitude to Dr Shake Toukmanian for her caring, thoughtfulness and support. I appreciate that they went that extra mile to help me complete this project.

I would like to thank the participants in the York II Depression Project for sharing their stories with me. Thank you to Mirka Ondrack for her most generous and inspired statistical contributions to this project.

I am grateful for having had the opportunity to solidify relationships with so many intelligent, caring and truly beautiful people during my graduate years, many of whom offered their time and energy to edit my manuscript during its various stages. To those who go unmentioned here, thank you for sharing your spirit with me.

Thank you Heidi Levitt, for your unwavering support and advice. Thank you Esther Olshansky, for helping me get the ball rolling and for your wisdom. Thank you Sandra, for offering your cottage as a weekend retreat to write and to Pavla, Janice and Alberta for making those weekends less about the stress of writing a dissertation and more about the journey we were taking together. Thank you to Jacqui, Steve, Tanya, Bill, Lisa,

Rebecca, Alex, Yifaht, Serene, Shari, Karen, Eilenna, Cathy ,Teri, Beverley, Erin and Mary-Ellen. Thank you to my coders, Jennifer Ellison and Laurie Hollis-Walker, who are friends.

Thanks to my best friend Mary Coates, who tried to understood how much energy it takes to write a dissertation and to her mother, Mrs Coates, who always asked how I was coming along. Thanks to Lauren and Karen for not hanging up the phone on me. Thank you to Alisha for the tennis diversion.

I would like to acknowledge the incredible support the I felt from my colleagues at the CDC, where I have worked in the last years. Special thanks to Polly, Cathie, Jeannine, Adam, Diana , Karen and Cheryl.

Thank you to my brother, Michael, for his support during my early academic years. Thank you to Akasha for making it easier to fly. Thank you to my family, which now includes the Armstrong family - - Marion, Howard, Sharon's children, her brothers and their families and her sister Carol - - for welcoming me into their fold. Herzlichen dank Tante Inge und Onkel Arnold and Ingrid und Claus - - Ich habe es geschaft!

Finally, I would like to thank those in my life who did not see the finished project and whose stories continue to be woven into mine after their deaths - - my mother, my father, Tante Ibby, Becky Ross, Joan Moore, Freud (my cat) and Mary Brown - - you taught me something about the courage to not only write, but to live one's story to its end.

Prologue

Although during the process of conducting this study, analyzing my data and writing this manuscript my topic of interest remained constant, I found myself entertaining questions that could not be served by a purely positivistic approach to methodology. I elected to honour this tension and to explore questions that in hindsight represent methodological pluralism. Therefore, in keeping with the current practice in qualitative research to include a disclosure of one's "horizons of understanding" (Rennie, 1994a), I have included this prologue for three reasons: firstly, to frame my background and experience; secondly, to make explicit for the reader my definition of narrative and its relationship to the individual's sense of self(ves); and thirdly, to make transparent my reasons for adopting a pluralistic methodology.

I have also included an epilogue to this manuscript. As an epilogue to a novel serves the functions to round out and interpret the work, I have allowed myself this space to openly discuss the contributions I feel this study has made to the narrative literature, to consider the efficacy of the interview I co-developed, as well as to reflect upon my experience of embracing a pluralistic methodology in my investigations. An epilogue seemed more fitting for this presentation since it afforded me the opportunity to conclude with my own experience beyond that of a section on future directions.

Background and Experience

I am a product of the Clinical Psychology program at York University, Canada, having completed all my degrees within its department. As a graduate student, I became immersed in Professor Lynne Angus' narrative research program and her team of

graduate students. This was a heady time for a group of young researchers who collaborated on the formulation of ideas, developed tools such as the Narrative Processes Coding System, and conducted empirical investigations, the products of which were presented at numerous conferences and resulted in several published articles. During that time I wore the hat of a scientist, a comfortable hat for a beginning researcher, and as such, my research focus was drawn from a positivistic and quantitative approach to the study of narrative.

My interest in focusing my doctoral dissertation on clients' stories was a natural extension of interpretations I made from my Masters' thesis. Here I found that, regardless of the brief experiential treatment modalities I investigated, participants primarily told their therapists stories about themselves. I subsequently set out to aim my doctoral work at developing a tool that would capture individuals' stories and to then examine whether or not these stories changed following successful treatment for depression. The study was initially intended to be exclusively an exploration of outcome. As such, I began my journey in a way that continued my work within a positivistic paradigm to formulate and subsequently explore my inquiries.

Narrative Defined

Like pearls on a necklace, I consider "narratives," or personally relevant self-stories, to be points of reference on the map of our overall life story. My definition of narratives, or stories, is further clarified by drawing upon a distinction between the term "micro-narrative," used to identify the prose type stories we construct, co-construct and

reconstruct over time (i.e., the who, how, what and when) from the term "macro-narrative", which refers to our overall life-story (Angus & Hardtke, 1994).

I resonate with Hermans' (2005) convictions in his formulation of a dialogical self in his narrative approach in that I believe that the telling of our stories serves two functions: firstly, to inform others about who we perceive ourselves to be; and secondly, to tell ourselves who we believe we are. Hermans (2005) writes: "when clients tell the stories of their lives or significant parts of their lives, they not only tell the story but also listen to the same story...it is precisely this listening which opens the gate to the retelling of the story...clients retell their stories by listening to their own formulations and reformulations" (p.175).

I also adhere to the constructivist view that narratives (or self-relevant stories) involve an interactive coupling between the narrator and his or her world (Maturana & Varela, 1992). I understand this to mean that we have a sense of self(ves) that is reinforced by how we perceive ourselves to exist within and act within our world. Our stories are constructed to illustrate this interaction and act like a biofeedback loop. At any time there are a number of stories that may be constructed to illustrate our sense of self(ves). Again, I resonate with Hermans' (2005) claim indicating that the self is made up of a multitude of authors (or story-tellers) narrating their stories with each voice, or position, telling a story from its own perspective. Moreover, the storied sense of self is constructed and re-constructed when different positions, perspectives, or 'story-tellers' gain or lose their voice.

I believe that dysfunction arises when we, as the story-tellers, find ourselves narrating from one perspective alone. In doing so, we either ignore or are unable to entertain different perspectives, to construct different stories. The construction of our reality/self-perception, or the stories we generate to illustrate our interaction with our world (and therefore who we know ourselves to be), become redundant and repetitive--distilled and overly simplified. Hence the problem-saturated stories indicated by the narrative therapists, White and Epston (1990), who propose that all other accounts, possibilities or stories, besides the problematic one, are "undermined." For example, when depressed, we constrain ourselves to construct stories that reinforce ourselves as depressed. I adhere to the basic assumption of narrative therapy (White & Epston, 1990) that change is the construction of new narratives that challenge and destabilize the problem-saturated one.

It is with these assumptions that I entered into my doctoral work.

Methodology

In my project of exploring clients' stories, together with Professor Angus, I developed the Narrative Assessment Interview (NAI; Hardtke & Angus, 1998). I was given the opportunity to conduct my interview with the participants in the York II Depression Project.

The interview generated a huge amount of data. I began to examine these data through a scientific lens of inquiry (i.e., positivistic) in line with my initial and main goal, which was to discover whether or not participants who recovered from depression disclosed different types of self-stories than their non-recovered counterparts. In line

with my adherence to a constructivist understanding of the self(ves), I was also interested in understanding how my sample of depressed participants viewed themselves and if that shifted or changed after their treatment for depression.

I spent an enormous amount of time and energy immersed in my data, developing and applying classification systems that would allow me to make claims regarding my research questions. I had planned to stop my analyses once these questions were addressed. I experienced, however, a growing desire to take off my positivistic hat and try on another--that of a qualitative researcher. In retrospect, I understand that this tension was fuelled by three influences I experienced during this time: 1) personal communications with, and peripheral mentorship on, epistemology by Professor David Rennie; 2) clinical training in Process Experiential Therapy by Professor Leslie Greenberg; and, 3) clinical practice as a therapist and therapy supervisor at the university's Counselling and Development Centre. These influences fostered an awareness of the importance of not only coding clients' stories, but also the richness of knowledge that emerges when we listen to them. As such, I continued with my analysis of the data to delve further into two participants' experiences of the NAI.

In reconstructing my development as a psychotherapy process researcher, I feel that there has been a constant tension within me between holding an interest in the possibility of delineating characteristics of narrative change on a normative level, while wanting to explore individual change, thereby respecting the uniqueness of an individual's narrative. The reader of this manuscript will conclude that the majority of my analysis was conducted, interpreted and presented under a positivistic methodological approach, while

less space was allowed for the qualitative inquiry. This was by no means a reflection of the weight I give to the two approaches but rather of the pragmatic constraints entailed in being a doctoral student.

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INTRODUCTION

"If you want to know me, then you must know my story, for my story defines who I am. And if I want to know myself, to gain insight into the meaning of my own life, then I, too, must come to know my own story." (McAdams, 1993, p.11)

Goldfried and Wolfe (1996) have described psychotherapy outcome research as having gone through three generations, each generation posing its own particular question, thereby directing its cohort down specific avenues of psychotherapeutic inquiry. In the 1950s and 1960s, the question addressing the first generation of researchers was whether psychotherapy was effective in producing personality change. During the 1970s and 1980s, the question became not whether psychotherapy was effective or not, but rather which specific procedures were more effective in dealing with specific clinical problems. According to Goldfried and Wolfe (1996), the 1980s and the introduction of "clinical trials"--terminology adopted from drug studies--marked the emergence of Generation III. Continuing in the tradition of Generation II, this most recent approach to outcome research focuses primarily on the use of a particular, theoretical approach in the reduction of the symptomatology associated with specific DSM diagnosed disorders (DSM; Diagnostic and Statistical Manual of Mental Disorders, American Psychiatric Association, 1987). These studies are extensive, expensive, and difficult to conduct (Goldfried & Wolfe, 1996).

In response to Seligman's (1995) Consumer Reports Survey of the need for, and the outcome, of psychotherapy and to the widening gap between psychotherapy practice and research, VandenBos (1996) called for the development of "new and expanded outcome measures that assess psychotherapy from multiple perspectives, which are also better

calibrated to actual behavioural functioning" (p.1006). In a special issue of the *American Psychologist*, Goldfried and Wolfe (1996) stated, "we firmly believe that, more than ever before, the time is ripe for us to develop a new outcome research paradigm that involves an active collaboration between researcher and clinician" (p.1007).

One approach that may bear fruit in this quest has been the conceptualization of clinical phenomena in terms of narrative. The concept of narrative has captured the attention of many psychotherapy researchers, as well as practicing clinicians representing a broad spectrum of psychotherapies. The individual as a story-teller, the act of story-telling and the stories individuals tell in therapy currently are considered useful areas of study in the quest to build comprehensive theories of human meaning-making. They also offer a framework to further our understanding of the nature of self-concept and subsequently self-change in psychotherapy.

It has been observed by McLeod (2004) that although the concept of narrative has amassed many suitors, few have ventured into the arena of developing comprehensive research agendas, or controlled outcome studies, which include investigating and documenting psychotherapy outcome from a narrative approach. Within the present day social, cultural, and political context, as there is increasing pressure to illustrate psychotherapy treatment efficacy (McLeod, 1999), as well as to close the gap between research and clinical practice (Goldfried & Wolfe, 1996), steering into this arena seems not only timely, but also a professional necessity.

To date, strategies for documenting and analyzing treatment outcome in depressed client populations continue to rely on, and are subsequently confined to, measures of

symptom reduction. Changes in psychiatric and psychological symptoms in this case are the indices of change. The motivation for the present study was fuelled by the current need to increase our arsenal of tools in an effort to enhance our knowledge of treatment efficacy and sustained recovery from depression, and to close the gap between psychotherapy research and practice.

Convinced that the stories clients tell about themselves are important threads in the fabric of their self-concept, in the present study I explored whether or not clients see themselves differently after they have experienced significant gains in therapy and the degree to which that change is mirrored in the types of stories they generate to describe themselves immediately after treatment and then again at follow-up to treatment. In other words, the question I asked was, are clients who have recovered from their depression able to generate specific personal narratives of change at post-treatment? Furthermore, do clients' abilities to generate specific stories of change influence their prognosis for continued recovery? To this end, a sample of depressed clients was administered the Narrative Assessment Interview (NAI; Hardtke & Angus, 1998), a brief semi-structured interview protocol that was developed for this study to explore and potentially assess client narrative self-change in psychotherapy.

In order to situate the NAI within the current understanding of self in terms of narrative, first an overview of the scope and functions of narrative expression in therapy is presented. A summary of how clients' narratives have been assessed (using both quantitative and qualitative methodologies) within the context of psychotherapy is presented, including a review of the studies on autobiographical memory narratives and

depression. This is followed by a review of key findings from research investigating narrative processes and client change in experiential therapies, using the Narrative Processes Coding System (NPCS; Angus, Hardtke & Levitt, 1996) that guided the development of the NAI protocol. The development of the NAI is presented next, followed by the present study.

NARRATIVE IN PSYCHOTHERAPY: A REVIEW OF THE LITERATURE

Narrative and the Study of Human Nature

In the last two decades, two competing approaches have occupied the main stage of inquiry in the area of psychotherapy research, each characterized by its own philosophy of human nature, and hence, its own methodological strategies of investigation (Ponterotto & Grieger, 1998; Rennie, 1995b; Toukmanian & Rennie, 1992). One approach, with its roots firmly planted in the realm of natural science and holding the epistemological position of foundationalism, is the positivistic, paradigmatic approach to the study of human nature. The positivist approach assumes that a reality exists independent of the observer (Bruner, 1986; Rennie, 1995b; Toukmanian & Rennie, 1992). A subject-object dichotomy is maintained and verification of hypotheses regarding observed phenomena may be taken as evidence of general laws (Elliott, Fischer & Rennie, 1999; Rennie & Toukmanian, 1992). In other words, knowledge is viewed as a process of value-free observation and the accumulation of discrete pieces of evidence. A further assumption woven into the positivist tradition is the view that human beings are passive organisms whose behaviours are reactions to the forces of the environment. Research methodologies in the study of human behaviour incorporated in this deductive, objectivist approach includes quantification, inter-observer agreement on measurement ratings and experimental control (Ponterotto & Grieger, 1998; Rennie & Toukmanian, 1992). Traditional treatment efficacy studies, that track depressive symptoms using the Beck Depression Inventory (BDI; Beck, Ward, Mendelson, Mock, & Erbaugh, 1961), exemplify a methodology under the umbrella of this approach.

The second approach is represented by an increasing number of researchers who question the ability of the positivist approach to capture the complexity of human nature. Approaches emerging to challenge the positivist world view share a number of assumptions. For example, they view the world as a relativistic and dynamic gestalt that must be actively construed in order to be understood. Context and the role of internationality in action (Levitt & Rennie, 2004; Toukmanian & Rennie, 1992), as well as the co-constructed nature of experience are emphasized (Angus & Hardtke, 1994; Angus & Rennie, 1989; Bruner, 2004; McLeod, 2004). The process of knowledge creation involves construction, re-construction and co-construction of personal and social meanings. A commonality among these approaches is that there exists no ultimate truth, and that human beings are proactive and future-oriented.

From a relativistic perspective, the concept of "narrative" has been used to represent a vehicle for how human beings make meaning of their experience. For example, referring to the seminal work of Bruner (1986), "narrative" represents a distinct "way of knowing" and is specific to each individual. Unlike the positivistic, paradigmatic explanation, which is deductive, demonstrative and quantitative, narrative explanation is inductive, hermeneutical and qualitative (Toukmanian & Rennie, 1992).

Drawing heavily on Kelly's work (1955), constructivism posits that personal meaning is derived from a number of sources including personal experiences, the social environment in which one lives, physical maturation and the schemas that evolve through one's developmental process (Polkinghorne, 2004). According to this approach, a self exists apart from the context in which we live and is central to the construction of one's

meaning system. For the constructivists, narratives involve an interactive coupling between the narrator and the world (Maturana & Varela, 1992). "This view is opposed to the dogma of immaculate perception, in which reality, untainted by bias or desire, bears forth information, and to the radical subjectivism in which knowledge springs forth from the mind of the observer, like Athena from the brow of Zeus" (Vogel, 1994, p. 245).

A cornerstone of the social constructionist approach is the idea that the generation of meaning is not solely personal, but rather is derived from the language, social systems, culture and tradition in which one lives (McLeod, 2004; Polkinghorne, 2004). According to McLeod (2004), "we construct--socially, together, through history--what we define as "real" and "true" (p. 325). Adherents of a social constructionist approach focus on the social embeddedness of human knowledge, criticizing, for example, both phenomenological and behavioural conceptions of the self, which, according to this view, strip the self of its socio-historical context (Gergen, 1985).

The role and function of narratives are being debated in the psychotherapy research community. Some authors have elected to define narrative as the stories told in the context of the therapy hour, while others argue that this definition precludes the primary role of narrative, namely, to capture the dynamic nature of an individual's development of an overall perspective, or sense of self. Before turning to a review of this literature and the research representing the various definitions of narrative, as well as different methodological investigations, the following section briefly acknowledges that an entire therapeutic approach has been built on the foundation of narrative and outlines this approach's mechanisms of change.

Narrative Therapy and Client Change

According to White and Epston (1990), people begin to experience problems for which they frequently seek therapy "when the narratives in which they are storying their experience, and/or which they are having their experience "storied" by others, do not sufficiently represent their lived experience, and that, in these circumstances, there will be significant aspects of their lived experience that contradict these dominant narratives" (p. 14). Although a sense of meaning and continuity is achieved through the storying of experience, it is gained at a price because our lived experience is richer than discourse (White & Epston, 1990). "Narrative structures organize and give meaning to experience, but there are always feelings and lived experiences not fully encompassed by the dominant story" (Bruner, 1986a, p.143, as cited in White & Epston, 1990).

Given the gaps between narrative structure and experience, therapy offers the individual the opportunity to re-author his or her life narrative, or macro-narrative, by identifying events, feelings, intentions and thoughts that currently fall outside the dominant narrative. The therapeutic process becomes a vehicle for the generation of alternative stories that incorporate vital and previously neglected aspects of individuals' lived experience (White & Epston, 1990). "When persons seek therapy, an acceptable outcome would be the identification or generation of alternative stories that enable them to perform new meanings, bringing them desired possibilities--new meanings that persons will experience as more helpful, satisfying and open-ended" (White & Epston, 1990, p. 15). The identification of unique personal outcome stories that challenge and destabilize problem-saturated macro-narrative plots is viewed as a key strategy to offer

new ways of seeing and valuing the self-in-the-world relation to others, and to establish alternative narrative plots that facilitate desired outcomes in life.

Representing a constructivist approach, Efran (1994) offers two modes through which psychotherapy can facilitate change. In the first case, therapists may offer their clients new stories, or understandings of their stories. Efran (1994) notes, however, that this approach does little to shed light on the nature of the assumptions held by the individual. A second mode through which psychotherapy may facilitate change is to introduce therapeutic interactions that are "orthogonal" to a client's usual interactions. In this case, the therapist models a different way of reflecting, selecting and deflecting experience. "It is as if the client can temporarily borrow the therapist's 'eyes', becoming a guest or stranger in his or her own life" (Efran, 1994, p. 222). Efran (1994) proposes that this process of "orthogonal interaction", a process coined by Maturana (1988), not only changes a person's structure, but also the person's relations with others. "When a person 'returns from abroad', those back home are always forced to accommodate...indeed a person can't go home again - that is, be the same at home as before. Besides, those at home have changed, and the person's return is likely to upset a number of interpersonal apple carts" (Efran, Lukens, & Lukens, 1990, as cited in Efran, 1994, p. 223).

Representing a social constructionist approach, McLeod (2004) claims that what changes in therapy are not the individual's symptoms, but rather the stories told by the person and the ways in which these stories can be used by the person to enable membership inclusion and engagement in meaningful action.

Do We Make Stories or Do Stories Make Us?

Assessing Client Narratives in Psychotherapy

We Make Stories

To date, most psychotherapy researchers have elected to define "narrative" as the description of personal events or stories that are told in the context of the therapy hour. As a result, much of the empirical research has defined 'narrative' as the external description of events or stories (Luborsky, Barber & Diguer, 1992; Luborsky & Crits-Cristoph, 1990; Luborsky, Popp, Luborsky & Mark, 1995; Rennie, 1994b). Utilizing this definition, narratives, or stories, are viewed as having definable boundaries in the therapy discourse. They can be identified as discrete units of text, or transcript, which can be decontextualized from the session for more intensive analysis. Moreover, several different narratives, or stories, may be told within the context of a single therapy session.

Luborsky and his colleagues have developed the Core Conflictual Relationship Theme (CCRT; Luborsky & Crits-Cristoph, 1990) in order to systematically examine the relationship between a client's stories and recurring behavioural patterns in brief psychodynamic therapy. The formulation of the CCRT from a client's narratives involves two phases. The first phase requires the rater to locate and identify relationship episodes. A relationship episode is defined as "a part of a session in which there is a clear narrative about relationships with others or at times even with the self" (Luborsky et al., 1990, p. 173). Similar to the plot of a written story, relationship episodes are typically defined as having a beginning, middle and end. Relationship episodes are evaluated for completeness during the initial phase of the CCRT method. Only those

relationship episodes judged as sufficiently detailed are selected and extracted from the therapy session transcript for further analysis. During phase two, a CCRT judge scores these relationship episodes in order to formulate the client's Core Conflictual Relationship Theme (CCRT). The three components of a client's CCRT include what the person wished for or wanted in the interpersonal context as indicated by the relationship episode, as well as the anticipated response from the other should the wish or want be acted upon. The third component of the client's CCRT is a delineation of how the client actually reacted.

The CCRT method is the most widely used and tested instrument developed within a psychoanalytic context for assessing relationship patterns or characteristic patterns of relating to others (Weinryb, Barber, Foltz, Goeransson, & Gustavsson, 2000). Since its inception, the CCRT method has stimulated the development of a host of related measures, most recently the Central Relationship Questionnaire (Luborsky, 2000) which is based on two alternative sources of narratives: narratives told during psychotherapy, and narratives told on request during the Relationship Anecdotes Paradigms interview.

Book (2004) recently illustrated the therapeutic applications of working with the CCRT within the context of dynamic therapy. This investigator maintains that the development of a client's CCRT during the assessment phase of treatment provides the arena in which the goals of psychodynamic psychotherapy may be realized. He wrote, "The CCRT approach in psychodynamic psychotherapy enables clinicians to identify, conceptualize, address and resolve transference distortions, repetition compulsions, and

compromise solutions...this process results in a decrease in symptoms and, in many cases, a promotion of positive personality growth" (Book, 2004, p. 83).

Rennie (1994b) intensively explored clients' experiences of story-telling within the context of a single therapy hour. Using the Interpersonal Process Recall procedure (IPR; Kagan, 1975), he conducted a grounded theory analysis (Glaser & Strauss, 1967) of the first person accounts of his research participants. In light of this analysis, Rennie conceptualized that, for all participants, the activity of telling a story was cathartic, while serving as a way of keeping distant, at least initially, from an inner disturbance. Within this general experience, however, some participants had the additional intention of getting in touch with the disturbance, whereas others used stories to defensively manage their beliefs about the inner disturbance. Finally, the story-teller often came to a new realization while telling the story, and thus underwent a therapeutic experience, regardless of the nature of the secondary intention motivating the story.

Building upon the foundation of a cognitive-constructivist model, Goncalves, Henriques and Machado (2004) also elected to focus on paradigmatic client narratives in their exploration of problem-focus and the construal of self in terms of narrative. Goncalves and his colleagues, however, broadly conceptualized the role and functions of narrative. In their "Cognitive Narrative Psychotherapeutic Approach", a complete short-term psychotherapy is focused on successive stages of narrative reconstruction. According to Goncalves, Korman and Angus (2000), therapeutic change corresponds to the progressive acquisition of a narrative attitude. This narrative attitude is characterized

by a variety of processes that allow clients to creatively and proactively introduce more flexibility to their narratives.

Goncalves and his colleagues (2004) identified five central narrative processes that are fundamental to an increase in the quality and diversity of each narrative: recalling, objectifying, subjectifying, metaphorizing and projecting. The therapeutic process is organized around the development of each of these attitudes as they apply to individuals' stories (or micro-narratives) and subsequently to the individuals' life experience (or macro-narratives). At each of these five stages, two distinct--although complementary--types of work are carried out. At the synchronic level (i.e., level of story generation), the therapy dyad applies the narrative attitudes to current life experiences, thus enabling the client to explore and deal with some immediate, symptomatic concerns. At the diachronic level, the dyad applies the narrative attitudes learned from each stage to the central themes of the client's life experience. According to Goncalves, working through these stages enables clients to achieve a more coherent, meaningful and diverse macro-narrative, by elaborating and learning to view their micro-narratives from a number of different perspectives (Goncalves & Machado, 1999).

Goncalves and colleagues (Goncalves, Alves, Soares & Duarte, 1996, as cited in Goncalves et. al. 2000; Goncalves & Machado, 1999) collected stories describing significant life events from individuals with different psychological dysfunctions and constructed a prototype narrative for each dysfunction using a grounded theory analytic procedure. Researchers then introduced these prototype narratives to both a clinical sample for each of the several diagnoses and to a control sample, and subsequently asked

these groups to evaluate the degree to which each prototype narrative related to their personal lives. Results indicated that each diagnostic sample evaluated the prototype narrative, constructed from the initial diagnostic group representing their dysfunction, as significantly more related to their lives than the control sample did. Goncalves and colleagues interpreted these results as support for the proposition that individuals with deteriorated psychological functioning seem to experience their lives as a continuous and vicious repetition of a single script and that these scripts could be differentiated amongst differing psychological dysfunctions.

Goncalves, Henriques, Alves and Soares (2002) elicited two different types of personal narratives, the *zenith* narrative (i.e., successful life narrative) and the *nadir* narrative (i.e., unsuccessful life narrative) from 40 patients diagnosed with agoraphobia. According to these authors, their research constituted a first effort to test the possibilities of three rating systems to evaluate narrative structure, process and content in psychological disorders. Results of their multi-pronged approach to exploring patients' narratives indicated that the rating systems used in their study indicated good inter-coder reliability and good internal consistency, as well as efficacy in discriminating the narratives generated by these patients with agoraphobia in terms of narrative structure, process and outcome.

Similar to the avenues of inquiry travelled by Goncalves and his colleagues, Dimaggio and Semerari (2001, 2004) have offered a classification of criteria that might distinguish an effective narrative, or story, from a dysfunctional one. In their investigation of the various types of stories disclosed during psychotherapy, the authors

first delineate qualities of a 'good narrative', which include: putting events in a space-time sequence; defining inner states; accessing one's own thoughts and emotions; giving the listener the means to get to know them better; and, having the capacity to handle multiple stories, to navigate the waters of interpersonal and intrapersonal change (Dimaggio & Semerari, 2001). In the same article (p. 22), they suggest that "the effect of a good narrative is to integrate bodily experience, the construction of meanings, and interpersonal relations."

In addition, they summarize schematically the various categories of narrative dysfunction--ways in which story-telling during therapy fails to meet the objectives of communicating knowledge to another person and of building the foundation of an agreed-upon text for building meanings and for solving problems. The researchers present two main categories that describe different forms of narrative disruption, with each category subsuming various subcategories that they have conceptualized in light of their examination of clients' stories. The first main category, which they call "Impoverished Narratives", is divided into two subcategories: 1) Deficit in Narrative Production and, 2) Alexithymical Narratives. The second main category entitled "Integration Deficit" is divided into the following four subcategories: 1) Basic Integration Deficit, 2) Deficit in Integration Between Multiple Self-Other Representations, 3) Overproduction of Narratives and Deficit in Hierarchization and, 4) Deficit in Attribution to the Correct Mental Function and Deficit in Distinction Between Reality and Fantasy (Dimaggio & Semerari, 2001). According to Dimaggio and Semerari (2001), it is difficult for story-tellers to decipher their own subjective experience or to move around in the world of

relationships. Markers identifying various forms of narrative dysfunction may subsequently be used to direct therapy towards specific interventions and provide researchers with a framework to track potential gains across treatment (Dimaggio & Semerari, 2001).

Although narrative, conceptualized by these researchers as the external description of events or stories, appears to have emerged as a useful heuristic in the area of narrative research, its representation seems to preclude a dynamic conceptualization of narrative reconstruction and change. The next section summarizes narrative research that has attempted to capture the dynamic nature of narrative construction and reconstruction by defining narrative differently.

Narrative Identity and Assessment

Our Stories Make Us

Like the pearls on a necklace, a client's personal stories can also be viewed as points along a continuum of the client's overall life story. Here personality researchers and clinicians have conceptualized narrative to refer to clients' development of an overall perspective, or sense of self, in which discrete events are placed in a temporal sequence and are meaningfully organized along a set of intrapersonal and interpersonal themes (Angus, Levitt & Hardtke, 1999; Baumeister & Newman, 1994; Bruner, 1986; Gergen & Gergen, 1983; Howard, 1991; McAdams, 1993; McAdams, Diamond, de St. Aubin & Mansfield, 1997; McLeod & Balamoutsou, 1996; Polkinghorne, 1988; Sarbin, 1986; Spence, 1982; White & Epston, 1990).

For example, Singer and Salovey (1993) have proposed that each individual has a unique collection of autobiographical memories and that taken together, these unique individual memories may be examined to generate insight into how persons define themselves. According to Singer and Salovey (1993), a self-defining memory is one that is "vivid, affectively charged, repetitive, linked to other related memories, and related to an important unresolved theme or enduring concern in an individual's life" (p. 13).

White and Epston (1990) have proposed that "the success of this storying of experience provides persons with a sense of continuity and meaning in their lives, and this is relied upon for the ordering of daily lives and for the interpretation of further experiences" (p. 10). Of like mind yet representing a constructivist approach, Vogel (1994) writes "narrative, seen as an activity, is the representation of the flow of events in a meaningful sequence" (p. 244). Without narration, argues Vogel (1994), there is no meaningful depiction of change over time and life is, as he recalls a teacher once saying, "just one damn thing after another" (p. 244).

Drawing upon the work of Baumeister and Newman (1994), Angus & Hardtke (1994) proposed that the term "micro-narrative" be used to identify the prose-type stories told in the therapy hour while the term "macro-narrative" be used to refer to the client's life story, which is implicitly and explicitly reconstructed over the entire course of the therapy relationship (Spence, 1982). The "macro-narrative", then, may be seen as analogous to an ongoing oral autobiography. It is the unfolding, co-constructed story of what people experience, how people feel and what people think. In essence, each chapter of the individual's "macro-narrative", or life story, may be viewed as being comprised of

"micro-narratives", of distinct, sequential events and the subjective experience and interpretation of those particular events. Furthermore, the thematic ordering of the client's "micro-narratives" may be viewed as a key factor in the structure of the overall "macro-narrative."

Attempts to conduct empirical investigations capturing the dynamic conceptualization of narrative reconstruction and self-change have proven an interesting challenge for researchers. Neimeyer (1994) notes the difficulty in analyzing narratives within the therapy discourse: "...attempting to specify the particular value of client-generated narratives in therapy is difficult not only because of the generality of the concept of narrative, but also because of the uniqueness of the each client's narrative production" (p. 239). Recognizing, however, the importance of narrative reconstruction, Neimeyer (1994) invited his colleagues to participate further in this area of research. The next section describes several creative and interesting interview protocols, which are emerging in the literature, designed to capture peoples' sense of their life stories.

Narrative interview protocols. McLeod and Balamoutsou (1995) have developed a pre-therapy narrative assessment protocol, which includes four individual writing tasks. "Writing Task 1" asks participants to devote at least three hours towards writing an autobiographical statement, or autobiography, covering their lifespan from birth to the present. Although participants are free to develop this task in any way that seems meaningful to them, instructions suggest that it would be helpful if participants could divide their lives into chapters, with each chapter focussing on a different stage. In the spirit of the Thematic Apperception Test (Murray, 1943), "Writing Task 2" asks

participants to respond to the following five questions: 1) what is your favourite fairy tale, book, short story, play, film or television program? 2) Why do you like this particular story? 3) Give a brief summary of the story, in your own words. 4) Who is your favourite character in the story? 5) Why do you like this character so much? The third task in McLeod and Balamoutsou's narrative protocol asks participants to articulate their hopes, fears and expectations regarding the counselling journey upon which they are about to embark. Finally, "Writing Task 4" asks a participant to share with the researcher how the writing tasks affected them and what, if anything, they have learned about themselves, having completed the narrative protocol.

Goncalves' (1997) Identity Interview is a structured narrative interview protocol, which asks participants to explore a number of aspects of themselves by asking them to remember several episodes in their lives and to recall these episodes as if they were watching a movie of their lives. During this interview, participants, together with the researcher, write the script of their lives with particular emphasis on those episodes participants feel are most representative of themselves. In doing so, the dyad builds upon the participant's core themes of self, linking past with present.

McAdams' (1995) Life Story Interview is also a structured narrative interview protocol that asks participants to use the metaphor of an autobiography to describe various facets of their experience of self. The first section of the interview protocol, entitled 'Life Chapters', asks participants to think about their life as a story; complete with characters, scenes, plots and so forth. In this first section, participants are asked to name and provide an outline of each of the main chapters in their lives. The second

section of the interview asks participants to describe specific moments in their life stories that stand out as significant. In this second section, entitled 'Critical Events', participants are encouraged to describe peak experiences, low points, turning points, earliest memories, important childhood events, as well as important adolescent and adult memories. The third section of the interview asks participants the single greatest challenge they feel they have had to face and how that challenge was met. The interview then proceeds to ask participants to describe both positive and negative influences on their life stories, as well as how other stories from various media (i.e., books, films, and television) have influenced them. The interview then shifts to a future tense by asking participants to imagine two different futures to their life story--one positive and one negative. Finally, participants are asked a number of questions regarding their fundamental beliefs and values. The interview ends with each participant being asked to consider his or her life story and to discern a central theme that runs through the past, present and future of it.

Building upon the premise that psychotherapy may be seen as a quest for clients to make sense of themselves and their histories (Siegelman, 1990, as cited in Levitt, Korman & Angus, 2000), Levitt, Korman and Angus (2000) proposed that this process of exploring and reconstructing a life story may be seen in clients' search for more coherent and encompassing personal metaphors. Specifically, these authors examined the use of "burden" metaphors and their relation to the experience of depression in one good and one poor outcome process experiential short-term psychotherapy dyad (Levitt et al., 2000). In their study, metaphors were identified as either having a "burdened" (e.g., "My

heart feels heavy") or "unloading" (e.g., "The pressure has lifted") quality (Levitt et al., 2000, p. 29). Furthermore, these authors incorporated the Client Experiencing Scale (Klein, Matheiu, Gendlin, & Kiesler, 1986), as well as the Narrative Processes Coding System (Angus, Hardtke, & Levitt, 1993) into their study's design in order to examine the potential processes at play when burden-metaphors were used in good and poor outcome therapies. Results from this study suggested that metaphors in the good outcome therapy were found to evolve from an emphasis placed on the experience of 'carrying a burden' in the initial sessions to the experience of 'unloading the burden' in later sessions (Levitt et al., 2000; Korman, 1995; Korman & Angus, under review). No such pattern was evidenced in the poor outcome therapy dyad examined in this study. Results from this comparative outcome study also suggested that in the good outcome therapy, 'burden' metaphors were used when the client was attuned to her emotional state (i.e., as indicated by higher levels of experiencing according to the Client Experiencing Scale ratings and internal processing according to Narrative Processes Coding System coding). In contrast, metaphors in the poor outcome therapy dyad were most frequently used during the process of external story-telling or for illustrative purposes (i.e., as indicated by lower levels of experiencing and external processing).

Despite this emerging literature of interview protocols designed to capture peoples' sense of their life stories, the question not yet addressed has to do with what this narrative change may look like, or sound like, at post-treatment, in comparison with before treatment interviews. Moreover, although valuable in their efforts to establish methods to elicit life stories, to examine features of functional versus non-functional narratives and

to explore themes emerging in life narratives, the above-presented interview protocols are monological and standardized, in the interest of a positivistic approach to research. As such, they do not assess the co-constructive nature of narrative expression that is fundamental to the therapeutic discourse and that can be captured by an interactive interview. It appears that clinicians would benefit from a brief, interactive interview protocol grounded in research, yet one that they may easily draw upon to access therapeutic movement and change.

The next section presents a review of the various types of autobiographical memory narratives that individuals recall when engaged in story-telling, thereby establishing the different sources from which the present study's tributaries of inquiry eventually flow.

Depression and Autobiographical Memory Narrative

The Types of Stories the Story-Teller Tells

Research on autobiographical memory narratives and psychological disorders, in particular depression, has developed from a number of perspectives. The trunk of research from which numerous branches of study have extended involves assessing types of autobiographical memory narratives generated using the Autobiographical Memory Test (AMT: Williams and Broadbent, 1986). In this paradigm, originally developed by Williams and Broadbent (1986), two types of autobiographical memory narratives were defined. The first type, the 'specific' autobiographical memory (ABM), was defined as the report of a single-event that takes place at a particular time and place and <u>does not last longer than a day</u> (e.g., I remember the day I defended my doctoral dissertation). In contrast, the second type, the 'over-general' ABM, which was subdivided into two

subtypes, included: 1) the 'categorical' ABM; and 2) the 'extended' ABM. The categorical ABM was defined as a summary of many events blended together (e.g., I remember the Sunday afternoons I spent writing my doctoral dissertation). The 'extended memory' was defined as events that lasted longer than one day, as required to be coded as a 'specific' ABM and included a series of events (e.g., the time I went to university). According to Williams (1996), categorical and extended memories were functionally independent of each other. "People who tend to respond with categoric memories do not also tend to give extended memories; cues that tend to elicit more categoric memories do not also produce more extended memories; and categoric and extended memories have significantly different associations with a range of memory variables such as the period from which events are recalled, the frequency, the emotionality, and the valence of the events (Williams, 1996, p. 259).

As the field of ABM research has grown, there has also grown some overlap of terminology. Before summarising the research on ABM and depression, I will briefly address this issue, with particular attention to the terminology used via the application of the AMT and the categories of Singer and Moffitt's (1992) Scoring System for Memory Narrative Type that was used in the present study.

The ABM categories of the AMT (Williams & Broadbent, 1986) appear to dovetail with those presented by Singer and Moffitt (1992), which were used to code ABM type in the present study. Specifically, Williams and Broadbent's (1986) definition of a 'specific' ABM mirrors the definition of a single-event ABM from Singer and Moffitt's (1992) coding system. Williams and Broadbent's (1986) second type, the 'over-general

ABM', appears to mirror the 'summary ABM' type presented by Singer and Moffitt (1992), with the 'categorical ABM' and 'extended ABM' (Williams & Broadbent, 1986) similar to the generic and eventless ABM. (Singer & Moffitt, 1992). (See Table 1 summarising the overlapping terminology used in differentiating ABMs by these researchers that may be used as a reference when reading through the following literature review of depression and ABM type)

Table 1

Autobiographical Narrative Memory Subtype Terminology: Williams and Broadbent (1986) versus Singer and Moffitt (1992)

Autobiographical Memory Test (AMT: Williams & Broadbent, 1986)		A Scoring Manual for Memory Narrative Type (Singer & Moffitt, 1992)
specific ABM	⇔	single-event ABM
over-general ABM	⇔	summary ABM
categorical ABM		generic ABM
extended ABM		eventless ABM

Research into ABM subtype has been informed primarily by studies using cue-word paradigms. For example, using the Autobiographical Memory Test (AMT: Williams & Broadbent, 1986), early studies by Williams and his colleagues demonstrated that depressed psychiatric patients (Williams & Scott, 1988) and suicide attempters (Williams & Broadbent, 1986) differed from controls in their capacity to recall and orally relate specific ABMs to positive events. Presented with positive cue words (e.g., happy or safe) and asked to recall specific ABMs, depressed patients in these studies responded with significantly more over-general ABMs than the controls and required additional prompting from the experimenter to be able to respond with specific ABMs. Results from these studies indicated negligible difference between depressed persons and controls when recalling ABMs in response to negative cue words (for example, 'angry' or 'lonely'). Furthermore, Williams (1996) reported on a re-evaluation of an earlier study

he conducted (Williams & Dritschel, 1988), noting that "the increased over-generality in the clinical group was wholly attributable to the excess of categoric errors" (p. 260).

Extending the ABM research to written narratives, Moffitt, Singer, Nelligan Carlson, and Vyse (1994) collected written ABMs from 90 non-clinical college students whose mood was assessed for depression. Using Singer and Moffitt's (1992) scoring system to distinguish between summary and single-event ABMs, these researchers also reported that participants with higher depression scores recalled significantly more summary ABMs in response to a request for a positive memory than did participants with lower depression scores. Again, mirroring the findings of the earlier William's et al. studies, Moffitt et al. (1994) reported no significant differences in the number of single-event and summary ABMs when participants were asked for a negative memory. In summary, research suggests that when depressed, people find it difficult to generate specific (i.e., single-event) positive ABMs.

Several hypotheses have been forwarded to account for depressed people's inability to generate positive specific or single-event ABMs. Carver, Ganellen and Behar-Mitrani (1985), for example, proposed that these results reflect the cognitive distortions evidenced in depressed clients, with overgeneralization being the most central. Much of the psychological research about cognitive biases in depression has of course been stimulated by Aaron Beck's cognitive theory of depression (Beck, Rush, Shaw, & Emery, 1979). According to Beck's theory, depression is characterized by autobiographical memory biases toward negative, self-relevant information.

Williams, Healy and Ellis (1999) proposed that the production of an ABM in a hierarchically organized memory system is aborted by depressed people, who stop and produce over-general descriptions of memories, thereby curtailing their access and subsequent ability to generate a specific exemplar. Williams (1996) has refined his memory search theory to account for the predominance of categoric ABMs found in studies of participants with depression by coining the term "mnemonic interlock", in which he argues "that the retrieval becomes deadlocked following the category description stage because of the tendency for an initial, self-referent categoric description to elicit other highly activated self-descriptions, so that retrieval moves across the hierarchy rather than down to more specific levels" (p. 245).

The findings from Moore, Watts and Williams (1988) suggest that depression is associated with a bias towards negative experiences. Although the cognitions of people with depression are likely to be dominated by relatively abstract representations of the past, "in the case of general negative memories, subsequent retrieval of specific negative instances is relatively easy, enhancing the realism of the abstract negative representations" (p. 276). General, positive ABMs are likely unsupported by specific ABMs that could provide evidence for them and as such are recalled less frequently and with more difficulty (Moore et al., 1988).

Researchers have also suggested that the tendency to narrate over-general ABMs may serve as a protective function, warding the story-teller off from negative emotional experiences associated with specific past events in his or her life (Singer and Salovey, 1993). According to Bruhn (1984), unpleasant feelings emerging from the elicitation of

specific ABMs may be warded off by collapsing several distinct memories into an over-general ABM, particularly if one is prone to avoiding negative emotion. Furthering this argument, Williams et al. (1999) suggest that although over-general ABMs have their own emotional consequences, these emotions are less-focused, secondary emotions (Greenberg & Safran, 1987). As a result, recalling over-general ABMs protects the story-teller from the emotional intensity associated with retelling specific ABMs.

An important aspect in autobiographical narrative memory research is the question of whether the types of ABMs recalled vary concomitantly with the affective state or remain stable over time. In other words, are the types of ABMs, recalled by participants in these studies, a function of the individual (i.e., a trait or stable cognitive style) or a function of their depression (i.e., a state influenced by mood)? In a 7-month follow-up investigation of ABM in major depression, Brittlebank, Scott, Williams and Ferrier (1993) reported that ABM scores did not change during remission and that failure to recover from depression was predicted by the tendency towards over-general ABM recall at initial assessment. According to these researchers, the tendency towards over-generality was more a product of a way of being in the world rather than a manifestation of their depression. In other words, these researchers argued that over-generality is not mood-dependent, but rather a trait marker, which can predict lack of recovery from depression.

In order to address the methodological shortcomings of previous studies, Mackinger, Leibetseder, Pachinger and Fartacek (2000) studied the autobiographical memories generated by women remitted from major depression and compared these with a control group of women without a history of major depression. Mackinger et al.(2000) reported

that women without a history of depression retrieved about twice as many specific ABMs and only half the number of categorical ABMs than the women in remission from major depression, despite the fact that the members of both groups were not depressed at the time of testing. (Note: these researchers did not state a differential hypothesis with respect to valence of cues). Women in remission from major depression retrieved significantly more categorical ABMs when responding to negative cue words than the women with no depression in their history. As such, their findings lent support for the notion that over-generality is not state-dependent: it does not disappear when the depression has remitted.

Studies suggesting that over-generalization represents a fairly stable cognitive trait among persons diagnosed with depression have been challenged in the literature. For example, Brewin, Reynolds and Tata (1999) followed a group of depressed patients for 6 months following treatment to investigate whether or not relapse was predicted by the presence of spontaneous, intrusive memories of stressful life events and performance on the Autobiographical Memory Test (Williams and Broadbent, 1986) at baseline. Brewin et al. (1999) reported that after controlling for baseline depression, the measure of over-general ABMs failed to make a significant contribution to predicting risk for relapse at 6 months following treatment and as such, the finding contradicted earlier findings suggesting that over-generality is a trait marker and therefore a predictor of relapse (Brittlebank et al., 1993).

Following the thread that memory deficits may have a detrimental effect on adaptive functioning and that individuals with depression exhibit deficiencies in social problem-

solving (Goddard, Dritschel & Burton, 1996), Williams, Teasdale, Segal and Soulsby (2000) explored whether or not autobiographical memory could be affected by psychological treatment. In their study, 45 recovered, depressed patients were randomly allocated to receive either follow-up 'treatment as usual' (TAU; continued care under their physician using whatever service they would normally use to reduce depressive relapse) or TAU with the addition of Mindfulness-Based Cognitive Therapy (MBCT). MBCT addresses the avoidant mode of processing by encouraging patients to practice noticing elements of their experience and to do so in a non-judgemental way. In this way, MBCT is designed to encourage not only more specific encoding of events but also more specific retrieval of past events by reducing the tendency for individuals to abort the search process (Williams et al., 2000). Using the Autobiographical Memory Test (AMT; Williams & Broadbent, 1986), findings from the Williams et al. study suggested that although control patients (i.e., TAU) showed no change in specificity of ABMs recalled in response to cue words, the treatment group (i.e., TAU and MBCT) showed a significantly reduced number of generic ABMs. Williams and his colleagues suggested that although memory deficit may arise from long-standing tendencies to encode and retrieve events generically, such a style may be open to modification.

Drawing upon the work of Leventhal (1984) and Teasdale and Barnard (1993), Philippot and Schaefer (2001) argue that the over-general ABMs carry the emotional information processed by the 'schematic system'--a generic and implicit system of representation that encodes the high-order recurrences of emotional events. In contrast, the specific ABMs are primarily concerned with information in the propositional system

(i.e., declarative knowledge about emotion) and are responsible for planning of voluntary action and coping strategies. According to this perspective, the activation of 'hot cognitions' and emotional intensity would be associated with the activation of over-general ABMs rather than specific ABMs. With respect to over-general ABM in depression, Philippot and Schaefer (2001) propose that "the schematic system is over-activated in depressed individuals, who consequently fail to activate the propositional system sufficiently to process the emotional information in such a way as to decide on appropriate behavioural options and coping strategies" (p. 108). As such, depression is maintained as the depressed individual fails to access the necessary coping strategies, possibly residing in the specific ABMs of past experiences that might facilitate successful coping with present circumstances.

Research entailing the induction of mood in participants has suggested that emotional intensity facilitates the access to generic ABMs rather than to specific ABMs (Philippot, 1997; Philippot & Dozier, 1996; Philippot, Schaefer & Herbette, 2003). Philippot and Schaefer (2001) have drawn upon these studies to support their argument that generic ABMs are linked to cognitive structures that generate 'hot' cognitions and emotional arousal.

To date, the majority of studies involved in investigating over-general ABMs in depression have been experimental in nature and reliant on the Autobiographical Memory Test (AMT; Williams & Broadbent, 1986), which utilizes the cue-word paradigm to elicit memories from subjects. Taking a bold and innovative move, Rotundi-Trevisan (2002) took her study out of the experimental lab and into the therapy hour to investigate the

types of ABMs clients generate over the course of treatment. Using the Narrative Processes Coding System (NPCS; Angus, Hardtke & Levitt, 1996), Rotundi-Trevisan extracted all the ABMs disclosed in the external narrative sequences from the therapy session transcripts of three good outcome and three poor outcome clients undergoing Process-Experiential treatment for depression. She then coded these external narratives according to Singer and Moffitt's Scoring Manual for Memory Narrative Type (1992). Findings from her study indicated that good outcome clients narrated significantly more generic memories in the first phase of therapy than the poor outcome group. The poor outcome group, on the other hand, narrated significantly more eventless memories in the second phase of therapy compared with the good outcome group. The two groups did not differ in terms of the frequency of any other memory subtype during any of the phases of therapy. Rotundi-Trevisan's findings of the potentially productive nature of access to generic memories early in therapy appeared in line with Philippot and Schaefer's (2001) contention that over-general ABMs are linked to cognitive structures that generate 'hot' cognitions. Moreover, this finding was in keeping with the theoretical tenets of Process-Experiential therapy, which encourages access and shifts in schematic emotional memories--a process theorized to lead to eventual successful psychotherapy outcome.

In summary, research into ABM subtype and depression has suggested that people with depression appear to generate contextually impoverished memories of autobiographical events. Furthermore, although results appear inconsistent, there has been suggestion that over-generality does not appear to be state-dependent--the majority of studies have indicated that it does not disappear when the depression has remitted.

Finally, over-general memory has been associated with poor problem solving and with poorer long-term outcome in emotionally disturbed people and as such may be a predictor for relapse.

To date, the branches of ABM study have largely grown from the use of the Autobiographical Memory Test (AMT). In a recent study, Rottenberg, Joorman, Brozovixh and Gotlib (2005) criticized the exclusive reliance of ABM research on this single procedure by noting several features of the AMT that may cloud efforts to understand the etiological significance of autobiographical memory functioning. According to Rottenberg and his colleagues (2005), there is some indication that the AMT may be sensitive to the degree of impairment of depressed persons, a factor that may vary across samples. Furthermore, they suggested that instability of results using the AMT may also reflect differences in how the test was implemented across studies. Rottenberg et al., (2005) drew on the results of a recent meta-analysis (van Vreeswick & de Wilde, 2004) that suggested minor procedural variations in the AMT can influence the magnitude of the over-general memory effects that are obtained (i.e., smaller effects were obtained when subjects were given less time to respond). Finally, these authors argued that the normative cue words used in the AMT to elicit autobiographical memory may not be personally relevant for some participants, resulting in the potential for low engagement in the task. As such, there appears to be a need for a personally relevant interview that requests the recall of self-relevant, specific memories, which in turn would significantly contribute to the research in this area.

Themes in Stories the Teller Tells

Another interesting avenue of inquiry into the stories people with depression generate is to explore whether or not these stories evidence themes that may be stable across situations and time. For example, in their study of social phobic patients, Hackman, Clark and McManus (2000) reported that early unpleasant social experiences may lead social phobic patients to develop a negative, observer-perspective image of their social selves that is repeatedly activated in subsequent anxiety provoking interactions. In other words, this image fails to update itself over time.

Returning to Beck's cognitive theory of depression, Beck's content-specificity hypothesis would suggest that depressed individuals' bias towards negative, depression-relevant, self-referent information would lead these individuals to recall stories of loss, deprivation, personal worthlessness, incompetence, failure, and pessimism (Beck, et al., 1979). Turning to the field of social psychology, Aronson's self-consistency theory (Aronson, 1999) and Steele's self-affirmation theory (Steele, 1988) may be interpreted as support for the notion that the stories one tells about oneself must be congruent with one's self concept in order to reduce dissonance. Exploring stories of change, therefore, may be a valuable indictor of how one sees oneself in general, while the stories one tells about oneself may be used as an indicator distinguishing remission or recovery from depression, as one investigates the ability of the story-teller to update stories in the light of new experiences and corrective information. In other words, when depressed, do individuals tend to generate stories that are thematically consistent with their depressed state and do the themes of their stories change when they are no longer depressed?

Carrying this line of thought one step further, could stories generated post-treatment that ground changes in self-perception be a predictor of recovery from depression at follow-up? An interview generating 'data' facilitating further exploration into this area would contribute significantly in shedding light on these questions.

From the Story to the Story-teller

The Classification System of Personal Constructs

Alongside my interest in exploring the stories individuals tell about themselves was my desire to draw back and look at the individuals themselves. The traditional study of personal constructs has focused on the structural relations among constructs emerging from quantitative methods of analyses (Feixas, Geldshlaeger & Neimeyer, 2002). Recently, the Classification System of Personal Constructs (CSPC; Feixas, Geldshlaeger & Neimeyer, 2002) has been presented to enhance study in this area by providing a classification system that is based solely on the content of personal constructs, rather than focusing solely on their structure. Pointing out limitations in the only other classification system of this type in the literature (i.e., Landfield, 1971), Feixas and his colleagues argued that the CSPC, together with the traditional analysis of construct structure, provides the researcher with a comprehensive and systematic means of studying the organization and thematic emphasis of an individual's systems of meaning.

The CSPC[1] was created from a sample of 430 personal constructs taken from the grids of 31 Spanish-speaking subjects who sought treatment at a Barcelona treatment centre (Feixas et al., 2002). The labels of the poles of these constructs were listed

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[1] The CSPC applies only to value or dispositional constructs, which include the meanings that people give to their own and others' psychological traits or characteristics.

independently in order of their frequency. Using a bottom-up process, 45 construct 'categories' were defined by means of successive grouping. The 'categories' are proposed to be exclusive and comprehensive. These 'categories' were then further divided into six comprehensive 'areas'. The hierarchical order of the system is as follows: 1) moral, 2) emotional, 3) relational, 4) personal, 5) intellectual/operational, and 6) values and interests (See Table 1, or page 77, for a chart illustrating the CSPC Categories and Areas)

Reliability of the CSPC

Reliability of the CSPC was determined by inter-coder agreement. According to Feixas et al. (2002), two students in their final year of study at the University of Barcelona were first trained on the system, after which they were instructed to independently code an identical sample of 843 constructs taken from the grids of 57 Catalan-speaking subjects who had sought treatment for various personal and clinical problems at a Barcelona health facility. Feixas and his colleagues (2002) reported very satisfying inter-judger agreement with respect to both "Categories" and "Areas." At the level of categorical analysis, a Cohen's Kappa of 0.90 was reported. At the level of area analysis, the authors report a Cohen's Kappa of 0.95 (See Feixas, Geldshlaeger & Neimeyer, 2002, for detailed presentation regarding the reliability of CSPC).

According to the authors of this system, the CSPC is applicable in the interest of determining if there are differences in the frequencies of the areas and categories of the CSPC among different clinical groups. They suggest that "such investigations would permit the confirmation of clinical and scientific hypotheses like that formulated by

Lorenzini and Sassaroli (1987) with respect to the lack of emotional constructs in agoraphobia" (Feixas, Geldshlaeger & Neimeyer, 2002, p. 10).

A literature search, as well as personal communication with the first author of the CSPC (Feixas, personal communication, 2005) indicated no previous studies examining the construct content of depressed individuals using the CSPC. Indeed there appears a dearth in the literature on construct content investigations. A recent literature search revealed only one article, which used Landfied's (1971) coding system to compare content of constructs elicited from female sexual abuse survivors through administration of the RepGrid to constructs elicited from a control group with no history of abuse (Harter, Erbes, and Hart, 2004). According to this study, sexual abuse survivors were best discriminated from the control group by fewer constructs referring to emotional arousal, to experiences of calm, peacefulness and relaxation, and to moral or religious standards.

Assessing Narrative Change In Psychotherapy

The Narrative Processes Coding System

The Narrative Processes Coding System (NPCS: Angus, Hardtke & Levitt, 1996), was developed as a heuristic to explore the reconstruction and co-construction of an individual's macro-narrative. It was offered to address a gap in the research, specifically the lack of a systematic method for unitizing therapy text, regardless of therapy modality. As such, the NPCS could be implemented to conduct comparative analyses of therapeutic approaches, using multiple, established psychotherapy process measures. Drawing upon the Narrative Processes Model (Angus & Hardtke, 1994, Angus et al., 1999), the NPCS

offers psychotherapy researchers an empirical tool to assist in the investigation of micro-narrative change processes and subsequent macro-narrative change appropriate for the assessment of therapeutic discourse (Hardtke, Levitt, & Angus, 2003).

The NPCS illustrates the use of constructivist methods to assess the topical and thematic shifts that characterize clients' accounts of their experiences (Angus, Levitt, & Hardtke, 1999). The following core assumptions are recognized within the NPCS framework as being of central importance to human functioning: clients' agency; human meaning making; the importance of story-telling and narrative themes in the construction of self; the co-constructive nature of the therapy dialogue; and, the conceptualization of the course of productive therapeutic change as one of a dynamic, dialectical process of narrative sequence shifting, which is presumed to result in both micro-narrative (i.e., individual story) and macro-narrative (i.e., life theme) change.

The NPCS is a two-stage coding system. First, an investigator using the system segments the dialogue of a transcribed therapy session into topic segments that are identified through shifts in protagonists and content themes. The first stage of coding allows researchers to consider how themes are maintained or changed across a client's therapy experience and how the treatment process can act to facilitate narrative development.

The second stage of coding requires investigators to return to each topic segment and unitize these segments of text according to shifts in one of the following three narrative processing modes presumed to lead to self-story change, in psychotherapy:

1. External Narrative Processes - an external story-telling process, which involves the generation of information and details about external events; real or imagined.

2. Internal Narrative Processes - an internal or emotion-focused mode that includes the expression and articulation of affect.

3. Reflexive Narrative Processes - a reflexive or conceptual meaning making mode, which draws upon the story-telling and emotion processes in the articulation of new life themes and new self understandings.

The NPCS is a categorical system requiring intensive textual analysis. Each topic segment is labelled according to the central issue and relationship foci, thus providing the conceptual framework--the "what" and the "who" of the individual's life story. Characterizing topic segments according to the NPCS provides researchers with a method of linking the content fragments of the client's life story within and across therapy sessions. Furthermore, the client's unique experiences are summarized during this stage as the description is grounded in the transcript discourse.

During the second stage of coding, topic segments are further subdivided according to shifts in narrative process type--the "how" of the client's story. This stage of coding may be seen as a template upon which the pattern of narrative process shifts engaged in by the client and therapist across the therapy hour may be tracked as the dyad actively co-construct and reconstruct the client's life story. In other words, given that therapists and clients are viewed as co-constructing meaning during the therapy hour, the NPCS offers the possibility of establishing an empirical index of therapist and client agency by

generating an account of both the frequency and kind of narrative process shifts initiated by clients and their therapists. The NPCS may be seen as an integrative conceptualization of constructive processing modes that considers the engagement of micro-narrative story-telling processes, emotion processing and reflexive meaning-making processes as key to the facilitation of significant client change in psychotherapy.

Assessing Narrative Change in Psychotherapy

NPCS Research Findings

Working primarily within the context of experiential/humanistic therapy for depression, one of the unique insights generated by the NPCS research has been the discovery that clients, irrespective of treatment outcome, tend to shift to external story-telling. This phenomenon commonly occurred despite the fact that the therapists, working within this modality, specialize in inviting clients to shift to emotion-focused and meaning-making modes of experiential engagement (Hardtke, 1996, Lewin, 2001). In other words, during the therapy hour, clients tend to shift away from a reflexive or meaning-making analysis of their experience towards a grounding of their experience in description of everyday events or external story-telling (i.e., what happened as opposed to how I felt or what I thought).

These early NPCS findings provided preliminary empirical support for the hypothesis that the external story-telling process is a significant factor in the therapeutic process, in particular, and possibly the act of human meaning making, in general. Indeed as Bruner notes "telling oneself about oneself is like making up a story about who and

what we are, what's happened, and why we're doing what we are doing" (Bruner, 2004, p. 4).

In the context of our research inquiries, we became increasingly taken by the notion that the stories clients tell about themselves are important threads in the fabric of their self-identities. We became intrigued with the question of whether or not clients see themselves differently after they have experienced significant gains in therapy--and, correspondingly, if that change is mirrored in the stories they generate to describe themselves post-treatment.

Baumeister and Newman (1994) have addressed the interplay between the description of events (i.e., focussing on the articulation of specific, context bound information) and the interpretation of those events (i.e., a focus on the identification of general rules or laws) in human meaning-making. These authors submit that both propositional (or paradigmatic) thought and narrative modes of thought (i.e., as defined by Bruner, 1986) contribute to the process of making sense of one's experience on an ongoing basis. The narrative mode of thought as conceptualized by Baumeister and Newman (1994) involves stories about particular personal experiences. These stories are temporally structured and context sensitive. This narrative mode of thought appears to reflect the processes characterized by the external narrative sequence type of the NPCS. In the NPCS external narrative processes mode, the dialogue reflects the articulation and detailed description of actual or imagined events.

According to Baumeister and Newman (1994), the narrative mode of thought provides the basic grounding for the identification of general themes or patterns of self,

which are built upon by means of reflective and abstractive processes, characteristic of paradigmatic thought. The processes of paradigmatic thought (i.e., reflection and abstraction) appear to resemble the processes characterized by the reflexive narrative sequence mode of the NPCS. Furthermore, these authors submit that "each event must be understood in narrative form, in order to grasp what is actually happening, before abstract inferences or generalizations can be made from it" (p.679).

At this point, the theoretical conceptualization of human meaning making as proposed by Baumeister and Newman (1994), and based on the work of Bruner (1992), converge with the empirical findings of the early NPCS studies presented above, suggesting a possible cyclical nature of the two processes in how we make meaning of experience. As Bruner (1986) suggests, it is the fundamental integration of narrative action (actions and events in the world) with the landscape of consciousness (personal meanings, emotions, and views of self and others) that is the axis of personal identity formation.

Increasingly convinced of the significance of client story-telling as a thread in the fabric of self-identity, the investigation of how clients' stories change in therapy emerged as an important and timely avenue of inquiry. Furthermore, a second line of inquiry involved the question of whether or not clients see themselves differently after they have experienced significant gains in therapy and, correspondingly, the degree to which that change is mirrored in the stories they generate to describe themselves post therapy. To initiate an empirical investigation, attention was directed to the clients themselves. Clients were asked to turn the focus of their attention to their views of self and to provide

personal memory narratives that illustrate these self-perceptions in the context of their interpersonal relationships. To this end, the Narrative Assessment Interview (Hardtke & Angus, 1999) was developed and it is this tool that was used to steer the research directions of the present study.

The Narrative Assessment Interview Protocol (NAI)

The Narrative Assessment Interview (NAI: Hardtke & Angus, 1998) was developed for this exploratory study to provide a heuristic for the exploration of self-story change in psychotherapy. The interview protocol, designed to be given immediately after the first session of therapy, post-treatment and any time during follow-up to treatment, involves three lines of inquiry. (Note: the NAI conducted following the first session of therapy will from here on in be referred to as the "Baseline NAI"). Before asking the first question of the NAI protocol, the researcher or clinician introduces the interview with a prepared statement intended to facilitate a safe, collaborative, non-judgemental atmosphere within which participants or clients may feel free to explore and describe their stories about themselves, the views they hold about others' perceptions of them and to give them an opportunity to articulate and explore their desires for self-change. This introductory statement also informs the clients or participants that the interview should take no longer than 15 minutes. After the completion of the introductory statement, the therapist or researcher then asks the participants the following questions (Note: the following presentation of the NAI protocol interchanges the dyads of therapist and client with researcher and participant to emphasize the suitability of the interview in both research and clinical contexts).

Question #1: How would you describe yourself? The purpose of this first question was to explore how clients see themselves prior to treatment: positively or negatively, externally or internally oriented in terms of singular or multiple perspectives. Participants are encouraged to take their time and generate as many descriptors as they can. Following each self-descriptor, the therapist prompts the client to provide a recent example from her or his life to illustrate the description provided. Examples or stories of client's lived experience that illustrate views of self, are elicited to explore the degree to which these experiences are congruent with the client's view of self or dominant narrative.

Question #2: How would someone who knows you really well describe you? The purpose of this question was to tap into the way clients perceive how others view them to assess further their view of self. This concept draws upon the notion of the "looking glass effect" (Popper & Eccles, 1997), "just as we learn to see ourselves in a mirror, so the child becomes conscious of herself by seeing her reflection in the mirror of other peoples' consciousness of herself" (p.110). This question illustrated our interest in exploring the possible implications of discrepancies between clients' view of themselves and how they percieve others view them. In other words, "Do I see myself as I feel or think others see me or do I perceive that others see me differently than I see myself?" Like question #1 of the interview protocol, participants are asked to provide a recent example of their lived experience to illustrate the descriptors generated in question #2.

Question #3: If you could change something about who you are, what would you change? The purpose of this question was to gain an understanding, early in treatment,

about what if anything participants hoped to change about themselves. The responses to this question also provided a concrete pre-treatment reference point to reflect on and from which to compare each participant's own conceptualization of change at therapy outcome.

The NAI is either audio-taped or videotaped and subsequently transcribed for further analyses. The transcription of the initial NAI is subsequently recorded on a Narrative Interview Summary Sheet (NAISS), which is a brief, yet comprehensive written record of the outcomes of the baseline NAI for the client to reflect on critically during the post-treatment, open-ended interview inquiry. Researchers interested in follow-up inquiries are directed to record the post-treatment NAI on a NAISS, which may be reviewed and reflected on by the participants at times post-treatment.

The Present Study

The purpose of the present exploratory study was to begin to map the largely uncharted territory of assessing psychotherapy treatment of depression through the lens of the individual as story-teller and the individual's stories as potential portholes into the realm of self-perception and self-change. Although narrative metaphors have amassed many suitors among researchers and clinicians alike, few have ventured into the arena of developing comprehensive research agendas, which include investigating and documenting psychotherapy from a narrative approach. The present study was designed to begin to address this gap.

Building on previous research indicating that the stories people tell about themselves are important threads in the fabric of their self-identities, as well as forging new avenues

of inquiry, this study investigated how brief humanistic/experiential psychotherapy treatment for Major Depressive Episode (MDE) affects the unique stories clients bring to treatment--to capture how, and to what degree, these stories, as illustrations of self-perception, change after treatment. To this end, the Narrative Assessment Interview (NAI; Hardtke & Angus, 1998) was developed to open up the following avenues of inquiry, which were pursued in this study.

Main Avenues of Inquiry

Given the exploratory nature of this study, avenues of inquiry were guided by paths established by previous research into narrative, as well as forging new paths of discovery. All research questions were examined using an Exploratory Data Analysis approach (Tukey, 1977), as well as the application of descriptive analyses, trend analyses and content theme analyses, as these are suited for both the exploratory nature of this study and the limited sample size. The lines of inquiry have been organized into those that address the participant as story-teller and those questions that investigate the stories participants generated across the NAI interviews.

One main avenue of inquiry was to investigate the 'data' generated via the application of the NAI. These questions addressed how participants saw themselves, how they felt others' viewed them and what, if anything, they would want to change about themselves prior to treatment.

The Story-teller

- Is there a depressive self-profile? (i.e., are specific self-descriptors more prominent in individuals diagnosed with Major Depressive Episode?) This

investigation was conducted at treatment baseline via the application of the Classification System of Personal Constructs (Feixas, Geldshlaeger & Neimeyer, 2002) to participants' self-descriptors in order to determine if there are differences in the frequencies of the 'Areas' and 'Categories' of the CSPC amongst different clinical groups.

- Do individuals see themselves differently when they are no longer depressed? (i.e., do self-descriptors/personal construct systems change when clients no longer meet diagnostic criteria for MDE?). Is there a discrepancy between how one views one's self and how one perceives others' see him or her when depressed? Do these vantage points converge when one is no longer depressed?
- What, if anything, do people diagnosed with depression desire to change about themselves before entering treatment? Do themes of self-change emerge when looking at responses to this question in a depressed sample?

The Story

The following lines of inquiry emerged subsequent to the review of the research investigating autobiographical memory narratives and were investigated using the Scoring Manual for Memory Narrative Type (Singer & Moffitt, 1992). This scoring system was selected in order to allow a meaningful comparative analysis to existing memory research due to its similarity to the memory classifications of the Autobiographical Memory Test. A second line of inquiry focused on whether participants generated stories of change versus stories of staying the same in their post-

treatment and follow-up NAIs. This development of the classification system to distinguish stories of change is elaborated upon in the procedure section of this study. The following questions loosely guided these two lines of inquiry:

- Do the stories that participants tell to describe themselves contain autobiographical memory narratives and if they do, what types of personal memories are narrated at treatment baseline and subsequently at post-treatment and during follow-up?
- Do the autobiographical memory narratives told by recovered participants change in type and frequency compared to those autobiographical memory narratives told by their non-recovered counterparts?
- Do participants who have recovered from their depression differ from their non-recovered counterparts in their ability to generate single-event self-stories of change?
- Is an individual's ability to consolidate change in stories a marker for sustained recovery from depression at 6-month follow-up?

The final avenue of interest addressed in this study was a descriptive/qualitative exploration of two clients' experience of participating in the three NAI interviews, in general, and the potential value of the NAI for clinical practice, in particular.

METHOD

The York II Depression Study

Research Participants

The data for this study included the transcripts of the baseline, post-treatment and 6-month follow-up Narrative Assessment Interviews (NAI: Hardtke & Angus, 1998, Hardtke & Angus, 2004) for 20 participants drawn from the participant pool of the York II Depression Study (Greenberg & Angus, 1998).

The York II Depression Study, jointly co-ordinated by Professors Leslie Greenberg and Lynne Angus, was a 2-year study comparing Client-Centred and Process-Experiential treatments for depression. The York II Depression Study, which began in 1998, was funded by a grant from the Ontario Mental Health Foundation and was conducted at the York Psychotherapy Research Clinic on the campus of York University.

This section begins by outlining the procedure of the York II Depression project from which the 20 participants for this study were drawn. This is followed by a detailed description of the inclusion criteria for the participants in the present study.

York II Depression Study – Recruitment

Potential participants suffering from depression were recruited for the York II Depression Study through local radio, television and newspaper advertisements. Posters indicating availability for short-term treatment of depression were also put up in area mental health centres and around the campus of York University, Toronto, Canada.

Initial telephone screening and assessment interviews. The assessment of potential participants for the York II Depression Study began with an initial telephone

interview that consisted of a checklist of questions, which served to screen out those individuals deemed as at high risk for suicide, currently in therapy or on medication for their depression, as well as individuals currently in an abusive relationship, those abusing recreational drugs or alcohol, and those who had experienced a recent death of a significant other (i.e., within the last 6 months). Individuals excluded at the time of the screening were provided referrals upon request. Those individuals not excluded by the telephone screen subsequently underwent two assessment interviews, conducted at the York Psychotherapy Research Clinic by advanced graduate students trained and supervised by the co-ordinators of the study.

Participants were selected to participate in the York II Depression Study on the basis of the following criteria: a diagnosis of unipolar, nonpsychotic Major Depressive Episode (MDE) according to the criteria of the Diagnostic and Statistical Manual of Mental Disorders (4^{th} edition-revised; DSM-IV, American Psychiatric Association, 1987), determined on the basis of the Structured Clinical Interview (SCID; Spitzer, Williams, Gibbon, & First, 1987) for DSM-IV (Spitzer, Williams, Gibbon, & First, 1989); a score of greater than 50 on the Global Assessment of Functioning scale (GAF) of the DSM-IV; and, a score of 16 or higher on the Beck Depression Inventory – Long Form (BDI-LF; Beck, Ward, Mendelson, Mock & Erbaugh, 1961). Further, participants selected had to be between the age of 18 and 65 at the time of assessment.

Individuals were further excluded on the basis of the following criteria: individuals reporting more than three prior episodes of Major Depressive Episode, having been diagnosed with an additional Axis I disorder (excluding Anxiety disorder); meeting the

criteria for an Axis II Borderline, Antisocial or Schizoaffective personality disorder; and, receiving ongoing treatment for depression elsewhere, which included being on anti-depressant medication or in psychotherapy.

Those selected who agreed to participate in the York II Depression Study were offered 16 to 20 weeks of individual psychotherapy as compensation. Participants were informed that they could withdraw from the study at any time. See Appendix A for a copy of the York II Depression Study Treatment Consent Form that covers the present study.

Once the assessment interviews and consent forms were completed, participants were randomly assigned to one of two treatment modalities: Client-Centred (CC) therapy or Process-Experiential (PE) therapy.

York II Depression Study: The Treatments

Client-centred treatment. The main goal of Client Centred (CC) therapy is to increase self-awareness by reflecting on current experiences and emotions and the personal meanings woven into them. Consequently, the therapy process largely focuses on providing the client a safe environment in which this exploration can occur. Included among the therapist conditions to create this environment are congruence, genuineness, unconditional positive regard and empathy (Rogers, 1957).

The basic motivational force and central hypothesis in Rogerian theory is the tendency of the human organism to self-actualize. Rogers' central hypothesis is that "the individual had within him or herself resources for self understanding and for altering their self-concepts, basic attitudes, and self-directed behaviour; these resources can be tapped

if a definable climate of facilitative psychological attitudes can be provided" (Rogers, 1980, p.115).

According to Rogers (1951), feelings are the unknown elements of self. Rogers argued that due to social constraints and constraints imposed by past experiences, it may have been dangerous, or indeed impossible, for a person to experience feelings freely and fully. By not experiencing fully, a discrepancy emerges between what Rogers called a person's "real self" and his or her "ideal self", leaving the person confused and in distress, for which he or she might seek therapy. The "ideal self" is comprised and governed by social expectations, social constraints and an individual's past experiences that all impose restraints on the individual from freely and fully experiencing his or her "real" feelings and thoughts. The "real self" consists of an individual's thoughts and feelings on a moment-to-moment basis and therefore is a fluid and ever-changing construct.

In the York II Depression Study, therapists conducted CC treatment according to the manual developed by Greenberg, Rice and Watson (1994), which was supplemented by readings by Carl Rogers (1951, 1975).

Process-Experiential treatment. Process-Experiential (PE) therapy is a process-directive therapy, which is emotionally focused and directed towards the activation and restructuring of maladaptive emotion-schemes (Greenberg, Rice, & Elliott, 1993). Emotion-schemes are hypothesised to be central, internal, synthesising structures with which an individual processes cognitive, affective and sensory information resulting in an individual's self-in-the-world experience.

According to the PE treatment model, individuals experiencing depression become blocked from healthy living in that their current experience is processed through dysfunctional emotion-laden schema. Proponents of the PE model submit that individuals who are vulnerable to depression have an internal self-structure which is characterized by both a "weak or bad" aspect of self and a "self-critical" aspect of self (Greenberg, Elliott, & Foerster, 1990). Symptoms of depression emerge when the "weak" or hopeless emotion scheme is activated in conjunction with the "self-critical" or judgmental self-schema.

The goal of PE therapy is to activate an individual's maladaptive emotion schema in order to facilitate their re-organization and re-structuring. This is achieved by helping clients attend to and explore their moment-by-moment experiencing, while the therapist attends to specific "markers" reflective of emotional processing problems. Once markers have been clearly identified, the therapist introduces PE interventions such as systematic unfolding of problematic reaction points, focussing, empty-chair and two-chair dialogues (Greenberg et al., 1993). In engaging in these tasks, it is proposed that clients are able to explore and differentiate the meaning of their experience at a more complex cognitive and emotional level, with the ultimate goal of integrating this awareness into their future processing of events.

York II Depression Study: The Therapists

Fourteen therapists volunteered their time to the York II Depression Study. Two of the therapists had a PhD in clinical psychology, while the remaining 12 therapists were advanced doctoral candidates in clinical psychology, each with at least 2 years of

psychotherapeutic experience in the Client-Centred (CC) and/or Process-Experiential (PE) therapy approaches.

Therapist training was provided by Professor Leslie Greenberg, an expert in the Client-Centred (CC) approach and one of the founders of Process-Experiential (PE) therapy. Before being assigned to clients, therapists received 24 weeks of manualized training (see Greenberg et. al., 1993). Therapists were also supervised by Professor Greenberg on a weekly basis to ensure adherence to the two treatment models. The therapists' video-taped sessions were used for this weekly supervision. Therapists were assigned at least one participant in each treatment modality thereby acting as their own controls.

York II Depression Study: Procedure

Individuals meeting the criteria to participate in the York II Depression Study were matched by their pre-treatment SCL-90 depression subscale scores and then randomly assigned to one of the two treatments modalities: Client- Centred (CC) treatment or Process Experiential (PE) treatment. Each therapist was randomly assigned an equal number of clients in each treatment condition. Participants took part in 16-20 weeks of individual psychotherapy and were informed that they could withdraw from the study at any time. All psychotherapy sessions were approximately 50 minutes in length and were audio-taped and video-taped with the participant's informed consent. Participants completed a battery of pre- and post-session measures during their treatment. Therapists were also asked to complete post-session measures throughout the course of treatment.

York II Depression Study: Post Treatment Interview and Treatment Follow-up Phase

Participants in the York II Depression Study took part in a semi-structured interview conducted 1 to 2 weeks after therapy termination. During this interview, participants were administered the LIFE-II for MDE and the NAI, which included having participants reflect on the NAI summary sheet generated from their baseline NAI. Participants also completed a battery of measures including the BDI-LF, SCL-90, RSE and IIP. Interviews were conducted by upper level graduate students who were members of the York II Depression Study research team. Efforts were made to ensure that the interview was carried out by someone other than the participant's therapist.

During the 6-month post treatment period, participants were asked to mail in a monthly BDI-LF, which had been provided to them. They were then invited to return to the York Psychotherapy Clinic 6 months after completing their treatment for a face-to-face interview. Each interview began with open-ended questioning regarding the 6 months since treatment termination. Interview questions progressively focused on more specific areas of interest including life events, social supports, and return to therapy. Participants were also presented with their baseline and post-treatment NAI summary responses and asked to critically reflect upon them. In addition to the interview component, participants were administered and rated on MDE according the LIFE-II with DSM-IV modification. Retroactive weekly psychiatric status ratings (PSR) for depression during the 6 months post treatment were collected. In other words, during the 6-month follow-up interview, participants were asked to retroactively generate weekly psychopathology measures (PSRs) on a rating scale between one (absent) and six

(present). These ratings are ordinal symptom-based scales with categories consistent with levels of symptoms used by DSM-IV designations, in this case, depression. Participants also completed the BDI-LF, SCL-90-R, RSE and IIP.

Participants in the York II Depression Study were contacted again 12 months after treatment, at which time they were interviewed over the telephone. These interviews were summarized on forms standardized for the York II Depression Study. Eighteen months following their therapy termination, participants were again asked to return to the York Psychotherapy Research Clinic for a final face-to-face interview. This final interview reflected the 6-month interview, in both its interview questions, as well as battery of measures used at that time. Post-treatment and follow-up interviews conducted at the York Psychotherapy Clinic were audio-taped.

The Present Study

Sample Selection

For the present investigation, 20 participants were selected from the pool of participants in the York II Depression Study. The focus of the present study was to investigate how brief experiential/humanistic psychotherapy treatment for Major Depressive Episode (MDE) affects both the story-teller, as well as the unique stories clients bring to treatment – to capture how, and to what degree, these stories, as illustrations of self-perception, changed after the experience of therapy and up to 6-months following treatment. In order to facilitate this exploration, subject selection first involved identifying those participants who no longer met criteria for MDE at post-treatment, as well as those who continued to struggle with their depression.

As primary researcher actively involved in the analyses of the data, I endeavoured to remain blind to the designation of post-treatment outcome of the participants selected for this study by recruiting a member of the York II Depression study team, whom I instructed to initially select participants using the strategy of theory-based or operational construct sampling (Morrow & Smith, 2000). According to this sampling strategy, participants are purposefully selected according to preset criteria on the basis that they can best illustrate the construct under investigation. Initially, this meant choosing participants who had benefited most from treatment interventions versus those who had benefited least, at treatment termination.

In the current study, post-treatment outcome was determined according to the Structured Clinical Interview for DSM-IV (SCID; Spitzer, Williams, Gibbons & First,

1989), as well as the Beck Depression Inventory – Long Form (BDI-LF; Beck, Steer, & Garbin, 1988; Beck, Ward, Mendelson, Mock, & Erbaugh, 1961). (Note: the Global Assessment of Functioning Scale (GAF) was referred to augment the SCID and BDI scores, particularly when gaps in the outcome data necessitated more information. As such, this measure was not considered a primary determinant of treatment outcome).

The SCID was used in the York II Depression Study (Greenberg & Angus, 1998) as a measure to determine a formal diagnosis of Major Depressive Episode (MDE), as well as to fully assess all Axis I and Axis II disorders for each potential participant. The Global Assessment of Functioning Scale (GAF) of the SCID was used to assess the participants' general level of functioning. The GAF is a single-item measure of client psychiatric disturbance ranging from 0 to 100. Exclusion criteria for the York II Depression Study included individuals who scored less than 50 on the GAF. The SCID interviews, which included the GAF, were conducted by upper level doctoral students in clinical psychology who were trained and supervised by the co-investigators in the York II Depression Study, both of whom are registered clinical psychologists.

The Beck Depression Inventory – Long Form (BDI-LF; Beck, et al., 1972), a 21-item inventory, is a self-report measure of depression severity. Responses are scored on a four-point Likert scale ranging from 0-3 resulting in total BDI-LF scores ranging from 0-63 with higher scores indicating greater severity of depression. According to Beck (1972), scores below 10 are regarded as falling into the normal population range. Internal consistency coefficients for this inventory have been shown to range from .73 to .93 and validity coefficients have ranged from .66 to .86. The BDI has also demonstrated good

construct validity (Beck, Steer, & Garbin, 1988), convergent validity (Gould, 1982), and divergent validity (Beck et al., 1961). The total BDI score was used as a measure to screen the suitability of participants to enter the York II Depression Study, part of the battery of measures to determine therapy outcome and to evaluate monthly severity of depression across the 6 months following therapy termination (Ellison, 2002).

Outcome Determination at Post-treatment

In the comparative outcome and follow-up analyses my interest was to examine those participants who continued to be depressed versus those who were not. As such, I referred to the general guidelines for cut-off scores with depressed patients outlined in the Beck Depression Inventory Manual (BDI Manual; Beck & Steer, 1987), as well as using the DSM criteria for Major Depressive Episode (MDE), in my designations of outcome at post-treatment and follow-up.

According to the BDI Manual, scores from 0-9 are considered within the normal range or asymptomatic, while scores of 10-18 indicate mild-moderate depression. In my sample, a bimodal distribution emerged with scores clustering around 10 and around 13. Supported by the post-treatment GAF rating, the decision was made to indicate the BDI cut-off score at 10.

In the current study, 'recovery' from MDE at post-treatment was defined according to the following two criteria:

1. the participant's score on the BDI was 10 or less, and

2. the participant no longer met DSM-IV criteria for MDE according to the Structured Clinical Interview for DSM-IV (SCID) directly after and up until two months following treatment.

'Non recovery' from MDE at post-treatment was determined if the participant met either of the following two criteria:

1. the participant's score on the BDI was 11 or more, or
2. the participant met DSM-IV criteria for MDE according to the Structured Clinical Interview for DSM-IV (SCID) directly following or up to 2 months following treatment.

(Note: those deemed 'recovered' at post-treatment according to the above criteria will, from here on, be referred to as 'recovered' and those that were deemed non-recovered will be referred to as 'non-recovered').

Additionally, as the 'data' for this study were the completed transcribed NAIs for 20 participants selected to represent 'recovered' and 'non-recovered', the participant selection process required that the following criteria be met:

1. The participant successfully completed all three NAIs (i.e., baseline, post-treatment and 6-month follow-up).
2. The three NAIs for each participant were successfully recorded on audio-tape to allow transcription of the interviews for analyses.

Although at the time of subject selection 41 participants from the York II Depression Study had at least been given the baseline NAI, several rounds of identifying potential participants according to the above-stated criteria revealed that a number of participants

did not complete all three NAIs. Furthermore, audio-taping difficulties leading to unsuccessful transcription of the NAIs further reduced the sample from which participants for the present study could be drawn. In the end, exhaustive sampling led to the identification of 20 participants who met the above inclusion criteria. From these 20 participants, 11 were identified as 'recovered', while 9 represented 'non-recovered' at post-treatment. Furthermore, although the purpose of this study was trans-theoretical in its exploration to conceptualize clinical phenomena in terms of narrative, and as such not directed to a comparative analysis of treatment modality in change, the final sample selected for this present study ended up being fairly evenly represented by both the process-experiential group (n=9) and client-centred groups (n=11) of participants involved in the York II Study of Depression.

Outcome Determination at 6-months Post-treatment

A designation of 'sustained full recovery' from Major Depressive Episode (MDE) at 6-months post-treatment was based on the following two criteria:

1. a BDI score equal to or less than 10 in any month during the 6-month follow-up, and

2. the participant no longer met DSM-IV criteria for MDE at the 6-month follow-up interview.

The two criteria for a designation of 'sustained non-recovery' from MDE at 6-months post treatment were:

1. a BDI score equal to or higher than 11 in any month during the 6-month follow-up period, and

2. the participant met DSM-IV criteria for MDE during the 6-month follow-up interview.

The two criteria for a designation of 'struggling' with continued symptoms of MDE at 6-months post treatment were:

1. a BDI score equal to or higher than 11 in any month during the 6-month follow-up period, and

2. the participant did not meet DSM-IV criteria for MDE during the 6-month follow-up interview.

The following three criteria for a designation of 'relapse' were:

1. the participant was deemed 'fully recovered' at post treatment, and

2. a BDI score equal to or higher than 11 in any month during the 6-month follow-up period, and

3. the participant met DSM-IV criteria for MDE during the 6-month follow-up interview.

The two criteria for a designation of 'recovered' from MDE at 6-months post-treatment were:

1. a BDI score of equal to or less than 10 during the 6-month follow-up period, and

2. the participant no longer met DSM-IV criteria for MDE during the 6-month follow-up interview.

Refer to Appendix B for participant demographics and Appendix C for the pre-tretment, post-treatment and 6-month follow-up scores used to determine outcome for the 20 participants selected for this study.

Transcription of the Narrative Assessment Interviews

The three audio-taped Narrative Assessment Interviews (NAIs) conducted at baseline, post-treatment, and at 6-month follow-up were transcribed according to the psychotherapy transcription standards outlined by Mergenthaler and Stinson (1992). Transcripts were coded and all identifying information deleted for confidentiality. Along with a researcher paid for by the co-ordinators of the York II Depression Study, I transcribed each of the 20 participants' three NAIs totalling the 60 NAIs comprising the "data" sample in this study.

Measures

A number of the research questions posed in this present exploratory study could not be addressed by the application of established psychotherapy process research tools. Consequently, a part of the procedure of the present study was to develop tools designed to allow the avenues of inquiry outlined in the present study to be travelled.

This section will first present the Narrative Assessment Interview (NAI; Hardtke & Angus, 1998), the tool developed to form the foundation of the investigative analyses in this exploratory study of clinical phenomena in terms of narrative. Next, the two established research tools selected to explore the 'data' generated by the NAI protocols are presented: 1) the Classification System for Personal Constructs (CSPC; Feixas, Geldshlaeger & Neimeyer, 2002) and; 2) the Scoring Manual for Memory Narrative

Type (Singer & Moffitt, 1992). This is followed by the procedure section, which will include the development of two further tools generated to address the remainder of this study's research questions, including their inter-coder agreement levels where applicable. (Note: Inter-coder agreements on the two scoring systems, as well as the classification systems developed for this study, start the Results chapter.)

The Narrative Assessment Interview Protocol (NAI)

The NAI (Hardtke & Angus, 2004; Hardtke & Angus, 1998) is a brief, semi-structured interview protocol developed specifically for studying clinical phenomena in terms of narrative. The NAI was designed to be completed after the initial therapy session, at post-therapy and subsequently, during periods of follow-up. (See Appendix D for a copy of the NAI protocol.) The data collection procedure consists of a three-stage process that entails the completion and audio-taping of a semi-structured interview in stage one, the generation of a written summary sheet (i.e., the Narrative Assessment Interview Summary Sheet: NAISS) of the pre-treatment (i.e., baseline) interview in stage two, and the completion of a post-treatment interview, including clients' reflections on the baseline NAISS in stage three. The open-ended format of the interview is intended to promote the exploration of the client's view of aspects of self in narrative form, without imposing the constraints of, for example, adjective checklists.

Stage one. In stage one, the clinician or researcher introduces the NAI to his/her clients/participants immediately after the first session of therapy with the following statement:

> Now I am going to ask you some questions about you. People are complex and although the questions I will ask may at first appear to be quite simple, some

> people find them difficult to answer. The difficulty may be in part because you have never been asked these types of questions before. I encourage you to take as much time as you feel necessary to think about what I ask you before you respond. The questions are about how you see yourself and how you feel others see you. This shouldn't take more than 10 minutes of your time.

After the completion of the introductory statement, the interviewer/therapist then asks clients/participants the following three questions:

Question #1: " How would you describe yourself?"

Question #2: "How would someone who knows you really well describe you?"

Question #3: "If you could change something about who you are, what would you change?"

Following Question #1, and then again after Question #2, the interviewer asks the participant/client to generate an example of a recent event that would illustrate the description in terms of his/her lived experience.

Stage two: The Narrative Assessment Interview Summary Sheet (NAISS). In the second stage of the NAI procedure, the audio-taped, baseline NAI is summarized and the key descriptors, generated by clients in relation to the three central questions, are recorded. The purpose of the NAISS is to provide a brief, yet comprehensive, written record of the outcomes of the baseline NAI for the client to critically reflect upon during the post-treatment open-ended inquiry interview.

Stage three: Post-treatment NAI. In order to facilitate a critical inquiry into the experiences of change, the final stage of the NAI protocol involves having clients read and judiciously reflect upon their own baseline NAISS within the context of a post-treatment interview.

In the York II Depression Study, participants took part in a post-treatment interview and were invited to return to the York Psychotherapy Clinic for an interview 6-months after completing their treatment. In preparation for this follow-up interview, the participants' post-treatment NAI was summarized on a NAISS. During the 6-month follow-up interview, the participant was presented with both the baseline and post-treatment NAISS in order to stimulate a critical reflection on his or her responses. This procedure offered a further opportunity to evaluate potential changes in participants' views of self and how they felt others viewed them; to further reflect upon earlier self-change statements, as well as potentially offering the opportunity to explore potential self-stories of change over time.

The Classification System of Personal Constructs (CSPC)

The Classification System of Personal Constructs (CSPC: Feixas, Geldshlaeger & Neimeyer, 2002) is a systematic means of studying the thematic emphasis of an individual's systems of meaning by examining the content of the personal constructs generated. The CSPC was used in the present study to investigate the content (versus structure) of the personal construct systems of individuals diagnosed with MDE at baseline in order to gain insight into the lens through which participants' stories are constructed.

The CSPC focuses primarily on what Feixas (1998) classifies as "value constructs (Crocket, 1965, described as dispositional constructs), which include the meanings people give to their own and others' psychological traits or characteristics" (Feixas et al, 2002, p.3). These value constructs are distinguished from, for example relational

constructs (i.e., those that would describe a relationship) and figurative constructs (i.e., comparisons with another person). The CSPC was selected to be used in this study due to its emphasis on content and focus on dispositional constructs, which in turn made it a suitable system to summarize the self-descriptors generated by the NAI protocols in order to make meaningful comparisons both within and between participants.

In terms of the present study, participants' self-descriptors generated in response to question 1) how would you describe yourself? and question 2) how would someone who knows you well describe you? of the NAI protocol were graphed on to the CSPC system's 'Categories', and subsequently organized in terms of the system's 'Areas'. Table 2 presents the Categories and Areas of the CSPC.

The Classification System of Personal Constructs (CSPC)

MORAL		EMOTIONAL		RELATIONAL		PERSONAL		INTELLECTUAL		VALUES	EXISTENTIAL*		CONCRETE*
								OPERATIONAL		INTERESTS			DESCRIPTORS
good	bad	visceral	rational	extro-verted	intro-verted	strong	weak	capable	in-capable	ideological,	purpose-ful	purpose-less	physical characteristics
altruist	egoist	warm	cold	pleasant	un-pleasant	active	passive	in-telligent	dull	political,	growth	stag-nation	social roles
humble	proud	optimist	pessim-ist	direct	devious	hard working	lazy	cultured	un-cultured	religious,	fulfill-ment	empti-ness	specific behaviours
respect-ful	judge-mental	balanced	un-balanced	tolerant	authori-tarian	organized	dis-organized	focused	un-focused	social, moral			others
faithful	un-faithful	specific emotions		con-formist	rebel	decisive	in-decisive	creative	not creative	and gender			
sincere	in-sincere	sexuality		depend-ent	indepen-dent	flexible	rigid	specific abilities		values			
just	unjust	others		peaceful	aggres-sive	thoughtful	shallow	others		values and			
respon-sible	irres-ponsible			sympa-thetic	unsymp-athetic	mature	immature			specific			
others				trusting	sus-picious	self-acceptance	self-criticism			interests			
				others		others				others			
* Supplemental Categories													

The 'Moral' Area, concerns an assessment made by the individual with respect to the moral value of the person or element described. This assessment assumes a judgement regarding the person's kindness, generosity, fairness, or other characteristics of this type. Self-descriptors coded into the nine categories subsumed by the 'Moral' Area include: generous versus thinks only of oneself (category – Altruist versus Egoist); devoted versus disinterested (category – Responsible versus Irresponsible; keeps word versus breaks word (category – Faithful versus Unfaithful); and good heart versus does not deserve acceptance (category – Good versus Bad).

The 'Emotional' Area concerns an element of differentiation with respect to the degree of emotionality or sexuality of the person described - to his/her emotional attitude towards life. Self-descriptors coded into the eight categories subsumed by the 'Emotional' Area include: expressive versus stoic (category – Visceral versus Rational); affectionate versus harsh (category – Warm versus Cold); positive thinking versus negativistic (category – Optimist versus Pessimistic); and calm versus irritable (category – Balanced versus Unbalanced).

The 'Relational' Area concerns all aspects that describe types of relationships, or ways of being, with others. Although the authors of the CSPC concede that all constructs influence relationships, this area concentrates primarily on aspects limited to the scope of relationships. Self-descriptors coded into the nine categories subsumed by the 'Relational' Area include: social versus shy (category – Extroverted versus Introverted); agreeable versus disagreeable (category – Pleasant versus Unpleasant); awaits approval

versus is indifferent to others' opinion (category – Dependent versus Independent); and, empathic versus obtuse (category – Sympathetic versus Unsympathetic).

The 'Personal' Area refers to a variety of characteristics traditionally pertaining to the area of personality, or ways of being. It defines itself largely by what it is not. It excludes those traits typically thought of as moral, relational, or emotional since they have been included in previous areas. Self-descriptors coded into the nine categories subsumed by the 'Personal' Area include: self-worth versus low self-esteem (category – Self-Acceptance versus Self-Criticism); lives life versus does not enjoy life (category – Active versus Passive); motivated versus unmotivated (category – Hard Working versus Lazy); and, open-minded versus stubborn (category – Flexible versus Rigid).

The 'Intellectual/Operational' area refers to a variety of skills, abilities, and knowledge both at the intellectual and operational levels. Self-descriptors coded into the eight categories subsumed by the 'Intellectual/Operational' Area include: intellectual ability versus finds intellectual effort difficult (category – Intelligent versus Dull); educated versus lacking education (category – Cultured versus Uncultured); and, centred versus scattered (category – Focused versus Unfocused)

The 'Values and Interests' Area includes constructs that refer to ideological, religious, or distinct values, as well as diverse interests – music, culture, sports, etc. Finally, the CSPC proposes two supplemental Areas. The first, labelled 'Existential', concerns an assessment of central existential projects or appraisals, often of the individual's own core sense of self or life, bearing issues on purpose, meaning or ultimate direction. The second supplemental Area, 'Concrete Descriptors', refers to concrete, as

opposed to abstract, features or positions of people, as well as their actions (i.e., married, professional, has children).

The Scoring Manual for Memory Narrative Type

Developed by Singer and Moffitt (1992), the Scoring Manual for Memory Narrative Type is presented as a reliable tool to categorize memory narratives into distinct autobiographical memory subtypes. Emerging from the analysis of the memories collected from their study of a large, normative, non-clinical college-age sample, Singer and Moffitt (1992) identified the following types of autobiographical memory narratives: the 'single-event' memory, the 'summary' memory of which there are two types: 'generic' and 'eventless', and the combined 'single-event and summary' memories. For the present study, the Singer and Moffitt (1992-1992) scoring system was modified for use on the stories participants generated in the NAIs. The following three autobiographical memory (ABM) subtypes were retained: 'single-event', 'generic', and 'eventless.'

ABM specificity subtypes: Single-event. The most common type of autobiographical memory (ABM) identified by Singer and Moffitt (1992) was the single-event memory, which they define as "a sequence of actions or images, identifiable as a unique occurrence and located in a discrete moment of time in an individual's life (p.239). The defining features of a single-event ABM, therefore, involve the detailed description or unfolding of a specific event occurring in a specific context and moment in time in a person's life. The generation of a single-event ABM indicates that the individual has a strong internal image to draw upon, which may also suggest a stronger

affective or emotional connection attached to it. Singer and Moffitt (1992) provide the following example to illustrate an ABM that is coded single-event according to their scoring manual:

> Two years ago I got into an awful fight with my father. I said I couldn't go to an acolyte picnic because I had to study for exams and he said I just had to go. So we fought...for about ½ hour until we both had forgotten about the picnic...it became purely a power struggle. Finally, I ran across the room, came within an inch of his face and cursed him...and he smacked me. It didn't hurt, just surprised me. He sat down and began to cry, so did I and I felt awful because I had driven him to do it and I knew it (p. 239).

ABM subtype: 'Summary' memories – generic and eventless. A second or 'summary' memory subtype, is defined as non-specific in its content, representing more of a summary of events over time rather than the specificity of time and place, which are the hallmarks of a single-event ABM. According to Singer and Moffitt (1992), "the defining feature of a summary [memory] narrative is its lack of a discrete connection to a particular moment in time [because it] locates events in larger time frames and/or blends unique event into an amalgam meant to represent all of its constituent experiences" (p. 239).

Singer and Moffitt (1992) distinguish two subtypes of 'summary' ABMs: 1) the generic summary memory is defined as the blending of many similar events repeated over a long period of time; versus, 2) the eventless summary memory, which is defined as an imageless and detail-barren narrative of a sweeping episode in an individual's life. Markers indicating the generation of a generic summary ABM include such phrases as: we always used to... every spring we would... I can't remember how many times... Examples of memories that would be coded as an eventless summary ABM would

include: my memory of moving out of my parental home; breaking up a long-term relationship; and, travelling to Europe after graduation.

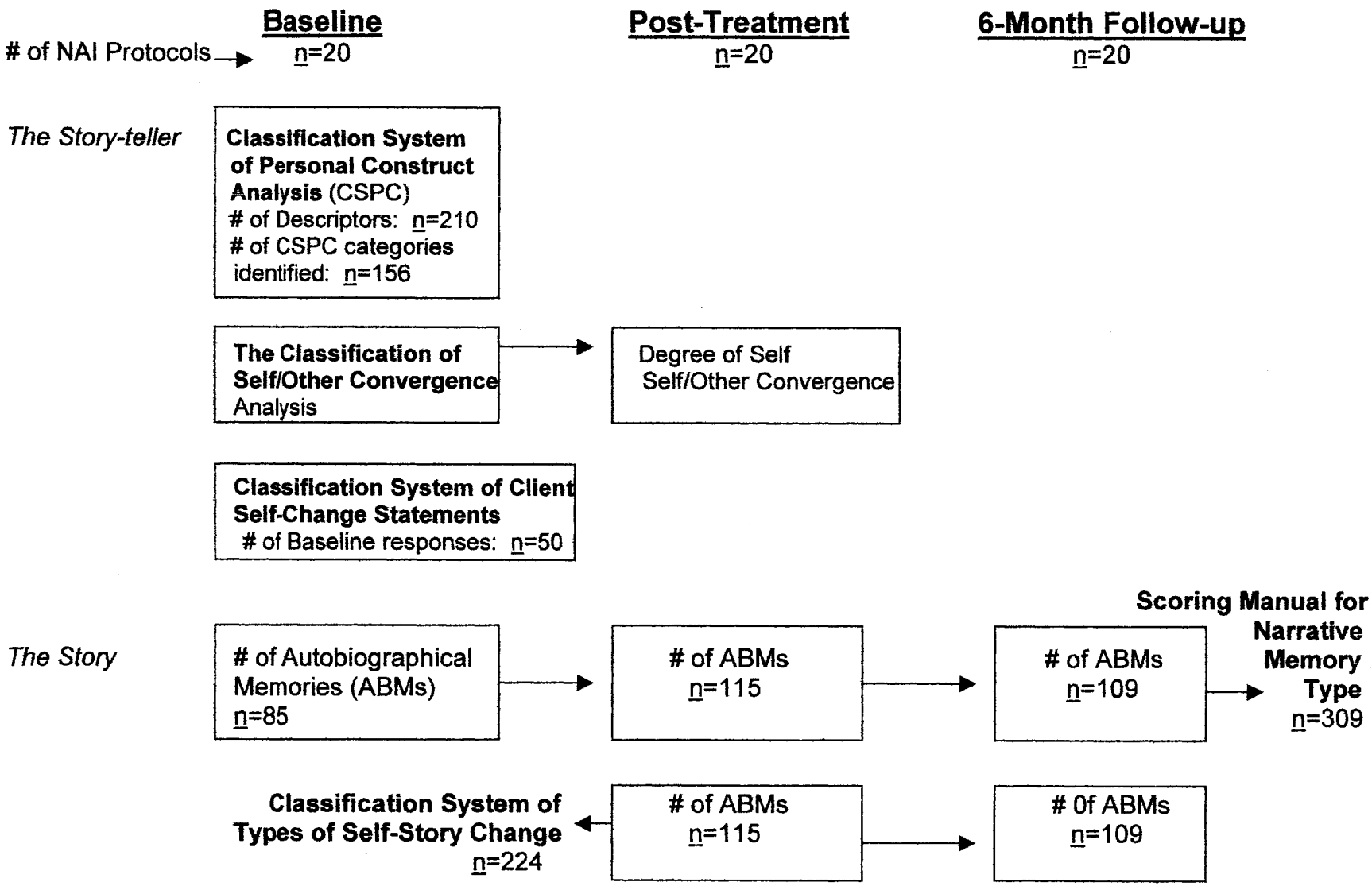
Singer and Moffitt (1992) have reported an average inter-coder agreement of 93% for coding memory subtypes with a mean Kappa of .78. The operational definitions of single- event ABM, as well as the two subtypes of the summary memory type (i.e., generic and eventless) outlined in the Scoring Manual for Memory Narrative (Singer & Moffitt, 1992) were used in the present study to code the memories/stories generated by the participants in response to questions in the Narrative Assessment Interview.

Procedure

The procedure of the present study unfolded along three general lines of inquiry. The first focused on the participant as story-teller and assessed the self-descriptors and self-change statements generated by participants in their baseline NAI protocols to lay a foundation upon which comparative analysis at treatment outcome could be built. The second focused on the participants' stories and assessed these stories according to autobiographical narrative subtype, as well as types of self-story change. These two avenues of inquiry are presented in Figure 1.

The third line of inquiry (not indicated in Figure 1) shifts from a positivistic and quantitative approach used in the first two sections of the results, to a qualitative approach in its investigation of two participants' unfolding of their unique stories of depression and treatment outcome. This exploration was not intended to be a comprehensive grounded analysis of these participants' experiences, but rather an initial attempt to address holistically their stories, as well as making salient the valuable clinical information that might be gleaned from participants' NAI material. Each of the three lines of inquiry involved a multi-step progressive procedure as shown in Figure 1.

Figure: 1 Outline of Descriptive Analyses



The Participant as Story-teller

Step one: Extraction of NAI Self-descriptors

All self-descriptors generated by participants in the context of answering Question #1 (i.e., how would you describe yourself?) and Question #2 (i.e., how would someone who knows you well describe you?) of the NAI were extracted from the baseline NAI protocols. Participants' responses to whether these descriptors had changed or remained the same at post-treatment, and their reflections on these descriptors again during the 6-month NAI, were summarized in an Excel file. Additionally, memos recording participants' reactions and experience of completing the NAI interviews were recorded in this file. This file also contained the 'data' used in the third line of inquiry (i.e., the exploration of the participants' testimonies of self-change and overall experience of participating in the NAIs.)

Step two: Classification System of Personal Construct Analyses

A hierarchical chart was designed to summarize the information generated by the application of the Classification System for Personal Constructs (CSPC) to the baseline NAI view of self and others' view of self descriptors for each of the 20 participants, which had been extracted from the baseline Narrative Assessment Interview Summary Sheet (NAISS). Two hundred and fourteen descriptors were identified and graphed on the CSPC. (See Appendix E for an example of how the NAI self-descriptors were graphed onto the CSPC).

Both the frequencies of the 'Categories', as well as the higher-order 'Areas' of the CSPC summarized in the chart were calculated and saved in an Excel file. In total, 156

Categories were identified and used the analysis of the participants' baseline NAI descriptors (see Figure 1).

Step three: Development of a Classification System to Explore the Degree of Convergence Between View of Self and Perceived Others' View of Self

I reviewed all participants' baseline NAI self-descriptors and generated a classification system for assessing degree of convergence between how the participants viewed themselves (i.e., responses to question #1 of the NAI protocol) and how they felt others viewed them (i.e., responses to Question #2 of the NAI protocol). The following four mutually exclusive categories were identified:

1) Same. The participant stated that his view of self was the same as how he felt others viewed him or the descriptors he generated to describe himself were exactly the same as those he generated to illustrate how he felt others viewed him.

2) Similar. The descriptors the participant generated to describe herself were judged to be similar to those she generated to illustrate how she felt others viewed her. Some descriptors were judged to be the same, while others were judged to be different. The majority of the descriptors were judged to be the same.

3) Different. The descriptors the participant generated to describe herself were determined to be the opposite to those generated to illustrate how she felt others' viewed her (i.e., I would describe myself as a pessimist while others would describe me as an optimist) or the participant explicitly stated that others would describe her as differently than how she would describe herself.

4) 'I Don't Know'. The participant was unable to generate a descriptor in response to Question #2 of the NAI (i.e., How would others who know you well describe you?) or the participant explicitly stated that he did not know how others would describe him.

The Classification System of Self/Other Convergence is considered an ordinal scale represented by the four mutually exclusive categories. The system is anchored by the category "I don't know' on the one end, moving to 'different', 'similar' and finally to 'same'. The system was applied to the descriptors generated by Questions #1 and #2 of the baseline and post-treatment NAI protocols for all participants by me and a second coder, or Coder 2.

The strategy of forced consensus was adopted by the two coders to first determine the degree of convergence between how participants described themselves at baseline and how they perceived that others viewed them. In order to conduct a comparative analysis after treatment, the two coders used the participants' post-treatment NAIs and compared them to their baseline classifications to determine if there had been a shift in the degree of convergence. Using forced consensus, baseline and post-treatment descriptors for each participant were assessed by the two coders to have either: moved to greater degree of convergence (i.e., to a higher category at post-treatment – 'similar' to 'same'); to have moved to lesser degree of convergence (i.e., to a lower category at post-treatment – "same' to 'I don't know'; to be the same (i.e., baseline and post-treatment descriptors were judged to be exactly the same) were still different (i.e., baseline and post-treatment

descriptors were judged to be different), or the participant still did not know how others viewed them following treatment (i.e., I still don't know)

Step four: Development of the Classification System of Client Self-Change Statements

Participants' baseline responses to question #3 of the NAI protocol (i.e., if you could change something about who you are, what would you change?) were extracted and transferred to an Excel file. Eight participants were randomly selected and copies of their data files summarizing their self-change responses were given to Coder 2 who was asked to review the files and independently generate descriptive categories to capture emerging themes in the participants' self-change responses. I performed the same analysis. We subsequently came together and reviewed the categories that we had generated. At that time, two categories we independently generated appeared to revolve around two distinct clusters of self-change statements. The first category was labelled by coder 2 as 'self-conceptual change', which I labelled as 'intrapersonal change'. The second category was labelled 'self-in-action' by Coder 2, which I labelled 'interpersonal change.' Three further categories of self-change statements we identified independently were labelled 'change my body/appearance', 'change my environment/circumstances', and 'global' statements of change. We agreed that the following five categories captured the self-change statements disclosed by participants and could subsequently be used in the analysis of the participants' baseline self-change statements. Together, the following were the five generated categories:

1) Intrapersonal Change For example, My self-esteem is a big big problem. I wish I had a little meter to keep my self-esteem up instead of watching it drop all the time and needing to yank it back up (ID401:BaselineNAI).

2) Interpersonal Change For example, I would like to be more charismatic. I find it hard to get along with people on a social basis, it is like pulling teeth, it is just so hard (ID452:BaselineNAI).

3) Change My Body/Appearance For example, I would like to take off 30 pounds, not 30, maybe 20 (ID440:BaselineNAI).

4) Global Statement of Change For example, I would like to have some peace (ID423:BaselineNAI).

5) Change my Environment/Circumstances For example, I would like to get back into a situation where I belong and can contribute (ID415:BaselineNAI).

The Participants' Stories

Step one: Identification and Extraction of Personally Relevant Narratives/Micro-narratives

The first step of the second line of inquiry (i.e., the participants' stories) involved the identification and extraction of the "micro-narratives" that participants generated across the three NAI protocols[2]. Micro-narratives are the prose-type stories told by individuals and are distinguished from macro-narratives, which are used to refer to individuals' life story. Micro-narratives are defined as distinct, sequential events and, the subjective

[2] See Appendix F for an illustration of the identification of micro-narratives across the three NAI protocols for one participant. This participant (ID:423) was one of the two participants selected for the qualitative inquiry in section three of the Results. ID:423 is "Inge".

experience and interpretation of those events (Angus & Hardtke, 1994; Angus, Levitt & Hardtke, 1999).

In this study, participants generated oral narratives in line with the NAI protocol. As it is unclear whether the story schema order of constituents of written narratives, upon which much of the research has been based, also applies to oral narratives or personal experiences (Gee, 1985), the reader is cautioned not to expect the micro-narratives in this study to illustrate the story structure of literary written narratives.

I bolded, indented, and numbered each micro-narrative identified in the three NAI protocols from each of the 20 participants for further evaluation according to ABM specificity subtypes and type of self-story change. Eligibility for inclusion in the analyses was determined by the parameters set out by Singer and Moffitt's (1992) Scoring System for Memory Narrative Type and as such micro-narratives in this study did not necessarily illustrate the coherent story structure evidenced in written narratives.

Step two: Autobiographical Memory Specificity Analyses of Micro-narratives

The NAI transcripts with the identified and bolded micro-narratives were supplied to two independent coders (myself and a graduate student considered an 'expert' in the application of Singer and Moffitt's (1992) Scoring System for Memory Narrative Type). Coders then applied the Scoring System for Memory Narrative Type to the micro-narratives identified in the transcripts -- coding them in terms of the following mutually exclusive categories: single-event Autobiographical Memory (ABM); generic ABM; eventless ABM; not autobiographical*; not a memory*; and, two short to code* (*indicates micro-narratives that were excluded from further analyses). Inter-coder

agreement between us was established. A total of 309 ABMs were identified across the three NAI protocols for the 20 participants in this study and formed the data for the ABM analyses.

Step three: Development of the Classification System of Types of Self-Story Change

The third step in the exploration of participants' ABMs was the development of the Classification System of Types of Self-Story Change to aid in the investigation of whether or not participants' stories of self-change reflected potential gains they had experienced after treatment. I read through the 115 ABMs coded in the post-treatment NAI protocols and the 109 ABMs coded in the 6-month follow-up NAI protocols with the initial goal of differentiating those ABMs that illustrated either a behavioural or attitudinal change, or stories that illustrated no change, on these two dimensions. The following five categories emerged from this initial coding: 1) 'story of the same', 2) 'story of the same – but okay', 3) 'reframe story', 4) 'story of changing'; and, 5)'story of change.'

Once these categories were generated and after consultation with Coder 2, the definitions of the categories were further refined. I then conducted a second round of coding of the total 224 ABMs coded in the post-treatment and 6-month follow-up NAI protocols. The categories, with their defining features are presented below:

Category 1: 'Story of the same.' 'Story of the same' was indicated when the participant generated a post-treatment ABM that reported that something that they had hoped to change did not, or that an aspect of themselves identified in the baseline NAI, which they wanted to shift or change, did not. Markers included the participant saying:

'no that has not changed unfortunately; I am still working on that; or, that is still an issue.' The following example illustrates a story coded as 'story of the same'.

> (behavioural and attitudinal change) A terrible husband is still an issue. That didn't go away. Partly because of the two-career thing, part of it the success thing, what it means to be successful, all those external roles, there is a tension there that I am not able to contribute financially right now, which beats me up, not that my spouse beats me up. (Interviewer: you beat you up). Oh do I ever, and that is the trigger that sends a whole series of downward spirals for me that end me up feeling, not functioning (incomprehensible). Uh, that would be probably the remaining two areas of my life that I have to sort of fix and move up and I'll be fine. (ID415:6MonthNAI)

Category 2: 'Story of the same—but okay.' Not all descriptors that participants generated in their baseline NAI represented aspects of themselves they wished to change. For example, some participants felt others viewed them as intelligent and competent without indicating that these would be aspects of self that necessitated change. In other words, things were the same, the participants indicated that they were okay with that and subsequently provided a ABM narrative to illustrate that things had not changed but that was okay. The following excerpt is an example of a story that was coded as 'story of the same – but okay.'

> (Interviewer [I]): And you said that others, or someone who knows you well, would describe you as smart, funny, and a really nice person. Would you still say that others view you in this way?) Yes I think so. (I: Is there a recent example in your life, which demonstrates how other people view you?) I think a recent negotiation I did, I think, you know, that they thought I really kind of examined all the angles. It was a year long deal, but we were renewing it, it was kind of getting the rate up. And I think it's the kind of thing that you often get dug in, there is a lot at stake, a lot of money and I think that they really felt that I had done my homework. I think that the person I was dealing with felt that I really knew their business, that I really examined it and was on top of it. And I injected a lot of humour into it. (I: So it was relaxed, it wasn't tense) It was relaxed. They felt that I would look after their business, that sort of thing. I am real nice, you know, but I have a handle on things. It's a business example. (ID430:PostNAI)

Category 3: 'Reframe story.' When reflecting on their baseline NAI responses, some participants indicated that what they had said meant something slightly different to them at post-treatment and/or during the 6-month follow-up NAI: not that the participants had changed but rather they found that although the descriptor still fit with their perception of self, there was a shift around what that descriptor actually meant to them. In other words, the self-descriptor did not change, but rather there was a sense of differentiating or reframing what the descriptor meant to them after treatment. The following two excerpts are examples of ABMs, which were coded as a 'reframe story.'

> (Interviewer [I]: A little scattered, childlike) Well I would say that I am still a bit scattered. I think that is just kind of part of my nature. Um, I think yeah, probably when I said that I think yeah, it was just, I was quite scattered in terms of emotionally and not even knowing that. But I think that part of it is just the nature of what I do in terms of work, acting obviously is something that is not steady and because it takes a lot emotionally to be creative, anything in the arts sort of, um just the nature of the work itself, um, you're busy here and you are not for a long time, so you want to keep active and you know (break-audiotape is turned over) Where were we? Yeah you tend to pick up from other peoples', where they are emotionally, you know, just because it is so hyped and they are in their own space and (I: So part of feeling scattered has to do with the nature of your business?) Yeah yeah, I think so. (ID405:PostNAI)

> (Interviewer [I]: I'm very friendly, and very open and very direct). Direct, uh, I don't know if that's a very good word, very direct, I am, in some ways I'm very direct, I'm uh, I'm very friendly, people tell me all the time how wonderful I am, and how much they like me and love me, I did it, and I always felt angry when they said that because I feel it's not, that's. I mean, part of me is like that but they don't know the bad part about me because I, so I guess, but people think I am very open, people tell me they think that I'm very open and direct but I know (I: you're hiding) I'm not a very open, I guess I'm fairly direct, I think I'm reasonably direct. (ID423:PostNAI)

Category 4: 'Story of changing.' Stories coded according to this category indicated that the participant's attitude or behaviour was in the process of changing. Markers

indicating 'story of changing' included: 'I don't do that much anymore; things have changed a little bit; I did it a little bit but it doesn't feel right; I have started drawing some boundaries but I need to do it more; and, I may not being doing it all the time but I notice a difference.' The following excerpts illustrate stories, which were coded according to this category.

> (attitudinal and behavioural changing) (Interviewer [I]: Now when your friend came over, were you trying to be more open with her or?) I have been making a little bit, I guess I don't know how to do it very well, I guess I feel like I, it's sort of like when I was with S.(participant's therapist). I know it was way worse with S. because I had been so alone for so long with this illness and uh, I was just bursting when I came in here, I just couldn't stop, I couldn't stop uh, and I had this fantasy from a little girl, always fantasizing about wanting somebody to talk to but I never did (laughs) but it was a fantasy, and uh, I started when I was with S. reading some books and uh, I never told anybody about the incest (I: mm-hm) never talked to anybody and somewhere I read that that was a good thing to do, so I did a little bit with my friend, so I'm trying to do it but it's not comfortable, it doesn't feel right and I don't feel I do it right (I: mm-hm). (ID423:6monthNAI)

> And so I guess I have been speaking on a more of a, actually communicating better, I'm definitely noticing that in relationships, not that long, but just in the short time we've been together, I've been very concerned, and uh, sort of forcing myself, not that I'm really forcing myself, but making sure that I do communicate you know, if I am upset (Interviewer [I]: right) everything, I do try to uh, realize that I'm not doing it all the time, but I may actually recognize when I'm doing it, and (I: mm-hm) from there I'm able to sort of step back and say, okay, why didn't you just say (ID405:6monthNAI).

Category 5: 'Story of change.' 'Story of the change' was indicated when the participant generated a story in the post-treatment or 6-month follow-up NAI protocol that illustrated either an attitudinal or behavioural change that had consolidated itself in the participants' lived experience. Markers indicating a 'story of change' included: 'I've stopped that; I used to think that way and now I don't; I don't see myself like that

anymore, I've changed.' The following excerpts are examples coded according to this category:

> (behavioural change) like L. (participant's sister). Every time I go on a shopping trip, I buy her something. I'm talking about expensive things, clothes. I get her at least once a month a new top. I've got this thing for bra and underwear sets. I guess, because I can't buy them for myself I get them for her. She's got an incredible selection of them. I'd always end up fifty bucks in the hole for her. always. And I've stopped that. (ID401:PostNAI).

> (attitudinal change) They (participant's sisters) think it is because I had that loan and can't afford it but it is more than that. I think that I've learned to cut out all the frivolous things in my life. If I want to save for a down payment for a home, I'd have to continue it at least for this year. And that's that. Of course, once I buy a home, it's got to continue because I won't be able to afford these things. It's forever. From now on, this is me. I'm not buying anybody's love anymore. (ID401:PostNAI)

> (Interviewer [I]): Okay, um, can you give me a recent example, a situation perhaps where before you might have been critical and now you're not?) - - um, - - - - well um, I recently went to a whole series of job interviews for a new job that someone had, a school friend had mentioned to me about and uh I had actually gone through three rounds of interviews and uh you know I'd felt good about the interviews and the person that I'd spoken to you know who who's friend was the friend of the person that was hiring also felt good about it and +// (I: uh-huh+) in my mind it was almost like you know I had gotten the job (I: right) but then / but then I found out you know that I didn't get the job (I: right) and uh I think that in the past that would have been completely devastating. (I: ah, uh-huh) uh (I: and what happened now?) Well I felt bad that day you know, but you know I mean I still make it through the day +I'm (I: right+) through my day (I: right) uh – and uh – then I then met up with a friend and we went to dinner and I I I still felt a little bad about it but then the next day you know it was like I'd forgotten about it +already so it's (I: hm mm-hm+ So you were kind of able to put it in perspective and) right +/it's it's / (I: and yeah I mean +it's something that we all feel bad about for) yeah +but it (I: a period+) wasn't like you know a big deal. (I: right, uh-huh) Like I said 'well you know there's there's always the next one' (I: Right, well that sounds great) and uh before that you know I would have been like you know 'I can't believe I didn't get the job you know, what's wrong with me, +what did I do wrong?' (I: mm-hm+) Then I would have spent hours and hours just you know picking apart you know the what I did wrong +you know (I: hm+) what you know what I thought was wrong with me and I didn't I didn't do that. (ID452:6monthNAI)

Analyses

An Exploratory Data Analyses approach (EDA; Tukey, 1977) was adopted in the analyses of the data in the initial two investigations undertaken in the present study. EDA is concerned primarily with exploration and description of data, not with inference. Thus, EDA consists primarily of summary statistics and the extensive use of graphical displays to help with the description of possible trends in the data that can be tested for future studies with larger samples (see Smith & Prentice, 1993, p. 335, and Wilkinson, 1999, for reviews). As such, the EDA approach is particularly suited to the analyses of the data from exploratory investigations such as the present study.

Exploring Participants' Reactions to, and Experience of, Participating in the NAI

The third and final avenue of inquiry shifted from a paradigmatic and quantitative approach to a qualitative and narrative approach in its investigation of the unfolding of two participants' unique stories of depression and treatment outcome as captured by their NAI protocols. This exploration was not intended to be a comprehensive grounded theory analysis of these participants' experience, but rather an initial attempt to break free from the limitations of a quantitative methodology in a quest to capture the stories of two participants with contrasting outcomes, as well as making salient the valuable clinical information that might be gleaned from participants' NAI material. I conducted this avenue of inquiry and read through these two participants' NAI protocols and used "memoing" and their testimonials as a framework for inquiry.

RESULTS

A report on inter-coder agreement levels on the various classification systems used in this study begins this section. This is followed by the results, which are presented in three main sections.

The first section gives the descriptive findings of participants' baseline views of self as identified by means of the Classification System of Personal Constructs (CSPC). Also reported in this section are the results of a baseline and post-treatment comparative analysis of the degree of convergence between participants' views of self and how they felt others viewed them. This analysis was conducted using the Classification System of Self/Other Convergence developed as part of the procedure for this study. These findings are followed by a thematic exploration of participants' baseline responses to the third question of the NAI protocol: "If you could change something about who you are, what would you change?" This analysis was conducted using the Classification System of Client Self-Change Statements that was developed as part of the procedure for this study. A comparative analysis of baseline self-change statements and post-treatment outcomes concludes this first section of the results.

The second section focuses on the autobiographical memory narratives (ABMs) or personal stories that the participants disclosed in response to the three questions from the NAI protocol across the three time periods. These included the personal stories (ABMs) that participants disclosed to illustrate their own views of self, how they felt others viewed them, and stories disclosed after having been asked, "if they could change something about who you are, what would you change?" Findings emerging from the

application of Singer and Moffitt's (1992) Scoring Manual for Memory Narrative Type (i.e., single-event stories versus summary stories – generic versus eventless) to the ABMs (n = 309) identified in all NAIs used in this sample are presented first. Next, the results from coding the ABMs identified in the post-treatment and 6-month follow-up NAIs (n = 224) according to the Classification System of Types of Self-Story Change are presented. The potential significance of consolidating self-change in single-event stories of change, and its relationship to treatment outcome and relapse at 6-month follow-up is the thread that weaves the findings reported in the second section.

The third and final section of the results reports findings from the investigation of the unfolding of two participants' unique outcome stories as captured by their NAIs. Using the BDI scores and SCID interview, the first participant was assessed as recovered from his depression at post-treatment and was indicated to have sustained recovery 6 months following treatment. The second participant selected for this descriptive/qualitative analysis did not recover from her depression at post-treatment and, according to standardized outcome measures, continued to struggle with her depression at 6-month follow-up. As indicated, this exploration was not intended to be a comprehensive grounded theory analysis of these participants' experience, but rather an initial attempt to break free from the limitations of quantitative methods to capture their stories of depression, as well as making salient the valuable clinical information that may be gleaned from participants' NAI material.

Inter-coder agreement

Classification System of Personal Constructs (CSPC)

Inter-coder agreement for the coding of personal constructs using the CSPC was established according to a two-step procedure. Firstly, a clinical psychologist practiced in qualitative analyses, in general, and grounded theory, in particular (this coder will subsequently be referred to as coder 2), agreed to review the article describing the CSPC (Feixas, Geldshlaeger & Neimeyer, 2002) and apply the categorization system to the self-descriptors generated by Questions #1 and #2 of the NAI protocols at baseline. Meanwhile, I embarked on the same analyses. Forced agreement between us was used to establish the 'expert' classification of baseline NAI self-descriptors according to the CSPC.

The second step to establish inter-coder agreement involved the recruitment of a third coder whose coding was compared to the 'expert' coding. A doctoral student in the department of Psychology at York University agreed to train independently on the CSPC by reviewing the 2002 article describing the system. This third coder was subsequently given a copy of the entire list of self-descriptors extracted from 75% of the baseline NAIs ($\underline{n}$=15; 134 descriptors) and asked to categorize these descriptors using the CSPC. These codings (i.e., categorization according to the CSPC) were compared to the 'expert' codings. The average inter-coder agreement between the third coder and the 'expert' coding for 134 baseline NAI self-descriptors according to the 'Categories' of the CSPC was 76.1%. The average inter-coder agreement of transforming the 'Categorical'

classification into the higher order 'Area' of the CSPC was 99.3% with a mean Cohen's Kappa of 0.851.

Autobiographical Memory Subtypes

Inter-coder agreement for the coding of ABM sub-types was established between myself and a graduate student pursuing her PhD degree in clinical psychology at York University, who had been identified as an 'expert' in the application of Singer and Moffitt's (1992) coding system.

Thirteen transcribed NAI protocols were randomly selected from the 60 protocols in this study to establish inter-coder agreement. Within these 13 NAI protocols, I identified relevant self-narratives, or micro-narratives, which I readied for coding by indenting and bolding them within the transcribed text. These micro-narratives from the 13 NAI protocols were subsequently coded as either single-event, generic, eventless, 'not autobiographical', 'not a memory' or 'too short to code.' Ninety autobiographical memories (ABMs) were identified within these 13 protocols and used to establish inter-coder agreement. These 90 ABMs represented 29% of all ABMs ($n = 309$) eventually identified in the 60 protocols that formed this study. The average inter-coder agreement for coding these 90 ABMs was 87.4% for ABM subtype with a mean Cohen's Kappa of 0.762.

Classification System of Client Self-Change Statements

Using the five descriptive categories of the Classification System of Client Change Statements, Coder 2 and I independently coded the self-change responses generated by all 20 participants to Question #3 of the NAI. A total of 50 baseline self-change

statements were generated and used to establish inter-coder agreement. The average inter-coder agreement for coding these 50 baseline self-change statements according the Classification System of Client Self-Change Statements was 88% with a mean Kappa coefficient of 0.826.

Classification System of Types of Self-Story Change

Inter-coder agreement for the Classification System of Types of Self-Story Change was established between Coder 2 and me. Fourteen of the 40 NAI protocols used in this study (i.e., post-treatment n = 20; 6-month follow-up n = 20) were randomly selected to establish inter-coder agreement. These 14 NAI protocols included 98 ABMs, which represented 44% of the total number of 224 ABMs identified in the post-treatment (n = 115), and 6-month follow-up (n = 109) NAIs. The inter-coder agreement between Coder 2 and me, using the Classification System of Types of Self-Story Change was 86.7% with a mean Kappa of 0.786.

Section 1.

The Baseline NAI Picture of Depression

Of the 20 baseline NAIs completed (i.e., one for each participant), a total of 210 descriptors were identified in response to the first two questions of the NAI (i.e., "how would you describe yourself?" (self-descriptors) and, "how would someone who knows you well would describe you?" (others view of self - descriptors). Table 3 illustrates the mean, range and percentage of the total self-descriptors, as well as others' view of self descriptors generated by the 20 participants at baseline.

Table 3

Self Descriptors and Perceived Others' View of Self Descriptors:

Baseline NAI: All Participants (N = 20)

	'View of Self' Descriptors	'Others View of Self' Descriptors	'Self and Other' Descriptors
M	6.4	4.1	10.5
Range	2-15	0-14	2-29
%	61%	39%	100%
Total (# of descriptors)	128	82	210
N	20	20	20

Although all participants in this study were able to generate self-descriptors at baseline to Question #1 of the NAI protocol, two participants reacted in ways that indicated they had some difficulty describing themselves. Their responses accounted for the large range of descriptors, as evidenced in Table 1. One participant's difficulty is illustrated in the following excerpt:

> Can we come back to that question? (Therapist [T]: Sure.) Okay (T: Yeah, we can come back to that one, um did anything come up?) No. (T: Nothing at all, okay, it's hard to describe yourself, okay.) (ID422:BaselineNAI)

The second participant's struggle with the same question is illustrated in the following excerpt:

> I'm wondering, I'm sure who I was last year, I'm not sure because it changes and the past is not me anymore so I'm not sure who I am. I know who I was but I don't know who I am now. (ID409:BaselineNAI)

Two of the 20 participants (10%) described their view of self as very rigid and unchangeable. For example, one participant indicated that her experience of herself was 'engrained', suggesting that her experience is a rigid and unchangeable core sense of self:

> I'm a jealous person, not a vindictive person...I'm just deep down I'm just jealous of everything and everybody and even if my brain tells me not to...but I was brought up like that, my mother was like that and I heard her and she talked to me since the age of that high, and we're poor and they're rich and we can't get this and they've got that, it just went on and on and on and on and even though my intellect tells me that the grass is not greener on the other side, deep deep down, I just, it's my make-up...it's engrained in me. (ID407:BaselineNAI)

A second participant, while telling a story about his relationship with his sister-in-law, also reflected on his experience of aspects of himself as unchangeable, as illustrated in the following excerpt:

> I wouldn't say she dislikes me, it's an annoying habit I have and that bugs her but I just can't help myself. (T: So it's just have to go for the jugular sometimes) yeah, which I suppose is my mother's trait there. (ID402:BaselineNAI)

Eighty-two of the 210 descriptors were generated at baseline in response to question #2 of the NAI protocol: "How would someone who knows you well describe you?" Several participants in this study appeared to have difficulty articulating how they felt someone who knew them well would describe them, which accounted for the lower number of 'others' view of self' descriptors and the wider range of these descriptors generated in response to this question #2. The following excerpts demonstrate this difficulty:

> (Therapist [T]): Okay, how would someone who knows you well describe you?) I have no idea. – that is part of my journey, um, I don't know who knows me well anymore (T: hm) um, I would have thought that my spouse knows me better than anyone else and she doesn't either. (ID415:BaselineNAI)

> (T: And how would someone who knows you really well describe you?) (?: / don't know). (T: so that's a blank?) yeah. (T: so that feels like a blank?) Well in thinking they may describe me as - - I don't know (T: okay) I really don't know. (ID422:BaselineNAI)

> (T: How would someone who knows you really well describe you?) They usually don't know me. (ID425:BaselineNAI)

> (T: Now how do you think that others would describe you? People that know you really well?) You know, I don't know. (T: mm-hm) I don't know because um, - out of all the relationships that I've had in my life, all these people know certain sides of me but they really don't know me, you know (T: mm-hm). Maybe it's me putting a mask on or, maybe it's me guarding other aspects of myself but my closest friends, I don't even know what they would say, as far as describing me. (ID422:BaselineNAI)

Participants' depressed state at baseline may have left them with insufficient energy, ability or insight to devote to such a complex mental process as exploring how they thought someone who knew them well might describe them, which may have accounted

for the lower number of baseline descriptors generated by participants when asked to describe how someone who knew them well would describe them versus how they would describe themselves

The NAI Baseline Descriptors: Classification System of Personal Constructs (CSPC)

CSPC – 'Areas'

A main avenue of inquiry in the present study was to explore and generate a profile of individuals suffering from a major depressive episode (MDE), in order to gain insight into how the story-teller sees himself or herself before entering treatment for depression. The Classification System for Personal Constructs (CSPC) was used to aid this exploration and to lay the foundation for an examination of the content of participants' personal construct system, the thematic emphasis of individuals' systems of meaning, in terms of their own generated self-descriptors and the descriptors they generated how they felt others' viewed them. For this analysis and unless otherwise indicated, the term 'self-descriptors' refers to having combined participants' responses to being asked how would they describe themselves and how they felt someone who knew them well would describe them.

Figure 2 presents the percentage distribution of CSPC Areas represented by the CSPC Categories endorsed by the self-descriptors generated by the participants at baseline in response to Questions #1 and #2 of the NAI protocol. In order to avoid having findings that were artificially skewed if a participant provided three descriptors that were coded under the Category 'Sympathetic' which falls under the 'Relational' Area, the 'Relational' Area was represented once (i.e., endorsed once) and the Category

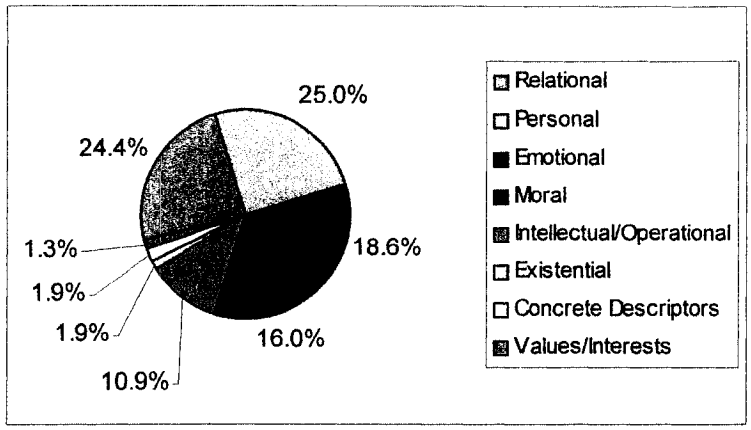
'Sympathetic' once. The frequencies, therefore, are the total of number of categories represented and endorsed by a self-descriptor provided by participants. One hundred and fifty-six CSPC Categories were represented by the 210 self-descriptors generated by the 20 participants at baseline.

Figure 2

Classification System of Personal Constructs – Areas

Baseline NAI Self-Descriptors

All Participants



As shown in Figure 2, 25% (n = 39) of the total 156 self-descriptors represented a Category subsumed under the 'Personal' Area, followed closely by 24.4% (n = 38) of the self-descriptors endorsing a Category that fell under the 'Relational' Area. Examples of self-descriptors generated by participants representing a Category that was subsumed under the 'Personal' Area included: "at times I feel unlikeable"; "I lack self-confidence"; "my husband has nothing good to say about me"; "I'm strong-minded and persistent";

and, "I am a perfectionist and tenacious." Examples of self-descriptors generated by participants representing a Category that was subsumed under the 'Relational' Area included: "I'm easy to get along with"; "I am introverted and quiet"; "I am a people-person"; "I am supportive"; and, "I am friendly, open and compassionate."

The 'Emotional' Area was represented by Categories that were represented by 18.6% (n = 29) of the self-descriptors generated at baseline. Self-descriptors falling under the "Emotional' Area included: "I am moody"; "I am sensitive and jealous"; "I am frustrated easily and short-tempered"; and, "I am analytical." Sixteen percent (n = 25) of the self-descriptors endorsed a Category that fell in the 'Moral' Area. Examples of self-descriptors generated by participants endorsing a Category, which was subsumed under the 'Moral Area' included: "I am generous, I go out of my way to give people a hand"; "I am a good person, a good mother"; "I put others first a lot, like to a fault"; and "I have a strong conscience." Ten point-nine percent (n = 17) of the self-descriptors represeneted a Category under the 'Intellectual/Operational' Area. Examples of self-descriptors coded under the 'Intellectual/Operational' Area included the following: "I'm smart and creative"; "I'm a little bit scattered"; "I am a problem-solver and resourceful"; and, "I am capable." Less than 2% of the descriptors were coded under the remaining Categories. (see Figure 2)

The overall profile provided by the CSPC Areas indicates that in the main participants described themselves using a variety of characteristics traditionally pertaining to the area of personality, character and way of being (i.e., 'Personal' Area). This result was expected given the way in which self-descriptors were elicited. By

asking participants how they would describe themselves and how they feel others would describe them, the NAI pulls for self-descriptors that illustrate personality or character, the cornerstone of the 'Personal' Area of the CSPC. The overall picture provided by the CSPC Areas also indicated that participants described themselves for the most part in 'relation to others' (i.e., 'Relational' Area), as well as in terms of their emotional attitude and experience of themselves (i.e., 'Emotional' Area). The latter finding would also be expected given that participants were assessed as struggling with a mood disorder at baseline.

The picture of how participants saw themselves at baseline is brought into focus by the findings illustrating the CSPC Categories. This depiction of participants' self-descriptors graphed onto the CSPC Categories is presented next.

CSPC – Categories

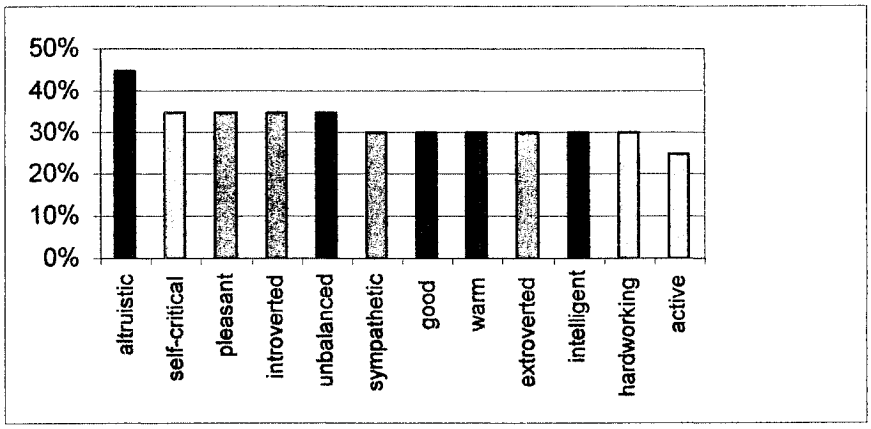
Figure 3 illustrates the percentage of participants whose baseline NAI self-descriptors were coded according to the 12 CSPC Categories that were most frequently endorsed by the participants. Each of these 12 Categories were endorsed by at least 5 of the 20 participants, or 25%.

Figure 3

Classification System of Personal Constructs – Top 12 Categories

Baseline NAI Self-Descriptors

All Participants



Nine of the 20 participants, or 45% of the sample, generated baseline NAI self-descriptors that were coded according to the CSPC category labelled "Altruist." Examples of self-descriptors in this Category included: "generous", "I can be counted upon", "I am concerned about others"; and, "I am selfless and giving." An interesting finding was that five of these nine participants (56%) described themselves as putting others first and giving to others to a fault. The following excerpts taken from participants' baseline NAI protocols illustrates this view of self:

> I put others first, like to a fault, you know what I mean? (Therapist: mm-hm) Like going to work early, staying through my break, coming home late, just trying to do a good job, and yet, you know, I should have left it and said 'oh well, too bad for him, my kids need me and they are waiting at home'...and I wasn't putting it into perspective. (ID412:BaselineNAI)

> I go out of my way, like even to you know to my own detriment, so that I wouldn't hurt someone else, my father was like that too, unfortunately, yeah unfortunately, that's all I know how to do. (ID407:BaselineNAI)

> And actually, this is interesting, um, again, I maybe catch myself being overly thoughtful to people because maybe I want to be liked or maybe / / here, I don't know. um no, there's really never any, sneaky intentions here but um, I invite / / but other people take me for granted because I am too easily giving my time, too easily saying yes and I can feel that when I do something for someone, uh they're not necessarily thankful and uh, because maybe it comes to easily for them they / / I guess it didn't take much to do that. (ID420:BaselineNAI)

Each of the four CPCS Categories: 'Self-criticism'; 'Pleasant'; 'Introverted'; and, 'Unbalanced' was represented by seven participants, or 35% of the sample. The category 'Self-criticism' was characterized by the following self-descriptors: "I am insecure"; "I am self-conscious about my looks"; "I'm not smart enough"; and, "I am very self-critical and I have no confidence." 'Pleasant' was indicated by the following: "I am humorous and funny"; "I am a real nice person"; and "I am agreeable". 'Introverted' was indicated by views of self being "quiet and unassuming"; "I am socially kind of shy"; and, "I am very quiet and reclusive." The Category 'Unbalanced' was characterized by the following: "I am irritable"; I get upset easily"; and "I am frustrated."

Each of the following six CPCS Categories was represented by six, or 30% of the participants: 'Sympathetic', 'Good', 'Warm', 'Extroverted', 'Intelligent', and/or 'Hardworking'. 'Sympathetic' included the following self-descriptors: "empathic", "loving", "understanding and listens", while 'Good' included the following self-descriptors "I have a good heart" and "I am a good person." The Category 'Warm' was characterized by "affectionate", "gentle", and "sensitive." The Category 'Extroverted'

was represented by "sociable", "has close friends" and "I am outgoing. " The Category 'Intelligent' was characterized by the following descriptors: "I am smart"; and I well-educated," and the Category 'Hardworking' was represented by "I am a hard-worker"; and "I am motivated and do best."

The final category in Figure 3, 'Active', was represented by 5, or 25% of the participants. This Category included those who described themselves as "I am a go-getter"; "I have high energy"; and, "I am adventurous."

To summarize, the portrait painted by graphing the CSPC Categories onto the self-descriptors produced by participants at baseline indicated that, before entering treatment for depression, participants described themselves as being largely altruistic (to a fault), self-critical, unbalanced, pleasant, and introverted.

CSPC – Participant Baseline NAI Profile

Recovered versus non-recovered at post-treatment. An important question addressed in this study was whether participants who benefited from treatment for their depression differed from their non-recovered counterparts in terms of how they described themselves at baseline.

Of the 156 CSPC Categories represented by the 210 self-descriptors generated by the 20 participants at baseline, 51.3% (n = 80) were attributed to the 11 participants who recovered from their depression at post-treatment, while 48.7% (n = 76) were attributed to the 9 who did not recover following treatment.

Of the 80 Categories represented by the 11 recovered participants, 27.5% (n = 22) were subsumed under the 'Personal' Area, 26.3% (n = 21) under the 'Relational' Area,

16.3% (n = 13) under the 'Emotional' Area, 12.5% (n = 10) under the 'Moral' Area, 10% (n = 8) under the 'Intellectual/Organizational' Area and, less than 4% were subsumed under the 'Existential, Concrete Descriptors and Values and Interests' Areas (n = 2, n = 3 and n = 1, respectively).

Of the 76 Categories represented by the 9 post-treatment non-recovered participants, 22.4% (n = 17) were subsumed under both the 'Personal' and 'Relational' Areas; 21.1% (n = 16) under the 'Emotional' Area, 19.7% (n=15) under the 'Moral' Area, 11.8% (n = 9) under the 'Intellectual/Organizational' Area and less than 2% subsumed under the 'Existential, Concrete Descriptors and Values and Interests' Areas (n = 1, n = 0 and n = 1, respectively).

A closer look at the CSPC Categories in Figure 4 indicates that the participants in the post-treatment non-recovered group described themselves as being 'self-critical, altruistic, good and warm' at baseline, whereas participants in the recovered group drew upon more descriptors indicating they viewed themselves as being 'hardworking and unbalanced'.

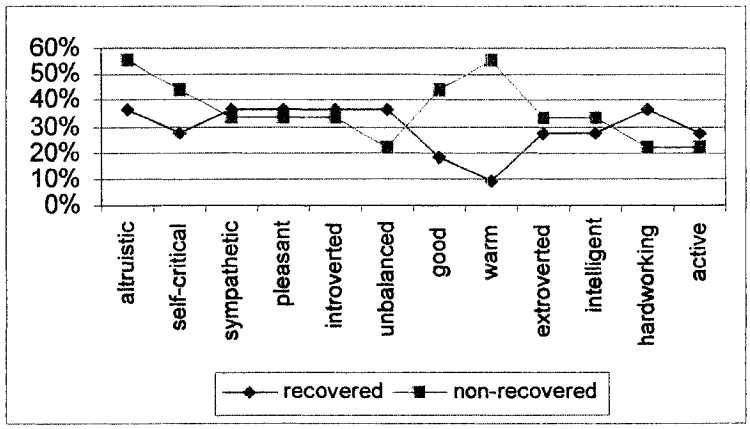
While we must remain cognizant of the small sample size, these preliminary findings suggest that there may have been some important differences between the post-treatment outcome groups in how they viewed themselves before entering treatment. Of particular interest is the suggestion that those participants who continued to struggle with their depression after treatment entered therapy by disclosing more self-descriptors indicating a negative self-perception (i.e., self-critical) and emphasizing their moral attributes (i.e., altruistic – to a fault; good) that did those that recovered after treatment.

Figure 4

Classification System of Personal Constructs – Top 12 Categories

Participants' Baseline Profiles

Recovered versus Non-recovered at Post-treatment



The Classification of Self/Other Convergence – NAI Baseline

One of the questions addressed in this study was when struggling with depression, to what degree does one's views of self converge with how one perceives oneself to be viewed by others? Figure 5 reports the results of the analysis of this phenomenon via the application of the Classification System of Self/Other Convergence.

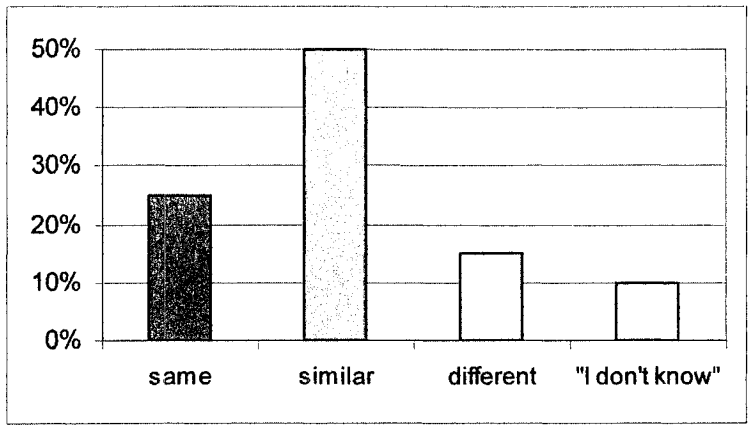
According to baseline findings, 25% (n=5) of the participants were judged to have viewed themselves as being the 'same' as how they felt others viewed them; 50% (n=10) to have viewed themselves as 'similar' to how they felt others viewed them, while 15% (n=3) were judged to have described themselves 'differently' than how they felt others viewed them. Ten percent (n=2) of the participants stated that they 'did not know' how others viewed them. The majority of participants (75%) felt that their view of self was either similar to how they perceived others viewed them, different from how they saw themselves, or they did not know how others would describe them. Only 25% of the participants were judged to have seen themselves in the same way that they perceived others viewed them.

Figure 5

Classification System of Self/Other Convergence

Baseline Analysis

All Participants



The Classification System of Self/Other Convergence

Recovered versus non-recovered at post treatment. Another question addressed in this study was the degree to which post-treatment recovered participants moved towards a greater convergence between how they viewed themselves and how they perceived others viewed them, compared to their non-recovered counterparts. In order to conduct this comparative outcome analysis, two coders reviewed the participants' post-treatment NAIs (i.e., their responses to the Question #2 and the reactions and stories that illustrated their responses) to determine if there had been a shift in the degree of convergence. Each participant was judged by the two coders to have either moved to a greater degree of convergence (i.e., to a higher category at post-treatment – 'similar' to 'same'); to a lesser degree of convergence (i.e., to a lower category at post-treatment – "same' to 'I don't know', to be 'still the same/similar' (i.e., baseline responses were categorised as either 'same' or 'similar' and that was judged not to have shifted at post-treatment); still different (i.e., baseline and post-treatment descriptors were judged to be different), or still did not know how others viewed him/her following treatment (i.e., 'I still don't know')

Of the 20 participants in this study, 11 participants were judged to have recovered from their depression at post-treatment. Of these 11, 27.3% ($\underline{n} = 3$) were judged to have shifted to a greater degree of convergence between how they viewed themselves and how they perceived others viewed them. The following excerpt illustrates this shift:

> (Interviewer reviewing with participant his baseline NAI response during the post-treatment NAI): That's part of the journey. I don't know who knows me anymore. That's true. That has shifted. This is a deep one. There is part of that that is still there and the knowing of self, I'm much more self-aware. So I'm now

> able to share that with a confidence that I did not have before...so do people know me? No, they're beginning to know me because I am more open now. (ID415:PostNAI)

None of the 9 non-recovered participants were judged to have moved to a greater degree of convergence between how they viewed themselves and how they felt others viewed them at post-treatment. Indeed, the analysis indicated that 44.5% (n = 4) of the post-treatment non-recovered participants were judged to have diverged from seeing themselves as how they felt others viewed them (i.e., responses classified 'less convergent' according to the post-treatment application of the Classification of Self/Other Convergence).

The following excerpt illustrates a shift to 'less convergence.' In his baseline NAI, this participant was assessed to have seen himself as 'similar' to others' perceptions of him. In this excerpt, taken from his post-treatment NAI, he was judged to have revealed a story indicating that he really doesn't know how others view him.

> (Interviewer: Um, now you also talked about how others would describe you and it was actually pretty similar as to how you would describe yourself, friendly, easy to get along with, outgoing, generous and caring. um, do you think that others still view you that way after the therapy experience?) Yeah I think so. I don't think, I mean again I've talked about that with L. (participant's therapist in the study) a number of times that I was actually thinking about handing them a little questionnaire like I've been facing, to certain people, just to, not necessarily about what the changes are but I guess just to say how do people see me, because it's not something I've really, it's something I've thought a lot about but I guess I've never really thought, 'well what is it, you know, my best friend really thinks of me.' (405:PostNAI)

Of the 11 post-treatment recovered participants, 45.4% (n = 5) were judged as 'still the same/similar' at post-treatment indicating that how they viewed themselves and how they perceived others viewed them prior to treatment (i.e., either 'same' or 'similar') had

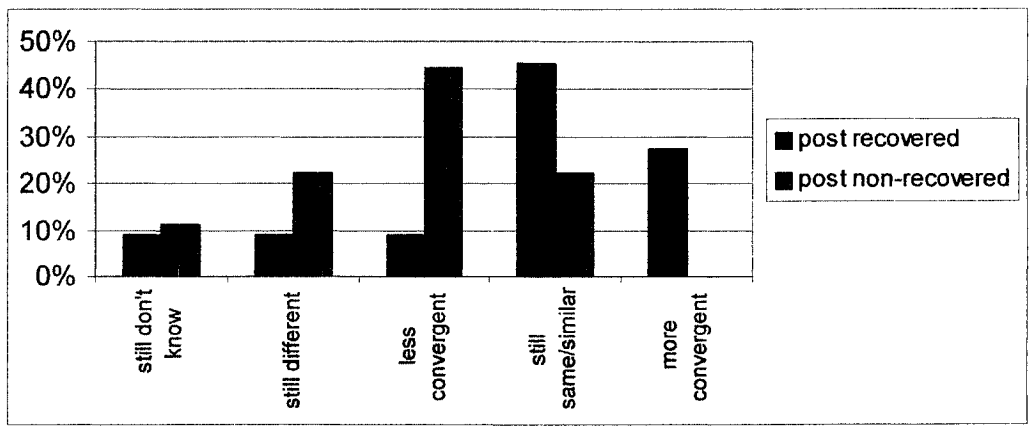
not changed. The remaining three post-treatment recovered participants (27.3%) fell into the categories of 'less convergent', 'still different' or 'still don't know.

Of the 9 post-treatment non-recovered participants, only 22.2% (n = 2) were judged as 'still the same/similar' at post-treatment indicating that how they viewed themselves and how they perceived others viewed them prior to treatment (i.e., either 'same' or 'similar') had not changed. The remaining three post-treatment non-recovered participants (33.3%) fell into the categories of 'still different' or 'still don't know.' (see Figure 6)

Figure 6

Classification System of Self/Other Convergence

Recovered versus Non-Recovered at Post-treatment



The Classification System of Client Self-Change Statements: Baseline NAI

A glimpse into what the participants wanted to change about themselves before treatment (i.e., at baseline) and how they did in treatment (i.e., post-treatment outcome) is presented as a segue to the next section of the results, which shifts from a focus on perceptions of the story-teller to a focus on the stories told.

If I could change something about who I am... Figure 7 presents the percentage of baseline self-change statements coded according to the Classification System of Client Self-Change Statements.

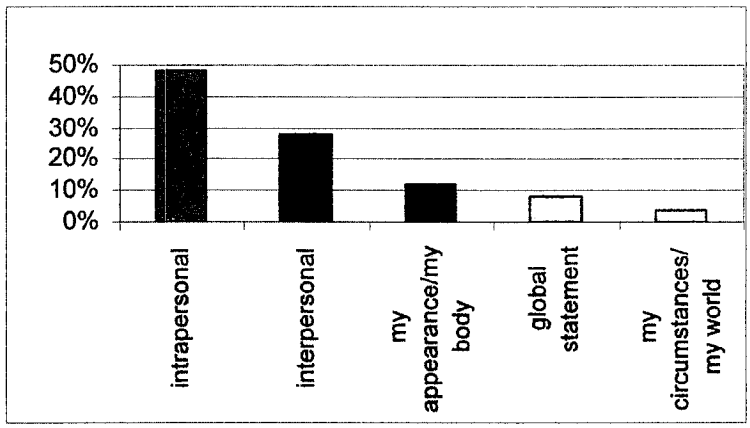
A total of 50 responses was generated at baseline by the participants in response to Question #3 of the NAI protocol: "If you could change something about who you are, what would you change?" Of these 50 responses, 24, or 48%, were coded as indicating that participants wanted to change an aspect of themselves (i.e., intrapersonal change), 28% (n = 14) as wanting to change how they reacted to others and to the world (i.e., interpersonal change) and 12% (n = 6) as wishing to change something about their physical appearance. Only 4 (8%) of the responses were coded as global statements about change, such as "I want peace in my life", and 2 (4%) as reflecting participants' wishes to change something about their circumstances or their world, such as "I want to be back in a position where I can contribute."

Figure 7

Classification System of Client Self-Change Statements

Baseline

All Participants



Classification System of Client Self-Change Statements

Post-treatment comparative analysis of baseline change statements. The question addressed by this analysis was whether or not the recovered and non-recovered outcome groups differed in what they felt they wanted to change about themselves before entering treatment. Figure 8 reports the percentage of self-change statements (i.e., baseline NAI responses to question #3, "If I could change something about who I am, what would I change?") by treatment outcome, according to the categories that emerged from an initial thematic analysis of participants' baseline change responses according to the Classification System of Self-Client Change Statements.

Of the 50 responses given by the 20 participants at baseline to the third question of the NAI, 26 (52%) of the responses were given by the 11 participants who recovered from their depression at post-treatment, while 24 (48%) of the responses were given by the 9 post-treatment non-recovered participants.

Of the 26 baseline NAI responses offered by the post-treatment recovered participants, 9 (34.6%) of the responses were coded as a desire for 'intrapersonal change', 11 (42.3%) responses were coded as a desire for 'interpersonal change, 2 (7.7%) statements were coded to indicate a desire to change 'my appearance/my body', while 2 (7.7%) statements were coded as a 'global statement' of change and 2 responses were coded wanting to change 'my circumstances/my world'.

Of the 24 baseline NAI responses given by non-recovered participants, 15 (62.5%) responses were coded as a desire for 'intrapersonal change', 3 (12.5%) responses were coded as a desire for 'interpersonal change, 4 (16.7%) responses were coded as wanting

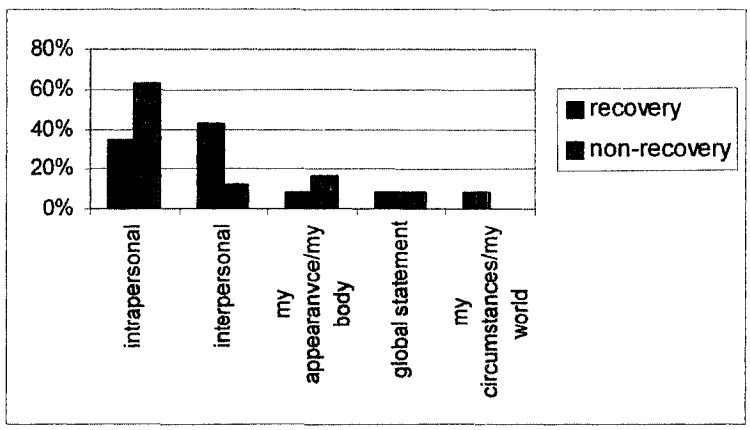
to change 'my appearance/my body', and 2 (8.3%) statements were coded as a 'global statement' of change. No responses in this group were coded 'my circumstances/my world."

These findings suggest that those participants who went on to recover from their depression indicated at baseline a desire to change how they experienced their world and how they interacted with others (i.e., interpersonal change), while their non-recovered counterparts entered treatment wanting to change primarily something about themselves; something about who they were (i.e., intrapersonal change). These results also suggest that discontent with one's physical appearance may play a role in depression and its maintenance.

Figure 8

Classification System of Client Self-Change Statements at Baseline

Recovered versus Non-Recovered



Section 1- Summary of Findings: The Participant as 'Story-teller'

Baseline NAI Profile

Table 4a is a summary of the most frequently coded categories represented by the three classification systems used in the initial analysis of baseline NAI data which, taken as a whole, provides a tentative baseline NAI profile of the 20 depressed participants in this study. According to this baseline NAI profile, participants described themselves largely in relation to others (CPCS Area: 'Relational'); they also used descriptors to represent aspects of character (CPCS Area: 'Personal'). More specifically, before entering treatment, the participants described themselves as being largely altruistic (to a fault), pleasant, introverted, self-critical and unbalanced. At baseline, there were a higher number of participants who were judged to view themselves as similar to how they felt someone who knows them well would describe them, as opposed to viewing themselves as the same. Finally, the participants' baseline self-change responses reflected a desire to change something about who they were (i.e., intrapersonal change versus interpersonal change).

An examination of recovered and non-recovered participants' baseline responses at termination of treatment revealed a couple of interesting trends. First, it was found that participants who recovered from their depression described themselves largely in interpersonal terms (CSPC Area: 'Relational') and indicated that what they wanted to change about themselves was the way they interacted with others and their world (i.e., interpersonal change). Second, there was also an indication that participants in the non-recovered group entered treatment using self-descriptors that reflected emotional and

moral attributes (i.e., CSPC Areas: 'Emotional and Moral') and reported that what they wanted to change was something about their personality (i.e., intrapersonal change) and/or their physical appearance. (See Table 4b.)

Table 4a. Baseline NAI Profile

Classification System of Personal Constructs (CSPC)

Areas	*Categories*
Relational	
	Pleasant
	Introverted
	Sympathetic
	Extroverted
Personal	
	Self Critical
	Hard-working
	Active
Emotional	
	Unbalanced
	Warm
Moral	
	Altruistic
	Good

Degree of Convergence

same
similar
different
I don't know

Self-Change Statements

intrapersonal
interpersonal
my appearance/my body
global statement
change my circumstances

Table 4b. Baseline NAI Profile by Post-Treatment Outcome

Post-Treatment Outcome	Recovered	Non-Recovered
	CSPC - Areas	
	Relational	Emotional
	Personal	Moral
	Self-Change Statements	
	Interpersonal	Intrapersonal
	Change my circumstances	My appearance/body

Section 2.

The Participants' Stories

The focus of this second section of the results is an exploration of the participants' autobiographical memory narratives (ABMs), disclosed in the NAI protocols at baseline, treatment termination, and 6-month follow-up. Two separate analyses were undertaken to assess participants' ABMs. The first involved the application of Singer and Moffitt's Coding Manual for Memory Type (1992) to all ABMs disclosed in the three NAI protocols completed at baseline, post-treatment and 6-month follow-up in order to asses ABM subtype specificity. The second analysis involved data emerging from the application of the Classification System of Types of Self-Story Change to the ABMs disclosed by the participants at post-treatment and at 6-month follow-up.

Autobiographical Narrative Subtype Analyses

Frequency of ABMs Across All Three NAIs: All Participants

In the present study, 309 personal narratives disclosed by participants in the context of the three NAIs protocols were judged to be autobiographical (i.e., contained information related to self) using Singer and Moffitt's (1992) Coding Manual for Memory Narrative Type and were found to contain sufficient information for coding.

Of the 309 ABMs identified, 135 (43.7%) narratives were in response to Question #1 of the NAI (i.e., "How would you describe yourself?"- - hereafter referred to as 'ABM-self'), 66 (21.2%) were in response to Question #2 of the NAI (i.e., "How would someone who knows you well describe you?" - - hereafter referred to as 'ABM-self/other') and 108 (35.1%) were in response to Question #3 of the NAI protocol (i.e., If

you could change something about who you are, what would you change?" - - hereafter referred to as 'ABM-change'). The mean number of ABMs generated by the 20 participants was 15.45 with median of 14, a mode of 14 and a range from 5 to 31. The fewest number of ABMs (n = 5) was generated by Participant ID:409, for whom English was not his first language. This finding indicates that participants in this study articulated stories of personal memories of past and current experiences and that the participants were able to generate stories in response to all three questions involved in the NAI protocol.

Frequency of ABMs by NAI Question Across All Three NAIs

Figure 9 summarizes the percentage distribution of ABMs in response to each of the three NAI questions across the three different time periods. At baseline, 64 ABMs-self (75.3%), 14 ABMs-self/other (16.5%) and 7 ABMs-change (8.2 %) made up the total of 85 ABMs disclosed by the participants. At post-treatment, 34 ABMs-self (29.6%), 27 ABMs-self/other (23.5%) and 54 ABMs-change (46.9%) made up the total of 115 stories generated by the participants. In the 6-month follow-up interview, 37 ABMs-self (34%), 25 ABMs-self/other (22.9%) and 47 ABMs-change (43.1%) were identified and made up the total of 109 ABMs generated by the participants in their follow-up interviews.

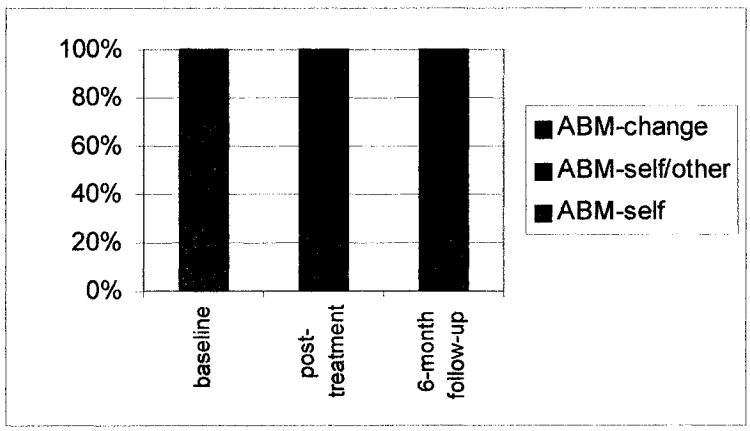
The findings suggest that participants were able to generate ABMs in response to the three NAI questions across all three time periods. One noticeable divergence from this pattern was the lower percentage of narratives disclosed at baseline to Question #3 of the NAI (i.e., "If you could change something about who you are, what would you change?"). This finding was to be expected, however, because participants were not

directed to provide illustrations of self-change at baseline. Exploration and illustrations of self-change were probed only following treatment.

Figure 9

Percentage Distribution of ABMs in Response to the NAI Protocol Questions Across the Three NAI Time Periods

All Participants



ABM Narrative Subtypes: Overall

The 309 ABMs disclosed by the 20 participants across the three NAI time periods were also coded according to Singer and Moffitt's Manual for Memory Type (1992). Overall, 45 (14.6%) of the ABMs were coded as single-event stories, 213 (68.9%) ABMs were coded as generic, while the remaining 51 (16.5%) ABMs were coded as eventless.

ABM Specificity Subtypes: Baseline, Post-treatment and 6-Month Follow-up

Table 5 presents a summary of ABM analyses across the three NAI time periods. Thirteen (15.3%) of the 85 ABMs generated in the baseline NAI were coded as single-event, 63 (74.1%) of the ABMs as generic, while 9 (10.6%) as eventless. At post treatment, 12 (10.4%) of the 115 ABMs generated by participants were coded as single-event, 82 (71.3%%) as generic and 21 (18.3%) as eventless. During the follow-up NAI 6 months following treatment, 20 (18.3%) of the 109 stories generated by the participants were coded as single-event, 68 (62.4%) as generic, while 21 (19.3%) were coded as eventless.

According to this analysis of ABM subtypes across the three NAI time periods, the majority of ABMs disclosed by the depressed participants at baseline were coded as generic and this finding is consistent with the ABM depression literature. At treatment termination, the number of single-event ABMs and the number of ABMs coded as generic remained relatively stable, while the number of ABMs coded as eventless increased. In the NAI conducted 6 months following treatment, to a certain extent the number of single-event ABMs increased and the number of generic ABMs decreased, while the number of eventless ABMs remained relatively stable.

Table 5

Summary of ABM Narrative Subtype Analysis Across the Three NAI Time Periods (N=20)

	Autobiographical Memory Narrative Subtypes			
Time	Single-Event	Generic	Eventless	Total
Baseline	13 (15.3%)	63 (74.1%)	9 (10.6%)	85 (28%)
Post-Txt	12 (10.4%)	82 (71.3%)	21 (18.3%)	115 (37%)
6-Mo.	20 (18.3%)	68 (62.4%)	21 (19.3%)	109 (35%)
Total	45 (14.6%)	213(68.9%)	51 (16.5%)	309

ABM Subtype: Overall: Post-Treatment Recovered versus Non-recovered Participants

Of the ABMs told by the recovered and non-recovered treatment outcome groups, the following comparative analysis addressed the question of whether there was a difference in the relative frequencies of the single-event ABMs in all three NAIs across these two groups. In other words, of the total of 309 ABMs told by all participants across all NAIs, did the two groups differ in the proportion of ABM narrative subtypes?

Of the total of 309 ABMs identified across all three NAIs, 152 (49.2%) were generated by the 11 recovered participants at treatment termination, while the remaining 157 (50.8%) were generated by the nine participants who were assessed to have not recovered from MDE at post-treatment.

The findings reflected little difference in terms of the relative frequency of ABM narrative subtypes between the post-treatment recovered participants and the post-treatment non-recovered participants.

Of the 152 ABMs generated by the 11 recovered participants, 16.4% ($\underline{n}$ = 25) of the ABMs were coded as single-event, 67.8% ($\underline{n}$ = 103) were coded as generic, while 15.8% ($\underline{n}$ = 24) were coded as eventless. Of the 157 ABMs disclosed by 9 participants deemed non-recovered at post-treatment, 12.7% ($\underline{n}$ = 20) of the ABMs were coded as single-event, 70.1% ($\underline{n}$=110) were coded as generic, while 17.2% ($\underline{n}$ = 27) were coded as eventless[3].

[3] In consideration of both the nature of my research inquiries and the unequal numbers across the outcome and follow-up groups, comparative analyses and their corresponding figures are largely presented using relative frequencies.

ABM Subtypes Across Time by Post-Treatment Outcome

This analysis explored whether or not there was a difference in the pattern of ABM narrative subtypes before and after treatment between the post-treatment recovered group versus those who had not recovered from Major Depressive Episode (MDE) at treatment termination.

Recovered subgroup. Of the 152 ABMs disclosed by the 11 recovered participants, 44 (29%) were told at baseline, 55 (36.2%) were told in the post-treatment NAI, while 53 (34.8%) were told in the NAI conducted 6 months following treatment.

Of the 44 ABMs disclosed by the recovered participants at baseline, 10 (22.8%) were coded as single-event, 28 (63.6%) as generic, while 6 (13.6%) were coded as eventless. Of the 55 ABMs disclosed by the recovered participants at post-treatment, 5 (9.1%) were coded as single-event, 41 (74.5%) as generic, and 9 (16.4%) as eventless. (See Figure 10a).

Non-recovered subgroup. Of the 157 ABMs disclosed by the 9 non-recovered participants, 41 (26.1%) were told at baseline, 60 (38.2%) were told in the post-treatment NAI, while 56 (35.7%) were identified in the NAI conducted 6 months following treatment. The frequency of the ABMs identified between the two post-treatment outcome groups across time were similar.

Of the 41 ABMs disclosed at baseline by the non-recovered participants, 3 (7.3%) were coded as single-event, 35 (85.4%) as generic, and 3 (7.3%) as eventless. Of the 60 ABMs disclosed at post-treatment by the non-recovered participants, 7 (11.7%) were

coded as single-event, 41 (68.3%) as generic, while 12 (20%) were coded as eventless. (See Figure 10b).

These findings suggest that the highest percentage of ABM subtypes in the baseline and post-treatment NAIs for both outcome groups pertained to the generic subtype. However, an initial distinction may be drawn when exploring the pattern of ABM narrative subtypes between the two post-treatment outcome groups. According to these findings, the post-treatment recovered group gave more single-event ABMs (22.7%) at baseline than did their non-recovered counterparts (7.3%). This finding suggests that before starting treatment, the recovered participants told more specific, detailed and concrete stories illustrating their views of self and how they perceived others viewed them. The non-recovered group, on the other hand, told more generic and, therefore, abstract stories to illustrate how they viewed themselves and how they felt others viewed them.

At the outset of this exploratory study, I had suggested that the ability to consolidate self-change in specific, single-event personal narratives would differentiate those participants that were no longer depressed versus those that continued to struggle with depression. In other words, recovered participants would generate more single-event ABMs at post-treatment as compared to their non-recovered counterparts. Contrary to this expectation, the number of generic ABMs increased for the recovered group and decreased for the non-recovered group at post-treatment, while the number of single-event ABMs rose only slightly at post-treatment for the non-recovered group and decreased only slightly for the recovered group. The frequency of eventless ABMs

remained stable for the recovered group and rose slightly for the non-recovered group at treatment termination.

Figure 10a

ABM Narrative Subtype at Baseline and Post-Treatment:

Post-Treatment Recovered Group

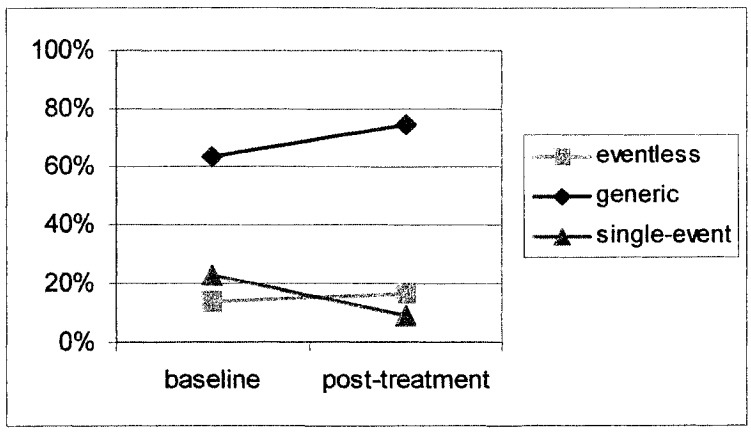
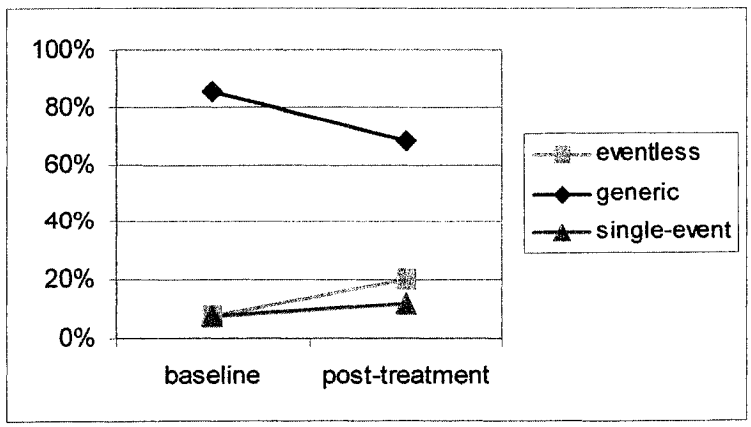


Figure 10b

ABM Narrative Subtype at Baseline and Post-treatment:

Post-Treatment Non-Recovered Group



ABM Narrative Subtypes Across Time by Outcome at 6-Month Follow-up

This final analysis focused on the frequency of ABM subtype across the three NAI time periods for the group of participants who sustained recovery at follow-up versus the group that continued to be depressed 6 months following treatment.

Of the 20 participants included in this study, eight were assessed to have sustained recovery from their depression at 6 months following treatment and five sustained non-recovery.[4]

Of the 309 ABMs told by the 20 participants, 110 ABMs were told by the eight participants who sustained recovery and 85 ABMs were disclosed by the five participants who sustained non-recovery at 6 month follow-up.

According to this analysis of relative frequencies, the sustained recovery group disclosed a higher percentage single-event ABMs at baseline (14.3%, n = 5) and more generic ABMs (77.5%, n = 31) at post-treatment than did their sustained non-recovered counterparts (4.2%, n = 1 and 54.5%, n = 18, respectively). However, the sustained non-recovery group disclosed a higher percentage of generic ABMs at baseline (83.3%, n = 20) and a higher number of eventless ABMs (27.3%, n = 9) at post-treatment than the sustained recovery group.

At 6-month follow-up both groups disclosed a similar number of single-event ABMs (17.1%, n = 6 and 17.9%, n = 5). The sustained recovery group generated a slightly

[4] The four participants who were assessed to continue to "struggle" with their depression at follow-up, the two participants who relapsed at 6 months following treatment and the one participant who recovered in the 6 months following treatment were not included in this analysis for two reasons: 1) the intent of this comparative analysis was to focus on sustained recovered and sustained non-recovered participants; and, 2) the small number in two of these groups prevented the suggestion of any meaningful trends.

higher percentage of generic ABMs (68.6%, n = 4 compared to 60.7%, n = 17) relative to the overall frequency of ABMs this group disclosed. (see Figures 11a & 11b.)

Figure 11a

ABM Narrative Subtypes Across Time By Outcome at 6-Month Follow-up

Sustained Recovery Group

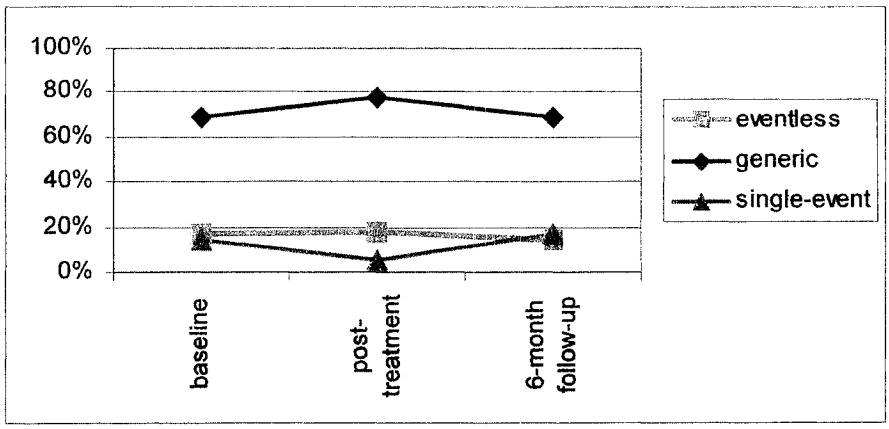
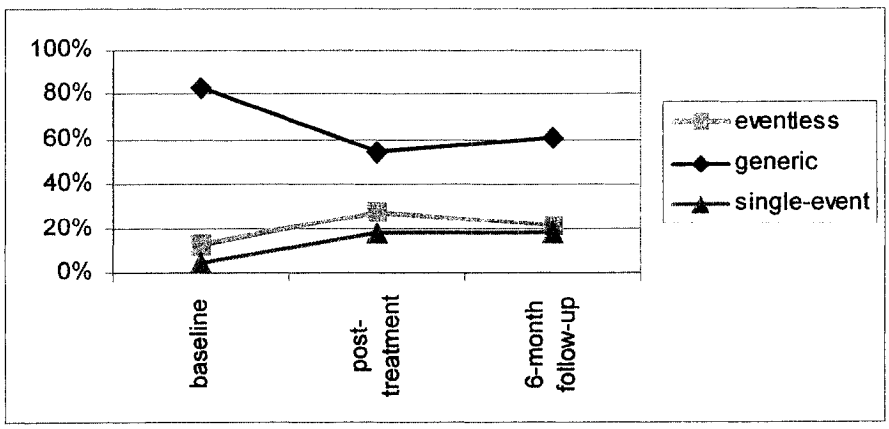


Figure 11b

ABM Narrative Subtypes Across Time By Outcome at 6-Month Follow-up

Sustained Non-Recovery Group



The Story: Analysis of Stories of Change

The next series of findings emerged from exploring the content of the ABMs disclosed by the study's 20 participants during the post-treatment and 6-month follow-up NAIs. Of the 309 ABMs, a total of 224 ABMs were produced at post-treatment (n=115) and 6-month follow-up (n=109). These 224 ABMs were coded according to the Classification System of Types of Self-Story Change. Of the total of 224 ABMs, 15.2% (n=34) were coded as a 'story of the same', 4.5% (n=10) as 'story of the same – but okay', 3.1% (n=7) as 'reframe story', 40.6% (n=91) as 'story of changing', and 36.6% (n=82) as 'story of change'.

A main avenue of inquiry in this study was to explore whether participants who had recovered from their depression differed from their non-recovered counterparts in their ability to generate single-event stories of change at treatment termination. The first analysis investigated the types of story change disclosed by the two outcome groups at post-treatment. This was followed by an analysis of types of story change by ABM narrative subtype to determine if indeed post-treatment recovered participants generated more single-event stories of change as compared to the post-treatment non-recovered participants.

Classification System of Types of Self-Story Change – Recovered versus Non-Recovered

In the post-treatment NAI, the 20 participants in this study produced 115 ABMs of which 55 (47.8%) ABMs were generated by the 11 post-treatment recovered participants and 60 (52.2%) by the 9 participants making up the post-treatment non-recovery group.

Of the 55 ABMs told by the post-treatment recovered participants, 5.5% (n= 3) were coded 'story of the same', 5.5% (n = 3) were coded 'story of the same- okay', 5.5% (n = 3) were coded as a 'reframe story', 36.4% (n = 20) were coded as 'story of changing' and 47.3% (n = 26) were coded as 'story of change'.

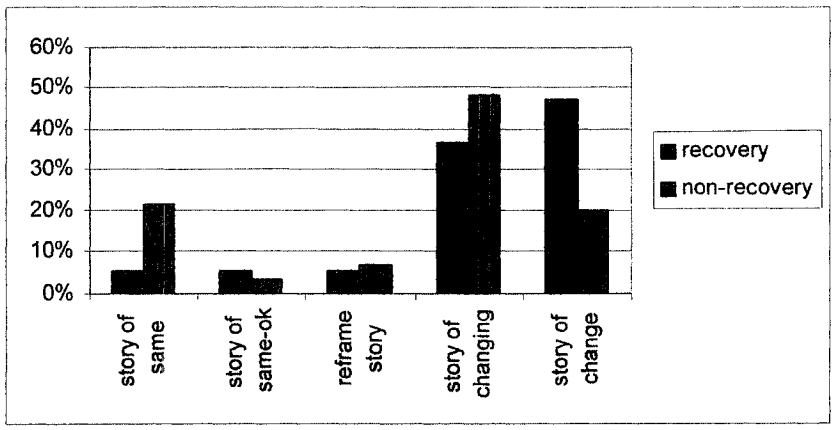
Of the 60 ABMs told by at post-treatment by non-recovered participants, 21.7% (n = 13) were coded as 'story of the same', 3.3% (n = 2) as 'story of the same- okay', 6.7% (n = 4) as a 'reframe story', 48.3% (n = 29) as 'story of changing', and 20% (n = 12) were coded as 'story of change'.

According to this analysis, a much higher percentage of ABMs given by the post-treatment recovered participants were coded as 'story of change' (47.3%) compared to their non-recovered counterparts (20%). The post-treatment non-recovered participants told a higher percentage of ABMs coded as 'story of the same' (21.7%) and 'stories of changing' (48.3%) as compared to post treatment recovered group (5.5% and 36.4% respectively). These results are presented in Figure 12.

Figure 12

Classification System of Types of Self-Story Change at Post-treatment

Recovered versus Non-recovered



Types of Self-Story Change by Post-treatment Outcome by ABM Subtype

This next analysis addressed the question of whether post-treatment recovered participants disclosed more single-event self-stories of change as compared to their non-recovered counterparts. Figure 13 illustrates the percentage of ABMs coded according to the Classification System of Types of Self-Story Change by ABM narrative subtype by post-treatment outcome.

The most striking difference between the post-treatment outcome groups emerging from this analysis was the ability of the recovered group to generate a higher percentage of both single-event and generic ABMs that were coded 'stories of change', while their non-recovered counterparts appeared to generate a higher percentage of single-event and generic ABMs that were coded as 'stories of changing' or 'stories of the same.'

Of the 55 ABMs disclosed by the post-treatment recovered participants, 41.8% (n = 23) were coded as single-event (n = 3) or generic (n = 20) 'stories of change'. Of the 60 ABMs generated at post-treatment by the non-recovered participants, 20% (n = 12) were coded as 'stories of change' of which 58% (n = 7) were coded generic and 42% (n = 5) were coded eventless. The non-recovered group told no single-event 'stories of change' at post-treatment.

In contrast to the recovered group who disclosed a higher percentage of 'stories of change', the non-recovered group disclosed a higher percentage of single-event and generic ABMs coded as 'stories of changing' at post-treatment. Of the 60 ABMs the non-recovered group generated, 48% (n = 29) were coded at 'stories of changing' of which 20.7% (n = 6) were coded single-event, 65.5% (n = 19) were coded generic and

13.6% (n = 5) were coded eventless. Furthermore, the non-recovered group disclosed a much higher percentage of generic and eventless ABMs coded as 'story of the same' than their recovered counterparts (21.7% (n = 13) compared to 5.5% (n = 3)).

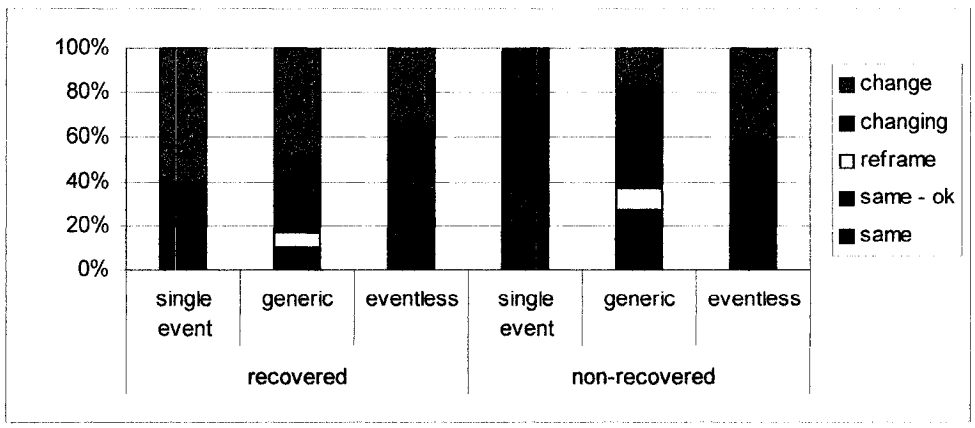
The findings suggest that the recovered participants in this study were able to consolidate change in the stories they disclosed after treatment, while their non-recovered counterparts appeared to still be in the process of changing, or unable to generate stories of change and instead returned to stories that indicated they hadn't changed (i.e., stories of the same). Note that none of the recovered participants told single-event stories of the same. See Figure 13.

Figure 13

Classification System of Types of Self-Story Change

by ABM Narrative Subtype

Recovered versus Non-Recovered



Ability to Generate Self-Stories of Change as a Marker of Sustained Recovery at Treatment Follow-up

The final analysis of autobiographical memory narrative explored whether those participants who sustained recovery from their depression 6-months following treatment generated more 'stories of change' at post-treatment compared to the group of participants who either sustained non-recovery or continued to 'struggle' with their depression.[5] As such, the question of whether consolidating shifts or gains from treatment in personal stories post-treatment was a potential indicator of sustained recovery following treatment was considered.

Of the 115 ABMs disclosed in the post-treatment NAI protocols, 40 (34.8%) were told by the eight participants who sustained recovery from their depression 6-months following treatment. Of these 40 ABMs told by the sustained-recovery group, 57.5% (n = 23) ABMs were coded as 'story of change', 27.5% (n = 11) were coded as 'story of changing', 5.0% (n = 2) were coded as 'reframe story', 2.5% (n = 1) story was coded as 'story of the same, okay', and 7.5% (n = 3) were coded as 'story of the same'.

Of the 115 ABMs disclosed in the post-treatment NAI protocols, 33 (28.7%) were told by the five participants who sustained non-recovery from their depression at 6-months following treatment. Of the 33 stories told by the sustained non-recovery group, 12.1% (n = 4) were coded as 'story of change', 42.4% (n = 14) were coded as 'story of

[5] The two participants in this study who relapsed at 6 months following treatment and the one participant who recovered were not included in this analysis because the number of participants in these groups were too small to even suggest meaningful trends.

changing', 3.0% (n = 1) was coded as 'reframe story', 6.1% (n = 2) were coded as 'story of the same, okay', 36.4% (n = 12) were coded as 'story of the same'.

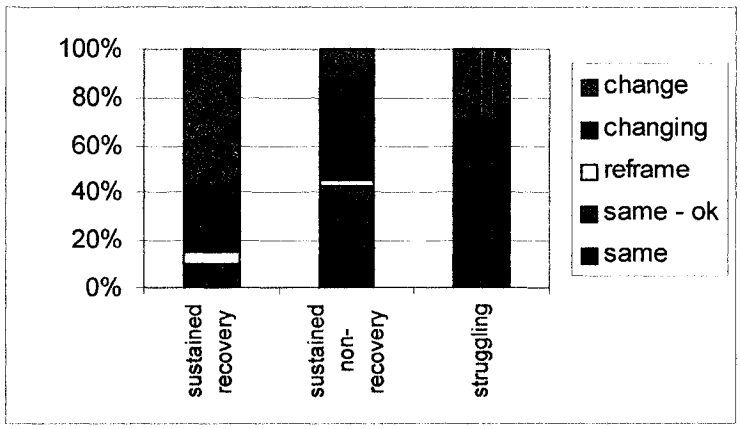
Of the 115 ABMs told in the post-treatment NAI, 27 (23.5%) were told by the four participants who deemed as 'struggling' 6-months following treatment. Of the 27 ABMs told by the 'struggling' group, 29.6% (n = 8) were coded as 'story of change', 66.7% (n = 18) were coded as 'story of changing', and 3.7% (n = 1) were coded as 'story of the same'.

These findings suggest that the ability to generate self-stories of change at post-treatment may be a significant indicator of sustained recovery from depression 6 months following treatment. According to this analysis, the sustained recovery group appeared to be able to identify and story their experiences of intrapersonal and interpersonal change at post-treatment and 6-month follow-up. The stories they generated indicated an updating their stories in light of new awareness gained in therapy. In other words, new experiences and insights in the context of their intrapersonal and interpersonal experiences were reflected in the content of their post-treatment stories. Those participants who continued to struggle with their depression following treatment told more stories of changing at post-treatment. The most intriguing interpretation of these results is that the sustained non-recovery group appeared to tell far more 'stories of the same' at post-treatment, suggesting an inability to consolidate new or alternative stories of self in the world, which in turn may be a significant indicator leading to their sustained non-recovery. See Figure 14.

Figure 14

Classification System of Types of Self-Story Change at Post-treatment by 6-Month Follow-up Outcome

Sustained Recovery, Sustained Non-Recovery and Struggling



Section 3.

A Qualitative/Interpretive Investigation of Participants' Depression Stories and the NAI.

This exploratory study was the first attempt to apply the Narrative Assessment Interview (NAI; Hardtke & Angus, 1998) to a sample of participants involved in a treatment study of depression in order to conceptualize clinical phenomena in terms of clients' narrative accounts of experiences of change pre, post and follow-up to treatment for their depression. The first two parts of the results section adopted a paradigmatic approach to addressing the data generated by the NAI protocols by applying classification systems in order to investigate how clients viewed themselves, as well as to exploring the frequency and pattern of story-type and story-content both within and across the NAI protocols. The third and final exploration undertaken and presented in the results section shifts from a positivistic and quantitative approach to a non-positivistic and qualitative approach in its' investigation of the unfolding of two participants' unique stories of depression and treatment outcome. This exploration was not intended to be a comprehensive grounded analysis of these participants' experience, but rather an initial attempt to capture the contextual richness of the narrative accounts provided by two participants with contrasting outcomes. It is also intended to demonstrate the intersection between quantitative and qualitative methodologies for an enhanced understanding of clients' experiences of change.

The first participant, who from here on in will be referred to as 'Alan', was a post-treatment recovered participant who was assessed to have sustained recovery from his depression at 6-month follow-up, according to standardized outcome measures. The

second participant, whom I will call 'Inge', did not recover from her depression at treatment termination continued to struggle with her depression 6 months following treatment. These are their stories.

Alan's Baseline NAI

Upon entering the York II Depression Study, Alan was a 48 year-old married father of three teenage children and a lawyer by profession, although in the last 3 years he had not been able to secure employment in his field: "I fell off my cliff 3 years ago; my career, my job, my life went crashing into a wall." According to Alan, as his career soured his wife found increasing success in her career.

During the baseline NAI, Alan described himself as: "very intelligent, well-educated with a good sense of self-awareness. I am the father of three – a good conscientious father. I am married. I am a professional, a problem solver, and a giver – a person who contributes to the welfare of others." Although the self-descriptors Alan generated in his baseline NAI were generally positive, his descriptions of self in the context of the roles he played in his life stood out as negative. For example, when asked to describe his role as a husband, Alan reported: "I'm a terrible husband; I can't meet my spouse's needs at this point." When asked what kind of father he was, Alan replied: "I wish I knew."

When asked to provide stories to illustrate the other descriptors he generated to describe himself, Alan either told sparsely detailed generic autobiographical narratives or gave no related story at all. For example, when asked to provide a recent story that might illustrate himself as intelligent, well-educated and self-aware, Alan reported,

> You mean, um - - not recently, um - - - I guess two parts of it would come in. There's a quick illustration, we're looking , what, last week...recently working

> through a bit of a business deal with a couple of other lawyers and sticking my neck out quite a bit, small stuff but taxing me non-the-less...um the second thing is that I am writing a history of uh, the county in S(name of country). Is that intelligent?

When asked to generate a story to illustrate himself as a contributor, a giver, Alan said,

> Um -- working through uh things with my family, with my oldest son right now, um things in his life, I contribute to people that, who have needs and come to me uh, with my - // uh, finding one a job or something, it's very important, so that people come into my life uh in any way shape or form and I try to give back good things.

Alan's responses to the second question of the NAI offered further insight into his experience of depression. What seemed important to his sense of self-worth was the extent to which he was able to fulfill the specific roles in his life; roles that appeared to be essential threads in the fabric of his self-identity. When Alan was asked to describe how he perceived significant others in his life viewed him (i.e., Question #2 of the NAI) he said, "I have no idea. – that is part of my journey, um, I don't know who knows me well anymore. I would have thought that my spouse knows me better than anyone else and she doesn't either." When the therapist asked Alan how his wife would describe him, Alan responded, "intelligent, hard working, that would be the two, intelligent, hardworking individual that I guess is very supportive in a number of ways." In response to the therapist's inquiry in how his kids would describe him, Alan said, "I think they would say I'm their dad – I don't know how they would describe me beyond that, I really don't."

Alan's response to the final question of the baseline NAI, "if you could change something about who you are, what would you change?", shed further light onto his

experience of himself as unhappy with his current life situation, as illustrated in the following excerpt:

> Uh, there are many things I would change (sigh) um - - - there's, I don't really have anywhere I'm at right now, but I would like to change my circumstances, if I was going to change one thing, that doesn't change me it just changes my role, my environment, where I'm at right now. I am not happy with my circumstances, so I would want to change that, I'd want to be wise enough and old enough to understand what I've gone through, so that's the internal side....where I'm at right now I have to change, I'm not happy with my situation, I know that has to change and I don't know where or how it will manifest itself or sometimes if it'll manifest itself. I have to be back in a situation where I belong and I can contribute, I have to change that...I know I have to laugh more – I don't laugh. (ID415:BaselineNAI)

A number of themes emerged from Alan's responses to the NAI protocol at baseline and the personal stories he shared began to weave a unique tapestry of his experience of himself when depressed. The extent to which Alan emphasized the roles he played as threads in the fabric of his self-identity and the extent to which he was unable to fulfill his roles or to find success in his profession appeared in the foreground fuelling a negative appraisal of himself and his self-worth. His view of self and the stories he shared from his life seemed incongruent. Alan's accounts of his current lived experience appeared to fall outside of his dominant narrative or view of himself as efficacious and successful. Furthermore, his inability to generate stories that illustrated how his wife and children viewed him indicated a further disconnect between his view of self and his current lived experience. Indeed, a desire to change his external circumstances to bring them into line with his sense of self was something he indicated he wished to change.

Towards the end of his baseline NAI, at which time his therapist conducted the NAI, Alan was asked if he had anything to add. At that time he reported that he felt the most

valuable part of the interview was having the opportunity to describe how others saw him:

> (Therapist [T]): Okay, - that's all for this piece is there anything you'd like to add?) Curiosity / / / / or as to the sequencing of questions here, uh what are they really or what is the question they're after or what are you after in this research part to try to fill out the uh the whole person, um - I think the uh the most valuable part of that questionnaire is how other people would see me (T: mm-hm) and that ties into the roles of how any human being is seen. (T: mm-hm) I am uh seen by some as a professional lawyer who can go out and be the um, the knight of the twenty-first century, uh fighting away the crimes, there's that role. (T: mm-hm) Some people would see me at it or used to anyway, some people see me as an educator, some people see me as a healer (T: hm) um - so how people see me reflects on how I see myself sometimes (T: mm-hm) and if I don't have people looking at and can taking / or their needs in me where I'm able to contribute something I won't (sigh) (T: hm -) That's a very deep thought (T: and +it /) /+ (T: like so yeah) / / / more fully, what I think that for any human being when you're trying to get a profile of an individual, what roles do you have and where you you're augmenting those roles and where you see those roles and where do they / near to life. (T: and I think that's a good / in how you see like the you know you asked before what uh they're looking for I don't think there's a specific formula as much as people see themselves in different ways, they describe +themselves in / /) and at different times+ in their lives +too S. um (T: definitely definitely+) If one was to take me um 10 years ago um senior executive, corner office, (T: mm-hm) um phone ringing off the hook, uh people standing in line, so that's in a different role. (ID415:BaselineNAI)

It is interesting to note that woven into his above remarks is Alan's validation of the importance of the questions asked in the NAI protocol, which included inquiries into how he saw himself and how he felt others who knew him well would describe them.

An exploration of the NAI material gathered from Alan before treatment suggested that he was living a fragmented and largely negative self macro-narrative woven with sparsely detailed stories of his inability to bring into congruence his sense of self with his lived experience. This disparity may have been seen as a key precipitant to his deteriorated mood and view of himself. Although possessing a fairly stable and positive

view of himself as indicated by his responses to the first question of the NAI protocol, his changing life circumstances and particularly his unemployment led him to question his self-efficacy and self-worth. Alan emphasized that how others viewed him determined how he viewed himself. As an unemployed lawyer, Alan said that he found himself retreating from others and socializing less for fear of being criticized. Alan's decreased sense of self-worth and self-efficacy appeared to have been cornerstones of his depression.

Inge's Baseline NAI

Upon entering the York II Depression Study, Inge was a 60-year old divorced woman who had had a 40-year career as a nurse. She had no children and was not partnered. When she entered treatment, she was struggling to secure disability insurance because she could no longer work as a nurse due to physical impairments. She noted that the prospect of an insecure financial future left her feeling quite desperate and she disclosed some suicidal ideation during the course of treatment. During treatment, Inge also revealed, apparently for the first time, a past history of childhood sexual abuse from which she felt she had not healed.

During the baseline NAI, Inge described herself as a woman who loved to laugh and had a good sense of humour. She commented:

> Sometimes I laugh too much…I use humour and laughter sometimes to, um avoid, cover up something else. I am very conscious of not wanting to upset other people, in fact most of my friends have no idea what I am going through because I don't want to talk with them, and I laugh a lot with my friends

Inge reported that people would tell her that she was easy to talk to but she emphasized that people saw what she wanted them to see: "Although people think that I am very extroverted, in fact, um, I am really quite shy and feel very self-conscious."

Inge went on to described herself as a perfectionist in some things, intelligent and a very kind and gentle person. When asked to provide an example in ways she was a perfectionist, Inge disclosed:

> I am probably a perfectionist in everything. I think that it is a problem so I try to, very hard, like, housecleaning, it's very hard for me to house clean because of my physical problem so I decided I had to learn to live with the dust, so I am not a good housekeeper, not at all. I guess, I think that the perfectionism interferes and it always has in a way because when I start to do something I have to do it perfectly or I don't do it. And I do things that, people say I go way beyond that what anybody would expect (Therapist: so the feedback you are getting and yet you probably don't see that happening because you are so) No I do see that myself, that doing that is a problem. Whereas people say it as a compliment, 'you've gone way beyond, oh you're so organized', on that way, it is at a tremendous cost to me. So I see that as a problem.

Inge's experience of herself as going beyond what is expected is further illustrated by the following excerpt:

> I always say to people, oh, I'll do it, don't worry. That is a really strong trait of mine. I will look after you. I will take care of things, don't you worry about a thing. And I do. I take on too much. I take on projects and then I get really angry because people expect it.

Inge added that she would describe herself as having a strong conscience and that she placed importance on being courteous. She also noted that she had recently become unaware of how much anger she carried within her.

In response to Question #2 of the NAI, Inge reported that "I don't know anybody who knows me well...people in my life haven't known me. They have me very

incorrect, very incorrect judgements of me." When asked to provide an example, Inge said:

> Well the one I hear quite a lot is that I am stubborn. I know why people say that is because I have very strong ideals and I have very strong standards but I don't have a lot of them but just the ones I have are very strong. So if you try and convince me, for example, I don't believe in God. That's a personal belief. I've thought about it carefully. I believe everybody has the right to believe in whatever you want but I don't believe in God. So if you wanted to get into a discussion with me about whether or not there is a God I will discuss it with you up to a certain point on a sort of philosophical, intellectual issue but not for long. And if you try and convince me that I was wrong, then you might say that I am being stubborn because I am not listening to you...to me its not stubborn, it's just, I won't act against my conscience...I am so flexible about things I am always shocked when people call me stubborn but I am called stubborn.

Inge went on to provide a number of descriptors regarding how she felt others saw her including "friendly", "open and able to share joy", "direct", "tenacious and fun." Woven into the stories Inge disclosed to illustrate a number of these descriptors, however, was the sense that she felt she had been incorrectly judged or misunderstood by others. Inge described her experience of her work colleagues in the following excerpt:

> I love my sense of humour but not everybody does and I guess, oh well, if you would ask the people I work with, this last group, they think that I'm terrible, no they do ah, I don't know what they think, yeah I do know what they think, they made it very clear, they cannot stand me, they can't stand me really.

When asked if she could change something about who she was, what would she change, Inge replied:

> I wish I could just be me and I wish that being me could include me getting angry and know how to. Because I think that anger can be constructive but I don't know how to deal with it and I wish I could. I wish I could just give into my pain and say it is okay to have it and it's also okay to let other people know that I have it but I don't even recognize it a lot of the time until it gets too bad that I can't, so I would like to do that. I would also like to have some peace in my life and I would like not to, I never had anybody in my life, for most of my life, but you

> know I do for the first time…I wish I could go back, I wish I had known a lot of the things I know now 20 or 30 years ago.

An exploration of the NAI material gathered from Inge before treatment suggested that Inge's struggle appeared largely intrapersonal as she appeared unable to negotiate her internal world (i.e., I have anger and don't know how to express it) with her external world (i.e., I don't like to upset people). There was a suggestion of her inability to establish healthy boundaries (i.e., I take on too much) but even before that, her inability to even recognize her own needs (i.e., I wish I could just be me and I wish that being me could include me getting angry and know how to). Unlike Alan, whose baseline NAI responses suggested a fairly positive view of self, which because of external circumstances left him feeling a sense of deteriorated self-worth, Inge appeared to present a fragmented and incoherent sense of self that left her feeling misunderstood by others and having to wear a 'mask' to hide her genuine self; a self from whom she herself was estranged. The differences between Alan and Inge are further widened by their desires for self-change. Whereas Alan appeared to desire congruence between his self-perception and his external circumstances, Inge seemed to first need to find congruence within her own sense of self.

Alan's Post-treatment NAI

Alan's post-treatment responses to a traditional battery of quantitative outcome measures, indicated that he no longer met the criteria for Major Depressive Episode. During his post-treatment NAI, Alan reported that he had experienced a "profound change" and that he was experiencing a sense of "wholeness and self-identity."

In his baseline NAI, Alan indicated that if he could change something about who he was, he would like to "change my life circumstances, to be wise enough and old enough to understand what I'm going through; I'd like to be back in a situation where I belong and can contribute; I have to learn to laugh more; I have to learn to have fun." When reflecting on these statements in the context of the post-treatment NAI, Alan reported that he was in the process of changing his life circumstances:

> This is marvellous. Have I changed my life circumstances, well that's obvious. And now I'm in the process of doing that. The real world is still the real world and I'm still facing a lot of career things that I faced 3 years ago when I fell off my cliff. The real world doesn't move because you want it to. But there is within me a new confidence...there came a point in my life where I was at a dead end. My career and my job, my life went crashing against a wall. And I wasn't happy with where I was, so I started, what was I meant to do? That paradigm shift that I went through. And that has come from inside, deep inside. So that answer to that is, have I changed? Fundamentally. And its' now with a confidence in what my gifts are. That I even speak differently now. I am starting to learn voice control. And a whole bunch of interesting and wonderful things...I started off as a college volunteer. There are a lot of places that I can contribute and I'm finding more.

Reflecting on his responses to his baseline NAI descriptions of self on the Narrative Interview Summary Sheet, Alan commented:

> I don't think that I've lost intelligence, I've gained it. Well-educated? Yes. Now I'm experiential. I have knowledge of the experiential side so I would think of myself as much better educated. Awareness of myself? Very very profound change...so yes, I am much more aware, to the point where I look back and say 'well gee, how could I have been so cut off from that part of myself?

Alan said that at this juncture he could describe himself as a "better father" and he was able to provide a recent, detailed story involving his son that illustrated this change. Alan stated that he felt distressed about having called himself a "terrible husband" in his baseline NAI. He reported:

> I saw myself as a failure. I remember that was terrible. I was unable to contribute to my other half. I'm not sure that, terrible, well if I said that, than that is what I said. That's an emotional response. That's judgemental...when I called you, the program, my wife was on a trip to the S.(country). She had found herself and I had a conversation with her, I was logically feeling, my logical side, that was in awe of her, that she was on this journey. And I had nothing more to offer her. Nothing more to offer. That's pretty low self-esteem to start off with. It was also rational self-esteem. I'm not giving you. Up here I don't know how to have fun. I now have Friday laughter days. Fridays we have to bring in something of humour, laughter. This is a conscious effort on my part to bring this in as an important part of what we are trying to achieve.

Finally, responding to the interviewer's probe into how he feels others see him, Alan said:

> They're just beginning to know me because now I'm more open...I had come to a point where I couldn't go out for dinner with anybody. I could not go out and talk to people. There was a whole sheltering. This affected my wife negatively as well. Don't dare let people know what I'm doing or not doing. Built all those shells and walls around us, but those are pretty well all gone. I can't think of too many people that I'm afraid of talking to. There is a richer side that I have to show (Interviewer: You're beginning to show that side but you don't really know how others view you?) No, because of this whole issue of, let's just say, knowing as a human being that's getting easier and easier. What I'm finding out as I got back and talk to people, that's all they want to know you as. And there are people out there who will say, 'well, what is it you do? what is your work?'

Alan's responses during his post-treatment NAI and his ability to begin to generate current stories of changing appeared to illustrate a growing congruence between his lived experience and his sense of self. This, in turn, seemed to begin to contribute to a growing sense of his own self-worth, although at this point he indicated that he was still unsure how others would see him. The threads of his identity, as represented by his autobiographical narratives, were beginning to become more strongly woven, thus giving potential insight into, and a lessening of, his depressive symptoms.

Inge's Post-Treatment NAI

Inge's post-treatment responses to a battery of self-report outcome measures, indicated that she continued to meet the criteria for Major Depressive Episode. Despite this outcome, Inge commented at post-treatment that she had found she had met a number of personal goals in treatment. Inge reported:

> It's amazing uh, because I feel like uh, I went through this little exercise before the therapy ended uh, because I wrote out some of my goals when it first started, and I went through them to see, and I was very surprised that I, I had set my goals very low actually, and I had achieved all of them and way more, it was lovely, lovely, lovely, lovely good experience, yeah really good.

In her baseline NAI, Inge indicated that if she could change something about who she was, she would "wish I could be me and I wish that being me could include the anger because I think that anger can be constructive. I wish I could just give in, I have pain and I recognize that I'm having pain and say it's okay to have it, but don't even recognize it a lot of the time until it gets so bad." When reflecting on these statements in the context of the post-treatment NAI, Inge reported:

> Have I changed? no I don't think that I've really changed, uh when the pain gets there bad enough, I know its there and I may or may not (Interviewer: so that hasn't really changed?) You know what, I'm not positive. I may have changed a little bit, I know S (her therapist) used to often say you can stand up if you want because I guess she saw me looking uncomfortable, uh, actually, I've noticed myself over the last couple of weeks saying uh, saying to myself well, now wait a minute, you have to go to the bathroom, so you might as well go right now instead of waiting, that's the nursing thing, you know, I've got all of these things to do, so I'll just go later (laughs), or um, you know, I said to myself two days ago, you've been freezing cold for 3 hours, why don't you just get a sweater, so I did. Or take a pill, you know, you're hurting you know, so maybe I have, maybe just starting a little bit.

It appears that in the context of her post-treatment NAI, Inge began to engage in a process of restorying her experiences, which at first she felt had not changed. Reflecting

on her responses to her baseline NAI descriptions of self on the Narrative Interview Summary Sheet, which included, "I'm so angry I don't know what to do with my anger", Inge commented:

> Yeah (Interviewer [I]: that's still there?) Uh, but I'm not as angry...(I: so there's some things going on with your anger?) maybe (I: sounds like its shifting a bit) maybe, well I did do something I've never done in my life, last week. I don't know what was getting me but I sat in a chair and I thought I felt like screaming, I've never felt like that so I picked up a pillow and I screamed!, oh I did it about four times.

Together with the interviewer, Inge continued to describe her experience of small shifts in how she viewed herself and how she felt others viewed her. For example, when reviewing her baseline self-descriptors "I love to laugh, sometimes I laugh too much, I use humour and laughter sometimes to avoid; I don't want to upset people and tell them what I am going through", Inge remarked:

> I think I may be doing a little, uh, more consciously, because you don't want, you don't want definitely to cover something up. I think that maybe I'm doing that a little less...no that's changed, uh, that's changed, none of my friends knew what I was going through last fall, I didn't tell them at all, but I discussed, that's changed, I'm telling them a little bit more.

NAI Follow-up and Epilogue

The exploration of the NAI material collected from Alan and Inge suggested that clinical change, in terms of their scores on standardized outcome measures, gave a limited snapshot of these participants' outcome. By including a narrative conceptualization of change, and by exploring their unique outcome stories via the application of the NAI, snapshots became portraits, which included a richer layering of their experience of, and the impact of, their treatment for depression. For example, although Alan was considered 'recovered' at post-treatment and 'sustained recovery' at 6

months following treatment, his stories indicated that he was still in the process of changing. Having not consolidated 'stories of change', he could be considered at potential risk for relapse. Indeed, during his 6-month follow-up interview, he indicated that he was still in the process of finding his purpose in life. At that time he commented on his previous Narrative Interview Summary Sheets with the following:

> Intelligent? I've learnt more everyday and ah, a good listener, better father, all that I can be. A terrible husband is still an issue. That didn't go away. Partly because of the two-career thing, part of it because of the success thing, what it means to be successful. All those external roles, there is a tension there that I am not able to contribute financially right now, which beats me up, not that my spouse beats me up (Interviewer: you beat you up). Oh do I ever, and that's a trigger that sends a whole series of downward spirals for me that end me up feeling, not functioning. That would be probably the remaining two areas of my life that I have to sort of fix and move up and I'll be fine. A flower can bloom but no-one appreciates the flower.

Although the quantitative battery of measures Alan completed at 12 months following treatment indicated that he had sustained recovery from his depression, his new macro-narrative does not appear to be firmly embedded in his lived experience, indicating a sense of fragility and signalling the potential benefit of further therapeutic work. His story gives the reader the impression that he is potentially vulnerable for a relapse into depression.

Following the review of Alan's three NAI protocols, I returned to the York II Depression Study data. Alan relapsed into depression 17 months following treatment.

In her NAI administered 6 months following treatment, although still depressed according to standardized outcome measures, Inge continued to narrate small, but personally relevant shifts in behaviour when reflecting on her two previous NAIs, particularly her stories around self-care. According to Inge, in the months since finishing

therapy, she had secured a disability insurance and was actively involved in group art therapy, a referral facilitated by her therapist in the study. Although still feeling depressed, Inge reported "ups and downs, sometimes it goes." Her final comments included:

> I felt coming to therapy with S.(her therapist in the study) was just so – it was really good. I felt she gave me um, (sniff) I think probably the greatest gift a person can give another person, she just listened to me.

DISCUSSION

Fuelled by the notion that the stories people tell about themselves are essential threads in the fabric of their self-identities, the present study set out to explore whether or not a sample of participants with depression saw themselves differently before and after experiencing significant gains in therapy and if, and in what ways, the stories they told about themselves changed following treatment. Although conceptualizing clinical phenomena in terms of 'narrative' has captured the attention of investigators in the psychotherapy research field, few have ventured into the arena of developing comprehensive research agendas that include assessing therapy outcomes from a narrative approach (McLeod, 2004). Heeding the call for the development of "new and expanded outcome measures that assess psychotherapy from multiple perspectives, which are also better calibrated to actual behavioural functioning" (VandenBos, 1996, p.1006) and to "develop a new outcome research paradigm that involves an active collaboration between researcher and clinician" (Goldfried & Wolfe, 1996, p.1007), this exploratory study presented the first comprehensive investigation of participant post-treatment narrative change using the Narrative Assessment Interview (NAI; Hardtke & Angus, 1998). In this present exploratory study, the NAI was administered at baseline, post-treatment and again 6 months following treatment to a sample of 20 participants who took part the in the York II Study of Depression. Throughout this section, findings are discussed in terms of their research and clinical implications.

Following the colloquial notion that "good things come in threes", this Discussion, like the previous Results section, is presented in three major sections. The first section

develops the perspective of participant as 'story-teller,' or "who am I?" This section begins with an overview of the self-descriptors generated by the NAI protocols, followed by a discussion of the participants' profiles (i.e., the content of participants' personal constructs) that emerged from graphing the Classification System of Personal Constructs (CSPC) onto their baseline NAI data. Findings from applying the Classification of Self/Other Convergence to participants descriptors is discussed. The findings from the thematic content analysis of participants' baseline responses coded according to the Classification System of Client Self-Change Statements are addressed next. Although the findings from each of the individual analyses are presented first, the most compelling picture of the story-teller experiencing depression emerges when the individual findings are pieced together. Here the findings indicating disruptions within the self, as well as disruptions in the individual's interaction with his or her world, are discussed as markers of vulnerability to emotional distress.

The second section of this chapter focuses on the findings emerging from the analysis of participants' autobiographical memory narratives (ABM). This section begins with a discussion of the findings emerging from the investigation of autobiographical memory (ABM) narrative subtypes identified in the participants' three NAI protocols (i.e., baseline, post-treatment and 6 months following treatment). This is followed by an examination of the ABM in terms of the Classification System of Types of Self-Story Change. A discussion of the potential significance of consolidating self-change in stories of change and its relationship to treatment outcome and relapse at follow-up is the thread that ties the final section of ABM findings together.

The first two avenues of inquiry taken by this exploratory study's investigations were driven by a positivistic approach to the NAI 'data' by developing and applying classification systems in order to investigate how participants viewed themselves and their desires for self-change, as well as exploring the frequency and pattern of story type and content both within and across the NAI protocols. Over a decade ago, Toukmanian and Rennie (1992) argued in favour of the richness of inquiries adopting methodological pluralism in the psychotherapy research investigation. "By methodological pluralism, we mean the combination, in the same study, of procedures expressive of both the narrative and the paradigmatic approaches to explanation" (Rennie & Toukmanian, 1992, p. 246). In the same vein, Ponterro and Grieger (1998) have argued for merging both qualitative and quantitative perspectives into one's research identity, of viewing quantitative and qualitative methods as complementary, rather than as competing camps. According to these authors, "the researcher who can 'wear two hats,' so to speak, shifting in sequenced and integrative fashion between small-group descriptive and large-group normative approaches, will be more effective and better able to capture the true complexity of the phenomenon under study" (Ponterro & Grieger, 1998, p. 56).

Consequently, the third section of the results if this study shifted from a quantitative to a qualitative approach in its investigation of the unfolding of the unique outcome stories of two participants with contrasting outcomes. In the third section of the discussion, an initial attempt to capture their stories of depression, as well as making salient the valuable clinical information that may be gleaned from participants' NAI material, is presented. This response to the calls of Toukmanian and Rennie (1992) and

Ponterro and Grieger (1998) is a vital aspect of this dissertation, given that despite the availability of various methods to explore therapy outcomes, there has been a dearth of research studies adopting a pluralistic approach to inquiry. As a recent break from this single-genre research, Klein and Elliott (2006) in their study of clients' accounts of personal change in Process-Experiential psychotherapy will be introduced in this final section of the discussion.

This chapter concludes with a discussion of the limitations of the present study and directions for future research.

Section 1. The Participant as Story-teller

Baseline NAI Profile

The NAI Self-Descriptors

Baseline findings indicated that the NAI protocol was successful in eliciting self-descriptors from the 20 participants in this study--in almost all cases, the participants in this study were able to generate a number of self-descriptors at baseline in response to questions #1 and #2 of the NAI protocol (i.e., 1. "how would you describe yourself?"; and, 2. "how would someone who knows you well describe you?")[6]

The descriptive summary statistics for the baseline descriptors indicated that the participants generated more descriptors about themselves than about how others viewed them. There was also a great deal of variability in the number of descriptors participants generated in response to the first two NAI questions. The following factors might have contributed to the fewer descriptors generated in responses to question #2 and the wide

[6] The reader is reminded that the baseline NAI was conducted by the participant's therapist immediately following the first therapy session.

range of descriptors both within and across the two NAI questions. Given the interactive, co-constructed nature of the NAI protocol, a lack of activity from either member of the dyad would influence the data generated. From the protocol transcripts, it is clear that some therapists were much more active and involved than others in prompting their clients for descriptors. For example, while some therapists appeared to only ask for descriptors once, others continued prompting their participants, resulting in a higher number of descriptors. Alternatively, some participants were naturally more verbose and/or more engaged in the interview. Another explanation for the variability in the results of particularly the self-other differential is that participants' depressed state at baseline may have left them with less energy to participate in the interview, as well as influencing their ability or insight into exploring how they felt someone who knew them well would describe them. In addition, one participant responded to Question #2 that others would view her as she would view herself. She did not specifically re-iterate the self-descriptors, which were subsequently not included in the summary self-other descriptive statistics, thereby potentially artificially lowering the mean number of responses. Finally, the participant who generated the least number of descriptors appeared not to have English as his first language. Although this may not have been a factor in the lower number of descriptors generated by this participant, it does raise a fascinating question with regards to the extent to which individuals might describe themselves differently when speaking in--versus not in--their first language. Potential answers to this question, while beyond the scope of this dissertation, might involve the

implications of language on how individuals view themselves and how they feel they are perceived by others.

The Classification System of Personal Constructs (CSPC)

A main avenue of inquiry in the present study was to explore and potentially develop a picture of individuals suffering from Major Depressive Episode--to gain insight in how the story-teller sees himself or herself before entering treatment for depression. The Classification System for Personal Constructs (CSPC; Feixas, Geldshlaeger & Neimeyer, 2002) was used as a first step in this exploration and it laid the foundation for an examination of the content of the participants' personal construct system--the thematic emphasis of individuals' systems of meaning, in terms of the descriptors the participants generated in the baseline NAI. Following the hierarchical nature of the CSPC, participants' descriptors generated in the baseline NAI were first graphed onto the categories of the system, which were then subsumed and labelled under the 'Areas' of the CSPC. In general, the descriptors generated by participants in the baseline NAI protocols graphed easily onto the CSPC 'Categories' suggesting that the system, which focuses on value or dispositional constructs, was a suitable choice to summarize the self-descriptors generated by the NAI. This exploration was also the first attempt to apply the CSPC to the personal construct contents of a depressed population (Feixas, personal communication, January 2005).

CSPC – 'Areas'. An initial glimpse into participants' self-perceptions before entering treatment was first acquired in terms of the CSPC Areas, the higher order classification that subsumes the CSPC Categories onto which the baseline self-descriptors

were graphed. This initial overview indicated that almost half of the total descriptors (49.6%) generated by participants at baseline represented the 'Personal' and 'Relational' Areas of the CSPC. Examples of self-descriptors generated by participants endorsing a Category that was subsumed under the 'Personal Area' included "at times I feel unlikeable"; "I lack self-confidence"; "I'm strong-minded and persistent"; and, "I am a perfectionist and tenacious." Examples of self- descriptors generated by participants endorsing a category that was subsumed under the 'Relational Area' included: "I'm easy to get along with"; "I am introverted and quiet"; "I am a people-person"; "I am supportive"; and, "I am friendly, open and compassionate."

The higher representation of the 'Personal and Relational 'Areas' of the participants' baseline self-descriptors would be expected given the way in which the self-descriptors are elicited by the NAI. Because the NAI asks participants how they would describe themselves and how they feel others would describe them, responses can be expected to capture aspects of participants' personality or character, the cornerstone of the 'Personal' Area of the CSPC, as well as descriptors capturing participants' self-relation-to others (i.e., 'Relational' Area).

The third most frequently represented CSPC Area was the 'Emotional' Area that accounted for 19% of the self-descriptors generated by participants at baseline. Examples of participants' self-descriptors falling under the "Emotional Area" included "I am moody"; "I am sensitive and jealous"; "I am frustrated easily and short-tempered"; and, "I don't laugh anymore." The finding that participants in this study frequently used constructs wedded to their emotional and internal states suggested their experiences of

depression not only influenced how they saw themselves but also how they felt they presented themselves to others in their world. While reflecting on his two previous NAIs during the 6-month follow-up interview, one participant, together with the interviewer, summarized the impact of his life-long struggle with depression, on his sense of self and his interactions with others:

> (Interviewer: um, has anything related to that question changed since the post therapy interview?) I don't know, um, I may have changed my general point of view on the issue. (I: okay, in what way?) I am beginning to think now that um, my personality can be defined as to my relative depression (I: ah, okay, so it's not like your personality is a fixed thing and that's the way you are it's like when you're depressed) I'm beginning to think now that yeah, that, sorry to interrupt you but I'm beginning to think now that if I wasn't depressed at all, I would be a lot (?: generally) a lot more positive, outgoing person, um (I: so it feels like your real personality and the depression takes it away) yeah. (I: okay, but this pattern that you talk about in both these interviews, there's a change, you said 'my mood swings aren't as big and they don't last as long') So what I'm saying is that if we take the premise then that um, I might be, well it's hard to say, I might be an outgoing person (?: normally) ah, but because of, I have constantly got um, depression hanging over me to a certain degree. It affects all my interactions with people. If I'm feeling very depressed, I won't even talk to you. um, and even in a social setting, if my, for whatever reason my depression increases, I withdraw from everybody, even in a social situation. And it can be more hourly. And this is where this whole thing talks about, I mean this day, or that week, I live with it from beginning to end but with waves everyday to +varying degrees (I: up and down+) yeah, I mean, I'm trying to think, when was the last time you saw Lake Ontario glass smooth? It may happen but I have never seen it, you know. and for me glass smooth would be no feelings of depression whatsoever. So now we're ripples or waves or storms. There is always something. you see. So now I'm beginning to wonder really who am I, without the depression? So that, I can't imagine. I think, but I don't really know. So then now I'm left with defining myself as depending on my current level of depression. (I: so the closest you can come is how you feel when you're not feeling depressed, which is that lively outgoing person) I do remember a time, I think I mentioned this to you, it was a long weekend and I was twelve years old and I'm sure at that time I had zero depression. And I surprised myself. I was feeling like, who is this person? (ID402:6monthNAI)

The fourth most frequently represented CSPC Area was the 'Moral' Area that accounted for 16% of the self-descriptors generated by participants at baseline. Examples of self- descriptors generated by participants endorsing a category that was subsumed under the 'Moral' Area included "I am generous, I go out of my way to give people a hand"; "I am a good person, a good mother"; "I put others first a lot, like to a fault"; and "I have a strong conscience." A fascinating aspect of how the participants in this study saw themselves at baseline was the frequency of self-descriptors, and as will be discussed next, the frequency of participants who endorsed a category subsumed by the 'Moral Area' of the CSPC. Participants in this study appeared to emphasize their morality at baseline, while frequently eliciting self-descriptors of themselves as good, generous and giving.

How the participants in this study described themselves before entering treatment for depression is brought into focus when examining the CSPC 'Categories' endorsed by the self-descriptors participants generated at baseline. A discussion of the findings from this application of the CSPC is undertaken next.

CSPC – 'Categories'. The second order of classification in the CSPC hierarchy are the Categories upon which the participants' baseline self-descriptors were graphed. An intriguing finding in this exploration was that almost half of the participants in this study elicited self-descriptors coded according to the Category 'Altruist.' Examples of self-descriptors in the 'Altruist' Category included "generous"; "I can be counted upon"; "I am concerned about others"; and, "I am selfless and giving." A closer look at the results revealed that five of these nine 'altruistic' participants (56%) spontaneously

extended their altruistic self-descriptions by adding that they put others first and gave to others, to a fault. The following excerpts taken from two participants' baseline NAI protocols illustrates this tendency to perceive oneself as putting others' needs ahead of one's own:

> I put others first, like to a fault, you know what I mean? (Therapist: mm-hm) like going to work early, staying through my break, coming home late, just trying to do a good job, and yet, you know, I should have left it and said 'oh well, too bad for him, my kids need me and they are waiting at home'...and I wasn't putting it into perspective. (ID412:BaselineNAI)

> I go out of my way, like even to you know to my own detriment, so that I wouldn't hurt someone else, my father was like that too, unfortunately, yeah unfortunately, that's all I know how to do. (ID407:BaselineNAI)

These findings indicated that the depressed participants in this study emphasized at baseline their morality and good nature. One interpretation of these findings was that although the perceptions of these participants was that they were extremely giving and generous, the experience of not having their own needs met -- either because they were unable to ask, were unable to set personal boundaries or did not know their own needs -- left them feeling that others were benefiting at their expense. Being able to intuitively respond to others' needs, they saw themselves as giving but because they didn't know, or couldn't ask to have their own needs met, they were left with a perception that they gave to others to their own detriment.

A further examination of construct content at baseline indicated that a high percentage of the total number of participants in this study used constructs related to self-criticism and being pleasant, introverted and unbalanced. The following excerpt

taken from a participant's post-treatment NAI illustrates the self-critical nature of his baseline self-perception, as well as his post-treatment reactions to his baseline statements:

> (Interviewer [I]: (During the baseline NAI you indicated that you viewed yourself as...married, professional, see yourself as a terrible husband...Do you still see yourself foremost in this way or has that shifted and changed for you?) I'm distressed that I said that. I saw myself as a failure. I remember that was terrible. I was unable to contribute to my other half. I'm not sure that terrible, well if I said that, then that is what I said. that's an emotional response. that's judgemental...(I: so you would no longer describe yourself as a terrible husband?) I don't think in one sense that I ever was. (ID415:PostNAI)

While remaining cognizant of the lack of a control group to which the NAI baseline profiles from this study could be compared, as well as the small sample size, the participant construct content profiles that emerged from the investigation of participants' baseline self-descriptors appear consistent with the depression research literature, which suggests the involvement of a negative self-evaluation, or the perceived negative evaluation of others, the resultant tendency towards introversion, the emergent emotional distress and the potential inability to have one's needs met due to an inability to confront conflict because one is 'pleasant'.

Individuals come to treatment with different types of presenting issues, different ways of construing their worlds, different needs, and are responsive to different types of therapeutic interventions (Blatt, et. al., 2001). Variability in the clinical presentation of depression has led researchers to propose discrete subtypes of the disorder with the goal of refining diagnostic practices and treatment interventions (Haslam & Beck, 1994). For example, Blatt and Zuroff (1992) have suggested that self-criticism is an important dimension of depressive experience. According to Blatt (1974) most psychopathology

can be accounted for by one of two basic dysfunctional dimensions, which constitute two distinct types of vulnerability to depression: 1) "analcytic" (or dependent); and, 2) "introjective" (or self-critical) depression (Blatt & Zuroff, 1992). While the dependent individual is characterized by feelings of loneliness, helplessness and weakness, and terrified by the prospect of abandonment by significant others, the self-critical type is plagued by a need for self-reliance and by feelings of failure, worthlessness, inferiority and self-doubt (Blatt & Zuroff, 1992). Furthermore, research has suggested that these two types may experience their worlds very differently and subsequently react differently, and benefit from, different therapeutic interventions (Blatt, Shahar, & Zuroff, 2001).

An intriguing question addressed in this exploratory study was whether participants who eventually recovered from their depression at post-treatment differed from their non-recovered counterparts in terms of how they described themselves at baseline. According to the findings from the CSPC analyses, there was a tendency for the post-treatment recovered participants to use more self-descriptors subsumed under the 'Personal' and 'Relational' Areas, as compared to their non-recovered counterparts. Those participants who recovered appeared to enter treatment describing their ways of being in the world and their selves-in-relation to others (versus intrapersonal descriptions.)

In contrast, post-treatment, non-recovered participants tended to used more self-descriptors subsumed under the 'Emotional' and 'Moral' Areas. These participants appeared to enter treatment emphasizing their moral attributes and elicited self-descriptors wedded to their emotional and internal aspects of self. Of particular interest

is the higher number of participants in the post-treatment non-recovered group who entered treatment with a negative self-construction (self-critical) and who emphasized their moral attributes (altruistic, good).

Findings from this exploratory study indicated that upon entering treatment, the thematic emphasis of the participants' systems of meaning differed and that preliminary trends from the comparative analysis suggested differing baseline profiles between the two outcome groups. As such, given the current movement to distinguish between depression subtypes and the subsequent appropriateness for differential treatments, the NAI may be considered a valuable tool for the practicing clinician in treatment planning and intervention, as well as the researcher interested in further differentiating depressive pre-treatment profiles.

Before leaving the discussion of participants' baseline self-perceptions, or "who am I?", a discussion of findings that spontaneously emerged from participants' responses during the baseline NAI is presented next.

The 'Rigid' and 'Unchangeable' Storyteller

Although it can be argued that inherent in the idea of asking participants to describe themselves is the notion that there is indeed a 'self', I believe it was important to note that two participants in this study offered their impressions that their self and self-other descriptions represented a core, unchangeable self. Although not specifically explored in this study but warranting further attention, this perception of a rigid and core self may be an important marker of potential resistance to change given the proposition by narrative theorists that therapeutic change involves the creation of alternative stories. According to

narrative theorists, the therapeutic process becomes a vehicle for the generation of alternative stories that incorporate vital and previously neglected aspects of individuals' lived experience (White & Epston, 1990). The identification of unique personal outcome stories that challenge and destabilize problem-saturated macro-narrative plots is viewed as a key strategy to offer new ways of seeing and valuing the self-in-the-world relation to others, and to establish alternative narrative plots that facilitate desired outcomes in life. Inherent in this process of change is the necessity of flexibility allowing an openness to alternative stories. This process may be blocked if the individual maintains a rigid and unchangeable view of self. This tendency for some of the participants to view aspects of them selves as 'engrained' is illustrated in the following excerpt:

> I'm a jealous person, not a vindictive person...I'm just deep down I'm just jealous of everything and everybody and even if my brain tells me not to...but I was brought up like that, my mother was like that and I heard her and she talked to me since the age of that high, and we're poor and they're rich and we can't get this and they've got that, it just went on and on and on and on and even though my intellect tells me that the grass is not greener on the other side, deep deep down, I just, It's my make-up...it's engrained in me. (ID407:BaselineNAI)

Another participant, while telling a story about his relationship with his sister-in-law, also described aspects of himself as unchangeable, as illustrated in the following excerpt:

> I wouldn't say she dislikes me, it's an annoying habit I have and that bugs her but I just can't help myself. (Therapist: So it's just have to go for the jugular sometimes) yeah, which I suppose is my mother's trait there. (ID402:BaselineNAI)

It is for further studies to explore the potential impeding nature of a rigid sense of self to the therapeutic process as conceptualized in narrative terms. An important initial differentiation might be to first ascertain the functionality or adaptive nature of that aspect of self that an individual perceives as unchangeable. A rigidly held, negatively

distorted lens through which an individual construes his or her world is well documented in the literature of contemporary cognitive views of depression, as illustrated in the work of Beck (1976).

An unexpected finding when reviewing participants' baseline self-descriptors, was that many of the descriptors were positive in nature. For example, many participants in this study described some aspect of themselves as "intelligent, hard-working, creative and capable." This finding appears curious given that the participants were depressed at baseline and as such, one would have expected they would have presented with a predominantly negative self-view. One participant, when reflecting on her baseline NAI responses in the context of her post-treatment NAI gives insight into this phenomenon: "Yeah that's me. (I: has that shifted or changed at all?) No. It's all positive stuff but I have negative stuff inside me too. I just don't like dwelling on it." (ID401:PostNAI)

Thus, one reason for the seemingly positive nature of a number of the descriptors this pre-treatment depressed participant sample may be explained by self-presentation theory, which proposes that the presence of others enhances an individual's desire to present in a favourable image (Bond, 1982). Given that the participants' therapists administered the first NAI after their initial therapy session and the fact that the participants were presenting themselves to their ongoing therapist may have influenced them to present themselves in a positive light (see Rennie, 1994a). A second reason for the frequency of positive descriptors generated by participants at baseline might be explained by their decision to approach treatment. Having made the decision to seek treatment and having the motivation to do so and indeed volunteer to participate in the York II Depression

Study may have contributed to a more positive sense of self at the time of entering treatment.

Whether the participants' descriptors were largely positive or negative could not be explored empirically in the present study due to the confines of the NAI protocol. A simple addition to the existing NAI protocol for researchers interested in further exploring the nature of the descriptors that participants generate could be, for example, to add a question having participants reflect on how adaptive, functional or positive they interpreted their self descriptors to be at baseline. The NAI protocol could be easily recalibrated to suit the needs of the researcher interested in exploring this phenomenon.

Classification System for Self/Other Convergence

A second avenue of inquiry taken in this study that added richness to the profile of the story-teller, at baseline, was to explore the degree of convergence between how participants viewed themselves and how they felt others viewed them. In other words, when struggling with depression, to what degree does one's view of self converge with how one perceives one is viewed by others?

According to the baseline NAI findings using the Classification of Self/Other Convergence, half of the participants in this study ($\underline{n} = 10$) were judged to have viewed themselves as 'similar' to how they felt others viewed them. According to this classification system, participants' view of self and how they felt others viewed them were judged to be 'similar' if, while some of the descriptors were different, most were judged to be the same. While the majority of participants in this study felt that their view of self was 'similar' to others' views of them, 25% ($\underline{n} = 5$) were judged either to feel that

others viewed them differently from how they saw themselves, or they did not know how others would describe them. The remaining 25% (n = 5) of the participants were judged to have viewed themselves as they perceived others viewed them. In general, these findings suggest a trend towards discrepancy in the self-other descriptors at baseline. The following excerpt taken from a participant's baseline NAI is presented as an illustration of this lack of convergence:

> (Therapist: Okay, how would someone that knows you really well describe you?) I have no idea. - - that is part of, this um, this journey, um I don't know who knows me very well anymore. Um, I would have thought that my spouse knows me better than anyone else and she doesn't either. (ID415:BaselineNAI)

The link between self-evaluation and emotional vulnerability is well-established in the literature. For example, a large body of research has been accumulated under the umbrella of Higgins' Self-discrepancy theory (Higgins, 1987, Strauman & Higgins, 1987). Higgins' model draws on Freud's (1917/1963) notion of Superego, Mead's (1934) generalized other, Kelly's (1955) theory of personal constructs and Rogers' (1961) idealized self. From the standpoint of this rich background, self-discrepancy theory purports that the self is made up of two cognitive dimensions: 1) standpoints on the self; and, 2) and domains of the self.

According to Higgins, there are two standpoints from which the self is viewed: 1) own, or 'myself as I see me'; and 2) other, or 'myself as I believe significant others see me'. He further suggests three domains of self: 1) actual, or 'the attributes I believe myself to possess'; 2) ideal, or 'the attributes that I would like to possess; and, 3) ought, or 'the attributes that I believe I should possess'. Together, the two standpoints and three domains form six possible self-states: own/actual, own/ideal, own/ought, other/actual,

other/ideal and other/ought. According to Higgins, the self-concept is represented by the own/actual and other/actual self-states, while the remaining four self-states, which Higgins calls "self-guides", are internally generated standards that vary from individual to individual. Self-discrepancy theory postulates that people are motivated to reach a condition where their self-concept matches their personally relevant self-guides (Higgins, 1987). Furthermore, the theory proposes that specific types of negative self-evaluation are linked to specific types of emotional distress. Discrepancies between actual self-state and ideal self-guide are presumed to be associated with dissatisfaction and dejection, while discrepancies between the actual self and the ought self-guide are presumed to be associated with apprehension, fear and anxiety (Higgins, 1987).

The first two questions of the NAI protocol (i.e., "How would you describe yourself?"; and, "How do you feel significant others would describe you?") appear to correspond closely to Higgins' own/actual and other/actual standpoints from which the self is viewed. Findings from this study's baseline analysis suggesting a lack of convergence between self-descriptors and other-descriptors is consistent with the self-discrepancy theory research, which proposes that a lack of convergence from these two standpoints is associated with emotional vulnerability and distress. Indeed a movement away from self/other convergence was shown by the comparative analysis of self/other convergence at treatment outcome undertaken in this study and is discussed next.

According to the post-treatment comparative analysis, none of the nine non-recovered participants in this study were judged to have moved to a greater degree of convergence between how they viewed themselves and how they felt others viewed them.

Indeed, findings from this study indicated that 44.5% (n=4) of the post-treatment non-recovered participants were judged to have moved further away from seeing themselves as how they felt others viewed them (i.e., responses classified 'less convergent' according to the 'Classification of Self/Other Convergence'). Seventy-eight percent (n=7) of the post-treatment non-recovered participants fell into the categories of 'less convergent', 'still different' or 'still don't know'.

In contrast, of the 11 post-treatment recovered participants, 27.3% (n=3) were judged to have moved to a greater degree of convergence between how they viewed themselves and how they perceived others viewed them. Another 45.4% (n=5) were judged to have continued to see themselves as 'same' or 'similar' and were judged not to have shifted in the degree of congruence at post-treatment and as such were coded 'same'. Only 27.3% (n=3) of the 11 recovered participants fell in to the categories of 'less convergent', 'still different' or 'still don't know'. The following excerpt taken from a participant's post-treatment NAI illustrates this movement towards a greater degree of convergence between how one sees one's self and how one perceives they are viewed by others:

> (Interviewer reviewing participant's baseline statement: "that's part of the journey. I don't know who knows me anymore") That's true. That has shifted. This is a deep one. There is part of that that is still there and the knowing of self, I'm much more self-aware. So I'm now able to share that with a confidence that I did not have before...so do people know me? No, they're beginning to know me because I am more open now. (ID415:PostNAI)

Although the sample size of this exploratory study was small, the trend towards a greater convergence between how one views one's self and how one perceives others view self in the recovered group, and the greater discrepancy between these two standpoints in the non-recovered group, appears consistent with the self-discrepancy

literature. As such, this aspect of the NAI 'data' could provide valuable information for both the researcher interested in this phenomena, as well as the practicing clinician. In the case of the researcher, the NAI protocol could easily be calibrated to include a question asking participants to indicate to what degree their view of self converges with how they perceive others view them. Initiating the NAI protocol with depressed clients early in treatment could provide clinicians with an early assessment of the discrepancy between their views of selves thereby providing valuable information, grounded in research, of initial baseline distress, as well as subsequently assessing movement towards therapeutic gain.

The Classification System of Client Self-Change Statements

The purpose of the third question of the NAI protocol that asked participants "If you could change something about who you are, what would you change?" was to gain an understanding, early in treatment, about what if anything participants hoped to change about themselves. For both researchers and clinicians, the responses to this question can provide a concrete pre-treatment reference point to reflect upon and from which to compare each participant's own conceptualization of change at therapy outcome.

According to the participants' baseline responses, which were coded according to the Classification System of Client Self-Change Statements, almost half (48%) of the responses were coded to reflect something the participant wanted to change about who they were (i.e., intrapersonal change). This category reflected desires for change in "how I see myself." Examples of participants' responses coded 'intrapersonal' included: "my self-esteem is a big big problem. I wish I had a little meter to keep my self-esteem up

instead of watching it drop all the time and needing to yank it back up." (ID401:BaselineNAI); "to be more of an active person, to follow through on my ideas" (ID409:BaselineNAI); "I would like to be more positive, have more of that spirit that people have, you know, 'love of life', not to feel so down on myself" (ID413:BaselineNAI).

Preliminary findings from a pilot study initially conducted to determine the validity of the NAI protocol in capturing individuals' sense of self suggested that when asked "If you could change something about yourself, what would you change?" people tended to reply with something they wanted to change about their appearance. As such, the third question of the NAI protocol was modified to ask "If you could change something about who you are, what would you change?" The prevalence of change statements coded 'intrapersonal' indicated that the rewording of the third question of the NAI protocol was indeed effective in capturing participants' desire for personally relevant areas of self-change.

According to the participants' baseline self-change responses, which were coded according to the Classification System of Client Self-Change Statements, 28% of the responses (n=14) were coded to reflect something participants wanted to change with regards to how they reacted to others and to how they interacted with their world (i.e., interpersonal change). Examples of participants' responses coded 'interpersonal' included: "I would like to improve my social skills" (ID431:BaselineNAI), "I would not care about what other people think, to come across as 'this is me' and not to think about how I come across to other people" (ID433:BaselineNAI), and "I wish that I could be

more charismatic, I find it hard to get along with other people on a social basis, it is like pulling teeth" (ID452:BaselineNAI). The finding that a number of responses elicited by participants in this study indicated a desire for interpersonal change suggests that how we interact with others is an important aspect of how we see ourselves.

Two further observations regarding the baseline self-change statements elicited by participants in this study are worthy of note. Firstly, despite rewording the third question of the protocol following the NAI pilot study, six of the participants in this study indicated that they wished to change their appearance, which included a desire to lose weight. This finding provides further evidence that societal norms do indeed influence how people see themselves and supports the notion that perceived marginalized membership may negatively affect how one sees oneself. This finding augments the prevalence of negative self-evaluation amongst the participants in this study as indicated by the CSPC findings presented earlier in this section.

Secondly, although few in number, participants' self-change responses coded as 'global statements', could be viewed as a clinical marker to indicate the potential benefit of further differentiation early in therapy in establishing therapy goals. The global statements generated by the participants in this study appear to reflect the qualities of an undifferentiated and automated kind of processing according to Toukmanian's Levels of Client Perceptual Processing (LCPP; Toukmanian, 1986). The LCPP is a measure of client in-therapy level of perceptual functioning that consists of seven discrete categories each representing a particular kind of mental operation ranging from simple to more complex that is assumed to reflect the model's conception of automated and controlled

processing. Given the qualitative similarity between the global statements and the first level of the LCPP, unpacking and differentiating these global statements that may arise in response to Question #3 of the NAI before treatment would allow the clinician an increased illumination of areas of therapy focus and would provide the client with an awareness of personally relevant treatment goals early in therapy.

Comparing baseline self-change statements in terms of post-treatment outcome indicated that recovered participants were more likely to disclose an initial desire to change how they interacted with others (i.e., interpersonal change), while non-recovered participants were more likely to begin treatment wanting to change something about themselves (i.e., intrapersonal change). It appears that those participants who benefited most from the brief humanistic/experiential treatment offered in the York II Depression Project entered treatment with a fairly coherent and potentially positive self-perception but lacking congruency between their sense of self and their lived experience. The non-recovered group appeared to first need to re-establish a coherent, positive and accepting sense of self before they could begin to re-integrate and re-story themselves in their worlds. This interpretation was supported by CSPC findings that the non-recovered group indicated that they were more self-critical and held themselves to higher moral standards (i.e., a perception of putting others' need ahead of their own) than the recovered group.

In a recently published article, Klein and Elliott (2006) illustrate the different understandings from investigations using different research approaches of what clients experience and potentially gain in therapy. Their sample consisted of 40 individuals

suffering from depression, anxiety, trauma, or other personal or interpersonal difficulties who engaged in up to 40 sessions of Process-Experiential treatment. Using the same qualitative, categorical approach used in the development of the present study's Classification System of Client Self-Change Statements, Klein and Elliott (2006) investigated post-treatment, client-described changes, whereas the present study focused on baseline to post-treatment client self-change statements. Interestingly, Klein and Elliott reported several different types of changes that they conceptualized as: "Intrapersonal changes" (i.e., symptoms, affect and self-evaluation); and, "Interpersonal changes" (i.e., changes in relationships and changes in functioning or performance). A comparison of the client change statements subsumed under these two categories by both the Klein and Elliott study and the present study, suggested that coding was qualitatively similar thus supporting the validity of these two dimensions of change when investigating the phenomena of client changes. Furthermore, as Klein and Elliott (2006) neither determined if there was a specific direction or sequence of movement by which this change process occurred, nor found that type of change was associated with point in treatment (i.e., post-treatment or follow-up), the findings from the present study (i.e., investigating baseline self-change statements) may be seen to add a significant piece to the puzzle of investigating and tracking desires for self-change from pre- to post-treatment.

The present study set out to explore whether a sample of participants with depression saw themselves differently after experiencing significant gains in therapy and if so, in what ways, the stories they told about themselves changed following treatment. Before

exploring post-treatment change, it was first necessary to establish how participants saw themselves before entering treatment. A summary of the baseline NAI findings including the various investigations exploring the participant as 'story-teller' is undertaken next.

The findings from investigating participants' responses to the baseline NAI protocol suggested that participants in this study described themselves largely in relation to others (CPCS Area: Relational), and they also used descriptors to represent their core aspects of self (CPCS Area: Personal). More specifically, before entering treatment for depression, the participants in this study described themselves as largely altruistic (to a fault), self-critical, pleasant, introverted, and unbalanced. At baseline, there were a greater number of participants in this study who were judged to view themselves as similar to - - as opposed to viewing themselves as the same as - - how they felt someone who knew them well would describe them. This suggests that there was a lack of convergence between how these participants viewed themselves and how they thought others viewed them. Finally, the majority of participants' baseline self-change responses reflected a desire to change something about who they were (i.e., intrapersonal change versus interpersonal change).

An intriguing question addressed in this exploratory study was whether or not those participants who eventually recovered from their depression differed from their non-recovered counterparts on their NAI baseline profiles. In other words, did the two contrasting outcome groups differ in how they saw themselves and what they wanted to change about themselves before entering treatment for their depression? Cognizant of the small sample size, several trends in these preliminary findings are worthy of note. At

baseline, those participants who eventually recovered from depression after participating in a brief humanistic/experiential treatment appeared to describe themselves largely in interpersonal terms (CSPC: Relational) and indicated that what they wanted to change about themselves involved how they interacted with others (i.e., interpersonal change/landscape of action). Those participants who did not recover from their depression appeared to enter treatment using descriptors that reflected emotional and moral attributes (i.e., CSPC: Emotional and Moral) and indicated that what they wanted to change was something about who they were (i.e., intrapersonal change). These findings suggest that participants in this study who benefited most from the brief humanistic/ experiential treatment for depression entered treatment with a coherent and acceptable sense of self (i.e., acceptable to themselves) and they articulated desires for interpersonal change.

Furthermore, findings from this exploratory study indicated that a number of post-treatment recovered participants were judged to have gained a greater degree of convergence between how they saw themselves and how they perceived others' viewed them. In contrast, post-treatment, non-recovered participants tended to move to greater discrepancy between self/other views. Whereas the NAI baseline profiles of the non-recovered group emphasized a disruption in how they viewed themselves, the post-treatment recovered group appeared to emphasize disruptions between their views of self and their lived experience at baseline.

According to Bruner (1986), it is the fundamental integration of the landscape of consciousness (personal meanings, emotions, and views of self and others) with narrative

action (actions and events in the world) that is the axis of personal identity formation. As such, the next section of the discussion will focus on the participants' stories to explore the degree of congruence between participants' self-perceptions, their lived experience and treatment outcome.

Section 2. The Participants' Stories

Autobiographical Memory Analyses

Participants in the present study told stories that involved the articulation of personal memories of past and current experiences. The participants were able to generate autobiographical memory narratives in response to all three NAI questions, across all three time periods that the protocol was administered. One noticeable exception was the lower percentage of narratives disclosed at baseline to Question #3 of the NAI (i.e., "If you could change something about who you are, what would you change?"). This finding is to be expected as participants were not directed to provide illustrations of self-change at baseline. Exploration and illustrations of self-change were elicited following treatment and as such, one would expect a lower percentage ABM-change at baseline.

According to the analysis of ABM narrative specificity subtypes across the three NAI time periods, findings from this present exploratory study indicated that participants primarily disclosed generic ABMs to illustrate their self-perceptions and illustrations of self-change. According to Singer and Moffitt's Scoring Manual for Memory Narrative Type used in this study, the generic summary memory is defined as the blending of many similar events repeated over a long period of time. The following excerpt is an example of a ABM generated in the baseline NAI and coded generic:

> (Therapist: Can you give me a recent example of a time that would illustrate you as reliable and dependable?) Oh, that's always in the place of work, you know, that uh, you need something done, guess who always gets it done, they need something resourced, researched (sigh) budgeted or whatever, it it's done, it's there, it's done in the timeline, - consequences, sometimes at my expense. Uh, because I always feel that I've got to perform. (ID440:BaselineNAI)

One interpretation of this finding is that our view of ourselves is an accumulation of many generic stories from which we abstract and distil out descriptors that we subsequently use to describe ourselves and our interactions with others and our world. This process appears to be analogous to good grounded research in which the researcher extracts numerous bits of information from a narrative or text insofar as those bits of information can be applied to a higher order category that captures the essence of meaning of those units. In grounded research, this process is an interpretive one (while all research may be considered interpretive, the nature of qualitative research is explicitly and intentionally so). Similarly, in accumulating stories about ourselves, we process information and interpret it to make meaning about ourselves. What if the interpretation of our experience is distorted by a depressive lens? In that case, new information and new stories do not get processed and therefore do not become part of the higher order categories that we used to describe ourselves.

According to narrative theorists, a sense of meaning and continuity is achieved through the storying of experience but it is gained at a price because our lived experience, is richer than discourse (White & Epston, 1990). Given the gaps between narrative structure and experience, therapy offers individuals the opportunity to re-author their self-narrative, or macro-narrative, by identifying events, feelings, intentions and thoughts that currently fall outside the dominant narrative. The therapeutic process becomes a vehicle

for the generation of alternative stories that incorporate vital and previously neglected aspects of individuals' lived experience (White & Epston, 1990). "When persons seek therapy, an acceptable outcome would be the identification or generation of alternative stories that enable them to perform new meanings, bringing them desired possibilities--new meanings that persons will experience as more helpful, satisfying and open-ended" (White & Epston, 1990, p.15). The identification of unique, personal, outcome stories that challenge and destabilize problem-saturated macro-narrative plots is viewed as a key strategy to offer new ways of seeing and valuing the self-in-the-world relation to others, and to establish alternative, narrative plots that facilitate desired outcomes in life. If however, there are blocks to allowing the flow of new stories that may challenge the dominant view of selves, how one sees oneself remains intact, solidifying a dominant narrative, which subsequently casts aside new and alternative stories one would draw upon to makes sense of one's self and one's interactions with the world. As such, an important factor in the change process may be the individual's ability to step off the treadmill of producing generic self-stories and instead to begin to identify and generate specific experiences that eventually pave the way to a re-storying of our sense of one's self and self-in-relation.

Challenging the proposition that over-generality is a cognitive style rather than a consequence of depression, Williams, Teasdale, Segal and Soulsby (2000) reported change in over-general autobiographical memory as a function, or as a benefit of, mindfulness training. According the these authors, mindfulness training is designed to encourage not only more specific encoding of events but also more specific retrieval of

past events by reducing the tendency for individuals to abort the search process. Using the Autobiographical Memory Test (Williams & Broadbent, 1986), findings from the Williams et al. (2000) study suggested that although control patients (i.e., patients undergoing treatment as usual) showed no change in specificity of autobiographical memories recalled in response to cue words, the treatment group (i.e., treatment as usual and mindfulness training) showed a significantly reduced number of generic autobiographical memories.

One interpretation of the above study is that when individuals are directed to remember specific events and experiences, for example, through mindfulness training, there will be a reduced tendency to produce generic ABMs and an increased tendency to entertain new information that may challenge the dominant story. According to narrative theorists, therapeutic change is involved in the production and subsequent consolidation of new stories that destabilize and reconfigure the individual's macro-narrative. Remembering specifics about new events and experience, therefore, may be an important aspect of this process of change. The Narrative Assessment Interview, which asks clients to illustrate their views of themselves in recent stories, offers the individual precisely this opportunity--to reflect upon and explore stories that may or may not challenge clients' macro-narratives. With regard to the present study, the question then turns to whether there were differing patterns of ABM specificity subtypes between the post-treatment groups, and later between those participants who sustained recovery from their depression compared to those that were still depressed at follow-up.

An avenue of inquiry undertaken in this study was to explore whether contrasting post-treatment and follow-up outcomes reflected a different pattern in either type and/or frequency of ABMs generated--specifically the ability to generate single-event ABMs. Findings from the ABM analyses suggested that the post-treatment recovered group disclosed more single-event ABMs at baseline than their non-recovered counterparts. This finding suggests that before starting treatment, the recovered participants told more specific, detailed and concrete stories illustrating their views of self and how they perceived others viewed them. It appears these participants entered therapy with a greater capacity toward specificity than the non-recovered group, who told more generic and therefore abstract stories to illustrate how they viewed themselves and how they felt others viewed them. According to the depression literature, remembering specifics about new events and experience may be an important aspect in the process of change. Entering treatment with a greater capacity towards specificity may be then viewed as a client marker and suggests that the NAI may be potentially used as a clinical assessment tool. Clients without this capacity may be flagged and introduced to interventions early in treatment that may facilitate this capacity and subsequently lay the foundation for facilitation of positive change.

Contrary to what had been expected (i.e., that the recovered group would disclose a higher number of single-event ABMs at post-treatment), the number of generic ABMs increased for the recovered group and decreased for the non-recovered group at post-treatment, while the number of single-event ABMs rose slightly for the non-recovered group and decreased slightly for the recovered group. The frequency of eventless ABMs

remained stable for the recovered group and rose slightly for the non-recovered group at treatment termination. In light of the trait/state debate currently in the ABM literature that suggests over-generality is not mood dependent but rather a function of the individual's total experience, findings from this exploratory study suggest that when generating stories to describe one's view of self, these stories are open to modification, which, as described earlier, is considered a significant process in narrative change.

The ABM findings suggesting a different pattern for differing treatment outcomes extended to the follow-up analysis. According to this analysis, the sustained recovery group disclosed more single-event ABMs at baseline and more generic ABMs at post-treatment than did their sustained non-recovered counterparts. The sustained non-recovery group disclosed a higher percentage of generic ABMs at baseline and a higher number of eventless ABMs at post-treatment as compared to the group that sustained recovery.

At this point in the present investigation, numbers in the comparative analysis had dwindled to make interpretations of the ABM patterns highly speculative. It soon became evident that in order for the ABM specificity results to be meaningful, it was necessary to return to the content of the stories participants were generating to illustrate their views of self and how others would describe them. For example, the following excerpt illustrates a generic post-treatment ABM generated by a recovered participant:

> (Interviewer[I]: You said that others would describe you, this is someone who knew you well. "other people would say that I am too down on myself and that I'm too serious"...Do you still think people view you like that?) Yes, definitely people see me differently. (I: This is someone who knows you well, remember. Is there a change in that or not? Would your daughter and your husband, for example, still describe you as being very down on yourself and serious?) Well, in

> fact, with my daughter there have been other changes. It's my realization that I need to do more things with her that would be more fun. Because I want her to perceive me as a fun person and not just very serious, dictating all the time. So in her view, she's lightened up towards me, is because I've done the same thing towards her. We do more fun things...she actually said, 'you know mom, you amaze me. Sometimes you're even cool. She used the word 'cool'. (ID433:PostNAI)

In this example, although the participant does not provide a single-event ABM to illustrate the changes she is experiencing, she does provide a story of change. This is contrasted with an eventless ABM generated at post-treatment by a non-recovered participant.

> I put others before myself, that I'm trying to do less now because I am trying to take care of myself first. (Interviewer[I]: Okay, do you have an example of that?) Well, I have, I have a younger sister and ah, she always seems to let me down you know, she says she's going to do something and she doesn't do it and I would end up kind of cleaning up after her. And ah, we haven't been talking for a while and initially it used to make me angry and we would have arguments. So I decided that I had other things to worry about and I was going to put her on the back burner until I was ready to deal with it (I: So what happened, did you talk with her, or?) I've talked to her recently and she wondered why I hadn't talked to her, well I said I've got other things to do. (ID432:PostNAI)

Although findings from this exploratory study indicate differing trends in ABM subtype for both the post-treatment and follow-up groups, it is for further studies to augment these findings in order to make meaningful interpretations of the role of ABM narrative generation, depression and sense of selves and change. This section now turns to a discussion of the types of stories of change, or no change, that participants in this study generated following treatment and during follow-up. Indeed, the major avenue of inquiry in this exploratory study was to investigate the role of participants' stories as an indicator of movement in treatment, particularly movement towards healing from depression.

Stories of Change Analyses

Heeding the call for the development of "new and expanded outcome measures that assess psychotherapy from multiple perspectives, which are also better calibrated to actual behavioural functioning" (VandenBos, 1996, p.1006), the main avenue of inquiry of this present study was to explore the phenomena of clinical change in terms of narrative. Fuelled by the notion that the stories people tell about themselves are essential threads in the fabric of their self-identities, the present study set out to explore whether participants who had recovered from their depression differed from their non-recovered counterparts in their ability to generate single-event stories of change at treatment termination and if this ability to generated stories of change was a marker for sustained recovery at follow-up.

According to the findings of participants' ABMs generated in response to the three NAI questions and coded according to the 'Classification of Types of Story Change', post-treatment recovered participants did indeed disclose a much higher percentage of ABMs coded as 'story of change' compared to their non-recovered counterparts. In contrast, the non-recovered participants told a higher percentage of ABMs coded as 'story of the same' and 'stories of changing', as compared to post treatment recovered group. In other words, when asked to reflect on their baseline self-perceptions and desires for change, findings indicated that the recovered participants in this study were able to consolidate change in the stories they disclosed after treatment, while their non-recovered counterparts appeared to still be in the process of changing, or unable to generate stories of change and instead returned to stories that indicated they hadn't

changed (i.e., stories of the same). Indeed, none of the recovered participants told stories of the same.

The most striking difference between the post-treatment outcome groups emerging from the findings from this analysis was the ability of the recovered group to generate both single-event and generic ABMs that were coded 'stories of change', while their non-recovered counterparts appeared to generate more single-event and generic ABMs that were coded as 'stories of changing'. Furthermore, the non-recovered group had much higher percentage of generic and eventless ABMs coded as 'story of the same' than their recovered counterparts.

These findings indicate that the ability to author new and concrete personally relevant stories of change was associated with better outcomes. The results support narrative theorists, such as White and Epston (1990), who assert that therapy becomes a vehicle for the generation of alternative stories that incorporate vital and previously neglected aspects of individuals' lived experience.

The final analysis undertaken involving participants' ABMs and coding for stories of change explored whether those participants who sustained recovery from their depression six-months following treatment generated more 'stories of change' at post-treatment compared to the group of participants who either sustained non-recovery or continued to 'struggle' with their depression. As such, the question is whether consolidating shifts or gains from treatment in personal stories post-treatment was a potential indicator of sustained recovery following treatment.

These findings indicated a trend that suggested that the ability to generate self-stories of change post-treatment may be a significant indicator of sustained recovery from depression six-months following treatment. According to findings from this study, the sustained recovery group appeared to be able to continue to consolidate shifts in actual self-stories of change from their lived experience after treatment. The stories they generated appeared to indicate an updating of their stories in light of new awareness gained in therapy. Those participants who continued to struggle with their depression following treatment told more stories of changing at post-treatment. This may be interpreted as work yet to be done as they continued to strive to achieve a congruence between their sense of self and their lived experience. The most intriguing interpretation of these results is that this sustained, non-recovery group appeared to tell far more 'stories of the same' at post-treatment. This suggests that an inability to consolidate new stories may be a factor leading to their sustained non-recovery and subsequently indicate a marker for further treatment.

Section 3. Qualitative/Interpretive/Descriptive Case Studies

Despite the established utility of quantitative methods in psychotherapy research, these methods do not, and cannot, provide a complete picture of client change. Although traditionally considered to be antagonistic, this present study, like the recently published study by Klein and Elliott (2006), illustrated how these research methods can be combined in a pluralistic manner resulting in a richer and more colourful picture of client change in therapy. A discussion of the findings from exploring two contrasting NAI case studies is undertaken next.

As indicated by Klein and Elliott's (2006) findings, and consistent with findings from the present study, qualitatively-described changes are at times unrelated to the amount of change shown on quantitative outcome measures. In the present study, the participant 'Alan' represented a recovered participant, who sustained recovery from his depression six months following treatment only to relapse a year after that. In the second case study, according to her responses to a traditional outcome battery of quantitative measures, the participant 'Inge' continued to struggle with her depression at post-treatment and was still considered depressed at 6-month follow-up, but subjectively felt better in a way that did not show up in the quantitative measures.

The analysis of Alan's post-treatment NAI material suggested that his largely fragmented and negative self-narrative, which was initially woven with stories of failure began to shift to a more coherent and positive narrative of self at post-treatment. During his follow-up interview, however, Alan's new view of self appeared to be fragile. His inability to fulfil his various roles, which he considered essential to his self-worth, was illustrated in the following story:

> ...intelligent, I've learnt more everyday. And ah, a good listener, better father, all that I can be. a terrible husband is still an issue. That didn't go away. Partly because of the two-career thing, part of it because of the success thing, what it means to be successful? All those external roles, there is a tension there that I am not able to contribute financially right now, which beats me up, not that my spouse beats me up (Interviewer: you beat you up). Oh do I ever, and that's a trigger that sends a whole series of downward spirals for me that end me up feeling, not functioning. That would be probably the remaining two areas of my life that I have to sort of fix and move up and I'll be fine. A flower can bloom but no-one appreciates the flower.

Indeed, embedded in his story as captured by the NAI, yet missed by the quantitative outcome measures, was a clear sense of Alan's potential for relapse, which he reported 17

months following treatment. Although it is for further comprehensive studies to confirm, preliminary findings suggest that material gathered by the NAI protocol, in general, and their stories, in particular, may be considered valuable to the researcher interested in increasing his or her tools in the investigation of treatment outcome, as well as providing useful information for the clinician interested in determining treatment planning and intervention.

For Inge, participating in the NAIs appeared to offer her the unique opportunity of re-authoring her sense of self, as well as to consolidate self-desired changes within the interview itself. Inge's baseline NAI material suggested that her depression involved an inability to recognize and subsequently honour her own needs. Following treatment, she first stated that nothing had changed. Inge then reconsidered, noting that she was not a positive person, and upon reflection, she did notice that she had begun to take notice of, and begin to act upon, her own needs, as illustrated in the following excerpt:

> Have I changed? No I don't think that I've really changed, uh when the pain gets there bad enough, I know its there and I may or may not (Interviewer: so that hasn't really changed?) You know what, I'm not positive. I may have changed a little bit, I know S (participants therapist) used to often say you can stand up if you want because I guess she saw me looking uncomfortable, uh, actually, I've noticed myself over the last couple of weeks saying uh, saying to myself well, now wait a minute, you have to go to the bathroom, so you might as well go right now instead of waiting, that's the nursing thing, you know, I've got all of these things to do, so I'll just go later (laughs), or um, you know, I said to myself two days ago, you've been freezing cold for three hours, why don't you just get a sweater, so I did. or take a pill, you know, you're hurting you know, so maybe I have, maybe just starting a little bit.

It appeared that it took her participation in an interview like the NAI for Inge to begin to recognize her own movement towards change. As such, she became a participant in her own experience of, and subsequent determination of, her own unique

treatment outcome. Furthermore, these changes, although considered highly valuable to Inge, appeared to be overlooked by the quantitative methods that determined her outcome to be poor. Inge's post-treatment NAI experience brings to light the possibility that the NAI could be viewed as an intervention and as such potentially important resource for clinical work.

Limitations of the Present Study and Future Directions

This exploratory study was the first attempt to apply the Narrative Assessment Interview (NAI; Hardtke & Angus, 1998) to a sample of participants in order to conceptualize clinical phenomena, particularly treatment outcome, in terms of narrative. The NAI material gathered from participants suggested potential avenues of research inquiry to include both quantitative and qualitative approaches (or in combination). As such, a pluralistic perspective in understanding individuals' experiences of, and recovery from, depression was possible. Furthermore, the NAI was presented as providing clinicians and their clients with valuable information regarding their 'selves', as well as their interactions with their worlds, in the context of struggling and recovering from depression. The NAI findings confirmed that this interview is an important contribution to generating a richer picture of clients' struggle with depression, both in idiographic and nomothetic terms.

The present exploratory study had a number of limitations. Firstly, the small sample size restricted the analyses to descriptive reports and graphical displays of potential trends in the data rather than allowing for results to be interpreted through inferential statistics. The purpose of the present exploratory study was to direct the research

community to the importance of individuals' stories in our understanding of clinical phenomena, in particular depression, and to begin to map profiles that might be used by both researchers and clinicians. Future studies should be undertaken that recruit larger samples and improve the NAI protocol to further its development as a tool of empirical analysis to address nomothetic understandings of narrative change and depression.

Secondly, the quantitative determination of the participants' outcomes from which comparative analyses in this exploratory study were conducted was restricted to three measures (i.e., SCID, BDI and GAF). Furthermore, although considerable energies were invested to adequately capture outcome according to these three quantitative measures (e.g., using established literature to determine outcome groups), one still must reflect upon the meaningfulness of the difference between cut-off scores used to determine treatment outcome. Although it was initially determined that the comparative analysis of outcome would be explored in terms of meeting criteria for depression (or not) versus residual gain scores indicating significant individual change, the latter may be an important area of investigation for future studies interested in conducting research in the area of narrative and depression.

The present study was conducted on a sample of depressed participants involved in a brief experiential/humanistic treatment study of depression. As such the homogeneity of the sample in terms of both clinical diagnosis and treatment modality suggests that research in this area would be considerably augmented by expanding the use of the NAI to explore both differing clinical populations, as well as non-clinical populations. Indeed, the NAI protocol has been shown to be a practical assessment tool for research conducted

outside the clinical arena. For example, the protocol has recently been used in an industrial/organizational setting to assess the impact of a leadership training program on employees' sense of self and self-in-relation to their co-workers. According to McCollum (personal communication, November 2005), preliminary analyses of NAI protocols suggest that participants in a leadership training program reported a shift in how they saw themselves and how they thought other employees perceived them, which included a leadership identity that involved assuming future leadership roles in the organization. It appears that the NAI holds some promise as an effective strategy for the assessment of organizational identity and change in organizations.

In his presentation at the Society of Psychotherapy Research, John McLeod (2000) reminded his audience that when we are conducting psychotherapy outcome studies, we are essentially asking the question: What "came out" of the process of therapy for the client? It was the purpose of this exploratory study to further illustrate and emphasize that the stories our clients generate are essential in addressing this question. Furthermore, heeding the call for the development of "new and expanded outcome measures that assess psychotherapy from multiple perspectives, which are also better calibrated to actual behavioural functioning" (VandenBos, 1996, p.1006) and to "develop a new outcome research paradigm that involves an active collaboration between researcher and clinician" (Goldfried and Wolfe, 1996, p.1007), this exploratory study presented the first comprehensive investigation of participant post-treatment and follow-up narrative change. The Narrative Assessment Interview (NAI; Hardtke & Angus, 1998) promises to

be a significant contribution to address gaps in the area of psychotherapy research and practice.

Epilogue

The main goals of my dissertation were the following: to expand upon the discussion of psychotherapy outcome to include a narrative conceptualization of change; to develop a tool that not only captured this phenomena, but that would be of use to both the researcher and clinician; and, to empower clients by fostering their understanding of their own change process. I feel that the NAI turned out to be an effective vehicle in allowing me to address these goals.

From my perspective as a researcher, I think that my study offered preliminary, empirical support for the underlying assumptions made by those attempting to conceptualize clinical phenomena according to narrative. I vividly remember the evening, after having declined a generous dinner invitation from my sister-in-law, who was visiting from Calgary, to stay at home and work on my analyses, when I found that my recovered participants were able to construct new stories of change, while those still depressed continued telling stories of the same. I felt proud of myself, proud of the NAI and rewarded for all the sacrifices I felt I made for my dissertation.

The interview format and having the participants reflect back on a summary of their earlier NAI responses in each successive interview leaves me satisfied that the questions comprising the Narrative Assessment Interview were successful in generating the information that I hoped to get from my participants. Although in hindsight I believe that having the participants' therapists conduct the baseline NAI may have contributed positively to the formation of the dyads' therapeutic alliance, there may have been some inconsistency among the different therapists regarding the energy and time they devoted

to its application, which would be something I would address in future research designs using the NAI. I understand that the quantitative analyses of my data and the claims I could subsequently make were constrained by my small sample size. However, I began this journey with the goal of introducing a new perspective on treatment outcome and think that in retrospect, my findings have underscored the importance of listening to, and understanding, the stories we tell.

From my perspective as a clinician, I have found myself using the NAI with my clients, albeit in a less rigorous fashion. Positive feedback from both participants and therapists in my study has been confirmed by my own experience of using the interview with my clients. Of greatest reward as a clinician has been my clients' awareness of shifts and changes that they have achieved when given the opportunity, in the context of the NAI, to reflect upon where they were and where they are now.

In retrospect, I am satisfied with the three classification systems that I developed as part of the procedure in my study. Because of the lack of certainty, or groundedness, I experienced in tackling the more qualitative/descriptive analyses, it was gratifying to read Klein and Elliott's recent work on clients' experience of change and how the categories that emerged from my use of an open-coding method were in tune with the categories that they had generated.

I believe that my findings have contributed to the narrative literature and I hope that my research will spur on my colleagues to continue to build research studies incorporating the NAI. I recently received correspondence from researchers at a university in Greece inquiring about the NAI as a potential instrument they might use in

understanding women's sense of self(ves) before and after treatment for breast cancer. I also understand from personal communications with Lynne Angus that modified versions of the NAI are currently being used in research with which she is associated.

Despite the recent call to apply multiple research methods to a single data set, few studies have set out to answer this call. I felt that I took up this challenge and as such, I consider my study to be original. Upon reflection, I feel that my journey co-developing the NAI, analyzing my data, developing three classification systems and writing this manuscript was an intense experience fuelled by moments of feeling excited and confident about my material, while at other times feeling stalled, tired and frustrated. I think that these mixed feelings were precipitated largely by the benefits and limitations of the various methodological approaches I drew upon in my efforts to understand and subsequently present my data.

Using a pluralistic methodology allowed me to explore my NAI data not only to quantify changes but also qualify what those changes might mean to the individual. This was important for me because as a researcher I wanted to have the opportunity to quantify, summarize and communicate my data to my research colleagues, while as a clinician I wanted to understand and qualify my data on the level of my clients. I understood and became immersed in the arguments surrounding pluralistic methodologies. Does one gain a richer, more interesting understanding of the individual? Are the methods philosophically incompatible? Perhaps I am side-stepping the issue, but I believe that it is difficult not to use a pluralistic methodology if a goal is to strengthen the bridge between research and practice. By this, I mean exploring phenomena and

using rhetoric that convinces the research community, while maintaining an awareness of what is important to the clinician – the individual.

This has been a challenging and rewarding experience for me but I admit I feel that if I could just do a little more work on the dissertation, it would be that much better. Someone shared with me recently that at the end of the dissertation journey one seldom feels that they have completed the dissertation, but rather that they have abandoned it. End of story.

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APPENDIX A

York II Depression Study Treatment Consent Form

I ..... agree to participate in a one-hour per week 16/20 week long individual therapy program at the Psychotherapy Research Clinic at York University designed to help me deal with my problems.

I understand that this program has a research component to it, and that I will be assigned to one of two treatments being studied. I am aware that this research is being conducted under the supervision of Dr. L. Greenberg and Dr. Lynne Angus of the Psychology Department both of whom can be reached at 736-2100 if I have any questions about the research of any concerns about my experience in the research or treatment. I many also contact Ms N. Swatman, Director of the Office of Research Administration at 736-5055.

I understand that all my therapy session will be audio and video recorded and that these recordings, as well as my responses to all the questionnaires, will be kept in strict confidence and will be used only for the purposes of research and training of therapists under the supervision of the principal investigators Dr. L. Greenberg and Dr. Angus. I understand that excerpts from tapes will be used for supervision and research purposes by the research team associated with the project. To protect my anonymity I am informed that all identifying information will be removed from the audio and videotapes and that test materials. I understand that my participation in this research project will not contain any foreseeable risks or discomforts to me other than possibly feeling depressed at times during treatment, but that these risks are not exclusive to this specific treatment or to treatment in general. I understand also that this treatment is likely to help, but I cannot be guaranteed that the treatment will work in my individual case. If treatment is not effective I will be referred to for further clinical care if I desire.

Furthermore, I understand that I can withdraw my participation from the research at any time and will be referred to another therapist. I realize that my participation is totally voluntary and that I can discontinue at any time without penalty or loss of benefits. I also understand that I will be offered a referral to a psychiatrist or hospital if I, or the treatment team, think this would benefit me.

My signature indicates that I have read and understood the content of this form.

_____	_____
Witness Signature	Signature
_____	_____
Name	
_____	_____
Address	Address
_____	_____
Date	Date

APPENDIX B

Participant Demographics

Participant Demographic Data

ID	Sex	Age	Marital Status	Education
402	male	45	married*	some High School
409	male	27	single/never married	completed University Undergraduate Degree
412	female	28	married	some College
413	female	29	single/never married	completed College
415	male	48	married	completed University Post Graduate Degree
420	male	40	divorced	completed College
425	female	28	divorced	some University Undergraduate
430	female	45	married	completed University Undergraduate Degree
431	male	27	single/never married	completed College
433	female	49	married	completed College
452	male	22	single/never married	some College
401	female	40	divorced	some College
405	male	33	single/never married	some College
407	female	54	married	some College
422	male	57	divorced	completed College
423	female	60	divorced	some College
429	female	44	married	completed College
432	female	34	married	completed College
440	female	47	single/never married	completed College
442	male	27	single/never married	completed College
n = 20	females=11	mean=39.2	single/never mrd = 7	some High School = 1
	males=9	median=40	marrried n = 8	some College = 6
		mode=27	divorced n = 5	completed College = 9
		range=22-60		some University Undergraduate = 1
				completed University Undegrad Degree = 2
				completed University Post Grad Degree = 1
* married or living with someone as if married				

APPENDIX C

Outcome Determination at Post-Treatment and 6 Months Following Treatment

Participant Outcome Data

Client ID	pre-tx BDI	pre-txGAF	post-txBDI	post-txGAF	post-txSCID	post1mo SCID	post2mo SCID	post-tx OUTCOME	bdi-mo1	GAF 1	BDI-mo2	GAF 2	BDI-mo3	GAF 3	BDI-mo4	GAF 4	BDI-mo5	GAF 5	BDI/L-mo6	6moSCID	GAF 6	6-month OUTCOME
402	21	61	2	n/a*	not dep	not dep	not dep	recovery	6	71	7	71	7	71	13	65	n/a	65	18	dep	55	relapse
409	16	62	1	61-70	not dep	not dep	not dep	recovery	3	90	5	85	3	85	3	90	1	85	7	not dep	85	sustained recovery
412	33	53	0	n/a	not dep	not dep	not dep	recovery	3	91	2	91	4	91	0	91	3	91	0	not dep	91	sustained recovery
413	33	70	0	85	not dep	not dep	not dep	recovery	n/a	91	n/a	91	n/a	91	n/a	91	n/a	91	0	not dep	91	sustained recovery
415	20	65	0	90	not dep	not dep	not dep	recovery	1	80	99	80	7	80	2	80	1	80	0	not dep	80	sustained recovery
420	22	70	1	n/a	not dep	not dep	not dep	recovery	2	95	99	95	2	95	3	95	5	95	0	not dep	95	sustained recovery
425	36	65	8	90	not dep	not dep	not dep	recovery	6	90	14	90	7	90	5	90	5	90	3	not dep	90	struggling
430	21	61	10	82	not dep	not dep	not dep	recovery	11	80	12	80	20	70	21	70	9	71	15	dep	65	relapse
431	31	60	10	70	not dep	not dep	not dep	recovery	6	81	4	81	2	81	2	81	8	81	2	not dep	81	sustained recovery
433	33	68	3	81-90	not dep	not dep	not dep	recovery	1	80	n/a	80	n/a	70	n/a	61	n/a	61	4	not dep	80	sustained recovery
452	23	65	6	n/a	not dep	not dep	not dep	recovery	4	71	0	71	3	71	4	71	2	71	3	not dep	71	sustained recovery
401	21	70	15	90	not dep	not dep	not dep	non-recovery	11	71	n/a	71	14	71	14	71	n/a	75	5	not dep	75	struggling
405	17	65	13	68	not dep	not dep	not dep	non-recovery	9	71	9	71	8	68	10	68	9	68	6	not dep	68	recovery
407	44	55	37	61-70	not dep	not dep	not dep	non-recovery	37	n/a	37	n/a	35	n/a	33	n/a	31	n/a	30	dep	50	sustained non-recovery
422	35	65	13	70	not dep	not dep	not dep	non-recovery	18	70	17	71	18	71	18	75	17	75	16	not 7 yes	75	sustained non-recovery
423	27	51	21	60	not dep	not dep	dep	non-recovery	24	70	33	60	26	60	22	65	25	60	21	dep	60	sustained non-recovery
429	30	70	18	70	not dep	not dep	not dep	non-recovery	n/a	80	n/a	70	n/a	60	n/a	80	n/a	80	17	not dep	70	struggling
432	39	n/a	26	61	not dep bu	not dep	not dep	non-recovery	n/a	70	n/a	70	19	70	25	71	n/a	55	47	dep	50	sustained non-recovery
440	32	71	25	78	not dep	n/a	n/a	non-recovery	19	70	14	70	15	70	15	70	15	70	12	dep	70	sustained non-recovery
442	31	65	13	70	not dep	not but	no but	non-recovery	13	60	23	60	10	80	8	80	11	95	2	not dep	100	struggling
* indicates data not available and presumed lost or never recorded																						
Note: legend key provided on next page																						

Legend to Appendix C

pre-tr BDI	= pre-treatment Beck Depression Inventory
pre-txGAF	= pre-treatment Global Assessment of Functioning
post-tx BDI	= post-treatment Beck Depression Inventory
post txGAF	= post treatment Global Assessment of Functioning
post txSCID	= post-treatment Structured Clinical Interview
post1moSCID	= one-month post-treatment Structured Clinical Interview for DSM-IV (SCID)
post2moSCID	= two-month post-treatment SCID
post-tx outcome	= post-treatment outcome
bdi-mo1	= Beck Depression Inventory one month following treatment
GAF1	= Global Assessment of Functioning one month following treatment
BDI-mo2	= Beck Depression Inventory two months following treatment
GAF2	= Global Assessment of Functioning two months following treatment
BDI-mo3	= Beck Depression Inventory three months following treatment
GAF3	= Global Assessment of Functioning three months following treatment
BDI-mo4	= Beck Depression Inventory four months following treatment
GAF4	= Global Assessment of Functioning four months following treatment
BDI-mo5	= Beck Depression Inventory five months following treatment
GAF5	= Global Assessment of Functioning five months following treatment
BDI/L-mo6	= Beck Depression Inventory-Long form six months following treatment
6moSCID	= six-month follow-up SCID
GAF6	= Global Assessment of Functioning at six-months following treatment
6-month outcome	= outcome determination at six-months following treatment.

APPENDIX D

The Narrative Assessment Interview (Hardtke & Angus, 1998)

Therapist Instructions

A separate tape (60 minutes) will be provided. You are not required to write anything down. A confidential spot to leave your completed tape will be arranged.

We are asking you to conduct a short narrative interview. The questions, issues, and areas we would like you to cover are provided on the sheet I have given you. Before going through the questions, I would briefly like to describe the atmosphere in which we would like you to conduct the interview.

Atmosphere in which the interview should be conducted:

- Client-centred (here we are trusting you to use your therapeutic skills)
- Interactive dialogue - - don't worry about following the questions verbatim, as long as the areas outlined in the interview are covered. You are not writing anything down leaving you open to focus on the dialogue.

Potential Problems – Trouble Shooting

Some clients have found the first question (i.e., "How do you describe yourself?") somewhat difficult to answer. If they find that they are unable to answer that question, start with Question #2 (i.e., "How would someone who knows you really well describe you?") and then go back to Question #1 asking how they would describe themselves.

Suggested Introduction to the Narrative Assessment Interview

Now I am going to ask you some questions about you. People are complex, and although the questions I will ask may at first appear to be quite simple, many people find them difficult to answer. The difficulty may be in part because you've never been asked these types of questions before.

I encourage you to take as much time as you feel necessary to think about what I've asked you before you respond. The questions are about how you see yourself and how you feel others see you.

This shouldn't take more than 10 minutes of your time.

NARRATIVE ASSESSMENT INTERVIEW

1. How would you describe yourself?

- If a person describes themselves in a role (i.e., I am a mother) go to "a" and then "b."
- If a person describes himself or herself using adjectives (i.e., I'm a nice person) go to "b."
- Follow both "a" and "b" by "c" and then return to 1. (Note: Try to pull for the participant to elaborate three or four major ways they might describe themselves)

a. What kind of _____ are you? (i.e., mother)

b. Can you give me an example of a recent event that would illustrate what kind of _____ you are? (i.e., mother or nice person)

c. You said that you would describe yourself as a (i.e., mother or nice person), how else would you describe yourself?

2. How would someone who knows you really well describe you?

b. Can you give me an example of a recent event that would illustrate what kind of _____ you are?

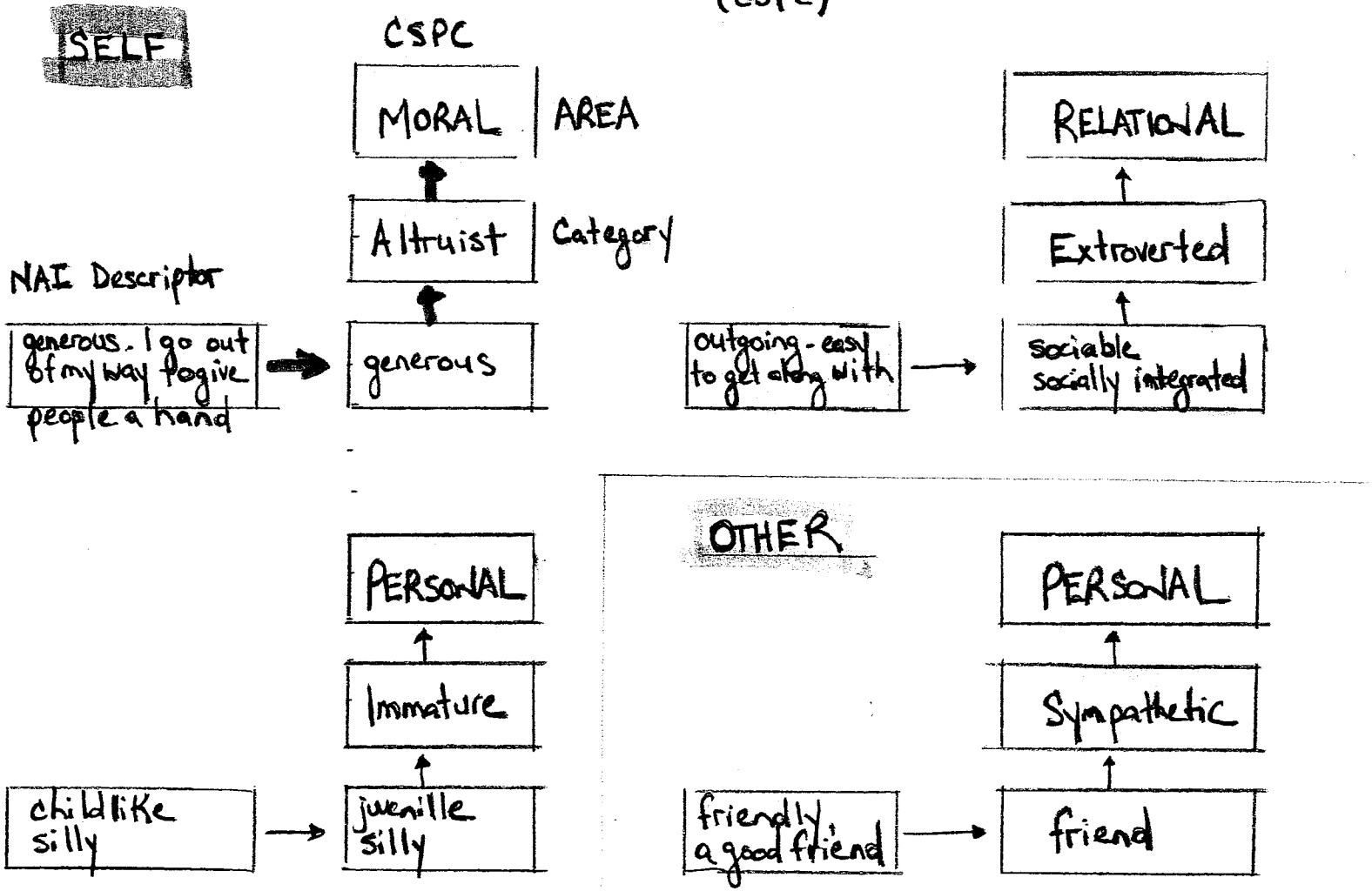
3. If you could change something about who you are, what would you change?

APPENDIX E

Illustration of How the NAI Descriptors Were Graphed on to the Classification System of Personal Constructs.

ID: 405

CLASSIFICATION SYSTEM OF PERSONAL CONSTRUCTS (CSPC)



APPENDIX F

Illustration of the complete NAI protocol for ID:423 – "Inge"

SUBJECT ID: 423; DATE; TEXT TYPE; BASELINE NAI

Legend: T: therapist; C: client

VIEW OF SELF

T: I'm going to be asking you some questions about yourself, um, and I am just going to read off here of what it says about this particular interview. um, // people are complex and although the questions I will ask may at first appear to be quite simple
C: not (laughs)
T: right (both laugh) // many people find it difficult. I am not sure /// the difficulty might be because you have never been asked these types of questions before. so, um, we want you to take as much time as necessary to think about each question before you respond to it and the questions are about how you see yourself and how you feel that others see you. and it shouldn't take much more than ten minutes
C: okay
T: okay
C: how many questions are there?
T: um, it is numbered to "three" but there are different parts
C: okay, alright, shoot
T: okay, so the first one is "how would you describe yourself?"
C: that's it?
T: that's it (both laugh). if you want to think about that for a minute.
C: ah, well, um, um, **I love to laugh, I have a good sense of humour.** and **sometimes I laugh too much.** um,
T: can you say a bit, something about that, just, sometimes you laugh too much.

> **C: well I use humour and laughter, sometimes to, um avoid, cover up something else. I am very very conscious of not wanting to upset other people, um, and in fact (?: / of my friends have no idea that I am going through because I don't want talk to them, and I laugh a lot with my friends.**

C: I am, I worry a lot about being very happy, free, sociable. **people tell me that I am very easy to talk to.**
T: and do you feel that you are, (?and is that how you would describe yourself?)
C: I think that I am easy to talk to.

> **(incomprehensible) I think that people really like (incomprehensible) you know, I think that I am very good at getting people to talk to me, people tell me, they often say 'you're so open, thank you for sharing your joy or whatever.' but I**

T: you shy away from sharing //
C: well, people see what I want them to see
T: ah-hah. so you hold back, kind of cautious about what you let them
C: and ah, **although people think that I am very extroverted, in fact, um, I am really quite shy and I feel very self-conscious** //. (incomprehensible) **I thought that I was**

very very dumb, I thought that I was very dumb until I had an "ah-hah experience" about 15 years ago, which was very exciting and I realised for the first time in my life that I was intelligent. it was a wonderful experience for me and I was (?: convinced). **I am a perfectionist in some things.**

T: can you give me an example in the ways that you would be a **perfectionist**?

C: I am probably a perfectionist in everything, I think that it is a problem so I try to, very hard, like, housecleaning, it's very hard for me to house clean because of my physical problems so I just decided I had to learn to live with dust. so I am not a good housekeeper, not at all. I guess, I think that the perfectionism interferes and it always has in a way because when I start to do something I have to do it perfectly (T: ah-hah) or I don't do it. and I do things that (?: people say) I go way beyond that what anybody would expect. (T: right. so that's the feedback that you're getting and yet you probably don't see that (?: that happening, because you're so)) no I do see myself doing that and I think that it is a problem (T: oh okay, so) whereas people say it as a compliment 'you've gone way beyond, oh you're so organized //" on that way, it is a tremendous cost //. so to me that it is problem.

T: ah, okay.

C: um, and I just, I was just thinking // **I am a very kind person, a very gentle person** and **I never knew until fairly recently how much anger I had**, I am so angry I don't know what to do with this anger.

T: right, anger (?: that is recent)

C: I think I felt it my whole life but I always told people /// yeah I think that I have a lot of anger

T: (?: that's interesting)

C: no (laughs) I don't like it, I don't like it, you know, I don't like it.

T: incomprehensible (both laugh)

C: I like people to be, **I like civilised discussions.**

I think that when there is a problem, you can either agree to disagree, you can discuss it (?: you know, no personal attacks) and we can agree to separate and go your own ways, or maybe we can come to some agreement, but civilised

T: so that is important to you, that you

C: **courtesy is very important**

T: you have given a number of dimensions, you actually alluded to question number 2. go ahead and stand up if you want to (therapist responds to client's need to move around due to back problems)

C: I will be okay if I shift around

SELF AS VIEWED BY OTHERS

T: okay, to how other people see you. and I guess what they are getting at here as well as you could think about someone that knows you really well, how would someone that knows you really well describe you?
C: ---- **I don't know anybody who knows me really well**
T: right, so sort of (?; maybe imagine)
C: how would, so how to think that an imaginary person who knows me really well? how would they describe me?
T: I think, yeah, I mean unless you can try to think of someone who knows you better than most people.
C: - - - - - people who have known me best in my life haven't known me. they have me very incorrect, very incorrect, judgements, very
T: what kind of judgements would you say?
C: well, **one that I hear quite a lot is that I am stubborn.**

> **I know why people say that is because I have very strong ideals and I have very strong- high standards, but I don't have a lot of them but just the ones I have are very strong. so if you try and convince me, for example, I don't believe in God. that's a personal belief, I've thought about it very carefully. I believe everybody has the right to believe // in whatever you want but I don't believe in God. so if you wanted get into a discussion with me about whether or not there is a God I will discuss it with you up to a certain point on a sort of philosophical, intellectual issue but not for very long. and if you try to convince me that I was wrong, then you might say that I am being stubborn because I am not listening to you**

T: yeah, that is a very personal
C: yeah but I hear it all the time
T: right, I wonder
C: that same thing that I was stubborn and I took it, to me that is not stubborn, it's just – and I won't act against my conscience
T: so you have a strong conscience
C: I have a very strong conscience but I am also, I seem so flexible about so many things but when people see that part where I am not flexible it is frustrating, I think (T: right) people always want to convince you to change your mind or change your way or something
T: so you'd say that maybe people that know you might be, run up against some of the, you said that you have just a few of these sort of standards and ideals but generally you're more flexible so
C: **I am so flexible about things I am always shocked when people call me stubborn but I am called stubborn /** (laughs)

T: okay, is there something else, um , that other people would describe you that you feel that know you quite well?
C: well, I'm told so often that **I am very friendly and that I am very open and very direct and that share what I think, people tell me that, um - - - - emotional**
T: that you have emotions, +that you share emotions?
C: **that I am emotional**+ - - - - **I've been told, well one person who knows me really well tells me he's never know anybody, now I don't like this, but he's never known anybody in his life who has had so much love to give that it is endless, the love I have to give**, that's not true, but that's what he sees
T: is that what you don't like about it, the untruth about it?
C: I don't like that that, because I think that it means that he wants more
T: ah, that he wants more
C: of this endless love I have
T: yeah yeah, the taking something away from you by saying that
C: yeah
T: you have this big beautiful bucket of love
C: it's not true
T: so you're saying the love has some boundaries, or /
C: tenacious, **very tenacious**, people tell me that I am up to a point. but other people see me um, - - - fun
T: you say that with a smile that is almost a smirk, I'm not sure
C: well because I am like that, I love to have fun
T: right, you said that at the very beginning of our session
C: I do, I love to have fun. I love my sense of humour but not everybody does and I guess, oh well, if you would ask the **people I work with, this last group, they think I'm terrible** (T: /) no they do, they (laughs) think, ah, I don't know what they think, yeah I do know what they think, they made it very clear, they cannot stand me (T: really) they can't stand me, um, really.
T: what +what
C: and+ I (?: get) them, because you have to maintain your sanity, you know so I (?:trick) them sometimes because I know they don't like it (?: they are so serious you know) so I sometimes do things that I know is going to make them mad but I think it is funny (incomprehensible.) yes, incorrigible
T: I get a picture of a little, like a little kid laughing, like a, you know that guy, like Tom Sawyer
C: Tom Sawyer?
T: yeah, watching the other kids painting
C: I'm not really that, I'm not really familiar with that, I've read it as a kid but I don't know what you're alluding to, what did he do?
T: I think it was the same one, if I've got the story right with the, he tricked his friends into painting the fence and sat back laughing
C: oh I wouldn't do anything like that. oh no, I always say to people "Oh, I'll do it, don't worry" that is really a strong trait of mine
T: okay

C: **"I will look after you. I will take care of things, don't you worry about a thing."** and I do
T: so you take on other people as +projects or
C: yeah I take on too much+ (T: yeah) **I take on projects and I really get angry because people expect it**
T: sure sure
C: (sighs)
T: okay that's good, well, well done, um and just the last question they're asking 'if you could change something about who you are, what would you change?'

CHANGE

C: well, at this moment, the thing I think of most, **I wish that I could just be me and I wish the being me could include me angry and knowing how to. because I think that anger can be constructive** but I don't know what to deal with it and I wish I could (sighs) **I wish that I could just "give in", I have pain and to recognise that I am having pain and say it is okay to have it and it's also okay to let other people know that I have it but I don' t even recognise it a lot of the time (T: ah hah) until it gets so bad** that I can't, so I would like to do that. but I guess, **I would like to have some peace in my life** (sighs) and I would like not to (incomprehensible) I never wanted anybody in my life, for most of my life, but now I do for the first time
T: wanting some companionship
C: yeah, (incomprehensible) on the other hand, I am lonely now, very lonely but this is a cleaner kind of loneliness than sitting right next to my husband, sitting right next to somebody. a reason to feel lonely. **I wish I could go back, I wish I had known a lot to the things that I know now 20 or 30 years ago**
T: well you certainly
C: finished that
T: gave a lot of answers, yeah
(end of tape)

SUBJECT ID: 423; DATE: May 28, 1999; POST THERAPY NAI

Legend: T = Therapist; C = Client B K.; S. = Client's previous therapist; Ca = client's friend

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VIEW OF SELF

T: alright so the next section is, you indicated that you viewed yourself in the following way
C: on the same page?
T: yeah **I love to laugh**
C: yeah
T: **I love to have, I have a good sense of humour**
C: mm-hm
T: **sometimes I laugh too much, I use humour and laughter sometimes to avoid**
C: I think I may be doing that a little uh, more consciously, because sometimes you don't want, you want definitely to cover something up. I think maybe I'm doing that a little less
T: okay, **I'm very conscious of not wanting to accept the uh, the fact that a lot of my friends have no idea what I'm going through because I don't want to talk to them** (C: yeah that's uh) the same?

> **C: no, that's changed uh, that's changed, none of my friends knew what I was going through last fall, I didn't tell them at all, but I discussed, that's changed, I'm telling them a little bit more (T: so you're not so closed) no**

T: **I laugh a lot with my friends, I'm very happy, free, sociable**
C: yeah, that's true
T: still same?
C: yeah
T: **I feel that I'm easy to talk to, I think that I'm very good at getting people to talk to me**
C: yeah
T: still the same?
C: yeah
T: **I want people to think that I am very extroverted, but in fact I'm really quite shy and feel very self-conscious**
C: oh yeah
T: same?

> **C: yeah in fact one of my big desires now is to just (sighs) be shy, I've always, I've always been shy and I would like to just be with somebody and feel shy and be shy, and not talk but I haven't really, cause it's okay to (T:**

that' s right) but I told my friend the other day that I had just been longing my whole life, I' ve been longing to spend some time with somebody, somebody I like, not just a casual thing where we don' t talk, just read a book or go for a walk, or whatever, but not talk, but be aware that you' re together (T: right) but she' s a bigger talker than I am, so / / /

T: okay, I thought that I was dumb until
C: oh yeah
T: I had an "ah-ha experience"
C: yeah it was so funny
T: so you' re not dumb, that' s the same then? You' re intelligent?
C: Oh yeah
T: okay
C: well intel, I didn' t say how intelligent, yes, that' s true

T: okay. I look after people, I take on other people, I take on far too much
C: yeah I do, I do
T: still do? **I am a perfectionist in some things**, perfection interferes because when I start something I have to do it completely or I don' t do it. I go way beyond what anyone would expect
C: **uh, I wonder if that' s all I said, uh, because I' ve been less, I' m still tend that way, but since this, like this thing in my spine prevents me from being a perfectionist I used to be, like in housework,** or
T: mm-hm
C: but I do go way beyond, I' m trying to well, I' m more conscious of that now, I' m trying to
T: okay, so that sort of tied in with the other one, of not wanting to upset people and not telling people anything, and just trying to be perfect, there' s a shift with those two things
C: well yeah there is, yeah yeah unless it' s little children and they' re suffering, then I can' t

T: okay. **I' m a very kind person, very gentle person**
C: yeah **I should also say I' m also tough, I also have a tough streak in me, but I am kind**

T: **I' m so angry I don' t know what to do with my anger**
C: yeah
T: that' s still there
C: **uh, but I' m not as angry**

C: a lot of my anger then was, and it still is, but it was directed against my employer and my insurance company, and I have no, in fact I just wrote a thing last week they, uh, I can get so angry because they' re really rotten,

they' re rotten, what they' ve done to me is rotten and if I just had a killer instinct which I don' t, I would do something about it, but I know they have a killer instinct, and I can get really riled when I think about them and if I have to write them a letter like I do right now, because they didn' t do their job and now I' m well anyway but I, I thought of, I wrote out my options, uh, I had a workshop with an art teacher last summer and I had this wonderful big painting that I loved parts of but I got stuck at one point, and he said okay, you' re stuck, now this is the time, you need to choose an area and paint it out black, and then go home and think about it and come back the next morning, and I didn' t want to, he chose my favorite area, but he was the teacher so, I with great fear painted black over this one area and the next morning it just took off in whole different direction so I thought last week okay, I have to write to my company, I must use what H. said, there must be some way of applying that art lesson (T: mm-hm) I have to write to A (insurance company) I have to write to the R., I shouldn' t have to, but because of their incompetence, and I, I can either, I can paint something out black because I get upset, it will ruin my life for a week, so I' m trying to think, what can I paint out black? So I decided I can write it with the anger, or I can write it without the anger, somehow I have to blacken out the anger but I haven' t figured out how to do that except by just ignoring it (T: mm-hm) mentally so uh

T: **so there' s some things going on with your anger**
C: **maybe**
T: sounds like it' s shifting a bit

C: maybe, well I did do something I' ve never done in my life, last week. I don' t know what was getting me, but I sat in a chair and I thought I feel like screaming, I' ve never felt like that so I picked up a pillow and I screamed! (T: ohhh) oh, I did about 4 times, it didn' t help but at least I (T: you did it) (laughs) (T: and you wanted to) laughs.

T: okay, the last one at the bottom
C: yeah
T: I feel that I have a strong conscience
C: yeah

SELF AS VIEWED BY OTHERS

T: alright so the next one, this is how other people viewed you, **so people tell me that I' m very easy to talk to**

C: mm-hm
T: do you still think people are viewing you in these ways?
C: oh yeah

T: people often say you′ re so open, frank, open, thank you for sharing joy, **people see me the way I want them to see me**

> **C: yeah and now it′ s, the second one is true, people have said that to me, uh, but now, I am talking to some people a little bit and uh, so there, they′ re perhaps seeing me a little bit more the way I am (T: instead of what you want them to see, you′ re not hiding so much anymore?) yeah yeah I think maybe a little bit stubborn, I don′ t / / people tell me I′ m stubborn, but I′ m not**

T: **stubborn, strong / , high standards,**
C: **yeah**
T: / / stubborn / / /
C: I know I′ m flexible, **I′ m very flexible (laughs) too flexible but some people think I′ m stubborn**

T: **I′ m very friendly and very open and very direct**

> C: **direct, uh, I don′ t know if that′ s a very good word, very direct I am, in some ways I′ m very direct, I′ m uh, I′ m very friendly, people tell me all the time how wonderful I am, and how much they like me and love me, I did it, and I always feel angry when they say it, almost always because I feel it′ s not, that′ s, I mean, part of me is like that but they don′ t know the bad part about me because I, so I guess, but people think I′ m very open, people tell me they think I′ m very open and direct but I know (T: you′ re hiding) I′ m not very open, I guess I′ m fairly direct, I think I′ m reasonably direct**
> (note: **changes to saying "not very direct")**

T: **okay. Emotional**
C: oh yeah
T: **I have so much love to give that it is endless.** That′ s what people think
C: well that′ s what somebody told me once, and I don′ t think that′ s true, it′ s not endless (laughs)
T: **tenacious?**
C: oh, I′ m tenacious as can be yeah

T: **fun, not everybody likes my sense of humour**
C: true, but I love it (laughs)

T: **and incorrigible**
C: yeah

T: okay, so has any of that changed?
C: no

T: that' s all still how people would view you?

C: well no, I, mmm, uh, perhaps changed a little bit, I think that some of my friends are seeing me a bit more the way I really am (T: that goes back to what we were talking about before) yeah (T: and just your talking a bit more, sharing a bit more) mm-hm (T: so they perhaps are seeing you more realistically?) I don' t think anybody now would tell me that uh, all I have to give is endless, cause it' s not (T: okay) uh

T: okay thanks, interesting eh? Looking back to see what you

C: *it' s amazing uh, because I feel like uh, I went through a little exercise before the therapy ended uh, because I wrote out some goals when it first started, and I went through them to see, and I was surprised that I, I had set my goals very low actually, and I had achieved all of them and way more, it was a lovely, lovely, lovely, lovely, good experience, yeah really good*

CHANGE

T: alright, we' re just going to change gears for a minute here
C: okay
T: this was the, I' ll give you a copy of it, this was the interview that S. did with you following the first session when she asked you what you' d like to change and
C: and this is what I said?
T: this is what you said
C: oh! (laughs)

T: you said, if you could change something about who you are, you would change the following. *I wish I could be me, and I wish the being me could include the anger because I think anger can be constructive*
C: did I say that?
T: apparently. I wish I could just give in, I have pain and to recognize that I' m having pain and say it' s okay to have it. But I don' t even recognize it a lot of the time until it gets so bad
C: mm-hm
T: I would like to have some peace, I wish I had known a lot of things I know now, twenty or thirty years ago
C: mm-hm

T: so uh

C: the anger I haven′ t made any progress with at all,

I just, and that′ s another thing that I, I mean, how can you get angry in the presence of somebody like S.? I don′ t know how to attack anger, and it terrifies me when I see it in other people. Not with patients, I′ m a totally different person with patients, but my own anger uh, I can express it if you′ re a clerk and you do something stupid, I can snap at you because I don′ t know you, but I can′ t uh (T: can′ t do it to people who are?) no (T: important or who matter) no, no / like that

T: okay so there hasn′ t been any change in that. What about the second one? **I wish I could give in**

C: well give in, the pain yeah, (sighs) well I do say I have pain, but you′ d be surprised how many people don′ t believe you (laughs) it′ s really, it′ s awful because I try very hard not, I don′ t want it to be a part of my relationship with people because people can feel so burdened if, so I try very hard to not let people know I′ m suffering, and I also try to do a lot of things which I probably shouldn′ t do but you have to have a life, so sometimes when I do say that I have pain or sometimes I even get very, I hate that, my mother used to do that, but sometimes I, you know, / / / (laughs) people don′ t like it, I′ ve seen it at my job, people don′ t know how to deal with dying and pain and stuff, so I do say I have, I′ m not good at, have I changed? No, I don′ t think I′ ve really changed uh, when the pain gets there bad enough, I know it′ s there and I may or may not (T: so that hasn′ t really changed)

C: you know what, I′ m not positive, I may have changed a little bit, I know S. used to often say you can stand up if you want to because I guess she saw me looking uncomfortable, uh, actually I′ ve noticed myself over the last couple of weeks saying uh, saying to myself well now wait a minute, you have to go to the bathroom, so you might as well just go right now instead of waiting, that′ s the nursing thing, you know, I′ ve got all these things to do, so I′ ll just go later (laughs) (T: right) uh, or I′ m, you know, I said this to myself two days ago, you′ ve been freezing cold for three hours, why don′ t you just get a sweater? (T: mm-hm) so I did, or take a pill, you know you′ re hurting, you know, you know, so maybe I have,

T: maybe there is
C: maybe just starting a little bit, about that
T: acknowledging your own feelings and your own physical condition and not putting it on hold all the time
C: oh yeah but if you ever worked in an intensive care unit
T: I didn′ t, but was an elementary school teacher and I taught kindergarten for 15

years and I learned then that, how to never go to the bathroom, and I swore when I stopped teaching that when I had to go to the bathroom for the rest of my life, I was going to the bathroom
C: (laughs)
T: I wasn′ t going to hold it for day anymore
C: ohh
T: nothing was going to be that important that I didn′ t need to eat
C: but you don′ t even, the thing is you′ re only peripherally aware of the pressure
T: exactly, oh you are
C: you walk into an intensive care unit in the middle of the night and you see nurses standing by the end of the bed and they′ re / / /
T: and they′ re standing
C: and they′ re working like this and you often have to say to them, go to the bathroom, I′ ll watch, because they′ re not even
T: paying attention to it
C: yeah until they can hardly make it anymore, they just tear out and
T: right
C: so uh, that′ s partly the nursing
T: right

C: I′ d like to have some peace, uh, that′ s a very general thing. I have peace at moments. I think that I was talking about the uh, I wish I had known, oh boy, that last, I wish I had known a lot of the things I now know twenty or thirty years ago, I′ ve learned so much more since the therapy, so that′ s still true
T: okay
C: even more

(end of NAI)

SUBJECT ID: 423; DATE: January 12, 1999 ; TEXT-TYPE: 6MONTH NAI

T = Therapist - ; C = Client ; S = client's previous therapist; J = researcher in study

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VIEW OF SELF

T: now the next question that you were asked was how would you describe yourself? **And before therapy you said "I love to laugh, I have a good sense of +humour"**
C: yeah+
T: **"I laugh too much, I use humour to avoid, cover up, +I'm"**
C: yeah+
T: **"very conscious of not wanting to upset people, a lot of my friends have no idea of what I'm going through, I laugh a lot with my friends, happy, free, sociable, I feel that I'm easy to talk to"**
C: yeah
T: **"very good at getting people to talk to me"**
C: (sniff)
T: **"I want people to think I'm very extroverted but in fact I'm really quite shy, and feel very self conscious, I thought that I was dumb until I had an / experience +and then realized that was intelligent"**
C: yeah (laugh) yeah (laugh)+
T: **"I look after people, I take on other people, I take on far too much, I'm a perfectionist in some ways, I'm very kind, very gentle"**
C: (sniff)
T: **"and I'm so angry I don't know what to with my anger, I feel I have a strong conscience, yet I'm flexible"**
C: mm-hm
T: and then **after therapy you said "I think I might be doing that a little less that +is using**
C: mm-hm+
T: **humour**
C: yeah
T: **to cover up, I'm telling a little bit more, being a bit more open with my friends, um I still laugh a lot, still very happy, free and sociable, still easy to talk to, one of my big**
C: (sniff)
T: **desires is to just be shy because that's okay, I think of myself as intelligent, I still take on too much**
C: (laugh)
T: **my physical injury prevents me from being a perfectionist, I still view myself as kind and gentle but I have a tough streak, I'm not as angry +at that**
C: (sniff)+

T: **time it was directed as an employer, I still feel I have a strong conscience"**
C: right
T: (shuffling papers) um so how has
C: (sniff) how are those +things changed well (sniff) uh I I
T: how are things, yeah have any of those things changed since+
C: **still like to laugh, it's a great relief um laughter is a great relief**
T: mm-hm
C: um, **I don't laugh enough for me**

C: +I I (T: hm+) got really, uh upset last week with the art therapy I mean not within this cause it was so hard, and I was thinking about um one and another thing I became aware of right now with you (laugh) (T: mm-hm) um is that when people talk to me I look at them and I listen and people do talk to me easily but when I'm talking about myself I don't look at people and I was thinking about feedback cause that came up in the group, and I was thinking well / I always think I'm / feedback but if you don't look at somebody +you don't get feedback right (T: maybe you don't right+) cause you see a lot in facial expressions +/ / so (T: uh-huh+) I started thinking about eye contact, I'm very comfortable looking at people when they're talking to me but I'm not when I'm talking about +myself (T: mm+) and I get so angry I (laugh) do just to laugh (laugh) it's really funny I think I did a picture of two eyes (laugh) (T: (laugh)) but I made into fishes swimming +(laugh) (T: oh yeah+) so it's in my art therapy book and uh so I laugh (laugh) (T: (laugh) / / somehow amusing) yeah uh (sniff) but um I don't I don't think I usually cover things up um I can't think of anything I don't do that as much anymore

T: **do you have an example to illustrate that change that you're not doing that anymore?** A recent example? - - - -
C: I can't think of anything, um I'm getting uh – oh I don't know (sigh) it's very hard for me I'm dealing with people, I'm I'm I really don't know I've been a nurse for forty years +all my (T: ah oh+) life so I help people who are in my business but it's a different relationship when +you're (T: right+) professional +it's (T: yes+) you're doing and so forth um it I've always found it very hard to deal with people on a personal, intimate, +close (T: mm+ mm-hm) way, uh, but I'm I'm really trying hard to uh and I find being with my friends is very tough, I like them but it's very hard on me, / / I'd say exhausting even really nice people, they aren't doing anything in particular it's me being tense cause I'm not nursing them +or helping (T: mm+) them I'm just being their friend so that's a situation where I would have used uh uh – uh I mean I can remember last year, see things have changed a little bit / / my friends are from art school and we used to all be in the same class and we'd go to get coffee after +class (T: mm-hm+) and and I was always joking, people were always laughing and always telling me how fun I was to be with

even when I was going through personal hell, even when I was actively planning to commit suicide I was doing that then, no idea, um – so I'm not I I guess I'm maybe I'm sharing a little bit more with them right now +so I don't (T: uh-huh+) feel that – urgent need to cover up +somewhat (T: right+) and I also don't see them very much

T: ah when was the last time you saw +your friends
C: well I I+ my girlfriend was over Saturday and +uh
T: uh-huh+
C: it was just exhausting and +I was
T: what happened?+
C: nervous I was nervous for days before she's coming and I haven't recovered yet um so it was just nothing happened when she she came over, we had lunch, we chatted, we took the dog for a walk, we had supper, we it was just
T: mm-hm, what was so exhausting about that?
C: um (sigh) – I I you know what I I with that I can't identify except that I know I'm always **there's only one thing that I I'm aware of and I became really aware with S.(therapist) (laugh) um is that I talk too much**
T: hm
C: I and I don't like to talk a lot, I really don't, I prefer
T: so is it kind of talking out of nervousness? +or
C: yeah+
T: oh
C: uh – yeah and yet people tell me all the time (incomprehensible) I mean they say things to me, you know my other girlfriend tells me I'm her muse and uh and it so there's a lot of encouragement to be that way
T: right
C: but
T: but it's not really you somehow
C: it's uh it's it's I guess it's part of me but it's it exhausts me
T: hm
C: and I'm just totally wiped out
T: ah
C: and I would just love to be able to – I guess this came up in group too, uh this idea of when I thought I was like wearing masks and a lot of the group had been told that they were negative people, it was a very common experience
T: mm-hm
C: it's not for me, the opposite is for me
T: mm-hm
C: **people tell me I'm so friendly and up and happy**
T: mm-hm
C: **because that's a mask for me**

T: right
C: it's not always
T: mm-hm
C: **but for me I would like to be able to, when I feel sad**
T: to let that
C: **to be sad**
T: right
C: **uh, and not feel that I have to talk and keep things going**
T: mm-hm
C: and uh, so I don't know, I haven't figured it out yet

T: now when your friend came over, were you trying to be **more open** with her, or

> **C: I have been making a little bit, I guess I don't know how to do it very well, I guess I feel like I, it's sort of like when I was with S.(therapist) I know it was way worse with S. because I had been so alone for so long with this illness and uh, I was just bursting when I came in here I just couldn't stop, I couldn't stop uh and I had this fantasy from a little girl, always fantasizing about wanting somebody to talk to but I never did (laughs) but it was a fantasy, and uh, I started when I was with S. reading some books and uh, cause I never told anybody about the incest (T: mm-hm) never talked to anybody and somewhere I read that that was a good thing to do (laughs) so I did a little bit with my friend, so I'm trying to do it but it's not comfortable, it doesn't feel right and I don't feel I do it right (T: mm-hm) so I'm not**

T: do you remember what kinds of things you said to your girlfriend
C: about the incest?
T: well about anything, just **trying to be more open?**

> **C: I / / when I talk about it, and it's hard too because I have the feeling that she's been through something and she doesn't - - / about it (T: mm-hm) I'm aware of, I don't want to intrude on her. uh, I told her a bit about the group, uh,**
>
> **and I'm starting to get panicky right now (T: oh) uh (sighs) (T: panicky about telling me this?) yeah I'm trying to / panicky because I'm blanking out about what we talked about (T :oh, I see, it's okay if you don't remember) and I can't uh, I can't uh, I can't remember, I will, I mean, / / / / / through that when I start feeling uncomfortable (T :okay, okay, well whatever you can remember is fine)**

C: because she told me about her father burning her with a cigarette (T: Oh) it's / / she's Japanese-Canadian and he's traditional Japanese and it was some kind of traditional, he father was samurai and when she was four years old uh and uh, I remember saying to her, you know, that's abuse uh to do that, and she said well you were talking about suffering and pain, I think maybe I was telling her how, oh, I know one thing, she told me that I looked really strained, I looked tired, and she said at the same time you also look good (laughs), uh, and I was telling her how hard and / the therapy is, this art therapy, it's really going to levels that I have not been before and it's really hard (laughs) so I told her that and she told me that she uh, I guess this is relating to the samurai tradition, that she's always felt very proud of the fact that she can suffer a lot, uh - - I don't think that's a great thing actually. I can't remember everything we talked about, we didn't just talk about this either

T: no, of course uh, so just kind of **to go back to the list, you are trying to continue in being more open with your friends but it's hard for you**
C: It is, and I, I withdraw a lot, I turn the phone off, I uh, I just don't see them very much

T: does that have an impact on your depression? Either trying to be more open, and the withdrawal that happens afterwards?
C: well I guess so, I, because I'm so, **sometimes I'm so lonely, well alone is really, I'm alone and I**
T: mm-hm
C: and I don't think that's normal and I think we're human beings and that's not the way you know, we thrive, to be just alone
T: mm-hm

C: when I get pressured or upset, I just want to pull the world in around me and I've always done that since I was a little child, I've always done that (T: right) so uh, so in a way it feels safe, and uh and it is safe, but at the same time I wish I could be some other way, I'm not sure (T: okay, so it's also isolating) It's very isolating, I think, I think all of this is worse for me now because of the illness, because I always worked before and I never had time to, to do this, I could do it in an evening, but I was working everyday and now I'm not doing that, so it's easier to withdraw now and I feel more like withdrawing anyway in some ways because I don't like what's happening to me physically and I don't want to, I also don't want friendships to be burdened with problems. it's a very easy way to lose friends, to be sick, or have a lot of problems and I don't know, that's why I wish I had a doctor I could unload to, a therapist, somebody (laughs)

T: mm-hm, right uh, I guess, we won't go through everything on the list because some things are just the same
C: we've already covered them
T: right you covered a lot of them. I guess the other one that I wanted to address is the anger
C: mm-hm

T: **before therapy you said I am so angry I don't know what to do with it and after therapy you said I'm not as angry, and just as we were saying earlier that you are still angry again**
C: **I am,** and the issues with my employer which I won't burden you with, have just been, oh, one good thing, I hope S. listens to this tape, uh, one good thing, I just had her / this problem with my employer and I just start getting overwhelmed when I think of them
T: mm-hm

C: uh, related to the illness, and the insurance company didn't pay me, just didn't send me money last year when I first came to S. and that was totally overwhelming to me at the time, totally, and S. said to me one day, why don't you just pile up all of your documentation and take it to a lawyer and set it down on a desk, and I couldn't do it, I just couldn't do it, but I did! just this uh, end of October, cause my employer (sighs) who's our health care system, they just – (sighs) – yeah I'm really angry, (T: frustrated) frustrating, and they did, they just put me through hell, total hell with the insurance company, total hell, and I didn't go to the lawyer / / plus I just didn't have the emotional resources to / / I was just going to kill myself and get it over with and uh, but I did, I had this year to sort of recover from the terrible things they did to me last year, and had some sort of time to relax a little bit this year, but then they did something else - - and I said, that's it, and I started getting really upset again and I said I can't, I'm not going to do this anymore, I cannot deal with this so I went to my lawyer, and he's so sweet, just about / / / I haven't gone / all these other things, and he listened to me for so long and I said they want you to write a letter to them, and he listened to all this stuff and he read my letters, and he said you know, it's going to cost you some money, just over five or six dollars, and I said, well it's the principle of the thing and it's five or six dollars every month which I don't have and they're wrong, they're screwing me again, and I, so that was really good that I just decided that was it. I'm not dealing with them anymore, I'm just not, so he wrote them a letter, he wrote them a really good letter and I feel good about that. he just sent them the letter today, but I made that decision and I'm not dealing with that, and in fact he told me that A., my insurance company, I already told him they had cut me off, and I put my condo up for sale and I bought clothes to die in, I was all ready, I was ready to kill myself except for one commitment I'd made and I, I didn't do it, and I

guess I'm not, but when they told me they'd cut me off with no notice, he said they can't do that, but that's what they did (laughs). I should have gone to them before, but anyway, S. will be glad to hear about it finally, but that was just interfering with my life so much because they were, I don't know if they were grossly incompetent, I don't think Aetna was, I think they were deliberately harassing me, I think my company was /, I think they were incompetent and they were harassing me and, it was sort of like my husband, my ex-husband, I was so unhappy for quite a few years before we separated and thinking that we should do it but not doing it, but then it just took one tiny little thing and I said that's it and that was the thing with this latest thing that made me go to the wire. it really wasn't a big thing but it was just enough (T: straw that broke the camel's back) straw that broke the camel's back, and uh, I just wrote them a letter today sending them some cheques because I have to pay for my health benefits and I said my lawyer tells me you have not responded to his letter and I said you have not cashed the last cheque for 300 dollars and all these delays and confusions are unnecessarily distressing me (laughs) (T: good for you) (laughs) (laughs) / / / / just felt like I have somebody to help me out (T: right right)

C: so
T: so is that
C: **the anger is, a lot of my anger was because of the, the stuff with my insurance company and my employer**
T: okay

C: and my lawyer also told me that because after cutting me off my benefits last year, that was terrible, uh, and I wrote letters to the chairman of the board of directors for that company and I wrote to everybody, oh, ten pages, because I was so, I was really bad and I didn't know what else to do and uh, and then they put me through some more stuff and that's when I, I didn't even, the last time they didn't pay me, I didn't even bother calling them or writing to them or anything I just said that's it, A. (insurance co.), I wrote to that company and put my place up for sale, bought clothes to die in, made all these plans, and then I get a letter saying you are now authorized to be on long term disability forever. I have been cleared to return to work and I waited two years and my employer never found me a job. They hired sixteen new people but they never (T: mm-hm) but that's why I think they were discriminating against me because of my age and my disability (T: mm-hm) but they would never say that (T: right) but they didn't find me work is the bottom line and I was just frantic and then they cut me off benefits, and then all of the sudden they put me on long term forever, and I don't know why and so my lawyer wrote another letter, if anybody, because my doctor doesn't even know why they put me on forever but he said, the lawyer said

that uh, now that they've got you on, they can't take you off and / / / they said subject to physical disability and my doctor has cleared me to return to work so I figured they, and he said no, they can't do that, they can't do that, he said I'm pretty sure you'll be on until you're 65 but he wrote in the letter to my employer that if Aetna or any other body finds that if I'm able to return to work, he expects / employer home-care program, and Scarborough community care access to find / / (T: right) so now it's in writing (T: mm-hm) and I don't think they give a damn, but, but it's good to just have it there

T: so it feels good, has that made you, has it in any way had an impact on you feeling depressed, or
C: well all this, this stuff, yeah, yeah
T: / right
C: how do you live without income? And I've been afraid all year, it's been a year anniversary now since they've cut me off before
T: mm-hm
C: and I've been waiting to get another letter and find out that the money is not there
T: right
C: cause they're totally brutal, and so I'm still worried about because I don't trust them
T: right mm-hm but it sounds like you've taken more charge of it and been proactive
C: well maybe a little, but they have that, I know that, I made the decision that I cannot live on eight hundred dollars a month
T: mm-hm
C: I don't know how I could, I don't choose to
T: right
C: and I will kill myself if I have to, I don't believe in God or heaven, I have no family, I have nothing, so it's not a big issue to accept that I will not try to live on eight hundred dollars a month, it's not the kind of life I want
T: right
C: so, and that feels comforting and I know I can, I already made my plans, so
T: mm-hm
C: (laughs) so, that's done, so, and I feel, I do feel a little relieved since my lawyer said that uh he thinks that they probably won't, I'm 62, so
T: so
C: but I don't trust them
T: right
C: I don't trust them, even if I was 64 I would expect them to say that's it
T: right
C: I mean, they're like that so, that's a constant
T: yeah
C: but anyway, worrying about it doesn't get me anywhere
T: mm-hm

SELF AS VIEWED BY OTHERS

T: right, now the third question you were asked is how you feel others view you, and **before therapy you said people tell me I'm easy to talk to, people tell me you're so open, thank you for sharing your joy, they see me the way I want t hem to see me, they see me as stubborn, strong, high standards, I'm called stubborn but I think I'm flexible, very open, direct, emotional, I have endless love to give, tenacious, fun, incorrigible**
C: (laughs)
T: and **after therapy you said, people still tell me that I'm easy to talk to**
C: yeah
T: **they see me a little more the way I am instead of hiding so much, some people may think I'm stubborn, but I'm flexible, people tell me I'm very open and direct, and I know that I am not very open but I am direct. And I don't think people would give is / /**
C: mm-hm
T: how has that changed in the last six months?
C: uh
T: how do people see you?
C: uh, **I'm still easy to talk to**
T: mm-hm
C: **uh, I think / / / I'm not always willing to talk now uh - - I'm not willing to do that, but**
T: mm-hm
C: **if I'm not feeling good, then I don't so often feel obligated / / somebody like I used to**
T: mm-hm
C: but I am easy to talk to
T: mm-hm
C: well that was, the way they say it here, one person said that to me, thank you for sharing / /
T: mm-hm
C: uh, I don't hear that very much anymore (laughs)
T: mm-hm
C: uh, I haven't been seeing people very much, so
T: I see
C: **so, people see me the way I want them to see me, yeah, I suppose pretty much the same, stubborn, I am not stubborn, but I've been told I'm stubborn**
T: I see
C: but I'm not stubborn
T: I see

C: uh, **I'm friendly, and perhaps I'm making a little less effort to go out of my way to be friendly**
T: I see
C: uh, I think I, I don't know if that's a good thing or a bad thing uh, I used to go out of my way to speak to people and go for walks and chat with people
T: mm-hm
C: like I really don't feel like
T: right
C: talking to people very much, I'm very direct and open uh, emotional, yeah S. will tell you I'm emotional, I was just a wreck with her uh, and I do, when I talk about some things I'm very emotional, but I also uh, endless love, somebody told me that once, I never knew anybody who had so much love to give, it's so endless, well that's a lot of crap (laughs)
T: mm-hm
C: it's not endless, and I am very tenacious, I am very tenacious uh, and I am incorrigible, I'm like that, but I'm not so much anymore (shuffling of papers) I mean, I've been told a few times this year, maybe that's because I'm being / / / a couple of people have said you're so strong and I don't know how you do it, I am strong, but that's not always a virtue
T: mm-hm
C: and I don't know how people see me

T: so it sounds that what's changed as a result of this is the way you, in terms of your interactions with people is that you're not as willing to go out of your way to, that you
C: uh (sighs) oh God, I get myself into such trouble, uh, I do, it's a terrible problem I have, take on stuff that I, if I would just stop for a second and just think I know I can't do it, it's just automatic, it's habit
T: mm-hm
C: uh - - - I think I'm in a state right now and I don't really care
(End of Side 1)
(Side 2 of tape)

> **C: uh, / / group, really is so good, I hope it's going to be good uh, one of the things we're doing is we're making little, sort of quilts (laughs) and at the end of each week we each get a little four by four and we draw or write something on it and it's all assembled into the uh, it's a canvas thing that we paint on (T: right) and we do that at the end of the group, and at the end of the group last week uh, I wrote that I felt disconnected from the group and from myself and that I felt paralyzed, and there was something else, I was feeling a little bit safe, and just a / / safe, I feel like I don't fit in the group, I drew a picture of the group for myself, not for the group, but for myself uh, of all of us sitting around the group, and I gave everybody colours and decorations that I felt fit with their, what I knew about their personality and I made them all into circles around a circular table, but I'm a square**

because I don't feel like I fit in, I don't think that's uh them, I think I've always felt that I don't fit in, so when we were talking about boundaries this week and we had to draw boundaries, and I drew my big stone wall (laughs) with barbed wire on the top and uh, and / / talking / /suggesting that maybe I am making a few boundaries but when I drew the picture of the boundaries uh, the way we draw our current boundaries, whereas I drew this huge big beautiful stone wall and inside the sun is shining and a ball is bouncing and it's, cause it's not bad because there's nice things about being inside my stone wall uh, and then we had to do a drawing of what we would like our boundaries to be like and I just, I did a, I did a balloon scape thing, I could see anything (T: mm-hm) I was really stuck, and I gather that's a problem with people who are incest survivors (T: mm-hm) with boundaries and I know that's true because I read something recently that people who suffer this kind of thing very often learn very early to take what they're given and just keep taking and taking and taking and that's what I have done (T: mm-hm)

C: and uh, so any boundaries uh, people take advantage of me just dreadfully (T: mm-hm) and I don't like it, I love doing things for people, I always have, I'm a kind person, I'm a generous person and I like it, but then it always goes to far when people expect and then I get angry uh, so the question of boundaries is something that I, I just uh, I ended up drawing a big question mark through it because I really don't understand about boundaries my idea of boundaries is you need, I give, whatever I give I'll look after you even if I'm sick, I don't do that, I'll give you money even if I don't have money, if I think you need money, and it's ridiculous, so and then somebody in the group said that she thought the problem was that the people who abused didn't have any sense of boundaries and that's true too (laughs) so I don't, I don't even know how to tackle that, but now that I've been talking to you I'm realizing that I, maybe I have been sort of drawing some boundaries, I don't know, I need to, I think that's an important issue

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CHANGE

T: uh okay now the first thing that you have is um when you started therapy at the end of the first session S.(therapist) would have done a little um separate interview with you in which she asked you three different questions
C: hm
T: and this is a summary of your answers, and then the second thing you would have had an interview about a week after therapy +ended
C: mm-hm+
T: and you were asked the same +three questions

C: / questions+
T: and this is a summary of your answers at that point
C: oh
T: and I'm going to
C: ask me +the same questions?
T: go through+ those questions again and refer to your answers +in pre
C: oh okay+
T: and post therapy +and
C: oh+ okay
T: talk to you about
C: I got a copy of that before the pre thing
T: right
C: am I going to get a copy of the +the
T: /+
C: second one?
T: yeah you can keep the the copy +there if you like
C: oh is that /?+
T: um yeah the first, this one is the pre and then this one is the one that you did at +the
C: oh+
T: end of therapy
C: yeah I have this one
T: you have +that one
C: so+
T: so you can yeah you can +keep
C: I have+ that one but I don't have this one
T: right, you can keep that

C: oh good, / /
T: okay so the first question was what would you like to change about yourself? And **before therapy you said "I'd wish that I could just be me, I wish**
C: mm-hm
T: **that being me could include the angry because I think anger can be constructive, I wish I could just give in, I have pain and to recognize that I'm having pain and saying it's okay to have it, but I don't even recognize it a lot of the time until it gets so bad"**
C: mm-hm
T: you said "**I would like to have some peace, I wish I had known a lot of the things I know now twenty or thirty years ago"**
C: mm-hm

T: and then after therapy you said "**there has been no change in the anger" you said "I'm starting to recognize my own feelings of physical condition and not putting that on hold all the time" you said "I had peace at the moment and I have learnt so much more since the therapy"**

C: mm-hm

T: now
C: mm-hm
T: has there been any change in that the answer that you would make to that question, that in the last six months?
C: well the the anger uh oh God I would agree that expressing anger (sniff)
T: mm-hm
C: um in fact when I came to therapy uh – I I I just was reading some / I / / / my own therapy / /
T: mm-hm
C: **I didn't know the difference between anger and guilt**
T: oh I +see
C: and when+ we're discussing it with my friend and +saying
T: uh-huh+
C: is anger and guilt the same, I wasn't sure
T: uh-huh
C: because I always thought I'd never felt guilty about anything but I learned in the therapy that (laugh) I feel very guilty about a lot +of things
T: I see+ okay
C: **so I think I know the difference now between anger and guilt** (laugh)
T: uh-huh

C: uh and anger uh I learned / is not good it um **I'm not good at uh expressing +anger**
T: I see+ I are you talking about anger towards people you know? I'm just
C: yeah +I I
T: / /+

C: I can express anger at a store clerk
T: okay +I'm I was just remembering
C: that's / / /+
T: the story you just told about the the guy who attacked +you
C: yeah+
T: you were very angry
C: I was furious
T: and you had no trouble expressing it
C: no no
T: so where what where's the with who are the difficult
C: my **with my friends and +it's always been like that**
T: with friends okay+
C: I um
T: okay, **so you get angry at them but you**
C: I +I don't say anything
T: you don't say something+

C: or I do something else that you know like I I had I have a real problem with anger I don't know how to, I'm very jealous of people I want the group last week one of the girls uh said um you know she's had much different lifestyle than I had +uh (T: uh-huh+) she's been in jail and I suppose you / / toughness if you're in jail but she apparently really tells people off um she she said at one point that she went to the grave of the person who incested her and just screamed and shouted at him (T: mm +mm-hm) and uh+ you know I just I sat there thinking "oh wow I wish I could do that" you know like I felt kind +of (T: hm+) jealous that she was able to +to do (T: okay+) that

T: so when you think about that it's that anger at the person who incested you +/
C: yeah+
T: is hard for you to express or to
C: I never felt that I was angry with him
T: ah +I see okay
C: (laugh) even+ that I am
T: okay, okay, **now I mean that sounds like a little bit of a change that you actually now recognize that you have anger +towards him**
C: yeah+ mm-hm yeah that is a change -
T: / and this is I guess it's upsetting just to talk about that
C: well **it's hard for me to be angry with family member, you're supposed to +love**
T: right+
C: them you know so he's +supposed to
T: right+
C: care about me (sniff)

T: yeah
C: and part of me does love him uh +he's dead
T: uh-huh+
C: anyway so it doesn't matter but +he really
T: uh-huh+
C: ruined my life I mean really um he didn't ruin it but (sniff) (sniff)
T: yeah
C: yeah I knew / feel angry about what he did but I don't know what to do I've been doing some paintings +(sniff)
T: uh-huh+
C: and they're horrible, and they're really frightening for me to look at +I don't
T: mm-hm+
C: know if they help or not, and the girl who said she shouted at this person's grave (sniff) I said "did it help or make you feel better?" and she said "no" so I don't know if there's a way that'll +(sniff)
T: right, in +resolving that

C: (sniff)+
T: somehow
C: yeah I have no idea, uh maybe I'll find out in group with other people doing the it's
T: uh-huh
C: like it / um I don't have no idea +(sniff)
T: ah+ hm
C: (sniff)
T: hm
C: so anyway um I'm **basically not a really angry person well**
T: mm-hm
C: anyway um
T: but that's something that you're justified in being angry about
C: oh I / / but that doesn't help +(laugh)
T: right (laugh)+
C: it doesn't change anything (sniff) +uh
T: yeah+
C: so (sniff) **I would say uh I there are things I would like to change about anger and**
T: mm-hm

> **C: I saw in, was this sweet little thing the other day when I, with her husband, what a nice little young couple, they were they were just darling it was so naïve and so so sweet (sniff) and they / in our condo all week end, they came to visit the other night when / / / business and uh I I remembered her in a condo meeting, in after she had just moved in and she was furious, she was shouting, she was / so angry and I told her at the end of the night that I remembered that and I felt so sorry for her cause somebody had really done her wrong, and she +was (T: mm-hm+) just – a but you can tell she is not an angry person but she could she felt angry and she just got it out (T: hm +mm-hm) and then+ she just goes on +with her life and I (T: mm-hm mm-hm+) that's what I would like and to feel angry inside and let it smolder is (sniff) (T: yeah) you know +if you're (T: it's+) if you're sort of annoyed with a friend uh I'd love I would love to be able to somehow really just say it somehow get it out and then get it overwith +but (T: hm+ mm-hm) I haven't been feeling that way yet I don't like to feel angry anyway (T: right +yeah) it doesn't+ it's not a good feeling (sniff)**

T: mm-hm, um now the other things you've said uh **at the end of therapy** you said that I **you were starting to recognize your own feelings and physical condition**
C: (sniff)
T: and **not putting it on hold +all of**
C: yeah+
T: **the time** +is that
C: yeah+

T: still true?
C: yeah yeah that's uh **I'm getting better** uh uh I'm still

I learned with S.(therapist) that uh I I / I had it started to come up in the group now, uh I didn't know what I felt (T: mm-hm) I couldn't identify feelings +it was (T: mm-hm+) just something I learned with S.(therapist), and she was always asking me "how are you feeling right now?" and most / / I couldn't tell her, I didn't know (T: mm-hm) and I would say "upset", that was the only feeling of (T: mm-hm) um and but I I started to think about that so I am able to identify some feelings I have +or the (T: mm-hm+) emotional feelings I have uh but I still get this overwhelming upset feeling

and I've been drawing lately (T: hm) and I've just lately discovered that it's exactly and J.(therapist) did a follow up with me (T: mm-hm) she had me / a tape in which I +was (T: right+) did you see that tape +or / (T: no I+ haven't seen it) uh and I was so shocked and she kept asking me what it was I was feeling at the +time (T: uh-huh+) and uh and that was a really good learning experience for me because it and and I I I said at the time I didn't know this feeling except it was something very deep and it felt like I just wanted to cry "mother where are you?" and that's what it sort of +felt like (T: hm+) very sort of primitive, deep feeling,

and uh last week I was / I was drawing I think it's we're we're dealing with issues of safety, how to feel safe +when (T: mm-hm+) you're at therapy (T: mm-hm) and uh I started thinking that I have never actually in my life felt safe except when I was a it's so exciting when you start reading this thing that I realize that I had felt safe it was probably when I was an infant, / a little bit (T: mm-hm) / safety but very early in my life or most of my life I haven't felt safe, and we were to draw safety and so I was drawing it in different ways with big walls, to me safety was a wall to protect me and I started drawing it at home after the group and I drew this thing was sort of looked like a / but a little black wall around it and then I , cause I was thinking about the group also so I drew another one and my idea is that I would have the two sort of coming together (T: mm-hm) at some point that both will have my wall is very strong but I was thinking maybe uh, I don't know but uh, very soon, I wasn't thinking of safety anymore, I was starting to put bright red and it was getting bigger, it was like huge waves of red pouring over me and it, it was , I was totally overwhelmed and I started thinking about my brother who brother who incested me (T: hm) and it wasn't a picture of safety at all it was a picture about being overwhelmed, totally just overwhelmed and I realized that that was that feeling, that's that (T: oh) feeling that that is the upset feeling, it's +just (T: uh-huh+) like I mean and you're frozen you're paralyzed +you're just (T: right+) totally like this giant red hot wave is sweeping over you +can't (T: mm-hm+) talk,

you can't think you just freeze so so that's um – uh I I guess I I have work to do on that but I think um I can see I'm making a little bit of (T: right)

C: uh progress, / / **I just feel a physical uh pain and I'm better at recognizing that now** +and
T: mm-hm+
C: um **I'm still having trouble in overdoing things and over committing but I'm getting better** / / so
T: mm-hm mm-hm, has that had any impact on whether or not you feel depressed?
C: the pain, the physical pain?
T: the the the being able to cope with it better or being able to recognize it or
C: well it makes it more yeah yeah well I mean that feels good but it's just is depressing to know +that this
T: mm-hm+
C: is the way it's going to be +forever
T: right+

C: and I keep +saying (T: so just+ having it is depressing) yeah. I I I keep over committing and saying "oh yeah I can do this, I can do that" cause I've always been a busy, active person and then they start doing it I I realize I can't do it +that it's (T: mm-hm+) this isn't the old days so that's +um (T: right+) it's depressing

T: mm-hm, and then the next thing you said at the end of therapy you said "**I have peace at the moment**" +which
C: um+
T: **at the beginning you said "I would like to have some peace"**
C: yeah
T: how is that for you now?
C: uh not so good
T: okay, so you had peace for a a bit at the end of therapy but it's
C: I felt so um I I coming to therapy with S.(therapist) was just so – it was really good
T: mm-hm
C: (sniff)
T: so it was really helpful to you +and you
C: yeah+
T: you really +connected
C: (sniff)+
T: with her I guess
C: I felt um she gave me she gave me um – (sniff) I think probably the greatest gift a person can give another person, she just listened to me

(end of NAI)

T: right
C: and she and I just knew (sniff) knew absolutely that she liked me
T: right
C: and that she had no ulterior motive +and that's
T: mm-hm+
C: something I don't think about people, I always think people don't care +or
T: hm+
C: / but +I do
T: mm-hm+
C: (sniff)
T: mm-hm
C: (sniff)
T: so +/ / /
C: so I came+ away feeling gee this is yeah
T: really cared for by her really
C: yeah and she did, she did really care for me
T: right
C: she did and I know it absolutely and I would never thought that about anybody in my +whole life
T: mm-hm+
C: (sniff) so um so I started feeling a little kind of safe (sniff) with her +she
T: right+
C: just let me be me, she let me spout off and on and on and on and on and and she never scolded me, she never humiliated me, she never embarrassed me she was +just (laugh)
T: right+
C: it was really nice experience and when I stopped therapy it was uh (sniff) that was upsetting for me
T: uh-huh
C: (sniff)
T: yeah
C: (sniff) so the peace uh (cough) (sniff) also I when I was having therapy with her I was kind of in a an excited state anyway because I was learning all these things I never had
T: oh mm-hm
C: and for me (sniff) I love learning things (laugh) and it it just feels when pieces start fitting together
T: right
C: in a puzzle (sniff) and then all of a sudden it just stops so (sniff)
T: right, - yeah
C: (sniff) but I'm still learning, still learning (sniff) and I still do have moments of peace but not not very many I I cause maybe cause I haven't been painting and I +(sniff)
T: oh+ I see
C: if I uh if I paint I (sniff) I do feel good