Process and Outcome of Narrative Therapy for Major Depressive Disorder in Adults:

Narrative Reflexivity, Working Alliance and Improved Symptom and Inter-personal

Outcomes

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Abstract

The inter-subjective and dialogical nature of narrative therapy, as commonly practiced, remains unarticulated. Further, there currently exists no rigorous empirical research investigating the process or outcome of narrative therapy.

The research aim, to investigate the process and outcome of narrative therapy, comprised theoretical and empirical objectives. The first objective was to articulate a theoretical synthesis of narrative theory, research and practice. The process of narrative reflexivity was identified as a theoretical construct linking narrative theory with narrative research and practice. The second objective was to substantiate this synthesis empirically by examining narrative therapy processes, specifically narrative reflexivity and the therapeutic alliance, and their relation to therapy outcomes. The third objective was to support the proposed synthesis of theory, research and practice and provide quantitative evidence for the utility of narrative therapy, by evaluating depressive symptom and inter-personal relatedness outcomes through analyses of statistical significance, clinical significance and benchmarking.

Founded in theories of self, language and narrative (James, 1890; Bruner, 1986; Gergen, 1991; Hollway, 2006; Vygotsky, 1934/ 1987), narrative therapy was conceptualized as involving dialogical and intra-personal processes. Narrative therapists generally apply a story metaphor and commonly focus on the inter-personal field (White, 2007). This thesis recognised the storied and inter-personal nature of narrative therapy, but proposed this does not represent narrative therapy in its entirety. The notion of story connotes monological processes, inconsistent with the conversations of narrative practice, and neglect of intra-personal dimensions is inconsistent with narrative notions of inter-subjectivity.

This thesis proposed an integration of dialogical narrative theory (Cooper, 2003; Hermans & Kempen, 1993; Lysaker & Lysaker, 2006) and narrative research (Angus, Levitt, & Hardtke, 1999) provides a model for understanding narrative therapy (White, 2007) as involving the inter-subjective and dialogical process of narrative reflexivity. During the process of narrative reflexivity, a person engages in dialogue with his or her own self and others as extensions of self, interpreting experience from diverse perspectives in the context of personal aspects, such as beliefs, values and intentions that give meaning to experience, to achieve a rich narrative and a sense of well-being.

To support this theoretical synthesis, a process-outcome trial evaluated eight-sessions of narrative therapy for 47 adults with major depressive disorder. Dependent process variables were narrative reflexivity (assessed at Sessions 1 and 8) and therapeutic alliance (assessed at Sessions 1, 3 and 8). Primary dependent outcome variables were depressive symptoms and inter-personal relatedness. Primary analyses assessed therapy outcome at pre-therapy, post-therapy and three-month follow-up and utilized a benchmarking strategy to the evaluate pre-therapy to post-therapy and post-therapy to follow-up gains, effect size and pre-therapy to post-therapy clinical significance.

Results indicated that when a sub-sample of clients were categorised into five least-improved and five most-improved groups (according to depressive symptom change), there was a differential change in the percentage of reflexive sequences in the discourse of clients at the end of therapy depending on outcome. Improvement in the quality of the working alliance was associated with improvements in depressive symptoms and inter-personal relatedness, with working alliance improvement from Session 1 to 8 sharing 19% of the variance in depressive symptom improvement and

17% of the variance in inter-personal relatedness improvement from pre-therapy to post-therapy.

The clinical trial provided empirical support for the utility of narrative therapy in improving depressive symptoms and inter-personal relatedness from pre-therapy to post-therapy: the magnitude of change indicating large effect sizes ($d = 1.10$ to 1.36) for depressive symptoms and medium effect sizes ($d = .52$ to $.62$) for inter-personal relatedness. Therapy was effective in reducing depressive symptoms in clients with moderate and severe pre-therapy depressive symptom severity. Improvements in depressive symptoms, but not inter-personal relatedness, were maintained three-months following therapy. The reduction in depressive symptoms and the proportion of clients who achieved clinically significant improvement (53%) in depressive symptoms at post-therapy were comparable to improvements from standard psychotherapies, reported in benchmark research.

This research has implications for assisting our understanding of narrative approaches, refining strategies that will facilitate recovery from psychological disorder and providing clinicians with a broader evidence base for narrative practice. Despite limitations of a repeated-measures research design, use of a standardised intervention protocol, coupled with outcome evaluation of clinical significance enhanced internal validity. Future research could examine narrative therapy in a larger sample, with different disorders, and with an alternative therapy or control group. Coding a greater number of therapy transcripts for evaluating associations of narrative reflexivity with working alliance and outcomes could enhance understanding of narrative reflexivity. Thesis strengths included a strong theoretical foundation underpinning the research design and arguments, examination of therapy process in the context of outcome, and a parsimonious evaluation of narrative therapy outcomes.

Conference, Symposium and Workshop Presentations

Date	Presentation	Title	Authors
17-06-04	35th Annual Meeting of the Society for Psychotherapy Research, Rome	Development and Implementation of a Manualised Narrative Treatment Program	L.Vromans,R.Schweitzer, R.Lowe, R. King
17-06-04	35th Annual Meeting of the Society for Psychotherapy Research, Rome	The Role of the Therapist in Narrative Therapy	R.Schweitzer,L.Vromans, R. Lowe, R. King
02-09-03	Ist QUT School of Psychology and Counselling Postgraduate Research Symposium	The Process and Outcome of Two Therapeutic Approaches in the Treatment of Depression	L. Vromans
04-09-04	Society for Psychotherapy Research Area Meeting, Mater Hospital, Brisbane	Narrative Complexity as a Mediating Variable in Psychotherapy Outcome	L. Vromans
30-10-04	16th Australia & New Zealand Association of Psychotherapy Annual Conference	Narrative Complexity and Transformative Conversation	L. Vromans
05-08-05 12-08-05	Training Workshop for Prince Charles Hospital, Department of Social Work	A Narrative Approach to Therapy: Guiding Principles and Practice	L.Vromans
20-09-05	2nd QUT School of Psychology and Counselling Postgraduate Research Symposium, Brisbane Park Royal	The Process and Outcome of Narrative Therapy in the Treatment of Depression	L. Vromans
25-11-05	Seminar for Disability Services Queensland, Brisbane	A Narrative Approach to Therapy: Guiding Principles and Practice	L.Vromans
22-06-06	37th Annual Meeting of the Society for Psychotherapy Research, Edinburgh	Transformative Conversations: Change in Narrative Complexity	L. Vromans & R. Schweitzer
30-08-06	3rd QUT Postgraduate Research Symposium, Brisbane Park Royal	The DoDo Bird Speaks	L. Vromans

Statement of Original Authorship

I, Lynette P. Vromans, declare that this thesis has not been previously submitted, either complete or in part, to meet requirements for an award to this or any other institution of higher education. This work results from original research and to the best of my knowledge or belief, contains no material previously published or written by another person except where due reference is made in the text of the thesis.

Signature:…………………………………………………………………………….

Date:…………………………………………………………………………........

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Table of Contents

List of Tables

List of Figures

List of Appendices

List of Abbreviations

ABS	Australian Bureau of Statistics
APA	American Psychiatric Association
BDI/ BDI-II	Beck Depression Inventory/ II
CBT	Cognitive Behaviour Therapy
CDQ	Client Demographic Questionnaire
CIDI	Composite International Diagnostic Interview
CMHC	Community Mental Health Centre
CONSORT	The Consolidated Standards of Reporting Trials
CT	Cognitive Therapy
DALY	Disability-Adjusted Life Year
DASS	Depression Anxiety Stress Scale
DASS-D	Depression Anxiety Stress Scale- Depression Sub-scale
DSM-III-R	Diagnostic and Statistical Manual of Mental Disorders, Third Edition, Revised
DSM-IV-TR	Diagnostic and Statistical Manual of Mental Disorders- Fourth Edition, Text Revised
ECT	Electroconvulsive therapy
GAS	Global Assessment Scale
HRSD	Hamilton Rating Scale for Depression
HSCL-90	Hopkin's Symptom Checklist 90
IMI-CM	Imipramine plus clinical management
IPT	Interpersonal Therapy
ITT	Intention-to-Treat
LOCF	Last Observation Carried Forward

M.I.N.I. 5.00	Mini International Neuropsychiatric Interview 5.0.0
NIMH	National Institute of Mental Health
NPCS	Narrative Processes Coding System
N-TIS	Narrative Therapy Integrity Schedule
OQ-45.2 IR	Outcome Questionnaire 45.2 Inter-personal Sub-scale
PI	Psychodynamic Interpersonal Therapy
PE	Process Experiential Therapy
PLA-CM	Placebo plus clinical management
QUT	Queensland University of Technology
RCI	Reliable Change Index
RCT/s	Randomised Controlled Trial/s
SCID-I	Structured Clinical Interview for DSM-IV Axis I Disorders
SCID-II-IV	Structured Clinical Interview for DSM-IV Axis II Personality Disorders
SMHWB	National Survey of Mental Health and Wellbeing of Adults
SSRI/s	Selective Serotonin Reuptake Inhibitor/s
STS-T	Satisfaction with Therapy Sub-scale
TDCRP	Treatment for Depression Collaborative Research Program
TDQ	Therapist Demographic Questionnaire
UHREC	University Human Research Ethics Committee
WAI	Working Alliance Inventory
WAI-S	Working Alliance Inventory-Short Form

CHAPTER 1

INTRODUCTION

1.1 Purpose of the Introductory Chapter

In essence, psychotherapy is a form of healing. The term, healing, derives from the Germanic word, *hailaz,* to make whole (Turner, 1989)*.* This thesis is interested in how psychotherapeutic healing comes about; specifically, how people achieve a richer and more meaningful narrative of self. Resembling other spheres of healing, psychotherapy is an evolving discipline, continually refining therapeutic processes as knowledge expands. Narrative theory has offered new conceptions of psychological distress and therapeutic change; conceptions with the potential to contribute to our understanding of psychotherapeutic change processes.

As an evolving orientation, diverse interpretations of narrative theory and narrative practice exist (Angus & McLeod, 2004). This thesis takes a broad view of narrative theory, but emphasises some specific perspectives that are relevant to the arguments proposed. For example, this thesis is particularly keen to communicate the notion of narrative as a dynamic process constituting the multiplicity of self in inter-personal and intra-personal fields of relating, as envisioned by narrative theorists like Gergen (2001a) and McAdams (1997). The relational narrative perspective of Hermans (2004), that psychotherapeutic healing occurs in the inter-subjective domain, within and between persons, through dialogic processes is particularly significant, as is the notion of reflexivity as a narrative process through which therapy dyads construct new meaning essential to therapeutic change (Angus, Levitt, & Hardtke, 1999). Likewise, this thesis takes a broad view of narrative practice, and although influenced strongly by the post-modern approach of Michael White and David Epston (1990), recognises the contributions of varied orientations. For example, Schafer (1976) emphasised the

importance of narrative to psychoanalytic practice, Gonçalves' (1994) constructivist approach focused on the transformation of clients' narratives, and the dialectical constructivist perspective of Angus et al. (1999) emphasised narrative as the organising framework of change through the integration of autobiographical memory, emotion and the reflexive meaning-making processes.

The intention of the current research is to investigate narrative therapy and narrative processes of change through philosophical and empirical inquiry. Chapter 1 introduces the topic under investigation. Statements of the research problem and research aims establish the precise areas of interest. A brief overview outlining each of the chapters then demonstrates how this thesis intends to address the research problem and carry out the research aims.

1.2 Problem Statement

Despite theoretical proposals and research which suggest dialogical processes enable a flexible and reflexive inter-play of different positions to create new perspectives and meanings of lived experience (Hermans & Kempen, 1993; Levitt & Angus, 1999), there exists no comprehensive integration of theorised dialogical processes, research into reflexivity and narrative therapy, as it is commonly interpreted and practiced in Australia (e.g., Freedman & Combs, 1996; Monk, Winslade, Crocket, & Epston, 1997; Payne, 2000; White & Epston, 1990). There also exists no empirical research into the processes of therapeutic change in narrative therapy. Nor is there rigorous research into the outcome of narrative therapy in the treatment of major depressive disorder in adults. Despite the vast amount of research into psychotherapy to date, we have only a rudimentary understanding of the process of psychotherapy change. Post-modern notions of language and self have provided new perspectives,

which are relevant to inquiries into psychotherapeutic change processes and psychotherapy outcome.

Qualitative and case study evidence suggests that narrative approaches are effective in the treatment of psychological disorder. Although a small number of studies have contributed empirical data to support narrative therapy, the measures and statistical analyses used were not consistent with traditional outcome trials, limiting comparison with outcomes from psychotherapies which have a broader evidence base. More specifically, there exists no rigorous empirical outcome research into narrative therapy in the treatment of major depressive disorder in adults, currently a major mental health problem for individuals and the community at large. Although research into narrative processes exists (e.g., McLeod & Balamoutsou, 1996), there is no research supporting theorised narrative processes of psychotherapeutic change in the context of an empirical process-outcome trial.

These omissions clearly represent gaps in our knowledge in the area of psychotherapy process-outcome research. The narrative construal of self as an inter-subjective, dialogical and reflexive process, that is transformable through conversations, has provided a means of investigating therapeutic change processes through the examination of therapeutic dialogues. Research into the process and outcome of narrative therapy has the potential to provide support for narrative practice and to contribute to our understanding of the processes of successful narrative therapy. Such research carries important implications for refining strategies that will facilitate recovery from psychological distress, for the training of clinicians and for assisting the development of future programs for disorders like depression.

1.3 Thesis Aims

The overall aim of this thesis is to investigate the process and outcome of narrative therapy in the treatment of adults with major depressive disorder. This aim comprises three major objectives. The first objective is to articulate a theoretical synthesis of narrative theory, research and practice. The second objective is to examine the processes of narrative therapy and the third objective is to evaluate narrative therapy outcomes.

1.4 Overview of Thesis

The thesis structure comprises three broad parts. The first part (Chapters 2 to 6) develops the theoretical and research background for the thesis and articulates a synthesis of dialogical narrative theory, research and narrative practice. The second part (Chapters 7 to 10) describes the practical component of this thesis, the rationales, preliminary research program, method and results of the current study. The final part (Chapter 11) interprets the current study in the context of previous research and theory, discusses theoretical contributions and practical implications and the research limitations and stengths.

Chapter 2 outlines the philosophical milieu from which narrative therapy emerged. The précis of modern and post-modern epistemologies provides the context for chapters that follow. Themes of plurality, inter-subjectivity and dialogue, which continue through the thesis, are introduced and the key assumptions and practice of narrative therapy are described. Importantly, Chapter 2 contributes to the rationale for the design of this research, which despite the tensions between modern and post-modern world-views, investigates a post-modern therapy with an empirical approach.

Chapter 3 examines psychotherapy process-outcome research, provides a theoretical background for the constructs of language and of self, and argues that

investigation into these broad constructs has the potential to progress our knowledge of successful psychotherapy change processes. A general theme of inter-subjectivity throughout the chapter underpins the identification of narrative reflexivity as a pivotal construct for investigation and emphasises the thesis' focus on both intra-personal and inter-personal fields.

Chapter 4 highlights the relevance of research into depression. Information within the chapter stresses the personal, social and economic costs of depression to Australians and society in general, and the scarcity of Australian depression outcome research.

Chapter 5 reviews meta-analytic and comparison outcome research into psychotherapy for adult depression. Description of findings on the effectiveness of psychotherapy for adult depression and the equivalence of standard psychotherapies provides benchmarks for later comparison. Discussion of the specific-common factor debate as ongoing and unresolved highlights the argument that our understanding of therapeutic change may be better progressed by an approach that utilises broader constructs that bridge the specific-common factor dichotomy; constructs like language and self.

Chapter 6 raises major methodological and statistical considerations in psychotherapy outcome research, providing premises for research design decisions in the current study. An outline of the limitations of randomised controlled trials and analysis of statistical significance precedes arguments for the relevance of clinical significance and benchmarking strategies to psychotherapy outcome research. This section also describes selected outcome data on clinical significance. The chapter finishes with a brief comparison of completer versus intent-to-treat analyses.

Based on the literature review, Chapter 7 introduces the current study, in which theoretical notions of language, self and psychopathology converge to provide a rationale for investigation into processes of narrative reflexivity and working alliance in the context of a process-outcome trial into narrative therapy for major depressive disorder in adults. After restating the research aims and posing the primary and supplementary research questions, description of the research design shows how this thesis addressed the research questions. Statement of the primary hypotheses specifies the major findings expected.

Chapter 8 situates the process-outcome trial in the overall research program. The chapter begins with an account of, and reasoning behind the preparatory stages for the main process-outcome study. Description of the procedures for evaluating the outcome and process of narrative therapy then follows, providing rationales where appropriate.

Chapter 9 details the method of the clinical trial that investigated the process and outcome of narrative therapy for major depressive disorder in adults. Report of the participants, materials and procedures involved presents a comprehensive account of how the investigator conducted the practical component of this thesis.

Chapter 10 reports the analyses and results of the clinical trial across the process and outcome dimensions. After a preliminary overview of major findings, a sequential exploration of the process and outcome research questions structures the chapter.

Chapter 11 first interprets the research data in the context of the hypotheses, previous research findings and theory. Discussion of the theoretical contributions and practical implications of findings is followed by an account of the limitations and strengths of the current research, and finally, potentials for future research.

1.5 Linking Narrative Theory, Research and Practice

To address clear omissions in psychotherapy process-outcome research, this thesis aims to link dialogical narrative theory of psychotherapeutic change and research into reflexivity with narrative practice, and to conduct a rigorous empirical investigation of narrative therapy and narrative processes of therapeutic change in the treatment of adults with major depressive disorder. With the intention of orienting the reader to the current research, Chapter 1 provided a statement of the research problem and the research aims and objectives. An overview of thesis chapters outlined how I embarked upon and addressed the research questions.

CHAPTER 2

THE PHILOSOPHICAL MILIEU

AND EMERGENCE OF NARRATIVE THERAPY

2.1 Changing Epistemologies: Modernism to Post-modernism

Fundamental differences in theories of knowledge distinguish modernist from post-modernist thought in the psychotherapeutic context. A shift away from belief in universal laws and the absolute in the late 1980s, and a movement towards belief in multiplicity and relativism characterised the emergence of post-modernism. Post-modernism provided an epistemology that has enhanced, but not necessarily replaced our understanding of human nature, and has informed narrative theory and practice. The tension between modernism and post-modernism is significant to this research, which involves an empirical investigation of a post-modern therapy.

In order to provide a rationale for the design of this research and as an introduction to the discussion that will follow, this chapter presents an overview of modern and post-modern perceptions of reality, language and psychopathology, situating narrative therapy philosophically. After an outline of fundamental elements of narrative practice, I argue that modern and post-modern ways of knowing the world are complementary, rather than mutually exclusive, and an empirical investigation of narrative therapy is philosophically coherent.

2.2 Notions of Reality

2.2.1 A Changing Focus: From Objectivity to Subjectivity and Inter-Subjectivity

A central feature in the progression towards post-modernism has been the changing notion of reality, which has been characterised by three waves of thought. The shift from empiricism in the modernist era to constructivism then social constructionism in the post-modern era heralded changes in emphases from

objectivity to subjectivity to inter-subjectivity. This shift was described as "...evolving from a focus on the observed world as object, to a focus on the observing person as subject, to a focus on the place between subject and object, that is, the inter-subjective domain where interpretation occurs in community with others" (Paré, 1995, p.3).

2.2.2 Empiricism

With the development of the natural sciences in the twentieth century came the empiricist stance, which conceived knowledge as derived from the senses. Empiricists conceptualised reality as singular and ultimately, knowable and describable (Carr, 2000). From this perspective, a world exists, separate from a person's subjectivity; but which a person can examine objectively. Although followers of logical positivism advanced one step by acknowledging the existence of propositional knowledge without sensory experience, they denied the existence of metaphysical phenomenon (Anderson, 1997). Empiricist and logical positivist notions have generally underpinned twentieth century psychological theory and research, which have been characterised by universal laws, objectivity, measurement, causality and replication (Lieberman, 1989; Neimeyer & Raskin, 2000).

2.2.3 Constructivism

More recently, constructivist ideas have challenged empirical and positivist assumptions and methods. Constructivists, part of the broader post-modern movement, argued that reality is subjective, dependent on each individual's sensory, nervous, information processing and belief systems. Considering that reality differs for each person, constructivists recognized multiple realities. Moreover, constructivists proposed that individuals construct meaning from their experience of reality as a means of interpreting the past and assisting function in the present and future. Constructivists were therefore interested in subjective meaning rather than

universal laws and facts. Constructivist ideas have exerted a powerful influence in the field of psychology, fuelled by an increasing acceptance of cognitive theory (Milner & O'Byrne, 2002; Neimeyer & Raskin, 2000; Neimeyer & Stewart, 2000).

2.2.4 Social Constructionism

A shift from the "experiential epistemology" of constructivism to a "social epistemology" (Gergen, 1985a, p. 268) underpinned social constructionism, also part of the post-modern movement. Like constructivists, social constructionists held reality to be subjective, and experience interpretable in many ways. That is to say, social constructionists recognised the construction of multiple realities, including the construction of multiple selves. In contrast to constructivists, social constructionists argued for the centrality of language and emphasised realities as negotiated and co-constructed with others within communities through dialogue (Gergen, 2004).

From a social constructionist perspective, the words that people use have developed inter-subjectively. The meaning attached to words changes in a continual process of renegotiation within communities and between individuals (Archer, 2003; Gergen & McNamee, 2000). Excepting the views of some radical constructivists, this does not mean there is no existence and meaning outside of language, or that the senses play no role in constructing reality. Rather, what society accepts as real influences what individuals believe to be real (Gergen, 2001a, 2001b).

2.3 Notions of Language, Focusing on Social Constructionist Ideas

2.3.1 Language as Representative Versus Language as Constitutive

From prevailing modernist and constructivist perspectives, language provides the vehicle for individuals to express their thoughts and feelings by providing representations of the world and experience (Locke, 1690/1997; Piaget 1923/1971). In

contrast, holding that language and thought are inextricably intertwined (Vygotsky, 1934/1987), social constructionists argue that language is socially negotiated, constituting reality (Gergen, 2004; Paré, 1995). In order to explain the social constructionist notion of language as constitutive, the following segments of Section 2.3 distinguish Vygotsky's social constructionist theory of language acquisition from modern learning (Bandura, 1986; Skinner, 1957) and constructivist (Piaget, 1923/ 1971) theories. The explanation continues by outlining the key features of a social constructionist perspective of language.

2.3.2 Major Theories of Language Acquisition

2.3.2.1 Modernist Perspectives: Bandura and Skinner

Modernist views of language are evident in learning theories of language acquisition. From these perspectives, children's knowledge and reasoning develop through language. Behavioural learning principles shape words and grammar. Learning theorists contend that language impacts thought and thought impacts language (Bandura, 1986; Skinner, 1957).

2.3.2.2 A Constructivist Perspective: Piaget

Observing young children when they played with others, Piaget (1923/1971) noted that very young children did not appear to consider the perspectives of other children and concluded that the thought of very young children was characterised by a natural autism. Piaget proposed that the thought of pre-schoolers was egocentric, reflected in non-communicative speech and he held that egocentric speech represented a transitional phase, occurring after the autism of early thought and fading as causal reasoning and dialogue with others begins. Based on these observations, Piaget held that cognitive ability constrains language and that language reflects but does not shape

thought. As children learn and discover their environment, language develops. Hence, from Piaget's constructivist point of view, thought determines language.

2.3.2.3 A Social Constructionist Perspective: Vygotsky

Social constructionists hold that thought is verbal; language being essential to thought. While accepting the observation of egocentric speech, Lev Vygotsky (1934/ 1987) disagreed with Piaget's (1923/1971) interpretation. Vygotsky argued that language and thought develop independently until around two years old, at which time, thought and language merge. From a social constructionist perspective, language develops and exists socially, and Vygotsky believed that the intention of even the earliest speech is to communicate with others. According to Vygotsky, inter-personal relationships are embedded in intra-personal thought. Although Vygotsky accepted that egocentric speech was a transitional phase, he conceived it as a step towards thinking in words through inner dialogue as the child "… transfers social, collaborative forms of behaviour to the sphere of inner-personal psychic functions…" (Vygotsky, p. 35). In the transitional phase, egocentric speech separates from communicative speech so that children engage in two forms of speech: speech to communicate with self and speech to communicate with others. This inner dialogue of verbal thought corresponds to the merging of thought and language.

2.3.3 Social Constructionist Conceptions of Language

Social constructionists emphasise the dialogic nature of language. Following Vygotsky's (1934/1987) ideas, social constructionists focus on the communal creation of language and the importance of inter-personal relationships to language (Wittgenstein, 1958). According to Bakhtin (1929/1984), each word spoken is linked within an infinite chain of words spoken in the past, present and future. At the same

time, society negotiates the meaning ascribed to words. Meaning changes according to

the context, as well as who speaks the word and who receives the word, so that words

mean different things at different times to different people in dialogue (Archer, 2003;

Gergen & McNamee, 2000).

From a social constructionist perspective, language is performative, and so

speaking within a dialogical relationship is agentive (Austin, 1962). Articulating this

point, Gergen (2004) stated, "Language does not describe action but is itself a form of

action" (p. 6). From a social constructionist perspective, therefore, language does not

simply represent reality or have pre-existing meaning; language constructs reality,

actively creating meaning through its use in dialogical conversations.

<p style="text-align:center">2.4 Notions of Psychological Problems</p>

2.4.1 Changing Emphasis: From Intra-personal to Inter-personal and Inter-subjective

A central topic when investigating psychotherapy concerns the

conceptualisation of psychological problems or distress. The disciplines of

psychology and psychiatry have therefore sought to determine the most useful

approach for understanding psychological entities. Emerging post-modern emphases

on the inter-personal and inter-subjective have challenged intra-personal perspectives,

which previously dominated the field of psychotherapy, and through the prevailing

medical model of psychopathology, still hold sway.

<p style="text-align:center">*2.4.2 Intra-personal Perspectives*</p>

Historically, modernist ideas underpinned our understanding of psychological

problems and psychotherapy, with a consequent focus on the intra-personal (e.g.,

Freud, 1905/1953). This focus is still evident in reliance on disease and behavioural

models, wherein psychopathology results from structural or functional abnormality.

Founded in modernist ideas, contemporary disease perspectives emphasise genetic,

biological, biochemical or neurological causality for mental illness. For example, Austin and Mitchell (1996) conceptualise melancholia as a dysfunction of parallel frontal sub-cortical neural networks. From this perspective, psychological problems are merely epiphenomenon for events in the brain. Breaking away from traditional intra-psychic perspectives, behaviourists (e.g., Skinner, 1974) considered that pathology was associated with conditioned or social learning, or otherwise with physiological needs; and therefore still based on intra-personal deficit.

Interestingly, there exists relatively little evidence supporting underlying organic causality for psychological problems, excepting those ensuing from genetic defects, medical events or injury (Gonçalves, Machado, Korman, & Angus, 2002). For example, although depression is associated with levels of the neurotransmitters, such as serotonin, norepinephrine and dopamine, there exists no evidence for a causal relationship (Firk & Markus, 2007; Leventhal & Martell, 2006; Merikangas, 2006). Clinicians generally identify psychopathology, not through organic evidence, but by the presence of specific symptoms, for example, as categorised across various editions of the Diagnostic and Statistical Manual of Mental Disorders (e.g., DSM-IV-TR; American Psychiatric Association, 2000).

Some authors have critiqued the disease and behavioural models as being inherently pathology-focused and as inadequate in understanding the subjective distress associated with psychological problems such as depression and anxiety, where personal meaning is significant (e.g., Bolton & Hill, 1996). Despite the later shift to cognitive perspectives, emphasising subjectivity, in practice, the focus of cognitive therapists remains on intra-personal deficit, for example, the notion of dysfunctional thoughts.

2.4.3 Inter-personal and Inter-subjective Perspectives

In the last 50 years in the field of psychotherapy, interest has been in the inter-personal domain; concerned with what happens between, rather than within individuals (Blatt, 2006; Muran, 2002). For example, movement from an intra-psychic to an inter-personal emphasis has marked contemporary psychoanalytic approaches. Harry Stack Sullivan (1953) held that persons are indivisible from their inter-personal field. Moreover, with evidence supporting the importance of the therapeutic relationship (Martin, Garske, & Davis, 2000), there has been increasing acknowledgement of psychotherapy as an inter-personal project.

The concept of inter-subjectivity, however, offers a more elaborate conceptualisation of psychopathology and psychotherapy than inter-personal perspectives. The notion of an "inter-subjective phenomenon" (Margulies, 2000, p.304) provides a comprehensive paradigm that incorporates both inter-personal and intra-personal relatedness. Inter-personal processes require the meeting and subsequent modification of at least two independent subjectivities. Clearly, the subjectivity of self is prerequisite to inter-subjectivity in inter-personal relationships. Each individual involved is a separate and autonomous entity (Auerbach & Blatt, 2001; Hollway, 2006). Conversely, following from the linguistic theories of Bakhtin (1930s/1981), Gergen (2004), Hermans (2004), Vygotsky (1934/1987), Winnicott (1871/1982) and Wittgenstein (1958), inter-personal relationships are prerequisite to subjectivity. From this perspective, the inter-personal and intra-personal dimensions of inter-subjectivity are reciprocally embedded; each person's self existing in the context of others (Auerbach & Blatt, 2001). That is to say, inter-personal and intra-personal relatedness; one does not occur without the other. How do intra-personal and inter-personal processes come about? Robert Stolorow and his colleagues developed

their inter-subjective perspective from previous inter-personal and object relations theories (Stolorow & Atwood, 1992; Stolorow Brandschaft, & Atwood, 1987). In contrast, the narrative theorist, Tappan (1999), contends that language mediates the inter-subjective interchange both between and within persons and narrative therapists emphasise the importance of language to psychological distress and psychotherapeutic change (White & Epston, 1990).

2.5 Narrative Therapy

2.5.1 Diverse Interpretations of Narrative Therapy Exist

From the philosophical milieu of modernism and post-modernism, narrative therapy emerged in the 1980s, informed largely by constructivism and social constructionism (McLeod, 2004). Bill O'Hanlon (1994) termed this the "third wave"[1] (p. 19) of psychotherapy and characterised narrative therapy as,

> - a willingness to acknowledge the tremendous power of the past history and the present culture that shape our lives, integrated with a powerful, optimistic vision of our capacity to free ourselves from them once they are made conscious. Third wave approaches talk to the adult within. (p. 23)

Narrative therapists eschewed the idea of intra-personal deficit and rather than limiting their focus to smaller social systems, such as the family, friendship and vocational contexts within which clients engage inter-personally, narrative approaches recognised the position of people within broad cultural norms and power relationships (O'Hanlon, 1994).

As an evolving orientation, diverse interpretations of narrative practice exist. All psychotherapies involve narratives, and narrative theory has influenced several therapeutic modalities (McLeod, 2004). Narrative therapy, however, is often

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[1] The first wave included pathology-focused therapies (e.g., psychodynamic therapy) and the second wave included problem-focused therapies (e.g., behavioural and cognitive approaches).

associated with the work of Michael White from Australia and David Epston from New Zealand, who deserve credit for interpreting narrative theory into narrative practice. The writings of Bruner (1986, 1990), Derrida (1978, 1981), Goffman (1961) and Myerhoff (1986) were particularly influential in this narrative approach. Although the work of White and Epston is widely acknowledged (Gergen & Gergen, 2006), there is not a single narrative therapy, and several therapeutic orientations have interpreted narrative ideas from their own perspectives. While these varied perspectives inform this thesis, because of their large contribution to narrative therapy, the post-modern approach of White and Epston (1990) strongly influenced sections on actual narrative practice.

2.5.2 Narrative Therapy: A Storied Conceptualisation of Problems

Oriented by constructivist and social constructionist notions, proponents of narrative therapy stress the significance of meaning (McLeod, 2004), and Hoffman (1990) proposed there is "… an evolving set of meanings that emerge unendingly from the interactions between people" (p. 3). From a narrative perspective, pathological classifications as narrative constructions, sets of meanings reduced to labels, existing within dialogues in communities (Gonçalves et al., 2002). White (1995) takes no position on the aetiology of psychological distress, viewing it as immaterial, and according to Lock, Epston, Maisel, and de Faria (2005):

> The issue is not 'What is mental illness *really*?', but how does a person make
> sense of their situation? The issue is not 'Is there *really* a problem'. The issue
> is 'What sense does a person make of "their problem"?; 'what relation do they
> have to this problem?'; and thus 'how might their relation with the problem be
> changed so as to make it less troublesome?' (p. 320)

From review of narrative practice literature, narrative therapists commonly employ a story metaphor when conceptualising problems and therapeutic change (e.g., Freedman & Combs, 1996; Monk, Winslade, Crocket, & Epston, 1997; Payne, 2000; White & Epston, 1990). Narrative theorists contend that people's narratives comprise numerous stories occurring simultaneously; each story embedded in a cultural context and impacted by powerful cultural discourses[2] (White, 2004). For example, the family, the school, and the medical communities each have their own discourse. Some discourses wield significant power in setting societal standards (Milner & O'Byrne, 2002) and individuals often evaluate personal stories in relation to powerful discourses. From White's (2007) perspective, experience of psychological distress is associated with personal narratives in which one or more stories dominate. Dominant stories obscure alternative stories of identity and their meanings, often shaping subsequent behaviour and compounding difficulties. As problem stories, and associated meanings, become more salient and powerful, alternative identity stories and their meanings become less powerful, maintaining the distress.

2.5.3 Key Assumptions of Narrative Practice

Informed by constructivist and social constructionist ideas, a mechanistic application of narrative strategies would be anathema to narrative therapists. Rejecting the idea of narrative therapy as a prescribed methodology, proponents of narrative practice assert that a specific world-view facilitates therapeutic conversations that open up possibilities. Key assumptions and practices distinguish narrative approaches

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[2] Payne (2000) defined discourses as "…habitual ways of thinking and assuming as a result of language habits, which are common currency within a particular social grouping…" (p. 58).

from standard therapies, such as cognitive behaviour therapy[3] (CBT; Beck, Rush, Shaw, & Emery, 1979; see Table 2.1).

Narrative therapists assume that individuals construct reality through conversations with others. That is, rather than an objective reality, narrative therapists conceive reality as linguistically co-constructed within communities (Paré, 1995).

Narrative therapists also assume that individuals impose order on multiple internal and external experience through narrative. By temporally sequencing and connecting each experience, people construct stories to make experience meaningful, allowing individuals to understand past events and function more adaptively in the present and future (Freedman & Combs, 1996; Milner & OByrne, 2002; Sarbin, 1986). Rather than revealing objective truth, narrative therapy seeks to establish narrative truth, such that the construction of events is consistent with clients' emotional experience and personally satisfying (Spence, 1983).

Narrative therapists assume that dual landscapes constitute healthy narratives. Jerome Bruner (1986) observed that two landscapes constitute peoples' narratives, the landscape of action and the landscape of consciousness. The landscape of action comprises "...the arguments of action: agent, intention or goal, situation, instrument, something corresponding to a story grammar" (p. 14). Bruner described the other landscape as, "... the landscape of consciousness: what those involved in the landscape of action know, think, or feel, or do not know, think, or feel" (p. 14). The landscape of consciousness gives personal meaning to the landscape of action (White, 2007).

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[3] Henceforth, this thesis refers to cognitive behavior therapy (Beck et al., 1979) as CBT, i.e, the acronym without reference.

Dimension	Cognitive-Behavioural Approaches	Narrative Approaches
Concept of Truth	Historical truth and paradigmatic knowing.	Narrative truth. By telling stories, persons make sense of the world.
Underlying Assumptions	Faulty thinking associated with disturbance of affect and behaviour.	The primacy of narrative in making sense of experience.
Conceptualisation of Problems	Problems as manifestations of underlying dysfunction. Dysfunctional beliefs as causal in disorder. Categories of disorder.	Problems as influential oppressive dominant stories. The person as separate from the problem. Localised experience.
Process of Change	Re-program information.	Co-authoring alternative preferred stories.
Goals	To challenge faulty thoughts and beliefs which are impacting on the client's life. To illuminate the impact of behaviour and thought on affect.	Deconstruction of problem stories. Construction of preferred stories. Open up new possibilities.
The Therapeutic Relationship	Collaborative relationship.	Collaborative relationship: Therapist co-constructor of stories.
Therapist Stance	A knower stance; the therapist as the expert.	A "not knowing" stance of respectful curiosity. Therapist privileges the "insider knowledge" of the person.
Conceptualisation of Self	Bounded autonomous self. A true self. Person as an information processor or computer.	Self as relational. Person as a social being. Self as a social construction.

Table 2.1.

A Comparison of Narrative and Cognitive-Behavior Therapy

2.5.4 Key Elements of Narrative Practice

2.5.4.1 A Storied Conceptualisation of Therapeutic Change

Narrative therapists also apply a story metaphor to conceptualise therapeutic change. Bruner (1986) proposed that experience that is contrary to the dominant story always exists. However, dominant stories tend to obscure alternative experience, reducing an individual's awareness of stories that are inconsistent with the dominant plot. With a reduced awareness of experiences that are inconsistent with the dominant story, the mobilization of resources to overcome the problem is diminished (Winslade & Monk, 1999). Therefore, an overarching narrative approach to therapeutic change is to incorporate previously neglected stories into the overall life story of the person. Although, for clarity, Figure 1.1 depicts the elements of narrative therapy as a linear process, narrative therapy is a recursive process, taking a circuitous course, circling and inter-weaving in the process of change.

2.5.4.2 The Therapist Stance

A narrative approach to therapy involves conversations within a collaborative relationship, wherein each member of the dyad influences the understanding of the other. Narrative therapists view that the therapist and person each contribute knowledge to the therapeutic endeavour. Rather than assuming a *pathologising, knower* or *curer* stance implicit in the hierarchical relationship of many other therapy orientations, narrative therapists strive to empower the person by taking a stance of respectful, questioning, curiosity, which prioritises the person's knowledges and resources (Anderson, 1997; White, 2002).

Problem Story

Deconstruction of
Problem Story

Incorporation of
Alternative Story

New Meaning

Construction of a Richer and Preferred Story

New Possibilities

The Enriched Story is Lived and Witnessed
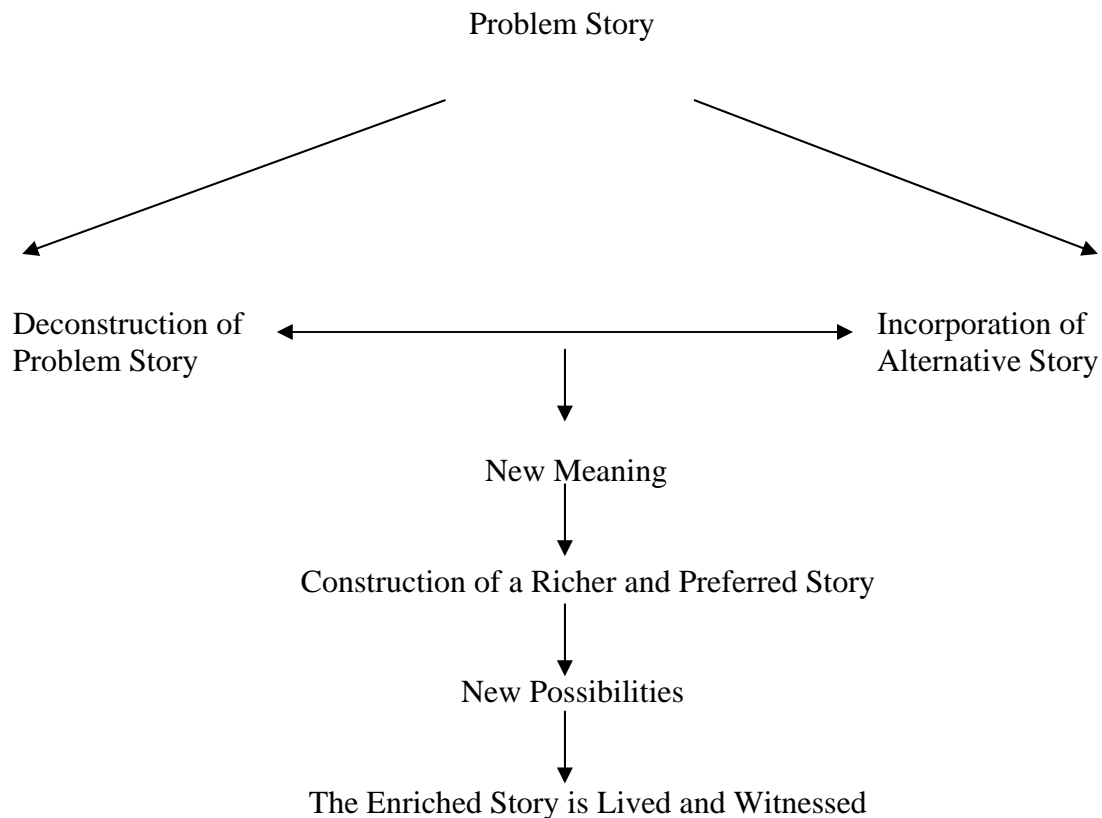
Figure 2.1. Key elements of narrative therapy occurring within and outside of the

therapeutic relationship

2.5.4.3 Eliciting Problem Stories

Since experiences that lie outside the problem story are beyond full awareness,

when people seek assistance for problems, the experiences related are largely those

that surround the problem story. People often speak as if the problem is inherent to

them. Proposing that internalizing understandings and statements act to pathologise

and disempower, White (2007) described the concept of externalising conversations,

subtle linguistic nuances, which disconnect the problem from the person's identity

and minimise possible iatrogenic effects associated with recounting the problem story.

During therapeutic conversations, the identity of the problem is exposed and

described and its boundaries delineated. Rather than universal descriptions associated

with modernist categories of disorder, narrative therapists are interested in local and personal experience.

2.5.4.4 Deconstructing Problem Stories

The concept of deconstruction is closely associated with the work of Jacques Derrida (1978), who proposed that a text does not communicate one truth. Each reader extracts his or her own meaning, so that many meanings can emerge from one text. The deconstruction of a text demonstrates the inconsistencies and omissions that are contained within the text. In the therapeutic context, deconstruction involves taking the problem apart to reveal the assumptions and beliefs that support the problem story, as well as important omissions in the story. Narrative strategies for deconstruction include those that draw from Bruner's notion of landscapes of action and consciousness and those that draw from Bateson's (1972) proposal that we learn by comparison, by noticing differences between phenomena. Therapists are alert to unique outcomes, events that are contrary to the problem story, and which flag the presence of alternate stories. From these conversations, awareness of personal values and identity emerges, often contrasting with previously held assumptions, and differences between existing and preferred ways of living are highlighted (Freedman & Combs, 1996; Monk et al., 1997).

2.5.4.5 Incorporating Alternative Stories

From multiple retellings of alternative stories, clarity in relation to identity and commitments emerges, illuminating openings in thin problem-saturated stories. Identity conclusions are transformed as conversations weave previously neglected aspects of experience into the tapestry of stories about the person's life. The person's position in relation to the problem changes so that the problem becomes less influential and new possibilities emerge.

2.5.4.6 Embracing and Living Preferred Stories

With multiple tellings and retellings of alternative stories, within and outside of therapy sessions in varied inter-personal contexts, additional information is exposed. The narrative tapestry becomes stronger and more richly described. A more richly described tapestry of stories enables the person to embrace the preferred story as his or her own, to reposition his or her self in relation to the problem, and perform the new story outside of therapy sessions (Anderson, 1997; Payne, 2000; Morgan, 2000).

2.5.5 The Dialogical and Inter-subjective Nature of Narrative Therapy

Narrative therapists generally reject the notion of a core and singular self, often associated with intra-personal orientations, particularly the notion of intra-personal deficit. Narrative therapists commonly focus on the inter-personal field, explicitly emphasising inter-personal processes, for example, with references to "outsider witnesses" (White, p. 189) and "re-membering conversations" (White, p. 136). Further, as described above, narrative therapists generally apply a story metaphor to explain problems of living and therapy change within a broader cultural field.

This thesis recognises the storied and inter-personal nature of narrative therapy, but proposes this does not represent narrative therapy change processes in entirety. Instead, this thesis emphasises the dialogical and inter-subjective character of narrative therapy, with intra-personal as well as inter-personal processes. Although references to intra-personal processes are vague, they are implicit in references to "internalizing understandings" (White, 2007, p. 25) and "externalising conversations" (White, 2007, p. 9). A story connotes a monologue and monological processes. Although not explicitly articulated, dialogical processes are inferred, for example, in

the importance given to "externalizing conversations" (White, 2007, p. 9), "re-authoring conversations" (White, 2007, p. 61) and "re-membering conversations" (White, 2007, p. 129). Although narrative therapists have privileged its storied and inter-personal nature, narrative therapy also involves dialogical and intra-personal processes, better represented by the notion of inter-subjectivity.

Several narrative theorists conceive of self as a multiple, dynamic and inter-subjective process, with intra-personal and inter-personal dimensions, (Nylund, 2002; Rober, 2005a). Weingarten (1991), for example, explained that a person's experience of self "…exists in the ongoing interchange with others…" which "…creates itself through narratives that include other people who are reciprocally woven into these narratives." (p. 289). From the dialogical narrative perspectives of Cooper (2003) and Hermans and Dimaggio (2004), psychological distress is characterised by disengagement from personal aspects that give meaning to people's lives, so that they are unable to engage reflexively with their selves[4]. Resonating with the notion of intra-personal healing, to make whole, individuals anecdotally describe their experience of psychological distress as "falling apart", "shattered" or "broken". Others suggest individuals should "pull themself together", and describe mental well-being as "being together". Although dialogical narrative theory[5] provides an understanding of dialogical and inter-subjective change processes, a synthesis of dialogical theory and narrative therapy, as commonly practiced, does not exist.

2.6 Measurement Complements Meaning

Throughout the twentieth century, Western tradition aligned notions of empiricism or logical positivism with truth in psychotherapy practice and research. Clinicians deemed the observation and description of clinical signs and symptoms as

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[4] Chapter 3 discusses the process of narrative reflexivity in the context of self in more detail.

[5] Section 3.5.5.3 and Section 3.6 discusses dialogical narrative theories in detail.

necessary for diagnosis, and researchers believed empiricism was the path towards understanding the human condition. Empirical research methodology provided a wealth of psychological knowledge, contributing valuable information. For example, objective principles helped to increase knowledge into neurotransmitters and their role in the treatment of depression (Geddes et al., 2003).

Reliance on objective methods alone, however, all but excluded methodologies with the potential to enhance our understanding of psychological well-being. Post-modernists' calls to recognize the importance of subjectivity and inter-subjectivity when research and practice relates to human mental states challenged objectivity as the only road to valid knowledge (Lieberman, 1989). Furthermore, clinicians criticised the form of psychotherapy used in modernist research methodologies, arguing that it was "not consonant with the linguistic, interactional, and contextual nature of psychotherapeutic interchange" (Kaye, 1994, p. 30). In all, the rise of post-modern perspectives came with a growing recognition that research methods and therapy practice, which tap subjective experience and personal meaning, yield valid knowledge and clinically important information (Lieberman, 1989). On this point, Jerome Bruner (1986) distinguished a second mode of achieving truth, in addition to the logical-scientific mode. This was a mode of thought that was associated with subjectivity and meaning, which he termed narrative thought.

Bruner's (1986) ideas were especially relevant to proponents of the emerging narrative approaches to therapy, who, inspired by Bruner's idea of a narrative construction of reality, turned to narrative research methodologies and generally rejected the use of objective research designs (Kelley, 1998). For example, according to Besa (1994), "…it would be both hypocritical and illogical to use a form of research based on normal curves and psychopathological classifications to study

effectiveness of NT [narrative therapy]" (p. 310). Besa held that empirical methods assume uniform processes in the therapy assessed and are therefore irrelevant to the evaluation of narrative therapy. Echoing the opinions of Besa, Busch (2007) recently proposed that as a discursive therapy, narrative therapy is theoretically incongruent with experimental methodology.

I argue that an empirical evaluation of narrative therapy is neither irrelevant nor inconsistent with its founding theories, in contrast to the views of Besa (1994) and Busch (2007). Although a tension between modern and post-modern notions is recognised, I suggest that this tension need not limit ways of understanding psychotherapy. My argument for an empirical component, when evaluating narrative therapy, is consistent with the argument of Jerome Bruner, a leading figure in narrative theory, who saw logical-scientific and narrative modes as complementary:

> There are two modes of cognitive functioning, two modes of thought, each providing distinctive ways of ordering experience, of constructing reality. The two (though complementary) are irreducible one to the other. Efforts to reduce one mode to the other or to ignore one at the expense of the other inevitably fail to capture the rich diversity of thought...A good story and a well-formed argument are different natural kinds. (Bruner, 1986, p. 11)

Bruner clearly believed that neither the logical-scientific nor the narrative way of knowing the world replace the other, and clearly stated that neither mode should be ignored or privileged. In their quest to pursue new ways of thinking, by rejecting objective research designs some narrative researchers disregarded a fundamental assumption underlying post-modernism. The concept of multiple constructions of reality is an inclusive concept, inconsistent with the exclusion of inductive thought. A

leading figure in the social constructionist movement, Gergen (2001b), contended that empirical psychology:

> … represents a tradition of discourse, practice, and politics that has as much right to sustain its existence as any other tradition. The point of postmodern critique…is not to annihilate tradition but to give all traditions the right to participate within the unfolding dialogues. (p. 808)

Reliance on empirical methods alone excludes methodologies, which have the potential to capture the richness and multiplicity of the human condition. Empirical methodology, relating meaning to the measurement of other relevant variables, however, makes a valuable contribution in understanding psychological difficulties. Further, according to Bruner (1986), empirical methods are not only consistent with narrative theory, practice and research, but are required for a comprehensive understanding of the world.

2.7 Empirical Investigation of Narrative Therapy is Philosophically Coherent

Post-modern ideas have challenged many modernist notions that have traditionally underpinned psychotherapy theory, practice and research, providing new perspectives of reality, language and psychopathology. Although a shift in focus from objectivity to subjectivity and inter-subjectivity has characterised the post-modern movement, leading post-modernists intended to augment, not replace conventional understandings. According to narrative and social constructionist theorists such as Bruner and Gergen, objectivity and subjectivity each have a place in enhancing our knowledge, each complementing the other. Since logical-scientific methods provide an acceptable means of attaining knowledge according to narrative theory, use of empirical research designs is consistent with the evaluation of narrative approaches to

therapy. In the chapters that follow, it will be taken as a given that an empirical

methodology is consistent with the evaluation of narrative therapy.

CHAPTER 3

PROCESS-OUTCOME RESEARCH

3.1 Process Research Seeks to Understand the Processes of Therapeutic Change

Investigating the process of therapy is a key issue for researchers wishing to gain

an understanding of factors contributing to successful therapy outcome. As

distinguished from therapy outcome, Orlinsky, Helge Rønnestad, and Willutski (2004)

described therapy change process as,

> … including (primarily) the *actions, experiences, and relatedness of patient and*
>
> *therapist in therapy sessions* when they are physically together, and
>
> (secondarily) the *actions and experiences of the participants specifically*
>
> *referring to one another that occur outside the therapy sessions* when they are
>
> not physically together. (p. 311)

As Orlinsky and his colleagues pointed out, this definition is more consistent with the

concept of *change* process rather than *therapy* process, and incorporates the possibility

of change occurring at both inter-personal and intra-personal levels, when the

therapeutic dyad is together or apart. Therapy change process refers to either temporal

or causal change. Temporal change involves change with time, and does not imply

causality. In contrast, causal change involves a progression in time that is associated

with a cause and effect relationship (Orlinsky et al., 2004). Despite occasional

difficulties in distinguishing therapy change process from outcome (see Stiles &

Shapiro, 1989), there is a growing recognition that process research is most valuable

when related to outcome (Marmar, 1990). Process-outcome research provides

opportunities to investigate whether specific processes correlate with or mediate

outcome, potentially supporting theoretical models of change and improving our

knowledge of the constituents of successful psychotherapy.

The overall aim of this chapter is to argue that investigation into the broad constructs of language and self may progress our knowledge of successful change processes in the context of psychotherapy, and to identify narrative reflexivity as a pivotal construct in the integration of narrative theory, research and practice. Narrative notions of language, self, psychopathology and psychotherapy inform the discussion and argument of this chapter.

A brief description of the current state of process-outcome research situates the present study. I then introduce the concept of narrative reflexivity, a primary focus of this thesis, as a process in which language and self are intimately connected. Next, I emphasise the importance of language when attempting to understand the processes of therapeutic change. I identify language as a broad construct that bridges intra-personal and inter-personal dimensions of therapy, as well as common and specific factors. I then outline the role of language in ordering and making meaning from experience. Throughout, the inter-subjective and dialogical nature of psychotherapy is emphasised.

Following the discussion on the importance of language to psychotherapy process research, focus then shifts to the role of language in constructing the self. Description of William James' (1890) seminal account of the self and post-modern notions of the self are intended to provide the foundations for understanding the dialogical self (Hermans & Kempen, 1993), which I highlight as engaged in the process of narrative reflexivity, and therefore particularly salient to the current research.

Connections made between disordered narratives, narrative reflexivity and disruptions to the dialogical self then underline the role of language in psychopathology and the processes of therapeutic change. The notion of narrative reflexivity is consistent with processes posited by narrative theorists (e.g., Angus, Levitt, & Hardtke, 1999; Hermans, 2004; Zimmerman & Dickerson, 1996) and proponents of narrative therapy

(e.g., White & Epston, 1990). Description of these approaches intends to point to the utility of the Narrative Processes Coding System (Angus, Hardtke, & Levitt, 1996) as a metric for examining narrative reflexivity in the context of investigating change process in narrative therapy.

The final section deals with the therapeutic relationship, focusing on the therapeutic alliance. This research is interested in the therapeutic relationship as an inter-personal element of an inter-subjective change process. Despite diverse conceptualisations of the therapeutic relationship, it has been associated with therapeutic outcome across several therapy orientations. There has been increasing evidence that the person of the therapist contributes importantly to outcome variance, distinct from the effect of the therapy orientation employed. Narrative therapy emphasises a specific form of relationship as pivotal to the process of therapeutic change.

3.2 Narrative Conceptualisations Offer New Understandings of

Therapeutic Processes

Over the past five decades, process researchers have attempted to gain a better understanding of therapeutic change processes (Toukmanian & Rennie, 1992), resulting in a myriad of proposed process variables. In order to clarify the current state of psychotherapy process-outcome research, Orlinsky et al. (2004) distilled information from a vast quantity of diverse research methodologies, theoretical orientations and measures. Orlinsky et al. categorised process variables from the period 1993 to 2001 into six broad categories that had previously emerged in the period from 1950 to 1992 as follows: therapeutic contract; therapeutic operations; therapeutic bond; self-relatedness; in-session impacts, and; temporal patterns. Self-relatedness and the

therapeutic bond are of particular interest to this research, which emphasises inter-subjective processes (comprising intra-personal and inter-personal dimensions) in therapeutic change. Sections 3.3, 3.4, 3.5 and 3.6 discuss different aspects of self-relatedness. Section 3.7 discusses the therapeutic relationship.

Orlinsky et al. (2004) reported that studies from 1993 to 2001 advanced our knowledge of therapy process, generally adding to our understanding of variables previously identified. They observed, however, that there was "...no radical change in conclusions reached previously on the basis of research from 1950 to 1992" (p. 362). Although the benefits of steady advances in knowledge is undeniable, the conclusion of no radical change in nine years from 321 sources, speaks to the need for new approaches. Narrative notions of language and a dialogical self provide perspectives of psychopathology and psychotherapy with the potential to contribute to our understanding of psychotherapeutic change processes.

3.3 Self-Relatedness: Focusing on Reflexivity

Self-relatedness can be defined as "…the reflexive aspect of the individual's experience while engaging in activities and relationships" (Orlinsky et al., 2004, p. 319). The initial capacity to relate to self begins to emerge around eighteen months to two years of age, reflected in children's ability to recognise their images in photographs and mirrors (Lewis & Brooks-Gunn, 1979). Children's relationship with their selves progresses from a consciousness or awareness of the physical body towards more complex understandings of abstract aspects of the self (Damon & Hart, 1988).

A number of associated constructs fall under the general rubric of self-relatedness (Orlinsky et al., 2004). The constructs of introspection (Descartes, 1641/1985), reflection (Locke, 1690/1997) and reflective functioning (Fonagy, 2002), for example, are ways of relating to the self. The form of self-relatedness of interest to

this research is *reflexivity*. Although several different interpretations of the term reflexivity exist, very broadly reflexivity refers to "…the subjective self, and the ability to turn back on itself" (Johns, 2002, p. 229). According to Rennie (1992), reflexivity is an integral process of successful therapy, through which clients' intentions are shaped. To my knowledge, however, a comprehensive integration, relating a theoretical understanding of reflexivity to the facilitation of reflexivity in narrative therapy has not been articulated.

The constructs of introspection and reflection, as used by Descartes (1641/ 1985) and Locke (1690/1997) respectively, have similarities with reflexivity. Both introspection and reflection, however, connote visual images, which are not useful in understanding reflexivity as an inter-subjective and narrative process as it is conceived in this thesis. Archer (2003) held that use of a visual metaphor implies an observer distanced from the observed, looking at his or her behaviour objectively. The visual metaphor supposes that looking at the *self* is analogous to a third-person onlooker viewing an external object. Such distancing is quite distinct from the intimacy of relating to self. Objectification and observation of the self discounts the experience of subjectivity (Archer, 2003). Analogy to the sense of touch may clarify this point. When touching a pencil, my finger subjectively feels the solidness of the pencil. In contrast, when touching my lip, my finger subjectively feels the warmth of my lip and my lip subjectively feels the hardness of my finger. When I experience my self, in a sense, there are at least two subjectivities, for example, my finger and my lip. Subjectivities engage with each other; each subjectivity is associated with an object which is also part of the self.

Interpretation of experience is constrained when informed by vision alone (Archer, 2003). When an observer sees another person, the observer knows little of

those qualities that are inaccessible to observation, such as the person's feelings, beliefs, values and future intentions. With little to inform interpretation, observation is generally not a generative process, and may even involve rumination, a static or possibly stagnant practice.

Rather than a passive *looking*, informed by Hermans and Kempen (1993) and Angus et al. (1999), this thesis conceptualises reflexivity as a dynamic, participatory and inter-subjective process of dialogue in which the self participates in conversations with self (and others as extensions to the self). Through these conversations, experience integrates with previous experience and meaning, involving interpretation and the consequent creation of new meaning and new understandings (Archer, 2003; Tomm, 1987; Zimmerman & Dickerson, 1996). The meeting and modification of two subjectivities is analogous to a cross-fertilisation of ideas in which creativity is implicit.

The notion of reflexivity as a narrative process of meaning-making is similar in many aspects to Russell Meares' conceptualisation of non-linear language, "…established by the reflective capacity that enables one to become aware of individual experience in a way that gives a sense of an inner life" (Meares, 1999, p. 1851). According to Meares (1998), non-linear language is "…a linguistic marker of 'self'" (p. 875).

The constructs of reflexivity and reflective functioning (Fonagy, Target, Steele, & Steele, 1998) share some important characteristics. Reflective functioning concerns self-relatedness, and has been defined as "…the ability to recognize the existence and nature of mental processes taking place in the self and others…" (Karlsson & Kermott, 2006, p. 65), resonating with the notion of a theory of mind. Like reflexivity, theories of development and self underpin the notion of reflective functioning (Fonagy, Gergely, Jurist, & Target, 2002; Karlsson & Kermott, 2006). Unlike the concept of reflective-

functioning (Fonagy et al., 1998), reflexivity, as conceived in this research, focuses on inter-subjective dialogue, underpinned by dialogical theory of self (Hermans, 2004).

A dialogical conceptualisation of reflexivity is consistent with the narrative proposition that we achieve a sense of self through inter-personal and intra-personal conversations (Gergen, 1999). Zimmerman and Dickerson (1996) described reflexivity as:

> A process in which ideas can bounce off other ideas; aspects of experience can come to the fore, so that persons can begin to notice and examine previously held assumptions. It is an in-between place - between persons, between representations and persons (e.g., letters from others), between experience and persons (e.g., music). (p. 101)

From this perspective, the dimension of *difference* is required; the reflexive creation of meaning requires the dimension of *other* (West, Watts, Trepal, Wester, & Lewis, 2001). While other can refer to inter-personal engagement, post-modern conceptualisation of self[6] as characterised by multiplicity, enables the conception of other within intra-personal engagement.

3.4 Language is Important to Psychotherapeutic Change

3.4.1 Language Links Broad Dimensions of Therapy

Despite the progress of process research, as evidenced by alliance research, the review of process-outcome studies by Orlinsky et al. (2004) and their conclusion of no radical change in nine years suggest limited advancement in our understanding of the components of the therapeutic process. Limited progress may be due to the relative neglect of language (Russell, 1987).

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[6] See Section 3.5.4 for a discussion of post-modern conceptualisation of self.

As the defining achievement of humanity, language is an important consideration when attempting to understand processes of therapeutic change. Language comprises a significant proportion of the therapeutic alliance, evidenced as an important component of therapeutic change (e.g., Martin et al., 2000). Language provides the crucible within which the specific techniques utilised or common factors proposed interplay, irrespective of therapeutic modality. Language pervades intra-personal and inter-personal experience (Wittgenstein, 1958; Bakhtin, 1930s/1981, 1929/1984). Language therefore bridges specific and common factors, as well as the intra-personal and inter-personal dimensions of therapy. Providing a conduit across dimensions of therapy, investigation into the language of order, disorder, and therapeutic change offers a broad perspective that may improve our understanding of therapy change processes.

3.4.2 Language is a Vehicle for Making Meaning

Adaptive functioning requires that humans' experience is meaningful (Bruner, 1986). According to Gendlin (1962), "…meaning is formed in the interaction of experience and something that functions as a symbol" (p. 8). If symbols are thought of as giving form to experience, both representing and constituting the experience (Greenberg & Watson, 2005), then language is symbolic. Narrative theory highlights the role of language in constituting meaning (Anderson, 1997; Brown & Augusta-Scott, 2007). Narrative theorists contend that language organises a person's multiple and diverse internal and external experiences, ordering the location and sequence of events to give meaning to that experience. Anderson (1997) defined narrative as:

> …a form of discourse, the discursive way in which we organize, account for, give meaning to, and understand, that is, give structure and coherence to, the circumstances and events in our lives, to the fragments of our experiences, and to our self-identities, for and with ourselves and others. (p.212)

The ongoing integration of experience results in a continual restructuring process to produce narratives that are coherent and personally meaningful (Arciero & Guidano, 2000; Gonçalves, Korman, & Angus, 2000).

The importance of narrative to making meaning has been highlighted by Jerome Bruner (1986). As mentioned in Section 2.5.3, Bruner proposed that when individuals speak, they construct two landscapes simultaneously: a landscape of action and a landscape of consciousness. The landscape of action comprises the objective dimensions of the story, the "…arguments of action: agent, intention or goal, situation, instrument, something corresponding to a story grammar" (p. 14). Freedman and Combs (1996) likened the landscape of action to the "…who, what, when, where and how of journalism" (p. 97). Like Meares' (1999) formulation of linear language, speech from the landscape of action offers information, but the self of the speaker is not discernible. The content of speech is effectively meaningless unless embedded in the landscape of consciousness. When people speak from the landscape of consciousness they are speaking of personal meaning. The landscape of consciousness comprises the subjective and intensely personal dimensions of the story such as values, beliefs, desires, intentions, goals, commitments, and motivations (Freedman & Combs, 1996). Bruner described the landscape of consciousness as "…what those involved in the landscape of action know, think, or feel, or do not know, think, or feel" (p. 14). As they unfold, narratives continually traverse the two landscapes, integrating and reintegrating the objective and subjective dimensions of experience to make meaning from that experience. To this extent, the self and narrative are mutually embedded (Bruner, 1986).

3.4.3 Transformative Conversations

3.4.3.1 Psychotherapy is a Conversation

Essentially, psychotherapy involves a conversation. Freud (1940/1964) observed that nothing but talk takes place between the patient and analyst. It is, however, a healing form of conversation, involving inter-subjective processes that aim to bring about change, by "…enhancing communication among regions of existence, whether this be between the holy and the mundane, between one person and another, between conscious and unconscious, or between the scientist and the laymen" (Bakan, 1967, p. 126).

3.4.3.2 Monologic Conversations

From the prevailing modernist perspective, language provides the vehicle for individuals to express thoughts and feelings by providing a representation of the world and experience (Locke, 1690/1997; Piaget 1923/1971). From this position, the therapist possesses privileged knowledge about the human condition, and therefore leads the direction of therapy. The emphasis of language is on deficiency and categorization. Based on clinical knowledge, therapists formulate and interpret problems, then advise to facilitate change (Anderson, 1997). According to Gergen and McNamee (2000), the conversation of traditional therapists is largely a monologic interchange. The client speaks about the problem. The therapist transforms the client's story into more complex professional pathologising language. The therapist diagnoses and treats the client from the vantage of an expert (Gergen, 1994). There is no doubt that monologic therapeutic conversations have helped countless clients. To be able to put a name to their problems, to know that others have similar problems, to hear the formulations and interpretations

of their situation from the perspective of an expert in the field is a relief to many individuals, offering some type explanation and coherence to their lives.

3.4.3.3 Dialogic Conversations Transform Meaning and Self

Narrative theorists contend that psychotherapy is a special form of conversation, whereby new meaning and self evolve through "transformative dialogue" (Gergen & McNamee, 2000, p. 343). Narrative therapists hold that each member of the therapeutic dyad brings knowledge and expertise to the conversation, influencing the understanding of the other (Payne, 2000). In addition to this inter-personal dialogue, dialogic narrative theory proposes that transformative dialogues also occur intra-personally. In essence, therapy is an inter-subjective and dialogic process wherein at least two subjectivities encounter each other, and are changed through this encounter.

The premise that individuals do not construct their selves and new meaning alone underpins narrative therapy's emphasis on conversation. According to MacIntyre (1981), "….we enter human society… with one or more imputed characters-roles into which we have been drafted….." (p. 216). That is, we can only be a co-author, even in our own story. From before we are born, the construction of self and meaning is a dynamic, continual and inter-subjective process occurring through conversations (Gergen, 1985b). Therapy is therefore a relational activity, transforming meaning and self.

Despite the communal generation of words, when in dialogue, words are personal and performative. Speakers infuse the words that once belonged to others, with their own meanings and intentions (Bakhtin, 1981). Words, however, involve both speaker and listener. When receiving the words and non-verbal expressions of a speaker, a listener actively assigns meaning to those words, meaning which may differ to that of the speaker. The personal meanings and intentions of the listener then shape

his or her response. This inter-subjective and dialogic process enables the meaning of the speaker to meet the meaning of the listener, opening possibilities for creating new meaning (Hermans, 2003).

From a narrative perspective, psychotherapy involves conversations and psychotherapeutic change emerges from transformative dialogues that give new meaning to experience, transforming the self and opening new possibilities. Considering that therapy can be conceived as transformative conversations, investigating psychological order, disorder and therapy from a narrative perspective has the potential to offer new understandings of therapeutic change processes.

3.5 Language Constitutes the Self: Narrative Perspectives

3.5.1 Changing Conceptualisations of Self

The self is an elusive and abstract concept. Although unobservable and unmeasurable, the self is nevertheless real. As Dennett (1988) explained, just as the centre of gravity of an object is real because it is the product of an object that is located spatially and temporally, the self is real, the product of the person's narrative. Everyday, individuals speak about their selves, for example, "I am not myself today". Such statements illustrate that the self exists subjectively, having a first-person ontology (Searle, 1998). The number of self-compound words listed in varied dictionaries supports the importance of self to communication and the proposition that the self exists in narratives. Throughout the history of psychology, a number of theorists have considered that the self is not only real, but also important in understanding psychological function, psychological distress and successful psychotherapy (Strauman & Kolden, 1997).

Early in the evolution of the discipline of psychology, William James (1890), from the pragmatist-functionalist school, outlined a notion of self as the reflective

ongoing stream of thought. Not long after James presented his conceptions of self, the emerging behaviourist trend all but eclipsed his work. Fuelled by the positivist paradigm, behaviourism dominated psychological research and practice for many years. Conceiving reality as static, single and observable, and disregarding unobservable or unmeasurable entities, radical behaviourists challenged the very existence of self (Brinich & Shelley, 2002).

Despite the dominance of behaviourism, a number of theorists perceived the self as valuable in understanding psychological distress and regarded change in a client's self to be of fundamental importance for successful therapeutic outcome (e.g., Blatt & Segal, 1997; Beck et al., 1979). Several theorists attempted to elucidate the nature of self, including those from cognitive, existential, psychodynamic and humanist approaches (e.g., Beck et al., 1979; Binswanger, 1963; Freud, 1940/1964; Rogers, 1951, 1961). Despite such considerable interest, prevailing modernist notions of reality meant the approaches generally conceived of a singular, core self that was essentially individualistic and static (Rober, 2005a). Nevertheless, these widely varying orientations provided the background through which narrative ideas evolved. Throughout, James' conceptualisation of self influenced theorists from many of these disciplines, providing the foundations for narrative and dialogical models of self.

The remaining segments of Section 3.5 aim to describe the relationship between language and self. After a brief report of William James' (1890) seminal account of the self as the stream of thought, I link thought to language, with reference to theories of language acquisition, connecting language to self. A linguistic notion of self is consistent with post-modern perspectives of self, and together with the work of James and Bakhtin (1929/1984) provided the foundations on which Hubert Herman's (2004) dialogical self emerged. Theory of a dialogical self offers a model of human

functioning, psychological order and psychological disorder, which provides a perspective through which psychotherapeutic change may occur. The interpretation of self as a narrative construction is consistent with narrative theory and has implications for the operationalisation of self in the current thesis.

3.5.2 William James

3.5.2.1 Self as Stream of Thought

James (1890) proposed a fundamental premise; the consciousness of self is the most significant portion of the ongoing stream of thought, concluding "…the passing thought…is itself the thinker" (p. 401). Acknowledging that this premise is not verifiable, James nevertheless held that "I think" (p. 226) is a conscious fact, arguing that a thinker cannot refute the veracity of a thought. Central to James' notion was a duplex self, distinguished as the *I* and the *me*, which he sometimes substituted with the reflexive "myself" (p. 238).

3.5.2.2 Self as Reflective: The I

James (1890) conceptualised the *I* as the subjective self, the knower, which reflects on the *me,* the knowable. James discussed three fundamental characteristics of the *I*: continuity, distinctiveness and volition (Damon & Hart, 1982).

Continuity corresponds to a "sense of sameness" through time and a sense of "personal identity" (James, 1890, p. 332), which James attributed to the stream of thought, "It is a *Thought*, at each moment different from that of the last moment, but *appropriative* of the latter, together with all that the latter called its own" (p. 401). Despite this continuity, James regarded the self as dynamic. Analogous to water drops in a stream of water, even though the thoughts in the stream of consciousness are always changing, the stream itself is continuous and he wrote, "…the *I* which knows

them cannot itself be an aggregate, neither… considered to be an unchanging metaphysical entity…" (pp. 400-401).

The sense of continuity is closely associated with a sense of distinctiveness. Humans feel separate from others. James (1890) held that people separate those entities that are not associated with their "…warm and intimate self…" (p. 333). Illustrating by scenario, James pointed out that when Peter wakes in the same bed as Paul, he recalls his thoughts of yesterday and "…reidentifies and appropriates the 'warm' ideas as his, and is never tempted to confuse them with those cold and pale-appearing ones which he ascribes to Paul" (p. 334). Although Peter sees Paul's body, he does not confuse it with his own because he both sees and feels his own body. That is, humans have a sense of distinctiveness from others, a distinctiveness that is embodied, "…the thoughts…do not fly about loose, but seem to belong to some one thinker and not to another. Each thought…is able to distinguish those which belong to its own Ego from those that do not" (pp. 330-331).

James (1890) proposed that thoughts of lived experience are not passively processed. From the chaos of the preceding stream of thought, the agentive *I* selects and appropriates meaningful thoughts, disregarding others. Volition therefore characterizes the *I* .

3.5.2.3 Self as Material, Social and Spiritual: The *Me*

James (1890) described the *me* as an aggregate of the objective, knowable attributes of self, referring to it as the empirical self (p. 291). He regarded the line between *me* and *mine* as difficult to distinguish. Diverging from the modernist conception of self as internally contained, James' *me* extended outwards to the environment, incorporating "…the sum total of all he can call his…" (p. 291).

James (1890) described three constituents of the *me*: the material self; the social self, and; the spiritual self. He maintained that thought was central to all three dimensions, and these thoughts intrinsically intertwined with emotions, which he referred to as "…excitement of a certain peculiar sort" (p319). James held that even if reasoning convinced a person that there was "…no self of yesterday…" (p. 332), the sense of personal existence would be felt, "…it would exist as a feeling all the same" (p. 332). That is, once more, James highlighted the self as embodied.

For James (1890), the material self comprised thoughts about tangible effects considered to be *me* or *mine*, such as the body, clothes, family, home, property, and those parts of wealth that are "saturated with our labor" (p. 293). He conceived of a social self as a plurality of selves, involving thoughts about recognition from others, and he explained "…a man has as many social selves as there are individuals who recognize him and carry an image of him in their mind" (p. 294). James described the spiritual self as the enduring and intimate aspects of self, our "…moral sensibility and conscience" (James, 1890, p. 296). James suggested these moral elements of self are "felt", requiring a reflective process to consider the thoughts and feelings of the "…inner and subjective being…" (p. 296).

3.5.2.4 James' Paradoxical Self

In sum, James (1890) presented a paradoxical self and was fully cognisant that he presented a self that might appear contradictory. For example, he explained:

> …if from the one point of view they are one self, from others they are truly not one but many selves. And similarly of the attribute of continuity; it gives its own kind of unity to the self-that of mere connectedness, or unbrokenness…this unbrokenness in the stream of selves…in no wise contradicts any amount of plurality in other respects. (p. 335)

Thus, James described a self that was at once embodied and relational, with intra-personal and inter-personal dimensions of existence; that was unified and plural; that was continuous but dynamic, and; that was a stream of thought intrinsically intertwined with emotion.

3.5.3 The Unity of Thought and Language: Implications for the Self

Despite widely varying world views of behaviourists (Bandura, 1986; Skinner, 1957), constructivists (Piaget, 1923/1971) and social constructionists (Vygotsky, 1934/1987), these different conceptualisations of language acquisition have proposed that language and thought eventually intertwine (see Section 2.3.2). Considering James' (1890) theory of self as stream of thought, this unity of verbal thought supports the relationship between self and language proposed by social constructionists who contend that language constitutes the self (Gergen, 1994; Paré, 1995).

3.5.4 The Post-Modern Self

3.5.4.1 Narrative Constitutes the Self

The trend towards a more empirical and less philosophical psychology nearly eclipsed James' (1890) reflections on self (Scheibe, 1995). However, many of James' notions of the self later re-emerged, albeit in an altered form, sustained by the narrative focus of post-modern epistemologies, which conceived the self as dialogical, plural and dynamic.

Social constructionists acknowledged constructivist challenges to the modernist concept of a singular, essential self, and their move to an understanding of self as personally constructed, with personal meaning and able to undergo psychotherapeutic change. Social constructionists, however, argued that language was central to self (Neimeyer & Raskin, 2000; Neimeyer & Stewart, 2000).

Building on James' (1890) work, Sarbin (1986) introduced the notion of narrative as a "…root metaphor…" (p. 3) in the discipline of psychology, characterising the reflexive self-process as organised through language, with the *I* as author and the *me* as protagonist of an emerging story. A storied organisation of self, involving a person interacting in a world of objects and people, echoed James' (1890) contention that the self extends to the environment and others in the person's world. Polkinghorne (1988) articulated the idea of a storied organisation of self:

> We achieve our personal identities and self-concept through the use of the
>
> narrative configuration, and make our existence into a whole by understanding it
>
> as an expression of a single unfolding and developing story. We are in the
>
> middle of our stories and cannot be sure how they will end; we are constantly
>
> having to revise the plot as new events are added to our lives. Self, then, is not a
>
> static thing or a substance, but a configuring of personal events into an historical
>
> unity which includes not only what one has been but also anticipations of what
>
> one will be. (p.150)

The storied organisation of self enabled a temporal conception of self; that is, a self with a past, present and future. From a social constructionist perspective, therefore, just as all concepts are socially and linguistically constructed, so too is the concept of self (Gergen, 1985b; Richert, 2002).

3.5.4.2 The Self is Relational, Multiple and Dynamic

Rather than an essential and singular self, social constructionists proposed a relational self. Bruner (1986) explained, "…selves are not isolated nuclei of consciousness locked in the head, but are "distributed interpersonally" (p. 138). From this perspective, an individual's narrative self intertwines with the narratives of others,

recreating his or her self through ongoing dialogues (Weingarten, 1991). Consistent with James (1890), a relational self implies a multiplicity of selves, dependent on the specific relationship and context (Gergen, 1991) and connotes a dynamic self that changes according to context. Gergen (1991) distinguished the self as "…an open slate…on which persons may inscribe, erase, and rewrite their identities as the ever-shifting, ever-expanding, and incoherent network of relationships invites or permits" (p. 228), a description which allows for infinite dynamic constructions and reconstructions of self.

Post-modernists therefore hold that multiple selves exist within a milieu of relationships and contexts in a dynamic process of ongoing change through conversations (McLeod, 1997; Niemeyer & Stewart, 2000). Conception of a multiple self that is transformable through conversation provided foundations for the notion of a dialogical self that relates to itself by engaging in reflexive dialogues amongst its myriad selves in a dynamic process of ongoing change (Hermans & Kempen, 1993).

3.5.5 The Dialogical Self: A Reflexive Self, Creating Meaning through Dialogue

3.5.5.1 The Dialogical Self is an Inter-subjective Self

The notion of a dialogical self illustrates the process of narrative reflexivity, providing a model through which we may better understand psychopathology and psychotherapeutic change. Post-modern theory of a relational self has been critiqued for its neglect of the intra-psychic (e.g., Holloway, 2006). A narrative conception of a relational self need not, however, connote a self without intra-personal processes. Inter-personal processes make sense only if the personal exists.

The notion of a dialogical self (Hermans, 2004: Hermans & Kempen, 1993; Hermans, Kempen, & Van Loon, 1992) expanded on Sarbin's (1986) previous metaphor of a storied self, offering a richer account of the self that is located in

conversational relationships both inter-personally and intra-personally. Drawing largely

from Bakhtin's (1929/1984) concept of the polyphonic nature of human consciousness,

and James' (1890) distinction between the *I* and the *me,* conceptualisation of the

dialogical self united notions of self, language, multiplicity and relationship, concepts

consistent with the narrative view of a relational and multiple self that is linguistically

and socially constructed.

3.5.5.2 Bakhtin: Dialogue Creates New Meaning

Bakhtin (1929/1984) noted that Feodor Dostoevsky wrote his characters from

the perspectives of several authors, rather than one. Each author told an independent

story from a personal perspective. Each author's voice had a distinct emotional and

volitional tone, a notion reminiscent of James' (1890) social selves. Bakhtin described

this literary form as a polyphonic novel, and likened it to human consciousness. The

importance of relationship permeated Bakhtin's conception, and he conceptualised

internalised voices in the unconscious, echoing those of significant other people:

> … the word does not exist in a neutral and impersonal language (it is not, after
>
> all, out of a dictionary that the speaker gets his words!), but rather it exists in
>
> other people's mouths, in other people's contexts, serving other people's
>
> intentions… (p. 294)

This perspective is consistent with Vygotsky (1934/1987), who proposed inter-personal

conversations transmute into internal speech.

Individuals do not necessarily "own" (Bakhtin, 1930s/1981, p. 293) internalized

words. Bakhtin likened some internalised words to "reciting by heart" (p. 341). When

recited by heart, words carry the meanings and intentions of the original speaker.

Recited words comprise a fixed monologue that is unavailable to change. A person

remains distanced from recited words; the meanings and intentions of the original

speaker subsume his or her own meanings and intentions. Bakhtin explained how individuals come to own their words:

> It becomes "one's own" only when the speaker populates it with his own intention, his own accent, when he appropriates the word, adapting it to his own semantic and expressive intention…one must take the word, and make it one's own…. (p. 293)

Speakers own their words when they instil them with their own meanings and intentions while engaged in dialogue. Importantly, a dialogue requires two separate subjectivities, each imbuing subjective meaning on words sent and received. Clearly, conversation between two people holding the same perspective is unlikely to generate new meaning, and Bakhtin (1986) placed great importance on the concept of *outsideness* noting, "In order to understand, it is immensely important for the person who understands to be located outside the object of his creative understanding" (p. 7). The meeting of two meanings generates new meaning. This creativity requires the element of difference, as offered by an outside and distinct other. That is, dialogue is an inter-subjective process of change.

Language is performative (Austin, 1962). Drewery (2005) held that people who are "…participants in the conversations that produce the meanings of their lives are in an agentive position…They participate in the creation of the narratives of their lives…in the production of their selves" (p. 315). That is to say, the self that emerges from an inter-subjective exchange that involves making new meaning, differs from the self that entered into the inter-subjective exchange. It should be noted, however, that dialogue can involve verbal and non-verbal structures and symbols of communication (Labov & Fanshel, 1977).

3.5.5.3 Hermans: A Community of Selves in Dialogical Conversations

Hermans (2006) proposed that just as an individual engages in an actual conversation with another person, so he or she engages in imaginary conversations with others. According to Hermans, imaginary conversations endow each person with a voice and perspective. For example, a teenager might imagine the conversation with her father when she informs him about damage to the car she was driving. In this imaginary conversation, the teenager has the capacity to oscillate between her own position (along with its associated perspective and emotional content) and that of her father (with his perspective and emotional tone) in a dialogical positioning and repositioning. That is to say, individuals engage in imaginary dialogical relationships. Moreover, Hermans proposed that just as individuals have imaginary conversations with others, people talk to their selves.

Hermans and Kempen (1993) built on James' (1890) notion of the *I* and *me* by situating the self across time and space. The ability to move through time and space allows people to contemplate past happenings, present circumstances and future prospects in diverse circumstances from different positions. Given that people live in multiple contexts, Hermans and Kempen proposed that the self moves through space and time across an imaginary landscape between multiple *I* positions. Each *I* position (subject) has an associated *me* (object). Each *I* position remains in dialogue with other *I* positions and with outside voices. Importantly, as part of the extended self, outside voices are also *I* positions. While similar to James' notion of self (which included the extended *Me*), Hermans and Kempen's extended self comprised others as *I* positions, each with its associated *Me.* Knowing one's self, therefore, requires knowing others (Hermans, 2006), resonating with notions of empathy and theory of mind.

Following Bakhtin's (1929/1984) idea of the polyphonic novel, Herman and Kempen (1993) conceived that *I* positions retain individual perspectives and, like James' (1890) self, are embodied, with individual voices, emotions, intentions, beliefs, memories and desires (Hermans & Hermans-Jansen, 2004). The voices are like characters in conversational relationships, each offering an independent stance on the person's experience, amenable to other perspectives. Rather than an executive *I*, Hermans and Kempen conceptualised a polyphony of voices expressing point and counterpoint, agreement and disagreement, question and answer, negotiation and co-operation, opposition and support. Each *I* position, guided by its individual experience and perspective, discusses the varied *me(s),* and thereby influences action. The meeting of different *I* positions through dialogic exchange enables the creation of new *I* positions (Hermans, 2006; Hermans & Hermans-Jansen, 2004). Although there is a fluid and ongoing re-positioning of *I* positions, ordered narratives require specific selves to be more powerful or enduring than other voices. For example, for a specific person, despite the difficulties of marriage and children, the *I* position that values family may both powerful and enduring. The self is thus ordered through multiple *I* positions in dialogical relationships. In an inter-subjective process, dialogues within the mind occur as part of dialogues in the broader communities in which the self relates to others (Hermans, 2006).

Although not explicitly labelled as a reflexive process, essentially, a dialogical conception of self involves a narrative and reflexive process of inter-subjectivity, wherein subjective selves engage with each other. Selves are embodied, with individual voices, emotions, intentions, beliefs, memories and desires. Section 3.6 discusses the implications of understanding the self as dialogical and reflexive, in the context of psychotherapy process research.

3.6 Language and Psychopathology: Narrative Perspectives

3.6.1 Disordered Narratives: Narratives with Diminished Reflexivity

Narrative provides a "…thread that gives meaning to life, provided - and this is a big if - that it is never broken" (Spence 1983, p. 458). The capacity to engage in a narrative dialogue with the self may diminish at any point across the lifespan. This section distinguishes disordered from ordered narratives, identifying ordered speech as rich in meaning and the disordered narratives of psychological distress or problems as impoverished, with diminished reflexivity.

Narrative theorists hold that narrative disorder is discernible in individuals' narratives. Just as narrative ordering is qualitatively recognisable in the conversations of individuals, theorists and clinicians have described a range of disordered narrative forms, some specific to particular psychological distress, trauma or problems. Narratives may be so impoverished that that speech is personally or socially unsatisfactory, and sometimes incomprehensible (Gonçalves et al., 2000; Lysaker & Lysaker, 2006; Meares, 1998; Neimeyer & Buchanan-Arvay, 2004; Spence, 1983; White, 2004).

Gonçalves et al. (2000) proposed psychopathology manifests itself in one or more of three fundamental narrative dimensions: (a) structure (b) content, and (c) process. According to Gonçalves et al., structure refers to the coherence or connectedness of experience, content refers to the diversity or multiplicity of experience, and process refers to the qualitative richness or complexity of the narrative. Rich, complex narratives express external and internal experience, and interpret the meaning of that experience reflexively. From a narrative perspective, intensely personal aspects of the self that give meaning and richness to experience and narratives, such as

individuals' intentions, values, beliefs, dreams, desires and purposes, are central to their narratives and crucial to psychological well-being (Freedman & Combs, 1997).

Psychological distress or disorder result when individuals are unable to engage reflexively with their selves (or others). Individuals become disengaged from those personal aspects that give meaning to their lives, resulting in impoverished rather than rich narratives (Cooper, 2003; Hermans, 2006; Hermans & Dimaggio, 2004). With limited reflexive capacity, a person may be unable to understand the meaning of what has happened, is happening, or could happen in his or her life (Goncalves et al., 2000). The importance of narrative reflexivity to self is consistent with ideas proposed by Meares (2000), who argued for the importance of early experience in the constitution of a coherent self and the role of trauma in a disordered self. According to Meares (2000), the linear speech of chronicles and scripts marks psychological distress, in contrast to the non-linear narratives of self that reflect well-being. Meares (1998) described clinical chronicles as, "…a catalogue of problems with the family, with work, and with bodily sensation. Nothing comes from the interior world. The individual's experience is outer oriented…" (p. 884). Even less complex than chronicles, scripts reflect more severe trauma. Scripts contain little of the self, and are characterised by repetition. Unlike healthy narratives, where events have a temporal dimension, time is absent; the trauma is current. External events that echo, however remotely, the original traumatic experience, can trigger scripts. Meares (1998) proposed that narratives, chronicles and scripts emerge from autobiographical, episodic and semantic memory respectively.

3.6.2 Disorder: Disruption to the Dialogical Self

The notion of a dialogical self provides a model for understanding disorder. According to Hermans (2006), psychological health requires the flexible interplay of the diverse perspectives that each person holds, necessary for people to engage fully with

their own selves. That is to say, to experience a sense of personal well-being, multiple *I* positions (subjectivities), reflecting on their respective *me(s),* engage with each other through narrative. Such interplay occurs through the capacity to engage in intra-personal and inter-personal dialogue, an inter-subjective process of reflexivity, wherein experience integrates with meaning.

When individuals experience psychological well-being, *I* positions relate to other *I* positions. With *I-I* modes of self-relating, each *I* position confirms other *I* positions in their otherness and entirety (i.e., each associated with a *Me*), taking the form of a dialogue (Cooper, 2003; Hermans & Dimaggio, 2004). Disordered narratives that underpin psychological distress or disorder reflect difficulty in maintaining reflexive dialogues amongst *I* positions (Gonçalves, Machado, Korman, & Angus, 2002; Hermans, 2006; Lysaker & Lysaker, 2002).

Lysaker and Lysaker (2006) described three types of disordered narratives reflecting diminished reflexivity: barren, cacophonous, and monological. Barren narratives are brief monologues that are characterised by unbending perspectives, which express compressed experience of past events and limited possibilities for the future. A rigid hierarchy comprising only a few inflexible self-positions underpins barren speech. Cacophonous speech, in contrast, expresses diverse experience, but is without logical organisation and therefore incoherent. Self-positions are without hierarchical organisation. Thirdly, monologues express multiple experiences, but interpret experience in limited ways. One or few dominant self-positions that silence other self-positions distinguish monologues. The notion of monologues echoes the dominant narratives proposed by White (2004) to be involved in people's psychological distress.

To illustrate the lack of reflexivity in the impoverished dialogue of psychological distress or disorder, Cooper (2003; 2004) referred to Buber's (1923/1958)

distinction between *I-Thou* and *I-It* modes of inter-personal relating. Drawing an analogy from inter-personal to intra-personal relating, Cooper proposed that when the dialogical self experiences psychological distress or disorder, instead of an *I-I* form of relating (analogous to *I-Thou*), relating takes an *I-Me* form (analogous to *I-It*).

According to Cooper (2004), there is a fragmentation of at least one self-position. The self-position becomes disengaged from those personal aspects that give the self-position meaning (e.g., emotions, intentions, beliefs, memories and desires), and can be known by alternate *I* positions only as a *Me;* a "dehumanised" (Cooper, p. 61) object of experiencing observed and reflected upon at a distance. Alternate I positions cannot encounter the emotions, intentions, beliefs, memories and desires of the self-position, unable to be acknowledged or owned by the self. As an object, the *Me* is unable to engage in dialogue, effectively silenced, and any *I-Me* relating takes the form of a monologue. Although individuals often speak to others or relate to their selves in this monologic way in their day-to-day lives, this form cannot result in the creation of new meaning through which change follows (Cooper, 2004; Rober, 2005b).

Very broadly, the fragmentation and silencing of self-positions significantly constrains the ability to access and voice important aspects of the self, reducing the capacity to engage reflexively with the self in dialogical conversations. Unable to interpret external or internal experience in the context of personal aspects of self, the individual can not make meaning from what has happened, what is happening or what will happen, essential to adaptive function (Dimaggio, Salvatore, & Catania, 2004; Hermans & Dimaggio, 2004).

Narrative therapists hold that dominant narratives underpin psychological distress and people often become totalised by their problem. Narrative therapists often engage clients in externalising conversations to separate people from the problems they

are having. Externalising conversations assist the client to position the problem outside of his or her self so that the problem is not an intrinsic part of his or her identity (White, 2004). A thorough dialogical interpretation of externalising conversations is beyond the scope of this research. However, while conversations that traverse landscapes of action and consciousness facilitate engagement between entire *I-Me* positions, I consider externalising conversations facilitate fragmentation of an *I-Me* position. Dominant problem narratives can be likened to the monological narratives described by Lysaker and Lysaker (2006). The client has difficulty in maintaining reflexive dialogues amongst diverse *I-Me* positions; some self-positions are silenced and others dominate. Informed by a dialogical perspective, externalising conversations might be explained as assisting clients to objectify and reflect on the problem in an *I-It* mode of relating, rather than engaging with the problem in an *I-I* mode of relating, which positions the problem as part of the self.

3.6.3 Therapeutic Change: Integration of Experience and Meaning through Reflexivity

3.6.3.1 Dialogical Theory and Reflexivity: Dialogical Engagement

Although not explicitly named, narrative reflexivity underpins dialogical theory. Based upon dialogical notions of order and disorder, a key process of therapeutic change is to facilitate a smooth and flexible interplay of self-relating (Cooper, 2003; Georgaca, 2001; Hermans, 2006). That is to say, therapists need to facilitate client narrative reflexivity, whereby individuals engage in dialogue with their selves and others as extensions of self, integrating experience and meaning by interpreting experience from diverse perspectives in the context of personal beliefs, values and intentions.

The notion of narrative reflexivity as a process of therapeutic change is consistent with Meares' (1998) proposal that the aim of therapy is to transform the

therapeutic conversation into one of greater narrative complexity. Although the conversation invariably begins with the linear language of chronicles and scripts, the objective is to progress towards the non-linear language of inner existence that underpins the self.

3.6.3.2 Narrative Therapy and Reflexivity: Traversing Landscapes of Action and Identity

Just as a reflexive interpretation of experience is an essential element of dialogical theory, proponents of narrative therapy emphasise the importance of integrating events and meaning in therapy through conversations with others (Freedman & Combs, 1996; White, 2002). That is, although not explicitly named, increasing narrative reflexivity is a significant process of narrative therapy. Therapeutic conversations across what Jerome Bruner (1986) referred to as the landscapes of action and consciousness (described as the landscape of identity by Michael White) constitute a key strategy through which narrative approaches attempt to make meaning from experience in order to facilitate therapeutic change. The landscape of action has been likened to the "who, what, when, where and how of journalism" (Freedman and Combs, 1996, p. 97), as described in Section 3.4.2. The following are examples of landscape of action inquiries:

Who were you with when you felt humiliated?

What happened just before you ran from the room?

How did you prepare to move 'assertiveness' in front of 'people pleasing'?

In contrast, the landscape of consciousness is concerned with aspects of identity that provide meaning to the landscape of action: emotions, beliefs, values, intentions, purposes and goals (Bruner, 2004). Examples of inquiries that facilitate landscape of consciousness conversations include:

You decided to go to your son's birthday party, despite the difficulty of your struggle with 'despair'. What does this say about your relationships with your family?

What does this mean about your intentions at the time?

What do your actions tell you about what you want for the future?

Why do you think it was a positive event when you were able to go to the cinema with your friend?

Narrative therapists scaffold therapeutic conversations across the landscapes of action and consciousness to explore the events and the meaning of events in people's lives. By weaving backwards and forwards across the two landscapes, individuals articulate their experiences in the context of their personally held values, beliefs, wishes and purposes with which they are intimately aligned (Freedman & Combs, 1996).

Through this process, thin, problem-saturated narratives are de-stabilised or deconstructed; endowing events and experience with new meaning and new perspectives, creating richer and more satisfying narratives. The reflexive examination and interpretation of experience provides new understandings of events, opening up new meanings, identities and possibilities for future ways of acting or being in the world (Bruner, 1986; 2004; Freedman & Combs, 1996; White, 2002).

3.6.3.3 The Narrative Processes Model and Reflexivity: Shifting Discourse Modes

The Narrative Processes Model (Angus, Levitt, & Hardtke, 1999) also proposed that the integration of experience and meaning is central to psychological well-being and essential to therapeutic change. Angus et al. proposed therapeutic change occurred by shifting therapy conversations across three discourse modes (external, internal and reflexive modes) that Gonçalves et al., (2000) succinctly outlined as follows:

(a) The external mode consists of the description of real or imagined events in

the past or present, (b) The internal mode corresponds to the elaboration of the

subjective experience in terms of feeling states and affective reactions, and (c)

The reflexive mode refers to interpretations, meaning constructions, and

understandings of the specific, subjective aspects of the experience. (p. 274)

According to the Narrative Processes Model, therapeutic dialogue brings about self-

change through the integration and interactions among a person's autobiographical

memory, emotion and the reflexive processes of making meaning, producing rich

narratives through which therapy dyads construct new meaning essential to therapeutic

change. Such conversations result in transformation of client narratives, equating with

transformations of self (Angus, Lewin, Bouffard, & Rotondi-Trevisan, 2004).

When engaged in external discourse, clients describe events. As delineated by

Angus and her colleagues (Angus et al., 1999; Angus & McLeod, 2004), clients

remember and articulate events in their lives, whether specific events or composites of

events, whether real or imagined. Clients chronicle information or events or otherwise

elaborate the details of events. Recalling previously forgotten, unacknowledged, or

partially acknowledged happenings helps clients to fill in gaps of the stories they bring

to therapy so that they may better understand their experience. During external

conversations, conflicting story lines inevitably emerge, often destabilising or

deconstructing problem narratives (Angus et al., 1999; Angus & McLeod, 2004).

During internal modes of discourse, clients communicate their experience of the

described events at the time of the event and during therapy (Angus et al., 1999).

Remembering and articulating life events provides the clients with opportunities to

become aware of their experience of those events. Clients become aware of

experienced emotions, feelings and responses that have been silenced or previously not symbolised through language. Subjective thoughts, perceptions, sensations, emotions and reactions (at the time of the events as well as how the events are experienced during the therapy session) are brought to awareness, expressed, and expanded upon within the safety of the therapy relationship (Angus et al., 1999; Greenberg & Angus, 2004).

When engaged in reflexive discourse, clients interpret or analyse the external events and internal experiences in terms of their meaningfulness in the context of their lives so that new understandings of events may emerge (Angus et al., 1999). Articulation of recalled events and subjective experiences provides opportunities for meaning to be attached to these events and experiences, especially in the light of the person's "personal expectations, needs, motivations, anticipations, and beliefs of both the self and those individuals who play significant roles in the client's life" (Angus et al.,1999, p. 1258). Through reflexive interpretation, new meanings and perspectives of events emerge, making them more understandable and leading to therapeutic change (Angus & Hardke, 1994; Angus et al., 1999).

3.6.3.4 The Narrative Processes Coding System

Importantly for this research, which seeks to investigate the process of narrative therapy, Angus, Hardke, & Levitt (1992) developed the Narrative Processes Coding System (NPCS), based on the Narrative Processes Model (Angus et al., 1999), later revised by Angus, Hardtke, & Levitt (1996), as a trans-theoretical means of examining narrative processes associated with successful psychotherapy. The NPCS enables both quantitative and qualitative examinations of psychotherapy narratives and offers a means of examining reflexivity in the context of therapy dialogues.

Early research by Angus, Hardtke, Pedersen, and Grant (1991) suggested that the reflexive process of integrating experience with meaning is associated with

improved therapeutic outcome. Angus et al. examined narratives from 18 session transcripts of Brief Dynamic Therapy for clients with psychological symptoms without psychosis. Researchers applied the NPCS to transcripts from the third, fifth and eighteenth sessions for three good outcome and three poor outcome therapist-client dyads, as determined by scores on the Behaviour System Index (Derogatis, 1983), the Social Adjustment Scale (Weissman & Bothwell, 1976), and the Beck Depression Inventory[7] (BDI; Beck, Steer, & Brown, 1996). Angus et al. found good outcome dyads had a lower percentage of external and internal narrative sequences and a higher percentage of reflexive sequences compared to poor outcome dyads after 15 sessions. Figures 3.1 and 3.2 show the percentage of the different discourse modes at sessions 3 and 15 in poor and good outcome clients respectively. By the end of therapy, good outcome dyads appeared to engage in more reflexive conversations, interpreting their experience in the context of personal meaning.

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available from the QUT Library

Figure 3.1. Percentage of narrative discourse modes in brief dynamic therapy after third and fifteenth sessions in poor outcome clients (Angus et al., 1991).

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[7] Henceforth, this thesis refers to the Beck Depression Inventory as the BDI i.e., the acronym without reference.

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Figure 3.2. Percentage of narrative discourse modes in brief dynamic therapy after third and fifteenth sessions in good outcome clients (Angus et al., 1991).

Later intensive narrative analysis by Levitt and Angus (1999) indicated that different therapy modalities generated different patterns of narrative sequences. Levitt and Angus compared narrative process modes in three different therapies: perceptual processing (Toukmanian, 1992), psychodynamic client-centred (Arlow, 1989), and process experiential (Greenberg, Rice, & Elliot, 1993) therapies. Therapists were experienced in implementing therapy, each having at least 20 years of experience. The therapists who developed the approaches implemented the process experiential and perceptual processing therapies.

Levitt and Angus (1999) analysed transcriptions from three initial, middle and final sessions from the three good outcome dyads (one from each modality). Several standardised self-report measures, appropriate to each therapy modality, assessed outcome. For example, the Tennessee Self-Concept Scale (Fitts, 1965) formed part of

the outcome assessment for perceptual processing therapy; the Inventory of

Interpersonal Problems (Horowitz, Rosenberg, Baer, Ureno, & Villasneno, 1888) was

part of the process experiential battery, and; the Social Adjustment Scale (Weissman &

Bothwell, 1976) was part of the outcome assessment in psychodynamic client-centred

therapy. The outcome measures determined that the three female clients achieved

clinically significant change post-therapy. Levitt and Angus found that when taken

across all sessions analysed, the proportion of discourse modes relative to each other

differed depending on therapy modality (Figure 3.3).

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*Figure 3.3.*Comparison of narrative modes in psychodynamic, perceptual processing

and process experiential therapies across sessions analysed (Levitt & Angus, 1999).

A more detailed examination of the data provided by Levitt and Angus (1999)

revealed that change in discourse modes from early to final sessions also differed

depending on therapy modality (Figure 3.4). When percentages of discourse modes

were analysed across sessions, Levitt and Angus (1999) found that reflexive sequences

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Figure 3.4. Percentage of discourse modes in early and final sessions for perceptual processing, psychodynamic and process experiential

therapies (Levitt & Angus, 1999).

dominated Toukmanian's (1992) perceptual processing approach, often occurring consecutively. The percentage of external and internal discourse decreased from early to final sessions, but the percentage of reflexive discourse increased substantially. According to Levitt and Angus, perceptual processing therapy emphasises broadening clients' perceptual processing and continued reflexive examination of external and emotional experience appeared to help the client identify and challenge core issues.

In contrast, Levitt and Angus (1999) found that when calculated across sessions, external sequences dominated psychodynamic client-centred therapy, followed by a high proportion of reflexive sequences. From early to final sessions, there was little change in the percentage of external, internal or reflexive discourse. According to Levitt and Angus, the notion of unconscious conflicts manifest in interpersonal relationship patterns underpins Arlow's (1989) psychodynamic approach and this approach therefore focused on themes in previous and present relationships. Levitt and Angus concluded that clients verbalised strings of past and current episodic memories, interspersed by reflexive interpretation of these experiences.

Process experiential therapy (Greenberg et al., 1993) was dominated by reflexive sequences, although Levitt and Angus (1999) found that a high proportion of internal sequences also characterised narratives. There was an increase in external and reflexive discourse from early to final sessions, and a decrease in internal discourse. Levitt and Angus concluded that since process experiential therapy concentrates on facilitating and reconstructing emotional experience, the therapist facilitated identification of emotional memories and the client appeared to make new meaning from external and internal experience.

Although the limited number of clients in the study prevents generalising findings, Levitt and Angus (1999) inferred that intervention modality affects the pattern

of narrative process modes. Excepting the psychodynamic dyad, an increase in reflexive

sequences appeared to be associated with improved outcome. Taken together the

research by Angus et al. (1991) and Levitt and Angus (1999) provide support for

narrative reflexivity as a process of successful therapy, at least in those modalities that

actively promote making meaning from experience as a therapeutic process.

Furthermore, these two studies indicate the usefulness of the NPCS in the empirical

investigation of narrative processes in psychotherapy.

Importantly for the current research, interested in the process and outcome of

narrative therapy in the treatment of adult depression, the Narrative Processes Model

(Angus et al., 1999) and narrative therapy (White & Epston, 1990) share some common

theoretical features. The idea of articulating past, present and future events and

experience and then reflexively processing these in the context of those dimensions that

are important to the self in order to create new meaning and understandings and richer,

more complex narratives, underpins both the Narrative Processes Model and narrative

therapy. This commonality provides the rationale for utilising the Narratives Processes

Coding System (Angus et al., 1996), based on the Narrative Processes Model, as a

metric to examine whether the process of facilitating a richer narrative (a key process

posited by proponents of narrative therapy), operationalised as the proportion of

reflexivity, is associated with improved therapy outcome.

3.7 The Therapeutic Relationship Focusing on the Therapeutic Alliance

3.7.1 The Therapeutic Relationship Contributes to Successful Therapy

Researchers and clinicians recognise the therapeutic relationship as an important

process of therapy. Although linked with successful psychotherapy from as early as

Freud (1913/1957), recent emphasis on inter-personal aspects of psychotherapy (Safran

& Muran, 2006), together with treatment equivalence research (Luborsky, Singer, &

Luborsky, 1975; Smith & Glass, 1977), have re-ignited interest in the role of the therapeutic relationship in psychotherapy outcome. Most therapy orientations acknowledge its importance, with several contemporary approaches (e.g., interpersonal therapy; narrative therapy) positing its centrality in their theoretical models (Castonguay, Constantino, & Grosse Holtforth, 2006; Goldfried & Davila, 2005).

3.7.2 Therapists Impact Psychotherapy Outcome

The therapeutic relationship comprises two people. One is the person of the therapist. Debate on the extent to which therapists affect outcome highlights the potential importance of the therapist to psychotherapy outcome, supporting the importance of the therapeutic relationship and challenging the role of specific treatments.

Recent research by Elkin, Falconnier, Martinovich, and Mahoney (2006) and Kim, Wampold, & Bolt (2006), reanalysed data from the National Institute of Mental Health (NIMH) Treatment for Depression Collaborative Research Program (TDCRP; Elkin et al., 1989)[8] in search of therapist effects, rather than therapy effects. Using hierarchical linear modelling, Elkin et al. reported that therapist differences explained 0-4% of the variance in outcome. Elkin et al. also reported the presence of outliers, therapists who appeared to be very successful or not successful in facilitating positive therapeutic change. In contrast, using multilevel modelling, Kim et al. found a therapist effect for the BDI (ie., one variable only), attributing 8.3% of the variance to therapists and 0% to the specific treatment. Furthermore, Kim et al. reported that after accounting for therapist effects, the superiority of IPT over CBT for severely depressed clients, reported by Elkin et al., (1995) disappeared. Soldz (2006), however, considered the sample sizes in the TDCRP too small for the multi-level analyses in the research by

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[8] Section 5.2.2 details the NIMH TDCRP.

both Elkin et al. and Kim et al. In response to findings of therapist effects by Kim et al., Elkin et al. argued that naturalistic rather than manual-based research provides an appropriate design for evaluating the effects of therapists. Crits-Christoph & Gallop (2006), acknowledging the naturalistic research by Okiishi, Lambert, Neilsen, and Ogles (2003) as a good indication of therapist effects, calculated that from the data accumulated by Okiishi et al., therapist differences accounted for 4.1% of the variance in outcome.

3.7.3 The Therapeutic Alliance Comprises the Interactive Elements of the Therapeutic Relationship

Emphasising the significance of the therapeutic relationship, a task force within Division 29 of the American Psychological Association, examined empirical support for the role of the therapeutic relationship in successful therapy outcome (Norcross, 2002). While the terms therapeutic relationship and therapeutic alliance have often been used interchangeably, the task force identified the therapeutic alliance as just one of the 11 overlapping and interactive elements of the therapeutic relationship that contributed to successful therapy.

Despite debate surrounding some conceptual aspects of the therapeutic alliance (Horvath, 2005; Safran & Muran, 2006), the therapeutic alliance commonly refers to the "…interactive, collaborative elements of the relationship (i.e., therapist and client abilities to engage in the tasks of therapy and to agree on the targets of therapy) in the context of an affective bond or positive attachment" (Constantino, Castonguay, & Schuta, 2002, p. 86).

Bordin's (1994) pan theoretical formulation of the therapeutic alliance is consistent with the definition proposed by Constantino et al. and is one of the most influential formulations in recent times. Focusing on its collaborative nature, Bordin (1979; 1994) identified three dimensions of the working alliance: bond, goals, and tasks. Bond refers to the presence of a positive interpersonal relationship between therapist and client, involving mutual trust and attachment, and where the client experiences the therapist as caring, understanding and knowledgeable. Goals are the objectives of therapy, as agreed by both therapist and client, requiring consensus on the nature of the problems, and the priorities and solutions of therapy. Tasks refer to agreed-upon means of achieving goals, such as the specific interventions, requiring confidence in these means. Bonds, goals and tasks are qualitatively dependent on the type of therapy, and need negotiation and renegotiation over the course of therapy, with successful outcome requiring repair of ruptures. Bordin's pan theoretical formulation of the therapeutic alliance founded the 36-item Working Alliance Inventory (WAI; Horvath & Greenberg, 1989) and its 12-item version, the Working Alliance Inventory-Short Form (WAI-S; Tracey & Kokotovic, 1989).

Research has revealed several characteristics of the therapeutic alliance. The strength of the alliance fluctuates, with the early alliance (the third to fifth session) predicting outcome better than the therapeutic alliance averaged across sessions or at mid-treatment (Horvath & Bedi, 2002). Patterns of fluctuation suggest ongoing repair of ruptures is a core task of the relationship (Stiles et al., 2004). Client-assessed therapeutic alliance is generally more predictive of outcome than therapist or observer assessments (Horvath, 2005).

3.7.4 Empirical Evidence Supports an Alliance–Outcome Relationship

Several outcome trials have provided empirical support for a moderate, but significant and consistent association between the therapeutic alliance and treatment outcome across different therapy orientations (Castonguay & Beutler, 2006). Krupnick et al. (1996), for example, examined 225 clients from the NIMH TDCRP (Elkin et al., 1989). Observer-rated scores of the working alliance significantly predicted treatment outcome for CBT and IPT as well as active and placebo pharmacotherapy controls. Early alliance scores accounted for 5% of outcome as measured by the BDI. The authors reported significant associations between alliance and outcome for early and mean alliance (derived from early, middle and late sessions).

Meta-analyses also support a robust relationship between alliance and outcome. Meta-analytic review of 24 studies across diverse therapies found that the therapeutic alliance predicted therapy outcome, with a mean correlation estimate of 0.26 (Horvath & Symond, 1991). A later review of 79 studies by Martin et al. (2000), covering a range of disorders, therapeutic orientations, and alliance measures, calculated the weighted alliance-outcome correlation as 0.22. Forty percent of the 199 studies involved in this meta-analysis used the WAI (Horvath & Greenberg, 1989) to measure therapeutic alliance. Meta-analytic figures, therefore, suggest that the therapeutic alliance-outcome correlation ranges between 0.22 to 0.26, equating to between 5% and 9% of outcome variance. These correlations appear lower in meta-analytic procedures than many of the research trials, suggesting the therapeutic relationship needs understanding in interaction with, and in the context of other variables, such as the specific treatments and disorders (Hentschel, 2005). Research comparing the alliance-outcome relationship in different treatment modalities has produced mixed results.

3.7.5 Mixed Research on the Strength of the Alliance-Outcome Relationship in Different

Therapeutic Orientations

Meta-analytic procedures by Horvath and Symonds (1991) found that the

alliance-outcome relationship did not differ significantly across a range of orientations,

including psychodynamic, cognitive, gestalt, and eclectic interventions. Similarly,

investigating the alliance in the NIMH TDCRP (Elkin et al., 1989) study of the alliance,

Krupnick et al., (1996) reported no significant differences in the observer-rated alliance-

outcome relationship between CBT, interpersonal therapy[9] (IPT; Klerman, Weissman,

Rounsaville, & Chevron, 1984), pharmacotherapy, and placebo control. Also analysing

the TDCRP data, Zuroff and Blatt (2006) reported that the quality of the therapeutic

relationship predicted outcome across all conditions and contributed directly to

outcome, irrespective of techniques used. Results finding that the therapeutic alliance

contributes to positive outcome across treatment conditions suggest that the processes

through which the alliance works are not bound to the specific techniques utilised.

Several trials have, however, found differences in the alliance-outcome

relationship between therapy orientations. A comparison trial by Raue, Castonguay, and

Goldfried (1993) found significantly higher alliance-outcome correlations in

psychodynamic inter-personal ($r = -.64$, $p = .02$) than cognitive-behaviour ($r = -.32$, $p =$

.20) therapies. The trial used observer ratings of the WAI (Horvath & Greenberg, 1989)

to compare alliance in the two psychotherapies for 31 clients with anxiety or depression.

Researchers obtained WAI scores from single sessions, nominated by therapists as

significant change sessions. Global Severity Index of Symptom Checklist scores

(Derogatis, Lipman, Rickels, Uhlenhuth, & Covi, 1974), obtained one or two weeks

after the significant change session indexed symptoms. The total WAI score for

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[9] Henceforth, this thesis refers to interpersonal therapy (Klerman, Weissman, Rounsaville, & Chevron, 1984) as IPT i.e., the acronym without reference.

cognitive-behavioural sessions ($M = 6.39$) was significantly higher, $t (29) = 2.31$, $p = .028$, than for psychodynamic-interpersonal sessions ($M = 5.82$). The authors hypothesised the difference in alliance outcome correlations resulted from the psychodynamic-interpersonal focus on relationship issues, with lower alliance scores resulting from a period negotiating a healthy therapeutic relationship.

Wettersten, Lichtenberg, and Mallinckrodt (2005) also found a difference in the alliance-outcome relationship between therapies. Wettersten et al. compared the alliance-outcome relationship in solution-focused brief therapy with brief interpersonal therapy. There were a range of presenting problems. The quality of the therapeutic alliance within these two orientations differs theoretically. While the therapeutic alliance is central to the brief interpersonal approach (Teyber, 1992), the importance of the bond component of the working alliance is minimised in solution-focused brief therapy (de Shazer & Berg, 1997); the goal and task components are emphasised. The researchers found that brief interpersonal, $t (37) = 4.00$, $p < .001$, and solution-focused brief therapy, $t (25) = 3.42$, $p < .01$, were effective, with no significant difference between residual change on outcome scores, $F (1, 61) = 2.74$, ns. The working alliance, however, was found to be associated with successful outcome in brief interpersonal therapy only ($r = -.31$, $p < .05$). That is to say, in solution-focused brief therapy, although scores on the WAI were comparable to those from brief interpersonal therapy, alliance scores were unrelated to outcome. From these paradoxical results, the authors hypothesised that the therapeutic alliance may be a necessary component of change, but not a mechanism through which change occurs. This perspective is consistent with Beck et al. (1979), who held that the therapeutic alliance contributes to the effectiveness of the cognitive techniques used but contributes little itself to bring about change.

3.7.6 Limitations of Alliance-Outcome Research

One important limitation of alliance-outcome research is that the processes through which the therapeutic alliance works are uncertain. A cause and effect relationship remains unconfirmed. From a temporal viewpoint, stronger correlations from earlier assessments of the alliance in comparison to later sessions (Horvath & Symonds, 1991) suggest that development of a positive therapeutic alliance precedes improved outcome. More research on the temporal relationship of alliance and outcome from multiple sessions over the course of therapy is clearly needed to clarify the processes through which the therapeutic alliance is associated with change (Castonguay, Constantino, & Grosse Holtforth, 2006; Kazdin, 2005).

Renewed interest in the therapeutic alliance emerged with the shift to inter-personal aspects of psychotherapy; however, we still know little about how the alliance connects with the relational elements of therapy to bring about change. Research suggests that both intra-personal and inter-personal relating play roles in the quality of the therapeutic alliance. For example, the quality of clients' intra-personal relationships with their selves in terms of self-concept correlates with alliance scores (Mallinckrodt, Cobble, & Grant, 1995; Marmar, Horowitz, Weiss, & Marziali, 1986; Marziali, 1984), as do the quality of past and current inter-personal relationships (Mallinckrodt, 1991; Marmar, Weiss, & Gaston, 1989; Piper et al., 1991). Furthermore, estimates that place the person of the therapist as contributing 9% of the variance (Wampold, 2001) speak to the importance of inter-personal relationships. Such findings raise the possibility that a clearer understanding of therapeutic relatedness may come from the theoretical and practical investigation of inter-subjective processes within therapy.

3.7.7 The Therapeutic Relationship is a Central Process of Narrative Therapy

Narrative therapy is a post-modern approach that emphasises inter-personal processes. Since narrative theory emphasises making meaning as a relational endeavour, according to narrative perspective, the therapeutic relationship is central to narrative therapy and the dialogue of the therapeutic alliance is pivotal to the process of change.

In practice, narrative therapists assume a very specific stance in relation to their clients. Narrative therapists hold that each member of the dyad contributes knowledge to the therapeutic endeavour and influences the understanding of the other. Power gradients inherent to a pathologising, knower, or curer stance are considered unhelpful (Anderson, 1997). The therapist stance is one that contributes, but is respectful, questioning and curious, prioritising the client's knowledge and resources.

Furthermore, continuing respectful negotiation between the therapist and client marks the therapeutic relationship in narrative therapy. This notion shares similarities with the conceptualisation of the therapeutic alliance by Safran and Muran (2006), which proposed that the therapeutic alliance emerges from ongoing negotiation between the therapist and client. According to Safran and Muran, continuing negotiation is an important change process, enabling the client to, "… learn to negotiate the needs of self and others in a constructive fashion, without compromising the self or treating the other as an object. This process of negotiation of needs in the therapeutic relationship thus plays an important role in helping patients develop some capacity for inter-subjectivity (i.e., the capacity to experience both self and other as subjects) and to develop a true capacity for intimacy or authentic relatedness…"

Narrative therapy emphasises the relational nature of meaning making. Therapists utilise specific modes of questioning to transverse the landscapes of action and identity. As part of the inter-personal interaction that is encouraged throughout the

therapeutic process (e.g., with significant others inside and outside therapy sessions, outsider witnessing and definitional ceremonies), the intention of conversations between the therapist and the client is to co-create new meaning. The quality of the therapeutic relationship is therefore pivotal to the facilitation of reflexive dialogues and therefore therapeutic change in narrative therapy.

To my knowledge, only one study has researched the relationship between the therapeutic alliance and reflexivity. Botella, Pacheco, Herrero, and Corbella (2000) suggested that the quality of the therapeutic relationship is important in fostering clients' reflexivity in process-experiential therapy. Botella et al. analysed the therapeutic dialogues of one good outcome dyad in 15 sessions of process-experiential therapy, to examine the conditions of the therapeutic relationship and therapeutic conversations. Using qualitative analysis informed by grounded theory methodology (Glaser & Strauss, 1967) and the NPCS (Angus et al., 1996) to index reflexivity, Botella et al. found that the collaborative and reflexive stance of the therapist enabled the client's reflexivity. Within a collaborative relationship, the therapist provided reflexive articulations of the client's reflections in a dialogue that enabled the client to voice new positions and reflexively examine her experience. Despite the centrality of the relationship between therapist and clients to narrative therapy, to my knowledge, there exists no research investigating the association of the therapeutic alliance with outcome or the process of reflexivity in narrative therapy.

3.8 Concluding Comments on Processes of Narrative Therapy

Throughout the history of psychology, several therapeutic perspectives considered change in a client's self to be important to successful therapeutic outcome (see Section 3.5.1), raising the possibility that self may be a fundamental element of

psychotherapy change. Unfortunately, the indeterminate nature of self has resulted in previous difficulties in definition, constraining investigation into this central construct. In this chapter, I argued that investigation into the broad constructs of language and self may advance our understanding of successful change in narrative therapy. From these two constructs, narrative reflexivity emerged as a dialogical and inter-subjective process whereby the self speaks with the self (and with others as aspects of the self), such that two subjectivities meet, creating new meaning from experience.

Narrative reflexivity was proposed to be a process common to dialogical narrative theory (Hermans & Kempen, 1993), narrative research (e.g., Angus, Hardtke, Pedersen, & Grant, 1991), and narrative therapy (White, 2004). From a dialogical perspective, individuals engage in dialogue with others and with their selves, enabling a flexible inter-play of different perspectives; conversations that create new perspectives and meanings of lived experience. Consistent with dialogical theory, the Narrative Processes Model (Angus, Levitt, & Hardtke, 1999) proposed that the integration of experience and meaning is central to psychological well-being, and research by Lynne Angus and her colleagues (e.g., Angus et al., 1991) has identified reflexivity as a narrative process through which therapy dyads construct new meaning essential to therapeutic change. Narrative therapists facilitate conversations across landscapes of action and identity to assist clients to interpret their experience in the context of personal beliefs, values and intentions, so that experience integrates with meaning, and individuals develop richer narratives and richer selves (e.g., Freedman & Combs, 1996; Monk, Winslade, Crocket, & Epston, 1997; Payne, 2000; White & Epston, 1990).

Narrative therapy emphasises the importance of a particular form of therapeutic alliance that facilitates dialogic rather than monologic conversations and is therefore

involved in the dialogical and inter-subjective processes of narrative therapy. Research into inter-subjective processes of narrative reflexivity and the working alliance in narrative therapy has the potential to contribute to our understanding of the process of narrative therapy and may add to our understanding of the working alliance and psychotherapeutic change processes overall.

CHAPTER 4

DEPRESSION

4.1 Introduction to Depression

While recognising the narrative perspective, that the term depression reduces a set of meanings to a label, as well as the active attempts by narrative therapists to avoid pathologising and totalising individuals with that label (see Section 2.5.2), consistent with the ethos of post-modern pluralism, this thesis uses the term *depression.* From a social constructionist perspective, society retains useful constructions and many practitioners find the category of depression is useful, providing a descriptive list that can assist communication with other professionals and lay people without lengthy explanation. Modernist conceptions and research underpin the current chapter.

The term depression, as used commonly across mental health disciplines, encompasses a combination of emotional, cognitive and behavioural symptoms, across a spectrum of severity. Descriptions of symptoms as defined by classification codes delineated by the American Psychiatric Association (APA, 2000) in the Diagnostic and Statistical Manual of Mental Disorders, text revision (DSM-IV-TR), largely underpin diagnoses of depressive disorders in Australia. The DSM-IV-TR, like the World Health Organisation's (1992), International Classification of Diseases, offers a dimensional model of depression; depression severity varying along a continuum. The DSM-IV-TR classifies three primary types of depressive disorders: major depressive disorder, dysthymic disorder, and depressive disorder not otherwise specified. Major depressive disorder is the most severe form of the depressive disorders, often superimposed over the milder, but more persistent dysthymic disorder, which by definition continues for at least two years (APA, 2000).

This chapter first profiles adult depression to highlight the relevance of research into this major mental health problem. Description of the symptoms, prevalence, co-morbidity, and effect of depression underscore its impact on individuals and the community, also providing statistics for later comparison. An outline of the pattern of primary medical care provides a rationale for decisions in the current research. Finally, the limitations of medication and the neglect of research into psychological treatments in Australia for this growing mental health problem highlight the importance of Australian research into psychotherapy for depression.

4.2 DSM-IV-TR Description of Major Depressive Disorder

According to the DSM-IV-TR (APA, 2000), the symptoms of major depressive disorder cause significant distress or impairment in important areas of functioning, but are not due to a medical condition, bereavement, or substance. A diagnosis of major depressive disorder requires the presence of at least one major depressive episode, without current or previous mania or hypomania. Additionally, the major depressive episode should not be a constituent of schizoaffective disorder, or overlay schizophrenia, schizophreniform disorder, delusional disorder, or psychotic disorder not otherwise specified (APA, 2000). A major depressive disorder can be classified as a single episode or recurrent. A range of specifiers assists diagnosis and treatment.

A major depressive episode is distinguished by at least five symptoms, present nearly every day, for the greater part of the day, for at least two weeks. Symptoms comprise at least one of depressed mood, or diminished interest or pleasure in most activities. Additional symptoms include significant change in appetite or weight, insomnia or hypersomnia, psychomotor agitation or retardation, diminished energy, feelings of worthlessness or inappropriate guilt, diminished thinking, concentration or thought, or, thoughts of death or suicidal thoughts or attempt (APA, 2000).

4.3 Alternative Classifications of Depression

Contention concerning the DSM-IV-TR dimensional classification of depression exists (Parker & Hadzi-Pavlovi, 1996). Heterogeneity marks the DSM-IV-TR category of depression. Within the category, individual experience of depression varies widely. For example, of two people diagnosed with major depressive disorder: one may report a loss of interest or pleasure in usual activities, with psychomotor retardation, weight gain, hypersomnia and feelings of worthlessness; the other may report depressed mood, with psychomotor agitation, weight loss, insomnia, and a diminished ability to concentrate.

In line with the notion of depression as a heterogeneous disorder, alternative classifications of depression have included various categorical formulations. For example, several theorists (Beck, 1983; Blatt & Schichman, 1983; Arieti & Bemporad, 1980) have proposed depression sub-types around themes of autonomous versus socially dependent. Others have proposed subtypes varying around Gillespie's (1929) binary theme of endogenous (determined physiologically) versus reactive (determined socially) depression. Parker (2005), for example, challenged the DSM-IV-TR model of depression, holding that it has little utility in selecting optimum treatment. Instead, Parker proposed a model with both categorical and dimensional domains.

Parker, Hadzi-Pavlovic and Boyce (1996) identified three major categories of depression: non-melancholic depression, melancholic depression and psychotic depression. According to Parker et al., non-melancholic depression, the most common form, has a psychological aetiology linked to stressful events, personality features and inter-personal problems. There is however, contributing serotonergic neurotransmitter involvement. Parker et al. proposed that non-melancholic depression responds well to varied treatments, including psychotherapy and anti-depressants. In contrast,

melancholic depression has a biological aetiology, with greater involvement from noradrenergic neurotransmitters. Melancholia is less common (1-2%) and characterised by more severe depression and psychomotor disturbance. Parker et al. consider that physical treatments such as antidepressants treat melancholia most effectively, with response to psychotherapy poor and spontaneous remission less likely than in non-melancholic depression. Psychotic depression is the least common form of depression, characterised by the most severe depressed mood, psychomotor disturbance, psychotic symptoms and guilt ruminations. According to Parker et al., psychotic depression has the lowest probability of spontaneous remission. Of neurotransmitters, dopaminergic involvement is greatest and Parker proposed that psychotic depression responds only to physical treatment.

4.4 Prevalence of Depression

Large-scale epidemiological investigations have indicated that depression is one of the most common forms of psychopathology. The Australian Bureau of Statistics (ABS; 1998) reported Australian statistics for adult depression from the National Survey of Mental Health and Wellbeing of Adults (SMHWB), conducted across all states and territories of Australia in 1997. Detailing data from the survey, the National Health Priority Areas Report on Mental Health (Australian Institute of Health and Welfare, 1999) described a 5.8% 12-month prevalence rate for depressive disorders (7.4% for females; 4.2% for males) for people over the age of 18 years. Prevalence varied with age, peaking at 7.2% between 35 and 44 years old, and was higher for females than males throughout the age groups. The prevalence for females peaked at 10.7% between 18 and 24 years, declining in other age groups. The male rate increased to a peak of 6% between the ages of 35 and 44 before declining. Figures from the most recent document on the burden of disease and injury in Australia in 2003 (Begg et al.,

2007) confirmed that the prevalence of depression remains higher for females, reporting that the burden from anxiety and depression combined was twice as high for females than for males. Data from the United States' National Comorbidity Survey are broadly consistent with Australian statistics, revealing an 8.6% 12-month prevalence rate for major depressive disorder. Females were more highly represented than males, with a female to male ratio of 11 to 6.1 (Kessler, Nelson, McGonagle, Liu, Swartz, & Blazer, 1996).

Research by Keller, Lavori, Mueller, and Endicott (1992) suggested that individuals with major depressive disorder spontaneously recover, steadily improving in stages so that by six months, 54% of individuals have recovered, with 70% recovered by the end of the first year and 88% recovered after five years. However, individuals who have experienced their first major depressive episode are likely to experience depressive symptoms subsequent to recovery, and are liable to experience an average of three other major episodes in their lifetimes (Judd, 1997).

4.5 Axis I and Axis II Co-morbidity with Depression

High rates of co-morbidity across Axis I and Axis II disorders typify depression. Data from the SMHWB (ABS, 1998) indicated strong associations between major depressive disorder, other affective disorders and substance use disorders. Anxiety disorders were present in over 50% of people with depressive disorders.

American statistics confirm Australian figures. Data from the United States' National Co-morbidity Survey (Kessler, Nelson, McGonagle, Swartz, & Blazer, 1996) indicated that in a 12-month period, 58.9% of individuals with major depressive disorder had one or more co-morbid Axis I disorders. Co-morbidity with anxiety disorders was particularly high, present in 51.2% of individuals with major depressive disorder. Co-morbidity with a substance use disorder was also high at 18.5%.

There is also a high prevalence of Axis II disorders in people with depression. Fava et al. (2002) studied an American population of 384 individuals diagnosed with major depressive disorder, finding that 64% also met criteria for at least one personality disorder. Twenty-six percent met criteria for cluster A personality disorders (paranoid, schizoid, or schizotypal); 26% met criteria for cluster B personality disorders (histrionic, borderline, narcissistic, or antisocial personality disorder), and; 58% met criteria for cluster C personality disorders (avoidant, dependent, obsessive-compulsive, passive-aggressive, or self-defeating). That is to say, when a client presents with psychological distress, depression is often a factor.

4.6 Depression: A Major Risk Factor for Suicide

Across major developed countries, the presence of depression is recognised as a major risk factor for suicide. For example, post-mortem investigation of 100 suicides (72 males and 28 females) in the Cork County of Ireland, over a period of five years by Kelleher, Keohane, Corcoran, Keeley, and Neilsen (2000) found that affective disorders (mainly depression) were diagnosed in 86% of the females and 50% of males. The Australian Department of Health and Aged Care (2000) document "Life-Living is for Everyone: A Framework for Prevention of Suicide and Self-Harm in Australia: Areas for Action" distinguished depression as the greatest risk factor for suicide and therefore an area for action. The American Psychiatric Association's (APA, 2005) practice guidelines suggested that there should be ongoing assessment for suicide risk in clients with major depressive disorder.

4.7 Impact of Depression

Depressive disorders are a significant health issue, both globally and for Australia, engendering enormous costs personally, socially and economically (Mathers,

Carter, Stevenson, & Penm, 1999). The Australian Burden of Disease and Injury Study,

conducted by the Australian Institute of Health and Welfare (Mathers, Vos, &

Stevenson 1999), implemented methodology developed by the World Bank's Global

Burden of Disease Study (Murray & Lopez, 1996), to calculate mortality, disability and

injury in the Australian population in 1996, using the disability-adjusted life year

(DALY) as a measure of disease burden. Researchers computed the DALY by summing

years lost through death with years of healthy life lost living from disease, impairment

and disability.

Report of results by Mathers et al. (1999) indicated depression was the leading

cause of non-fatal disease burden in Australia, and a major cause of personal disability.

Taking account of death and disability, depression contributed 6.3% to Australia's

disease burden, following only ischemic heart disease for adults aged 25 to 64 years old.

In addition to the personal distress experienced with depression, lost time during one of

the most productive periods of the life cycle, negatively affected physical health, family

and work responsibilities, as well as academic, social, and career trajectories (Australian

Institute of Health and Welfare, 1999). The most recent document on the burden of

disease and injury in Australia in 2003 (Begg et al., 2007) provided statistics for

depression and anxiety combined. Begg et al. reported that depression and anxiety

contributed 7.3% of the total burden of disease in Australia and was the third leading

cause of disease burden for males and the leading cause for females. Australian statistics

broadly concur with international figures. The 1990 Global Burden of Disease Study

revealed uni-polar depression contributed 6.8% of the total disease burden, second only

to ischemic heart disease in established market economies (Murray & Lopez, 1996).

Without accounting for the cost of lost productivity, depression cost the

Australian economy an estimated 495.4 million dollars for the period 1993-1994, which

was allocated to hospitals, nursing homes, doctors, allied health professionals, pharmaceuticals and research (Mathers & Penm, 1999). Globally, the World Health Organization (2002) predicted increases in neuropsychiatric disorders (with depression the major contributor), from around 10.5% of the total disease burden in 1990 to nearly 15% by 2020. Depression is therefore a major mental health issue confronting Australia and the global community at large, clearly warranting further research into ways of responding to this form of psychological distress.

4.8 Pharmacotherapy for Depression

Pharmacotherapy frequently constitutes the first line of treatment in major depressive disorder. When confronted by depression, general practitioners are often the first health professionals contacted, usually within the first year of initial symptom onset (Lecrubier, 1998). Research, using stratified random samples of primary care patients from Seattle in the United States of America and Groningen in the Netherlands, indicated that general practitioners diagnosed approximately 10% of their patients with major depression (Tiemens, VonKorff, & Lin, 1999).

Of individuals diagnosed with depression, general practitioners prescribed antidepressants for approximately 43% (Narrow, Reigier, Rae, Manderscheid, & Locke, 2003). Selective serotonin reuptake inhibitors (SSRIs) have replaced tricyclic antidepressants as the most popular medication for depression (Anderson, 2000), and in Australia, represented 64.5% of antidepressant prescriptions in 2002 (Mant et al., 2004). For outpatients, meta-analytic comparisons by Anderson indicated equivalence in the efficacy of the two classes of antidepressants (SSRIs and tricyclics), but improved tolerability for SSRIs. The beneficial effects of antidepressants generally occur before six weeks, although in elderly patients beneficial effects may take up to nine weeks to occur (Anderson, Nutt, & Deakin, 2000; Snow, Lascher, & Mottur-Pilson, 2000).

Despite the prescription and implementation of antidepressant treatment for depression, many clients remain distressed. Naturalistic research found a 50% recovery rate from treatment with antidepressants in people who present for primary care with major depression (Schulberg, 1996). A large proportion of people therefore remain symptomatic, regardless of antidepressant treatment. Furthermore, antidepressant treatment is unpleasant or contra-indicated for many individuals. Even with the improved tolerability for SSRIs, research by Thompson, Peveler, Stephenson, and McKendrick (2000) revealed that 67% of clients experienced significant adverse side effects, such as headache or nausea, and 30% did not comply with antidepressant treatment.

Considering the large percentage of people who remain symptomatic when taking antidepressants, it is not surprising that clients frequently combine antidepressants with psychotherapy (Kaplan & Sadock, 1998). A recent study of 681 patients with chronic depression by Keller et al. (2000) compared nefazodone treatment (an antidepressant that acts on the reuptake of serotonin and norepinephrine), with a variant of CBT and with the antidepressant and psychotherapy combined. After 12 weeks of therapy, 55% and 52% of patients in the antidepressant and psychotherapy conditions (respectively) improved, compared to 85% in the combined therapy condition. Results suggest that combining antidepressants with psychotherapy has an additive effect. Research into the psychotherapeutic treatment of adult depression will be covered in more depth in the chapter following.

Many clients who present for psychotherapy have already commenced antidepressant medication. Research supports sequencing treatments to address residual symptoms. Implementing CBT, for example, has been shown to improve residual symptoms subsequent to pharmacotherapy both when pharmacotherapy was continued

(Paykel et al., 1999) or withdrawn (Fava, Grandi, Zielezny, Rafanelli, & Canestrari 1996). Conversely, the addition of antidepressant treatment improved residual symptoms subsequent to psychotherapy (Thase et al., 1997).

4.9 Other Treatments for Depression

Research has examined a variety of treatments for depression. Although a comprehensive review of other treatments into depression is beyond the scope of this research, to acknowledge their high profiles in the depression outcome literature, this section briefly mentions electroconvulsive therapy (ECT), exercise and St. John's wort.

Recent meta-analyses by Carney et al. (2003) suggested that ECT is superior to medication in the treatment of depression and is an important option in managing severe depression. Based on research analysed, the authors concluded that the extent of the temporary anterograde and retrograde amnesia, associated with ECT, depends on ECT protocols used. There is little research evidence, however, into the long-term cognitive effects of ECT or the efficacy of ECT for subgroups of depression.

Despite early support for comparability of St. John's wort with anti depressants (Freide, Henneicke von Zepelin, & Freudenstein, 2001; Schrader, 2000), more recent research results have been inconclusive (APA, 2005). Moreover, St. John's wort is often contra-indicated because of its interactions with many other medications (Markowitz et al., 2003; Wang et al., 2004).

Babyak (2000) assessed the use of exercise in the treatment of individuals with major depressive disorder. Comparing outcomes from exercise, sertraline (an SSRI), and combined exercise and antidepressant conditions, Babyak found that a comparable proportion of patients remitted across conditions.

4.10 Australian Research into Depression

Despite the personal, social and economic impacts of depression in Australia, at the time of the National Health Priority Areas Report: Mental Health 1998 (Australian Institute of Health and Welfare, 1999), Australia had contributed only around 2-3 % of the global research publications on depression. Furthermore, studies undertaken primarily addressed descriptive aspects of depression, such as aetiology, classification, assessment, co-morbidity, and diagnosis, or examined biological treatments. In comparison, research into psychological treatments was substantially less. Consequently, the report expressed a need for Australian research into non-pharmacological treatments in the community or in primary care (Australian Institute of Health and Welfare, 1999).

4.11 Concluding Comments: Research into Depression is Warranted

Several factors warrant Australian research into psychotherapy for depression. The high proportion of individuals experiencing depression (even when taking medication), the associated personal, social, and economic costs and its high rates of co-morbidity highlight the potential benefits of such research. Despite the availability of other treatments for depression, such treatments are not suitable for all individuals experiencing depressive symptoms. These factors, along with the scarcity of Australian research speak to the usefulness of Australian research that seeks to examine potentially successful psychotherapies for depression, or the processes through which successful psychotherapy occurs.

CHAPTER 5

OUTCOME RESEARCH:

PSYCHOTHERAPY FOR ADULT DEPRESSION

5.1 Introduction

Psychotherapy outcome research evaluates the "…immediate or long-term changes that occur as a result of therapy…" (Hill & Lambert, 2004, p. 84). High prevalence of depression is likely to have underpinned its popular use in psychotherapy outcome and process trials. Higher prevalence of depression assists access to greater numbers of research participants, enabling effective comparisons of statistical and clinical significance across different psychotherapies. That is to say, although depression research is worthy in its own right, it also serves as a generic means for examining the impact of innovative treatments and the processes through which therapeutic change occurs.

Although medication often initiates the primary care of individuals experiencing depression, psychotherapy plays an important role in the management of depression. As previously noted, antidepressants are contra-indicated for a large proportion of clients. Many individuals continue to experience symptoms while taking antidepressants, suffer adverse effects from antidepressants, or do not comply with antidepressant treatment (Jorm, Angermeyer, & Katschnig, 2000; Schulberg et al., 1996; Thompson, Peveler, Stephenson, & McKendrick, 2000). Moreover, since Hans Eysenck (1952) first challenged psychotherapy outcomes as being no better than spontaneous remission, psychotherapy researchers have responded by building an evidence base that supports the efficacy of a number of standard psychotherapies (e.g., cognitive-

behaviour, interpersonal, brief dynamic and emotion-focussed approaches) in the treatment of depression in adults (Lambert & Ogles, 2004).

This chapter examines literature on psychotherapy for adult depression. Rather than being an exhaustive review of the vast number of outcome studies of psychotherapy for depression, it concentrates on representative meta-analyses and large, well-respected comparison trials, which provide benchmark statistics for later comparison, or illustrate points relevant to the current research. Areas covered include research supporting the efficacy of standard psychotherapies into adult depression and methodological concerns that have emerged in comparisons of different therapeutic modalities. Evidence arising from psychotherapy comparison trials, supporting the equivalence of standard psychotherapies then precedes an outline of the specific-common factor debate, a ubiquitous issue in current psychotherapy literature. Discussion of the specific-common factor dichotomy forms part of my overall argument that questions the usefulness of research that continues to dissect psychotherapy along these dimensions and stresses the importance of examining broader constructs that bridge specific and common factors when attempting to investigate processes through which psychotherapy works, such as language and self. Narrative theories underpinning narrative therapeutic approaches focus on language and self, and the final section raises the lack of empirical investigation into narrative therapy, specifically in the treatment of depression in adults, as a significant omission in psychotherapeutic outcome literature.

5.2 Evidence Supports Psychotherapy in the Treatment of Adult Depression

5.2.1   Standard Psychotherapies Treat Adult Depression Effectively

Numerous research trials responded to Eysenck's (1952) assertion that psychotherapy is only as effective as spontaneous remission. Of note is the reanalyses of Eysenck's data by McNeilly and Howard (1991) which found that 15 sessions of

psychotherapy produced results equal to two years of spontaneous remission. Several psychotherapy meta-analytic studies and comparison trials have supported the findings by MᶜNeilly and Howard. These studies found that post-treatment scores from a range of psychotherapies for adult depression were superior to those from pre-treatment (Elkin et al., 1989; Robinson, Berman, & Neimeyer, 1990; Stuart & Bowers, 1995; Westen & Morrison, 2001), no-treatment controls (Dobson, 1989; Steinbruek, Maxwell, & Howard, 1983) and wait-list controls (Dobson, 1989; Gaffan, Tsaousis, & Kemp-Wheeler, 1995; Gloaguen, Cottraux, Cucherat, & Blackburn, 1998; Robinson et al., 1990). Meta-analytic research (aggregating results across a range of therapeutic orientations) has therefore consistently shown that psychotherapy is effective in the treatment of depression in adults.

5.2.2   Standard Psychotherapies are as *Effective as Antidepressants for Mild to Moderate Depression at Treatment End*

Meta-analytic research and comparison trials suggest that psychotherapy is generally as effective as antidepressant medication at treatment end. A possible exception is the treatment of severely depressed clients, for whom outcome results from comparisons of psychotherapy with antidepressant treatments are inconsistent.

A recent well-designed trial by DeRubeis et al. (2005) compared paroxetine (an SSRI antidepressant) treatment and cognitive therapy (CT; Beck et al. 1979) with pill placebo as a control. DeRubeis et al. found that paroxetine and cognitive treatments were equally superior to pill placebo for moderate to severe depression, especially when experienced cognitive therapists provided treatment. Of the 240 clients diagnosed with major depressive disorder, 50% of clients treated with antidepressants, 43% of clients treated with CT and 25% of clients taking the pill placebo improved, defined as achieving scores ≤ 12 on the Hamilton Rating Scale for Depression (Hamilton, 1967).

In contrast, meta-analysis by Thase et al. (1997) found that when implemented

alone, antidepressants were superior to psychotherapy for moderate to severely

depressed clients. While the small number of studies (six) and the studys' small sample

sizes suggest a cautious interpretation of findings, results are consistent with the large,

multi-site, well-designed NIMH Treatment for Depression Collaborative Research

Program (TDCRP; Elkin et al., 1989).

The TDCRP compared the outcomes from manualised CBT and IPT,

implemented by experienced therapists, using imipramine (a tricyclic antidepressant)

plus clinical management (IMI-CM) as a standard reference, and pill-placebo plus

clinical management (PLA-CM) as a control. Of note, the PLA-CM condition provided

support and encouragement through regular contact with an experienced therapist and

therefore did not constitute a no-treatment control. Of the 239 clients that began

treatment, 155 completed at least 12 sessions and 15 weeks of treatment. To avoid

confusion, this thesis discusses results of this completer[10] sample only. King's (1998)

dissemination of the TDCRP results, however, pointed out that outcomes differed

depending on the measure used and the sample analysed. Outcome measures comprised

the HRSD (Hamilton, 1967), the Global Assessment Scale (GAS; Endicott,, Spitzer,

Fleiss, & Cohen, 1976), the BDI and the Hopkins Symptom Checklist-90 (HSCL-90;

Derogatis, Lipman, & Covi, 1973).

Elkin et al. (1989) reported that symptom outcomes, collapsed across less and

more severely depressed clients, indicated that all clients improved significantly in all

four conditions ($p < .001$) on all measures from pre-therapy to post-therapy[11]. As

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[10] Other client sets analysed were: (a) an intent to treat sample and (b) a sample of clients, who completed 3.5 weeks of treatment.

[11] Section 3.7.2 of Chapter 3 discussed the recent debate on therapist effects, relevant to conclusions on therapy effects in this trial.

assessed by BDI scores, CBT and IPT were equally effective as antidepressant treatment (see Table 5.1). Results suggested that IMI-CM was more effective than PLA-CM ($p < .006$), as assessed by the HSCL-90. When symptom outcomes were analysed according to initial symptom severity, however, antidepressants were superior to psychotherapy for clients who had both severe depressive symptoms and highly impaired function.

Table 5.1

Beck Depression Inventory Pre-therapy and (Adjusted) Post-therapy Mean Scores and Standard Deviations for Cognitive Behaviour Therapy and Interpersonal Therapy: Results from Elkin et al. (1989)

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Research therefore suggests that psychotherapy is as effective as antidepressants for mild to moderate depression. Findings on severe depression remain inconsistent.

5.2.3 Standard Psychotherapies Produce Medium to Large Effect Sizes

When evaluating psychotherapy, researchers often calculate effect size to indicate the magnitude of treatment effects, independent of sample size. One commonly used measure of effect is Cohen's *d*. The *d*[12] statistic calculates "…the degree that the mean of the difference scores deviates from 0 in standard deviation units" (Green & Salkind, 2004, p. 163). By convention, researchers consider *d* values of 0.20, 0.50 and 0.80 as small, medium and large effect sizes respectively, regardless of sign (Cohen, 1988).

A recent meta-analysis of psychotherapy for major depressive disorder in adults (Minami, Wampold, Serlin, Kircher, & Brown, 2007) estimated pre-treatment to post-treatment effect size benchmarks. Minami et al. found that higher severity of pre-therapy depression and the number of weeks of therapy were related to larger effect sizes. The authors, however, pointed out that the calculated benchmarks should not be compared with results calculated from sample sizes under 100 because critical values for comparison increase sharply as sample sizes decrease.

Recent meta-analysis by Westen and Morrison (2001) calculated mean effect sizes, using Cohen's *d* (1988), for pre-therapy to post-therapy and treatment to control comparisons. Their meta-analysis examined 12 studies of adult depression published between 1990 and 1998. Inclusion criteria were stringent. Only rigorous experimental studies, which had tested a recently refined treatment against a wait-list control, alternative psychotherapy, or pharmacotherapy, were included.

Using scores on HRSD (Hamilton, 1967) and the BDI to measure outcome, Westen and Morrison (2001) found large pre-treatment to post-treatment effect sizes (*M*

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[12] Commonly calculated as $(M_1 - M_2) / \sigma_{pooled}$, where: $\sigma_{pooled} = \sqrt{[(\sigma_1^2 + \sigma_2^2)/2]}$; σ = standard deviation, and; M = mean.

= 2.23; *SD* = 0.78), and medium treatment versus control effect sizes (*M* = 0.50; *SD* = 1.10). When combining research in meta-analyses, researchers often weight research effect sizes according to the sample size of each study because studies with smaller samples are likely to bias meta-analytic calculations when sample sizes are less than 20 (Hedges, 1982). Although Westen and Morrison did not report weighting effect sizes, since participant numbers ranged from 36 to 180, any bias was unlikely to be problematic. Generalisation of findings by Westen and Morrison to all psychotherapy may be limited, however, considering that the strict exclusion criteria meant that cognitive, behavioural and interpersonal approaches dominated the psychotherapies examined. On a different point, one important finding by Westen and Morrison was that greater client improvement was associated with more stringent exclusion criteria, suggesting that extensive exclusion criteria in experimental trials may inflate psychotherapy effect sizes.

An earlier meta-analysis by Robinson et al. (1990), which included a broader range of therapies than Westen and Morrison (2001), also indicated that psychotherapy substantially improved outcomes for adults experiencing depression. Researchers examined 58 controlled outcome studies published in or before 1986, including cognitive, behaviour, cognitive-behaviour, and general verbal approaches. The general verbal group comprised psychodynamic, client-centred, and interpersonal approaches. The mean number of sessions was 8.7. Although earlier than Westen and Morrison, Robinson et al. controlled for bias that had emerged as problematic from earlier meta-analyses, including limited study selection, investigator allegiance, sample size, and dependence on the BDI as the single outcome measure. Using wait-list controls, Robinson et al. reported a higher treatment versus control mean effect size than Westen and Morrison, reporting Cohen's *d* as 0.84 (*S.D.* = 0.69), *p* < .05, when weighted for

sample size (from the 29 studies that provided effect size information). The authors did not provide pre-treatment to post-treatment effect sizes.

Results from another large well-designed comparison trial, the Second Sheffield Psychotherapy Project (Shapiro, Barkham, Rees, Hardy, Reynolds, & Startup, 1994), also revealed a large pre-therapy to post-therapy effect size. Shapiro et al. examined psychotherapy for depression, comparing CBT with a psychodynamic interpersonal approach (PI). Founded upon Hobson's (1985) Conversational Model, PI combined aspects from psychodynamic, interpersonal and experiential modalities. Adults with depression ($N = 117$) were randomly allocated to either 8 or 16 therapy sessions. When the researchers combined data from the different orientations, therapy dose and level of severity, overall results indicated that clients improved significantly, with a pre-therapy to post-therapy effect size (d) of 1.77.

5.2.4 Standard Psychotherapies Improve Depressive Symptoms by Treatment End

The meta-analysis by Robinson et al. (1990) provided detailed data about the impact of therapy on depressive symptoms at treatment end, useful for illustration and comparison. For example, BDI data (Table 5.2) supported psychotherapy as improving depressive symptoms. Comparison of treatment and wait-list control groups for the 22 studies that provided pre-therapy and post-therapy mean BDI scores weighted by sample size, revealed moderate pre-therapy BDI scores for both treatment and control groups. Treated clients' post-therapy BDI scores fell in the minimal range; control scores decreased, but fell into the mildly depressed range.

Table 5.2

Beck Depression Inventory Mean Scores and Standard Deviations for Clients Treated

with Psychotherapy for Depression: Meta-Analytic Results from Robinson et al. (1990)

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Although clients treated with psychotherapy improved overall, standard deviations

revealed that some clients experienced residual symptoms. Robinson et al. calculated

that clients who improved with psychotherapy remained significantly more

symptomatic, t (23, 7) = 4.95, p < .001, than individuals in the general population.

Meta-analytic data from Robinson et al. therefore suggests that clients improve

consequent to psychotherapy, but experience more depressive symptoms than the

community in general.

Results from Robinson et al. (1990) were broadly consistent with the TDCRP

(Elkin et al., 1989), Table 5.1 in Section 5.2.2.shows change in BDI scores from pre-

therapy to post-therapy. Shapiro et al. (1994) also reported symptomatic improvement

in clients participating in the Second Sheffield Psychotherapy Project (see Section

5.2.3). For example, combining results across severity (low, moderate and high)

modality, and duration (8 and 16 sessions), Shapiro et al. reported that BDI scores

decreased substantially from pre-therapy to post-therapy (Table 5.3) after eight sessions

of therapy.

Table 5.3

Beck Depression Inventory Pre-therapy and Post-therapy Mean Scores and Standard

Deviations for Cognitive Behaviour Therapy and Psychodynamic Interpersonal

Therapy Combined: Results from Shapiro et al. (1994)

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5.2.5 Maintaining Improvements

Given high relapse rates in major depressive disorder (Judd, 1997); it is important to maintain treatment effects. Despite meta-analytic reviews of clinical trials which have concluded that improvements from psychotherapy are generally maintained (e.g., Lambert & Ogles, 2004), fewer follow-up results are reported and those that are reported appear to differ depending on follow-up duration.

In the meta-analysis by Robinson at al. (1990), researchers assessed follow-up at 13 weeks on average, ranging from 2 to 52 weeks for 34 studies that provided follow-up information. From nine of these studies, which provided both post-treatment and follow-up effect sizes, follow-up effect sizes ($M = 0.70$, $SD = 0.67$) did not differ significantly, $t(8) = 0.79$, $p = .50$, from post-treatment effect sizes ($M = 0.74$, $SD = 0.61$). Results from Robinson et al. (1990) echoed earlier meta-analysis (Neitzel, Russell, Hemmings & Gretter, 1987) of 31 studies into uni-polar depression, which also

found that post-treatment scores remained stable at follow-up, when the average follow-up period was 16.4 weeks.

The stability of follow-up results found by Robinson et al. (1990) and Neitzel et al. (1987) were consistent with comparison research by Shapiro et al. (1995), who examined follow-up data from the Second Sheffield Psychotherapy Project. Shapiro et al. found that BDI scores, pooled across severity (low, moderate, high), modality (CBT, PI) and duration (8 versus 16 sessions), were maintained from the end of treatment ($M = 9.34$; $SD = 7.87$) to three-month ($M = 9.71$; $SD = 8.48$) and one-year follow-up ($M = 7.79$; $SD = 8.18$) for 104 clients who provided one-year follow-up data. One-year follow-up data for the eight-session condition, however, differed for CBT and PI. The superior maintenance of gains by CBT in comparison to PI for eight-session treatment suggests that maintenance of treatment gains may depend on the interaction of therapy modality and treatment duration, as well as the length of the follow-up period.

Meta-analysis by Westen and Morrison (2001) of four studies, which provided 12 to 18 month follow-up statistics (i.e., a considerably longer follow-up period than those provided by Robinson et al. (1990) and Neitzel et al. (1987), observed a small to moderate decrease in efficacy over time. Of clients that improved post-therapy, an average of 37% ($SD = 14.1$) maintained improvement. Although conclusions by Westen and Morrison were criticised (Lambert, 2001) as being based on a low number of studies, their results are consistent with a report of follow-up data from the NIMH TDCRP. Analysis by Shea et al. (1992) indicated that among patients who had recovered, 36% of those who received CBT and 33% of those who received IPT relapsed by 18-month follow-up.

5.2.6 Standard Psychotherapies Treat Depression in Adults Effectively

In summary, the above review demonstrates evidence supporting standard psychotherapies as effective in the treatment of adult depression. Outcomes from standard psychotherapies are superior to spontaneous remission, pre-treatment, no-treatment controls and waitlist controls. Standard psychotherapies are as effective as antidepressants for mild to moderate depression and produce medium to large effect sizes. Depressive symptoms improve by the end of therapy, although many clients experience more symptoms than the general population. Clinical reviews generally support the sustained efficacy of psychotherapy. However, researchers have reported far less follow-up than post-therapy data, and conflicting results from recent meta-analyses indicate the need for more research into the enduring effects of psychotherapy for depression in adults.

5.3 Comparison of Psychotherapy Modalities

5.3.1 Varied Treatment Approaches

Proponents of a number of psychotherapeutic approaches have conceptualised depression from their own theoretical orientations and many of these have offered specified treatment protocols. From the myriad of meta-analytic and comparison studies investigating outcomes from various interventions, this section reviews those pivotal studies that mark major points in psychotherapy research relevant to the current study.

5.3.2 Meta-Analyses Finding Treatment Superiority

Throughout the psychotherapy outcome literature are claims of treatment superiority. The American Psychiatric Association's (2005) practice guideline for major depressive disorder included the caveat that CBT has been more extensively researched than other modalities and research claiming disparity between therapeutic orientations

has often focused on the superiority of cognitive therapy in outcome comparisons, for example, Dobson (1989) and Gloaguen et al. (1998).

Dobson's (1989) early meta-analysis examined 28 studies conducted between 1976 and 1987 that compared cognitive approaches for depression with control, psychotherapy and pharmacotherapy groups. The authors concluded that results indicated cognitive approaches were superior to wait-list or no-treatment controls ($d =$ 2.15), pharmacotherapy ($d = 0.05$), behavioural approaches ($d = 0.46$) and other psychotherapies ($d = 0.54$). The other therapies examined included insight-oriented, interpersonal process, non-directive, and psychodynamic approaches. The included studies assessed outcome according to BDI scores.

Data from a large and more recent meta-analysis (Gloaguen et al., 1998) of 48 randomized treatment trials for depression from 1977 to 1996 confirmed many of Dobson's (1989) findings. Results suggested that cognitive and behavioral approaches were equivalent and superior to wait-list-placebo controls amalgamated ($d = 0.82$), antidepressants ($d = 0.38$) or the miscellaneous other therapies ($d = 0.24$) investigated. Other therapies included supportive, insight-oriented, non-directive, interpersonal, bibliotherapy and relaxation approaches.

5.3.3 Research Finding Treatment Equivalence

In comparison to findings by Dobson (1989) and Gloaguen et al. (1998), results from many earlier and later research trials found equivalent outcomes across varied treatment modalities (e.g., Nietzel et al., 1987; Robinson et al., 1990; Wampold, Minami, Baskin, & Tierney, 2002), challenging the superiority of cognitive approaches over other therapies. In addition, a number of researchers have contested claims of treatment superiority, pointing to methodological confounds as explanations for

findings of superior outcomes, like biased outcome measures, investigator allegiance, and *non-bone fide* comparisons.

One criticism of Dobson's (1989) study concentrated on the use of the BDI as an inclusion criterion, which restricted both the sample and the outcome evaluation. Underpinning this criticism was research suggesting that the BDI favoured cognitive approaches in comparison trials. In their comparison of CBT and PI, the Second Sheffield Psychotherapy Project (Shapiro et al., 1994) used seven measures to examine levels of depression before and after therapy sessions. Pre-therapy to post-therapy change in the adjusted scores for six of the measures were not significant. Inconsistently, there was a significant treatment effect for CBT when measured by the BDI. Shapiro et al. concluded that use of the BDI in comparisons trials advantaged CBT.

Critiques of Dobson's (1989) meta-analysis also raised the issue of investigator allegiance, which describes a researcher's differential preference for treatments they are comparing. Although previously hypothesized to be a potential confound (Luborsky, Singer, & Luborsky, 1975), Dobson did not account for investigator allegiance. Allegiance has now emerged as an important consideration in comparison trials, calculated to account for 69% of the variance of effect size when comparing treatment outcomes (Luborsky et al., 1999).

Re-analysis of Dobson's (1989) data by a later meta-analysis (Gaffan et al., 1995) found a relationship between researcher allegiance and outcome, accounting for approximately half of the between-treatment effect between CBT and other treatments. In addition to Dobson's 28 studies, Gaffan et al. analysed a further 37 studies published between 1987 and 1994, weighting effect sizes by sample size. Interestingly, the authors reported that cognitive therapy was superior to other psychotherapies and

pharmacotherapy in the later studies, but found no researcher allegiance effects. Gaffan et al. concluded that the correlation between investigator allegiance and outcome had weakened over time and was therefore an historical artefact.

Despite the use of advanced statistical techniques to lessen confounds, an important methodological flaw also marked the meta-analysis by Gloaguen et al. (1998). Noting heterogeneity of effect sizes arising from comparisons of cognitive therapy with other therapies, Wampold et al. (2002) proposed that this heterogeneity resulted from aggregating *bona fide* and *non-bona fide* interventions. Wampold and his colleagues (Wampold et al., 1997) had previously relegated *non-bona fide* interventions to the status of placebos, arguing that non-bona fide interventions lacked the common factors necessary of *bona fide* therapies.

Wampold et al. (2002) re-analysed data from Gloaguen et al. (1998), excluding the *non-bona fide* interventions. The reanalysis revealed that outcome from cognitive therapy was equivalent to that of *bona fide* therapies.

Findings of treatment equivalence by Wampold et al. (2002) were consistent with those of the earlier meta-analysis by Robinson et al. (1990), which found treatment equivalence for cognitive, behavioural, cognitive-behavioral, and general verbal approaches to therapy. Findings of treatment equivalence in meta-analyses are also consistent with results from the TDCRP (Elkin et al., 1989), which concluded that there was no evidence that CBT and IPT differed from each other in reducing depressive symptoms. Equivalence of psychotherapy outcomes across diverse orientations underpins what is known as the dodo bird verdict (Luborsky et al., 1975), following from Saul Rosenzweig (1936), statement "Everybody has won, and all must have prizes", citing the dodo bird from Alice in Wonderland.

5.3.4 Psychotherapy Outcome: The Role of Specific and Common Factors

5.3.4.1 Explanations for Equivalent Outcomes across Diverse Therapies

How can we explain equivalent outcomes across application of techniques specific to diverse psychotherapy models? Theorists have considered several possible explanations. Some maintained that outcome differences due to factors specific to particular therapies do exist, but are obscured by the classifications or methodologies used (Parker, 2005; Sexton, Ridley, & Kleiner, 2004). Others proposed that evidence of treatment equivalence supports the existence of curative factors that are common across most therapies (Wampold, 2001). The different viewpoints have been instrumental in initiating numerous studies examining specific and common factors of therapy, with the intention of gaining a better understanding of successful psychotherapy. Remaining paragraphs of Section 5.3.4 present major elements of the debate on specific and common factors and argue that our knowledge of therapy may be better progressed by an approach that bridges specific and common factors.

5.3.4.2 Specific Factors

Traditionally, the medical model has underpinned psychotherapy, whereby a specific disorder requires a specific treatment technique (Wampold, 2001). Different therapeutic techniques have developed from different theoretical formulations of psychotherapy change. Oei and Shuttlewood (1996) defined specific factors as those elements of a therapy, which have been "…clearly delineated by proponents of a given therapy as the active components of change" (p. 83).

The cognitive model of therapy change in depression provides a useful example of a specific factor. Proponents of the cognitive model (Beck, Rush, Shaw, & Emery, 1979) proposed that individuals hold relatively stable schema, developed through early

learning experience. Cognitive theorists posit that dysfunctional schema bias cognition negatively, with consequent irrational automatic thoughts and cognitive distortions. Consistent with cognitive theory, the specific techniques of cognitive therapy are to identify, challenge and change irrational automatic thoughts and cognitive distortions with the specific action of changing underlying dysfunctional schema, purported to initiate and maintain depression. Thus, facilitating change in cognitive processes is a specific factor of the cognitive model (Beck et al., 1979).

For those who proffer the primacy (primacy referring to contributing most largely to variance) of specific factors, the main issue is specificity. Proponents of specificity maintain that methods used to arrive at conclusions of treatment equivalence disregard the specificity and complexity of *in vivo* psychotherapy (Sexton et al., 2004). Articulating the position of those who held this stance, Paul (1967) believed the question should be, "*What* treatment, by *whom*, is most effective for *this* individual with *that* specific problem and under which set of circumstances?" (p. 111). Theorists from this perspective have refuted findings of treatment equivalence, based on a number of proposed flaws in classification, method and logic.

Parker (2005) proposed that amalgamating various sub-populations into one category masks differing outcomes from the different sub-populations. According to Parker, the category of major depressive disorder comprises a heterogeneous group of people with several sub-populations. Since sub-populations suffer from essentially different disorders, different cohorts vary in response to different interventions. That is, Parker challenged the validity of the DSM-IV dimensional categorisation of major depressive disorder, questioning its validity in research outcome trials and its utility in treatment selection.

Methodological flaws in psychotherapy research relating to the treatment of depression pose other points of contention. The aggregation of data, inherent to large comparison trials and meta-analyses likely disguises the diversity of client outcomes (Crits-Christoph, 1997; Howard, Krause, Saunders, & Kopta, 1997; Roth & Fonagy, 1996; Sexton, Ridley, & Kleiner, 2004). Other arguments included the use of inadequate measures, procedures or statistical power to capture differences, or the irrelevance of research methods to clinical practice (Kazdin & Bass, 1989; Norcross, 2002). Others proposed that the presence of common factors does not necessarily follow from treatment equivalence. For example, the varied specific factors may have resulted in equivalent results (DeRubeis, Brotman, & Gibbons, 2005).

Despite its major finding of treatment equivalence, the NIMH TDCRP study (Elkin et al., 1989) demonstrated the importance of specificity. Analysis of NIMH TDCRP data using random regression models by Elkin et al. (1995) indicated that initial depression severity with impaired function predicted different treatment effects, as measured by the HRSD, with IMI-CM superior to psychological treatments. When initial symptom severity and outcome were measured by the BDI (cut-off BDI score = 30), IMI-CM and IPT were superior to CBT and PLA-CM. IPT was therefore significantly more effective than CBT for a specific cohort of clients. This conclusion, has however been challenged by research that accounts for therapist effects (Kim, Wampold, & Bolt, 2006), as mentioned in Section 3.7.2. Debate continues on the effects of therapists and initial severity on treatment outcome.

The elevation of empirically validated or supported treatments by the Task Force on the Promotion and Dissemination of Psychological Procedures (American Psychological Association, 1995) and the Division 12 Task Force (Chambless & Ollendick, 2001) advanced the notion of specific factors. Promotion of practice that is

evidence-based is currently an important element of the American Psychiatric Association policy (APA, 2005). Concerns about ethical practice, accountability, litigation, and cost effectiveness have prompted research into the efficacy of interventions, and consequent recommendations of specific interventions for specific disorders, as informed by outcome research (American Psychological Association, 2006; Lohr, Olatunji, Parker, & DeMaio, 2005; Oldham, 2006). Recurring findings of superiority of one treatment over others for specific populations reinforced this policy, as in the example of cognitive therapy for panic disorder (DeRubeis, Brotman, & Gibbons, 2005). Arguing against the evidence for treatment equivalence, the Task Force held that specific therapies were appropriate for specific populations (Chambless & Ollendick, 2001).

5.3.4.3 Common Factors

A number of theorists have taken the findings of treatment equivalence as support for the existence of curative factors, common across most therapies (Wampold, 2001). Wide adoption of eclectic or integrative therapeutic practice in clinical contexts (Lebow, 2003) has underscored the limitations of specific models of therapy in addressing the complications and intricacies of practice.

Recent interest has been in distinguishing the contribution of therapeutic factors, common to different orientations (DeRubeis, Brotman, & Gibbons, 2005; Wampold, 2005). While several definitions for the term exist, this thesis adopts Castonguay's (1993) definition of common factors as, "…a set of variables that are present in more than one form of therapy" (p. 275).

In relation to the specific effects of therapy, an important result from the TDCRP (Elkin et al., 1989) involved the placebo condition. HRSD (but not BDI) scores

in the completer sample, indicated only a trend towards the superiority of the IPT ($p <$ .021) condition (but not the CBT condition) over the PLA-CM condition. Given that the PLA-CM condition provided minimal supportive therapy, Elkin et al. concluded that results demonstrated limited specific effectiveness for IPT and no specific effectiveness for CBT. King's (1998) review of the TDCRP (Elkin et al., 1989) findings challenged whether results indicated treatment specific effects, considering that no treatment had superior efficacy to the placebo condition. King, like Elkin et al., held the placebo condition to constitute a form of psychological treatment in itself, and the outcomes from the placebo condition reflected non-specific[13] treatment effects. Based on this premise, King questioned the validity of the term *evidence-based* when referring to such psychological treatment.

Advocates for the primacy of common factors seek to distinguish core factors of change across therapy modalities, viewing these as the effective components of change (Lambert & Ogles, 2004). From the time that Rosenzweig (1936) coined the term common factors in his seminal article on the concept, theorists proposed a myriad of variables as potential common factors. Grencavage and Norcross (1990) attempted to bring order to the numerous proposals. Based on a review of the literature, they identified the most commonly mentioned common factors in 50 published articles or books from 1936 to 1989. The most agreed upon common factor was the development of a therapeutic alliance, with 56% consensus. A later study (Weinberger, 1995) identified the therapeutic relationship as one of five common factors that were evidence-based at that time (e.g., Martin, Garske, & Davis, 2000). Conceptualised as a common factor of therapy, a process of successful therapy, and a marker of outcome (Frieswyk et

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[13] The term 'non-specific factor' is often used inter-changeably with the term 'common factor'. In this thesis, the term 'non-specific factor' refers to a factor that has not been specified as an active ingredient of change in a specified therapy orientation.

al., 1986), the therapeutic relationship is relevant to the current research, which is interested in inter-subjective therapeutic processes. Section 3.7 of the chapter on psychotherapy process-outcome research discussed aspects of the therapeutic relationship.

5.3.4.4 Specific and Common Factors are Intrinsically Intertwined

When evaluating the capacity of specific and common factors to predict therapeutic outcome, researchers (e.g., Zuroff & Blatt, 2006) have generally teased specific and common variables apart in order to clarify contributions to outcome (Stevens, Hynan, & Allen, 2000). Although research distinguishing common factors, such as the therapeutic alliance, from specific factors has been useful to our understanding of psychotherapeutic change, results from this reductive method fail to reflect the complexity of psychotherapy (Gustafson, 1995).

The process of psychotherapy is highly complex and recursive. A specific-common factor dichotomy is essentially an "artificial heuristic" (Ogles, Anderson, & Lunnen, 1999, p. 218). Several researchers have recognised that specific and common factors of therapy are intrinsically intertwined (Ackerman & Hilsenroth 2003; Gelso, 2005; Goldfried & Davila, 2005; Hill, 2005). Frank (1971) clearly supported the idea of common therapeutic factors, proposing that successful therapy comprised: (a) an emotionally charged confiding relationship with a healer; (b) a socially sanctioned setting that facilitates a client's expectancy of healing; (c) an understandable rationale explaining their symptoms and how change occurs; and (d) a believable ritual that provides new learning for change. Within Frank's conceptualization, techniques and the socially sanctioned helping relationship are reciprocally embedded. From this perspective, the interactions between the specific and common factors of therapy involve a complex, reciprocal and recursive configuration of effects. That is, de-

contextualizing and evaluating the parts of therapy discounts the complex, reciprocal and recursive effects of specific and common factors of therapy and is likely to lead to misunderstanding of the elements of psychotherapy.

Studies, which have found relatively small contributions to positive outcomes when evaluating specific and common factors separately, might reflect the unnatural dissection of psychotherapy. Results from comparison trials, demonstrating the superiority of one therapy over another, attribute only around 10% of the variability in change to the specific factors (Castonguay & Beutler, 2006). Likewise, meta-analyses investigating the relationship of the therapeutic alliance with outcome indicate modest mean correlations of only 0.22 (Martin, Garske, & Davis, 2000). Meta-analysis of 80 outcome studies (Stevens et al., 2000) that included treatment, common factor and no-treatment groups and were weighted by sample size, also found small effect sizes. The researchers calculated that the mean effect sizes of specific factors and common factors were 0.38 and 0.22 respectively, with the effect size of specific factors significantly higher, $F(1, 455) = 16.8$, $p < .001$, than for common factors. Interestingly, as the severity of client difficulties increased, specific techniques appeared to be more beneficial than the common factors of therapy.

Deconstructing the integrity of specific and common factors even more, the development of the therapeutic relationship can itself be a specific technique of therapy. A process-outcome trial of CT (Beck et al., 1979) for depression by Castonguay, Goldfried, Wiser, Raue, and Hayes (1996) clearly illustrated the inter-dependence of specific and common factors. Castonguay et al. found that assisting clients to associate thoughts and feelings, a technique pivotal to successful CT, was negatively associated with positive therapy outcome for client-therapist dyads with strained therapeutic relationships only. Development of a therapeutic relationship is proposed as a specific

and essential task of narrative (White, 2002) and emotion-focused (Greenberg & Watson, 2005) approaches to therapy.

The specific-common factor dichotomy is artificial. Although research into specific and common factors has contributed importantly to our knowledge of successful psychotherapy, maintaining a research focus on a dichotomy that does not represent actual practice separates research from the needs of clinicians (Sexton et al., 2004), potentially limiting possibilities of answering fundamental questions on the process of therapy change. Rather than adopting positions or research that promote a specific-common factor dichotomy, understanding of therapy may be better progressed by approaches that bridge specific and common factors.

5.3.4.5 Investigation into Constructs Bridging the Specific-Common Factor may be Useful

In summary, research providing evidence for treatment outcome equivalence provided the background for the identification of common factors as important to therapeutic change, as well as the specific-common factor debate (Sexton et al., 2004; Wampold, 2005). From a range of proposed variables, the therapeutic relationship figures largely in psychotherapy literature as a factor of successful therapy, common to different modalities, and has emerged as important and evidence-based. There remains, however, considerable disagreement on the factors that account for successful therapy. After several decades, debate and research into specific and common factors continues (e.g., Derubeis, Brotman, & Gibbons, 2005). Since isolating variables removes them from their context, and is unrepresentative of actual practice, I argue that the specific versus common factor dichotomy has limited meaning. Investigation into broader constructs that bridge the specific-common factor dichotomy, such as language and self, may be more clinically meaningful.

5.4 The Status of Narrative Therapy in Depression Outcome Research

Narrative therapy focuses on language and self as transformative meaning-making processes. According to White and Epston (1989), '…a person gains a reflexive perspective on their life, and new options become available to them in challenging the "truths" that they experience as specifying them and their relationships' (p. 33). Therapies informed by narrative theory have gained momentum over the past decade (Belchamber, 1997; Kelley, 2002). White and Epston (1990) developed a post-modern formulation of narrative therapy, based on the work of several theorists, including among others Bateson (1972; 1979), Bourdieu (1988), Bruner (1990), Derrida (1978; 1981), Erickson (1980), Foucault (1980), Gergen (1985a) and Turner (1982).

In the field of psychotherapy, easily manualised and quantified therapies, like CBT, have predominated outcome research. As such, these orientations have received the empirical support that clinicians require. Less easily objectified therapeutic orientations have received less empirical research. Although such approaches may have anecdotal and qualitative support, if not subjected to empirical research methods, the evidence base for the approach is not complete. Not only are narrative approaches less easily objectified, many narrative researchers eschew the use of empirical designs (Besa, 1994; Kelly, 1998), preferring narrative-based research methods (as outlined in Section 2.6), which they perceive as fitting better with their overall philosophy. As a result, there is little empirical evidence to support narrative therapy, specifically in the treatment of depression.

With the current emphasis on managed care, ethical practice, and cost effectiveness, The Task Force on the Promotion and Dissemination of Psychological Procedures (1995) and the American Psychological Association Division 12 Task Force (Chambless & Ollendick, 2001) actively promoted empirically supported treatments

(using RCT designs). Promotion of empirically supported treatments prompted considerable research on the efficacy of various interventions for specific disorders (American Psychological Association, 2006; Lohr, Olatunji, Parker, & DeMaio, 2005; Oldham, 2006). Despite the recent movement towards evidence-based practice (American Psychiatric Association, 2005; Levant, 2005), a more inclusive notion than empirically supported treatments, endorsing a range of research designs, increasing concerns about litigation and accountability (Sederer & Bennett, 1996) require that narrative therapists are able to justify their intervention as empirically supported.

Apart from the growing popularity of narrative therapy amongst clinicians, several studies suggest that narrative approaches are effective across a range of problems, disorders and contexts. Most narrative research, however, has relied on case study or qualitative approaches (e.g., Betchley & Falconer, 2002; Draucker, 1998; Rothschild, Brownlee, & Gallant. 2000; White Epston, 1990). The limited research base for narrative therapy overall is reflected in the small number of studies into narrative therapy for depression.

Using a case study approach, Kropf and Tandy (1998) reported results from narrative therapy in the treatment of an 80-year old woman who was experiencing depression associated with various health declines related to aging and grief over the loss of her husband. Following narrative therapy (60-minute sessions over three months), the authors reported that the dominant narratives of fear and depression were deconstructed and a new narrative, dominated by survivorship, was constructed.

In a qualitative study of narrative therapy for depression, Wirtz and Harari (2000) implemented a narrative ten-session group-work approach with eleven people they were working with who were experiencing depression (three males and eight females aged between 18 and 55 years old). The narrative intervention used by Wirtz

and Harari comprised a simple outline of three primary themes, which were in essence: exploring dominant societal beliefs; externalising and deconstructing depression, and; thickening alternative stories. At the end of both six sessions and ten sessions, all participants rated themselves as being "…more in control of depression…" (p. 51) compared to at commencement of the program. At three-month follow-up, some group members reported maintaining their control over depression, while others reported some regression. The researchers requested feedback about the usefulness and the effects of the group approach for depression. Wirtz and Harari found that several participants reported a significant impact from "…hearing others and sharing with others in the group…" (p. 50). Participants also reported experiencing a sense of, "…having power and control in their lives…" (p. 50).

Several studies have used simple quantitative strategies to investigate narrative therapy for difficulties other than depression. For example, Besa (1994) evaluated the effectiveness of narrative therapy in reducing parent-child conflict. For each of the six families involved, there was a single-case behavioural analysis with multiple baselines. Parents rated the outcome by responding to the following statements: "Not doing chores"; "Attention seeking instead of doing homework"; Making too many phone calls", and; "Not doing homework" (Besa, p. 311). According to these ratings, parent-child conflict decreased after narrative therapy (decrease ranging from 88% to 98%) in five of the six families. A larger study by Seymour and Epston (1989) evaluated narrative treatment of childhood stealing, addressing stealing rates in 45 children aged between 7 and 15 years old. For the 39 children that completed therapy, there was substantial reduction or cessation in 81% of the children at 6-12 month follow-up.

In the context of narrative therapy for depression, Weber, Davis, and McPhie (2006), used quantitative and qualitative methods to examine depression and eating problems utilising group narrative therapy for rural Australian women (N = 7), aged between 20 and 39 years. Although the researchers employed broad inclusion and exclusion criteria for eating problems, the women self-identified themselves as experiencing depression. The intervention was a 10-week program, each session lasting 2.5 hours. Using a pre-post therapy design, Weber et al. enquired into the women's subjective experience of depression and eating problems, measured levels of depression, anxiety and stress with the 42-item Depression, Anxiety, Stress Scale (DASS: Lovibond & Lovibond, 1995), and measured eating problems with the Eating Disorders Inventory-3 (Garner, 2004). Although the researchers did not conduct statistical analysis on outcome data, or provide mean DASS-D scores, they reported that pre-therapy DASS scores indicated that six of the seven women who completed the intervention scored in the severe or extremely severe range for depression. At post-therapy, DASS scores indicated one woman's scores fell in the moderate range, one woman's score was in the mild range, and five fell into the normal range. The women reported changes in daily practices related to eating problems, less self-criticism, more use of helpful strategies, and more experience of hope for change. Although this study examined narrative therapy for depression quantitatively, the methods and statistical analyses used were not consistent with traditional psychotherapy outcome trials and therefore not suitable for comparison with outcomes from standard psychotherapies.

Overall, many clinicians currently practice narrative therapy and previous qualitative and quantitative research suggests that narrative therapy is useful in alleviating psychological distress. In the current climate of evidence-based practice, it is

important that clinicians have a broad evidence base that includes empirical research to justify the use of narrative therapy in the treatment of depression in adults.

5.5 Concluding Comments on Psychotherapy Outcome Research

Psychotherapy outcome research has provided convincing evidence that standard psychotherapies are generally effective in the treatment of adult depression. In the initial response to psychotherapy, it appears that clients improve, although a significant proportion of clients remain symptomatic. Clinical reviews generally support the sustained efficacy of psychotherapy. However, more research, drawing from an array of approaches is needed into the enduring effects of psychotherapy for adult depression.

Despite continuing arguments that centre on the role of specificity in the findings of treatment equivalence, given the evidence from comparison trials and meta-analytic studies, the overall conclusion of treatment equivalence across standard psychotherapies in the treatment of depression is convincing. Such debate has generated further dialogue and research distinguishing specific and common factors of therapy (Derubeis, Brotman, & Gibbons, 2005), which has in turn provided useful information, particularly concerning the relevance of specificity and the importance of the therapeutic alliance.

Teasing apart specific and common variables, however, does not reflect actual practice (Butler & Strupp, 1986; Samstag, 2002), and continued focus on this dichotomy may impede investigation into a more fruitful understanding of the processes of change. More productive psychotherapy research may result by examining constructs that bridge the specific-common factor dichotomy, such as language and self. Founded in post-modern ideas, narrative approaches to therapy focus on language and self as processes that make meaning in the lives of individuals. Despite increasing popularity

and the requirements of evidence-based practice, there is no rigorous empirical research

into the outcomes of narrative therapy in the treatment of adult depression.

CHAPTER 6

OUTCOME RESEARCH: METHODOLOGICAL CONSIDERATIONS

6.1 Evaluating Psychotherapy Outcomes

Emphasis on accountability coupled with an increasingly litigious society demand that therapists be able to justify their practice. Important questions in psychotherapy research, therefore, concern the evaluation of therapy outcome. What methods can most effectively determine whether therapy has been successful? How many sessions are required in evaluating therapy? Which sample set should be analysed? Clinicians' traditional reliance on empirically-supported treatments when selecting therapy for specific disorders (Chambless & Ollendick, 2001) has been recently replaced by the more inclusive concept of evidence-based practice (American Psychiatric Association, 2005; Levant, 2005), which promotes the use of a range of research designs when investigating or selecting psychotherapy for research or clinical practice.

With the intention of providing rationales for research decisions in the current study, following sections consider some methodological and statistical aspects of psychotherapy outcome research. Discussions on the appropriateness and expense of randomised controlled trials (RCTs), the practical and ethical limitations of control groups, and the limited relevance of statistical significance to clinical practice (Lick, 1973; Barlow, 1981; Jacobson & Traux, 1991), precede arguments that the analysis of clinical significance and benchmarking strategies provide alternative protocols that are relevant to fundamental questions of psychotherapy outcome research.

6.2 Randomised Controlled Trials

6.2.1 Randomised Controlled Trials Provide High Internal Validity

Traditionally, researchers have emphasised the utility of RCTs and analyses of statistical significance in evaluating psychotherapy outcome (Chambless & Ollendick, 2001). RCTs are highly controlled experimental situations, involving the random assignment of participants to groups. Random assignment, intended to result in homogeneous groups by addressing potentially biasing non-treatment factors, contributes to the high internal validity of RCTs. Researchers compare results from a group of people treated with a specific therapy for a specific disorder with results from a a control group or a group of people treated with an alternative therapy. Statistically significant differences between group means and variations between and within groups are calculated. Inferential procedures, calculating statistical significance, provide support that results are not due to chance. Overall, RCTs have enabled the conduct of many complex statistical analyses that have assisted our understanding of psychotherapy.

6.2.2 Randomised Controlled Trials have Limited External Validity

There has however, been a growing dissatisfaction with traditional experimental and statistical protocols when investigating psychotherapy (Ogles, Lunnen, & Bonesteel, 2001). Many authors have challenged the validity of generalising results from highly controlled experimental situations to clinical contexts, where client characteristics are heterogeneous and the different needs of clients often dictate flexible treatment protocols (Addis et al., 2004). As early as 1972, Bergin and Strupp recommended building new techniques, stating, "Among researchers as well as statisticians there is a growing disaffection from traditional experimental design and statistical procedures which are held inappropriate to the subject matter under study.

This judgment applies with particular force to research in the area of therapeutic change…" (p. 440).

6.2.3 *Randomised Controlled Trials Require Large Resources*

The numbers of participants necessary to provide research with adequate power to detect differences between groups underline the resources required to conduct RCTs in terms of participants, therapists, money and time. In an evaluation of the power of psychotherapy outcome studies to detect differences between two or more treatment conditions, Kazdin and Bass (1989) concluded that small to medium effect sizes are likely. By convention, psychotherapy researchers generally use two-tailed tests, setting alpha at .05. Cohen (1988) recommended a .8 level of power. By these conventions, capacity to detect a small effect size requires approximately 392 clients per group and a medium effect size requires approximately 63 clients per group to meet statistical criteria. Without large resources, recruitment and provision of therapy to such a large number of people is often impracticable. The time and financial resources required to conduct well-controlled comparisons of psychotherapies render them feasible only for large, well-funded institutions. Reliance on RCTs, diverting focus from other viable methodologies, has possibly hindered psychotherapy research.

6.2.4 *Control Conditions in Psychotherapy Outcome Research have Practical and Ethical Limitations*

Practical and ethical limitations of control groups affect the feasibility of conducting RCTs in psychotherapy outcome research. In psychotherapy, control conditions generally comprise groups of people, who receive standard treatment, placebo treatment or wait to receive therapy after a specified time (Lambert, 2004). Previous research has indicated that large effect sizes are likely when comparing treatment and control conditions (Kazdin & Bass, 1989). In comparison to the large

number of people required to detect a difference between two therapies, detecting a difference between a treatment and control group therefore requires a much smaller number of people, approximately 25 participants per group. Control groups, however, have limitations that affect their utility in psychotherapy research.

Standard treatment controls comprise routinely used interventions (for the specific problem and population under investigation) that equate with the experimental condition for non-specific factors such as treatment duration and expectancy (Kendall, Holmbeck, & Verduin, 2004). In practice, this equality is difficult to achieve. When investigating psychotherapy for depression, for example, a standard treatment control condition requires random allocation of participants to a situation in which they receive the routine treatment for depression. The most likely routine treatment for depression is antidepressant medication administered by a medical practitioner (see Section 4.8). Since appointments with medical practitioners are considerably shorter than psychotherapy sessions, a standard treatment control is unequal in the non-specific factor of duration. In psychotherapy for depression, therefore, the standard treatment does not provide an adequate control condition.

The idea of placebo controls in psychotherapy follows from the logic of placebos in pharmacotherapy research. Intended to be equivalent to the experimental condition except without the active ingredient or specific factor, researchers use placebo conditions to control for non-specific factors of treatment, such as clients' expectancy of improvement (Kendall, Holmbeck, & Verduin, 2004). In practice, a placebo condition is virtually unattainable in psychotherapy research. In contrast to medication trials in which the specific (chemical) factors are easily distinguished from non-specific (in this case, psychological) factors, to treat a subset of a psychotherapy session as if redundant is impossible considering that specific and non-specific factors are not clearly

discernible (Sexton, Ridley, & Kleiner, 2004; Wampold, 2001). Placebo controls are therefore not realistic in the context of psychotherapy.

Wait-list control conditions involve delaying treatment for the period of treatment while administering assessments equal to those receiving treatment (Kendall, Holmbeck, & Verduin, 2004). Withholding or delaying treatment raises serious ethical concerns when investigating disorders such as depression, where participants are experiencing significant distress or are at risk of suicide (see Section 4.6). Psychotherapy can be expensive and beyond the financial reach of many people, and some participants may volunteer to receive therapy at no cost. Withholding or delaying psychotherapy from people, who are more vulnerable to distress or self-harm than the general population, but whose access to psychotherapy is limited financially, is ethically questionable at the very least.

When researching psychotherapy for individuals experiencing depression, significant practical and ethical matters affect the feasibility of conducting RCTs. The costs associated with RCTs, limiting them to large organisations, and the ethical and practical limitations of control groups impact decisions on research design when investigating psychotherapy outcome.

6.2.5 Statistical Significance has Limited Clinical Relevance

Statistical significance is of limited practical value when evaluating psychotherapy outcome, offering little information on the impact of therapy for individual clients or the meaningfulness of change. Traditionally, analyses in RCT outcome trials have relied on the statistical significance of group differences, providing useful information on the reliability of change. Several researchers and clinicians, however, have questioned the consequent eclipse of individual results and the clinical

relevance of statistical significance in the evaluation of psychotherapy (Barlow, 1981; Bergin & Strupp, 1970; Ogles, Lambert, & Sawyer, 1995; Wise, 2004).

Use of group results, inherent to inferential statistics, focuses on the average response of the group to treatment. Results demonstrating statistically significant change for a particular group of people may not reflect results for each individual of that group (Jacobson & Traux, 1991; Lick, 1973). That is, group averages obscure individuals' results.

If research involves large numbers of participants, a small magnitude of change may be statistically significant, without being clinically meaningful (Ogles, Lunnen, & Bonesteel, 2001). Statistically significant results can occur, for example, when the groups' mean post-treatment score falls with the range identified as severe depression (Bakan, 1966; Kazdin, 1999). Although evaluating effect size provides a means of assessing the magnitude of change irrespective of sample size (Cohen, 1992), addressing one problem of statistical significance analysis, it does not address the eclipse of individual results.

Despite advantages of RCTs, relating to high internal validity and the capacity to conduct complex statistical analyses, the use of RCTs when investigating psychotherapy has significant limitations. When considering an RCT, researchers need to weigh the high internal validity offered and the potential for complex statistical analyses against the high costs involved, the practical and ethical problems of comparison conditions, the limited meaning of statistical significance and the low external validity.

6.3 Clinical Significance

6.3.1 Clinical Significance is a Stringent Index of Psychotherapy Impact

When appraising psychotherapy, the importance of clinical significance has been increasingly recognised (Ogles, Lunnen, & Bonesteel, 2001). Kazdin (1999) referred to clinical significance as the "practical or applied value or importance of the effect of an intervention- that is, whether the intervention makes a real (e.g., genuine, palpable, practical, noticeable) difference in everyday life to the client or to others with whom the clients interact" (p. 332). Considering that analysis of clinical significance compares each person's scores against normative results and since each person acts as his or her own control, a control condition is unnecessary. Clinical significance takes into account outcomes for individual clients, addressing the issue of specificity, and is therefore a more stringent index of treatment effect than statistical significance (Hansen, Lambert, & Forman, 2002).

6.3.2 Clinical Significance is Operationalised According to Normative Comparisons and Measure Error

Several methods for evaluating meaningful change have evolved (Wise, 2004). For example, Hsu (1989) introduced the Gulliksen-Lord-Novick approach to address confounding of post-test scores through regression to the mean. After comparing different methodologies, however, Bauer, Lambert, and Nielson (2004) concluded that the statistical method introduced by Jacobson and his colleagues (Jacobson, Follette, & Revenstorf, 1984) and refined by Jacobson and Traux (1991) is widely used and a conservative estimate of clinical significance in outcome studies compared to other methods compared, including the Gulliksen-Lord-Novick approach.

Jacobson et al. (1984) used social comparison as a way of examining the meaningfulness of therapeutic change by comparing clients' scores with those of

normative reference groups before and after treatment. In this method, clinical significance is operationalised as movement from a dysfunctional to a functional population (based on normative comparisons) resulting from treatment. For change to be reliable, movement needs to be of a magnitude unlikely to be a consequence of measurement error.

6.3.3 Establishing a Cut-off Score

Calculating clinical significance necessitates normative comparisons (the functional distribution of scores) be established. A cut-off score, replacing the criterion of significance level in statistical significance, is the score at which the client is equally likely to belong to both functional and dysfunctional populations. Although Jacobson and Traux (1991) proposed three possible methods of calculating cut-off points, Bauer et al. (2004) considered that the weighted midpoint between functional and dysfunctional population means offered the optimal cut-off point.[14]

6.3.4 Establishing a Reliable Change Index

The reliable change index (RCI)[15] determines whether the change is reliable beyond error measurement. The RCI is calculated from pre-therapy and post-therapy mean scores and the standard error of measurement[16] (Bauer, Lambert, & Nielsen 2004). Calculation of a RCI that is equal to or greater than the *z*-score of 1.96 establishes a 95% probability level of reliable change, indicating that change after treatment is unlikely to result from measurement error (Jacobson & Traux, 1991). Where normative functional and dysfunctional distributions do not overlap, then

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[14] Cut-off point = [(SD_{clinical} x $M_{\text{non-clinical}}$) + ($SD_{\text{non-clinical}}$ x M_{clinical})] / ($SD_{\text{clinical}} +$ $SD_{\text{non-clinical}}$), where SD = standard deviation; M = mean.

[15] Using Jacobson and Traux's (1991) method: RCI = $(x_{\text{post-therapy}} - x_{\text{pre-therapy}}) / \sqrt{2 S_E^2}$, where x = client score; S^E = standard error of measurement

[16] $(S_E) = SD \sqrt{(1 - r_{xx})}$, where S_E = standard error of measurement; SD = standard deviation of the pre-treatment sample; r_{xx} = internal consistency of measure.

researchers deem movement from the dysfunctional to functional distribution as reliable (Jacobson, Roberts, Berns, & McGlinchey, 1999).

6.3.5 Distinguishing Change Categories: Clinical Significance, Improvement, No Change, Deterioration

According to Jacobson and Traux (1991), change is *clinically significant* when the client moves from a dysfunctional to a functional population (i.e., beyond the cut-off after treatment) and change is reliable; that is, when it is more probable that the client's post-test score belongs to the functional than dysfunctional population. Since it is sometimes unrealistic to expect severely impaired people to move into a functional population, *improvement*, when change is reliable but not sufficient to move into the functional population, is also of interest to clinicians and researchers (Kazdin, 1999). Clients are *unchanged* when change is not reliable and they have not moved to the functional population. Clients have *deteriorated* when scores changed reliably for the worse.

6.3.6 Clinical Significance as Indexed by the Beck Depression Inventory

Despite evidence that the BDI favours CT (Shapiro, Barkham, Rees, Hardy, Reynolds, & Startup, 1994), as one of the most frequently employed measures of depression in psychotherapy trials, it provides useful comparison data for evaluating the clinical significance of outcome from a previously untested psychotherapy. Adjusting for regression to the mean, Ogles, Lambert, and Sawyer (1995) evaluated the clinical significance of results from the NIMH TDCRP (Elkin et al, 1989) based on BDI scores from individuals who had completed 12 sessions and 15 weeks of CBT or IPT (Table 6.1). The researchers used data from previous research to calculate the BDI cut-off score as 13.46 and the RCI as 9.

Table 6.1

Percentage of Clients Attaining Change as Indexed by BDI Scores, Comparing

Cognitive Behaviour and Interpersonal Therapies: Results from Ogles et al. (1995)

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Seggar, Lambert, and Hansen (2002) added significantly to the literature on

clinical significance by formulating normative data for the BDI. With the intention of

providing a means for consistency across future outcome studies, Seggar et al.

calculated a reliable change index and cut-off point for the BDI. Following from

preliminary work (Jacobson et al., 1984; Nietzel et al., 1987; Tingey, Lambert,

Burlingame, & Hansen, 1996), Seggar et al. distinguished scores from a clinically

symptomatic population (inpatients and outpatients) from those of a community

population (non-patients), calculating the cut-off point for the BDI as 14.29 and the RCI

for the BDI as 8.46.

6.3.7 Clinical Significance as Indexed by the Outcome Questionnaire-45.2

When appraising psychotherapy, Kazdin (1999) emphasised the importance of examining markers of change other than symptoms. The Outcome Questionnaire-45.2 (OQ-45-2; Lambert, Hansen, Umpress, Lunnen, Okiishi, & Burlingame, 1999) provides a measure of intra-psychic, interpersonal and social function. Like the BDI, the OQ-45.2 is a standardised, valid and reliable self-report measure, demonstrating sensitivity to change (Vermeersch et al., 2004). As well as providing scores on general symptoms, the OQ-45.2 supplies scores for interpersonal relations, role function and a total score, summing results from the three subscales. Lambert et al. (1996) used methodology by Jacobson and Traux (1991) to calculate cut-off points and RCIs for the OQ-45.2 based on data from community and outpatient clinical samples for total and subscale scores.

Studies using the OQ-45.2 have generally aggregated results across different diagnoses and treatment orientations (e.g., Asay, Lambert, Gregerson, & Goates, 2002; Bauer, Lambert, & Nielsen, 2004; Beckstead et al., 2003; Lambert, Hansen, & Finch, 2001; Lambert, Ookiishi, Johnson, & Finch, 1998; Vermeersch et al., 2004). Several of the above studies examined expected rates of improvement, extending the dose-response paradigm. Across studies, the number of sessions at which clients attained clinically significant change according to the OQ.45.2 ranged widely. Diverse client, therapist, and treatment characteristics used within each study and across the studies possibly explains disparate results.

However, one study has reported OQ.45.2 results from clients described as suffering primarily from anxiety and depression. Kadera, Lambert, and Andrews (1996) reported that 50% of a sample of 64 clients attained clinically significant change by 6 sessions, and 75% by the 26th session. Table 6.2 presents pre-therapy and post-therapy means and standard deviations for the total scale and inter-personal sub-scale of the

OQ-45.2 from the 40 clients that completed at least seven therapy sessions in the

Kadera et al. study, as reported by Lambert et al. (1999).

Table 6.2

OQ-45.2[a] Pre-therapy and Post-therapy Means and Standard Deviations from 40

Clients for Seven Sessions of Psychotherapy: Results from Lambert et al. (1999)

This table is not available online. Please consult the hardcopy thesis available from the QUT Library

6.3.8 Evaluating Psychotherapy by Analysis of Clinical Significance

Considering that clinical significance is a more stringent index of treatment

effect than statistical significance (Hansen, Lambert, & Forman, 2002) and addresses

the issue of specificity (a limitation of statistical significance), its use in evaluating

psychotherapy outcome is warranted. Furthermore, given that the analysis of clinical

significance does not require the addition of a control group, it provides a valid

alternative or addition in situations where control conditions are impractical or unethical

such as in the evaluation of an empirically untested psychotherapy for adults with

depression.

6.4 Benchmarking

Benchmarking also addresses some of the practical and ethical limitations of

RCTs when evaluating psychotherapy. Benchmarking, for example, eliminates the

practical and ethical problems associated with control groups (see Section 6.2.4).

Sperry, Brill, Howard, and Grissom (1996) referred to benchmarking as "the establishment of reference points that can be used to interpret data" (p. 145). Benchmarked reference points provide alternative comparisons to the more commonly used control and alternative therapy conditions. Increased use of benchmarking is evidenced by a number of published studies in the prestigious Journal of Consulting and Clinical Psychology that have used benchmarking methodology (e.g., Franklin, Abramowitz, Kozak, Levitt, & Foa, 2000; Barkham et al., 2001; Merrill, Tolbert, & Wade, 2003; Wade, Treat, & Stuart, 1998; Weersing, 2005; Weersing & Weisz, 2002).

Researchers initially used benchmarking strategies to investigate the transportability of evidence-based treatments to practice settings. For example, Wade et al. (1998) investigated the transportability of CBT for panic disorder by benchmarking results for the treatment of panic disorder in a community health setting with results from two RCTs examining CBT for panic disorder. Franklin et al. (2000) also used benchmarking to investigate the transportability of an evidence-based treatment for obsessive-compulsive disorder (exposure and ritual prevention) to practice settings. Also examining the transportability of an evidence-based treatment to a practice setting, a recent study by Merrill et al. (2003) examined the transportability of manualised cognitive therapy (Beck et al., 1979) for adult depression to a community mental health centre (CMHC) setting. The researchers first compared CMHC and RCT samples on demographic and clinical characteristics. After the implementation of CT to 192 adult outpatients diagnosed with major depressive disorder, researchers benchmarked outcome results (as assessed by several measures, including the BDI-II) against outcomes from two RCT design studies (Hollon et al., 1992; Elkin et al., 1989). Finally, Merrill et al. categorised clients according to the BDI-II RCI index and clinical cut-off point defined by Ogles et al. (1995).

Weersing and Weisz (2002) extended the benchmarking paradigm by using benchmarking in a comparison trial of two treatments. With the goal of evaluating the treatment for adolescent depression in a CMHC setting, Weersing and Weisz identified the current best treatment for depressed adolescents from the relevant RCT literature and created composite statistical benchmarks for treatment and control conditions from different measures reported in the RCT research. In order to be comparable to youth in RCTs, Weersing and Weisz applied inclusion and exclusion criteria to the community clinic condition. For example, participants were required to meet diagnostic criteria for major depressive disorder and/or dysthymic disorder according to the Diagnostic and Statistical Manual of Mental Disorders, Third Edition, Revised (DSM-III-R; American Psychiatric Association, 1987) and to have scores of 12 or greater on the Children's Depression Inventory (Korvacs, 1992). Four stages distinguished the data analysis: (a) comparison of the CMHC sample with the RCT sample; (b) comparison of CMHC treatment with RCT treatment; (c) comparison of the CMHC mean depression symptom trajectory with RCT benchmarks, and; (d) examination of the impact of key variables on the symptom trajectory. Weersing and Weisz set a precedent in psychotherapy research, utilising a benchmarking strategy to compare two treatments.

By comparing results with those from previous RCTS, benchmarking offers a valid and feasible alternative for evaluating psychotherapy, and is consistent with analysis of statistical and clinical significance, providing important data for clinicians. While recognising that benchmarking designs are without within-trial control groups and therefore cannot verify the causality of psychotherapy outcomes, benchmarking can substantiate the comparability of outcomes of psychotherapy with outcomes from previous RCTs (Evans, Connell, Barkham, Marshall, & Mellor-Clark, 2003).

6.5 Therapy Dose

Brief psychotherapy, usually referring to treatment of 25 sessions or less, is now common in research and clinical practice (Shapiro et al., 2003). In practice, financial considerations often restrict the number of psychotherapy sessions delivered to clients experiencing depression. Psychological disorder correlates with poverty (Belle, 1990). Impaired productivity and educational failure associated with depression (Australian Bureau of Statistics, 1998) mean that individuals with depression are often financially constrained. For this population of people, access to psychotherapy therefore depends on government funding, which often prescribes short-term treatments (Cameron, 2006). For example, in the United States psychotherapy sessions are usually limited to between four and eight sessions (Lambert, 2007). The Australian Government recently introduced Medicare rebates enabling patients with specified mental disorders, referred by medical practitioners, to access eligible psychologists, social workers and occupational therapists for treatment (Australian Department of Health and Aged Care, 2006). While this was a huge step forward in terms of financial assistance for people experiencing psychological distress, rebates are presently available for up to 12 sessions only (with a GP review after 6 sessions). In response to economic considerations, many psychotherapy protocols offer brief treatments.

While some individuals are interested in or require long-term psychotherapy (Goldfried, 2004), many clients expect or choose short-term treatment to address their psychological difficulties (Shapiro et al., 2003). Findings from early studies, for example Kleinke (1994), suggested clients generally terminate sessions before 10 sessions, and the median treatment dose is six sessions. More recent research by (Hansen, Lambert, and Forman (2002), which collected data from 6,072 patients cross six sites calculated that clients chose to attend a mean of 4.3 ($SD = 3.5$) sessions.

The median number of sessions was three. Of individuals who commenced therapy, 33% chose not to return after only one session. Client behaviour therefore often dictates short-term therapy.

Economic, pragmatic and ethical considerations influence researchers' choices when evaluating untested psychotherapies. The logistical problems associated with conducting a research trial are higher for long-term treatments in comparison to short-term treatments, as are the costs in time and resources (Shapiro et al., 2003). Moreover, maintaining research participants on a lengthy but unevaluated therapy is ethically questionable.

Although research into the number of sessions required for improved outcome is mixed, the utility of brief intervention is supported. A substantial proportion of clients appear to improve in relatively few sessions. Seminal meta-analytic research (Howard, Kopta, Krause, & Orlinsky, 1986) investigated dose-response in 2,431 people, described as generally depressive or anxious neurotic. The researchers reported that over 10% of clients improved before the first therapy session, 53% demonstrated significant improvement after receiving eight weekly sessions of psychotherapy, with 75% demonstrating significant improvement by 26 sessions.

Although a higher proportion of clients appear to show improvement as the number of therapy sessions increase, research suggests that improvement proceeds at a decelerating rate. For example, in the research by Howard et al. (1986), cited in the previous paragraph, an increase from 8 to 26 sessions resulted in an improvement in an extra 18% of the clients. This phenomenon is corroborated by recent findings from quasi-experimental research. Barkham, Rees, Stiles, Hardy, and Shapiro (2002) combined and analysed data from the large Second Sheffield Psychotherapy Project (Shapiro et al., 1994), the Collaborative Psychotherapy Project (Barkham et al., 1996)

and research by Barkham, Shapiro, Hardy, and Rees (1999). The analysis compared 2, 8 and 16 sessions of either IPT or CBT for individuals with mild depression (BDI scores of 16-25). The authors reported that 38% of clients, who were in the dysfunctional range before therapy, achieved clinically significant change after three sessions, with 56% and 68% achieving clinically significant change after 8 and 16 sessions respectively. That is, over half of the clients improved after eight sessions, with an extra 12% of clients improving with double the number of sessions.

Response to treatment depends on client characteristics such as co-morbid diagnoses and severity of impairment (Shapiro et al., 2003). For example, in the research by Howard et al. (1986), depressed clients improved more quickly than those with anxiety or personality disorders. The Second Sheffield Psychotherapy Project (Shapiro et al., 1994) stratified clients according to depression severity (mild, moderate, severe) and allocated clients to either 8 or 16 session conditions for treatment with either PI or CBT (see Section 5.2.3). Researchers reported a significant interaction between severity and duration. Compared to the 16-session condition, severely depressed clients allocated to the eight-session condition demonstrated less symptomatic improvement, as measured by the BDI.

Relevant to therapy dose are findings suggesting that therapy change proceeds in phases, each phase building on previous ones (Howard, Lueger, Maling, &.Martinovich, 1993; Kopta, Howard, Lowry, & Beutler, 1994). According to these researchers, acute symptoms associated with subjective well-being (e.g., crying) alleviate initially, followed by resolution of more chronic symptoms (e.g., interpersonal problems), followed by improvement in long-standing characteristics (e.g., overeating). Consistent with the phase model, recovery from interpersonal problems has been found to be

slower than from depressive symptoms, requiring more therapy sessions (Barkham et al., 2002; Barkham et al., 1996).

In terms of conducting research that is relevant to clinical practice, implementation of brief therapy is coherent with the actualities of financial limitations and client behaviours, whereby individuals who seek psychotherapy usually access relatively few sessions.

6.6 Choosing the Primary Analysis Given Client Attrition:

Intention to Treat, Completer and Follow-up Samples

An important decision in psychotherapy outcome research concerns which data is the primary analysis to report. Several samples are possible, and choosing the most representative sample while remaining conservative are important considerations. Many research participants do not complete a given research intervention, withdrawing from therapy before the end of the intended intervention for a myriad of reasons. The pre-therapy to post-therapy or post-therapy to follow-up results of clients who withdraw are frequently unavailable.

The attrition of research participants remains a significant problem in generalising results from psychotherapy trials (Lambert & Ogles, 2004). In clinical practice, attrition is common. Meta-analysis (Wierzbicki & Pekarik, 1993) of 125 studies researching psychotherapy found a mean rate of client dropout of 46.86%. The problem of attrition transports to psychotherapy trials. In the benchmark NIMH TDCRP study (Elkin et al., 1989), for example, of the 239 clients that commenced, 155 completed 12 sessions and 15 weeks of therapy (i.e., 35% attrition). Although there is considerable variation in attrition rates across studies, researchers estimate that 20% of participants will not complete the intervention (Mason, 1999). Alternatively, some clients commence another form of treatment during the research intervention period,

and their data may confound the validity of results. Likewise, some participants complete the intervention but do not provide follow-up data (for a myriad of reasons), or their responses suggest that their data may confound results.

Although some psychotherapy trials incorporate several assessment points (e.g., pre-therapy and before or after each session), many are characterised by pre-therapy and post-therapy assessment points only, sometimes with the addition of one or more follow-up assessment points. From these designs, at least three potential samples are possible for analysis. In psychotherapy research, an *intention-to-treat* (ITT) sample comprises all participants allocated to a group regardless of treatment received or participants' behaviour (Heritier, Gebski, & Keech, 2003). A *completer* sample comprises individuals who complete all sessions of the intended intervention and have valid data (e.g., have not commenced an alternative treatment). A *follow-up* sample comprises individuals who completed the intervention and provided valid data at the follow-up assessment.

At first glance, completer clients appear to be the most representative sample to provide data to evaluate treatment impact; participants have completed the intervention and supplied valid data. From a comparison of completer and ITT samples in the context of psychotherapy for depression, however, Minami, Wampold, Serlin, Kircher, and Brown (2007) concluded that exclusion of dropouts resulted in significantly larger pre-treatment to post-treatment effects sizes. When comparing results from naturalistic research to RCT data, Minami et al. recommended comparing non-completer clients with ITT sample set data and comparing completer clients with completer sample set data. The Consolidated Standards of Reporting Trials (CONSORT) was developed to improve criteria for the uniform reporting of clinical trials. The CONSORT statement proposed that report of intention to treat data was preferred (Moher, Schulz, & Altman,

2001). The use of the last score obtained as the treatment-end outcome score, or last observation carried forward (LOCF) for the relevant measures is used to provide a conservative estimate of outcome. Adopting ITT analysis makes most sense when researchers obtain data at several stages of the intervention and follow-up period.

There are potentially biasing problems with both ITT and completer analyses (Crits-Chritoph & Gallop, 2006). Arguably, adopting ITT analysis that uses pre-therapy data to substitute missing post-therapy values or follow-up values, and post-therapy data to substitute missing follow-up values presents several opportunities for error. Underpinning LOCF analyses is the assumption that clients do not change over time. On the other hand, underpinning completer analyses is the assumption that missing values are missing completely at random. Arguably, researchers need to use the analysis, which makes most sense in the context of their own research, or otherwise, present both analyses.

6.7 Analysis of Clinical Significance and Benchmarking Provide Valid and Clinically Useful Evaluations of Psychotherapy Outcome

The intention of this chapter was to highlight important methodological and statistical considerations when conducting psychotherapy outcome research involving individuals with psychological distress, such as major depressive disorder. In doing so, I seek to justify major research design decisions in the current study, as well as decisions on therapy dose and sample analyses. This chapter also presented data on clinical significance, useful for later comparison.

In summary, randomised controlled trials have provided a wealth of information, adding to our understanding of psychological disorder and psychotherapy outcome. Calculation of statistical significance and effect size offers important information on the reliability and magnitude of psychotherapy change. Practical and ethical considerations

associated with RCTs (treatment versus treatment or treatment versus control) mean that such research designs are not always appropriate.

Analyses of the clinical significance of outcome, together with a benchmarking strategy provide useful additions to the analysis of the statistical significance of pre-therapy to post-therapy change. Statistical procedures calculating clinical significance use normative comparisons, eliminating many of the practical and ethical problems associated with the use of comparison groups in RCTS. By providing information on the impact of therapy on individuals, use of clinical significance minimises the gap between research and clinical practice. Similarly, benchmarking eliminates the necessity of within-trial comparison groups and offers a procedure of comparing psychotherapy with previous RCTs, providing additional useful information. Although analysis of clinical significance and benchmarking do not replace RCT designs, understanding of psychotherapy can be progressed by these alternative research methodologies and statistical procedures that provide valid and clinically relevant findings. Such methodological considerations have informed the design of the current study.

CHAPTER 7

THE CURRENT RESEARCH

7.1 Introduction to the Current Research

This research is motivated by the potential that a theoretical synthesis of dialogical narrative theory with narrative research and practice might improve our understanding of narrative change processes (see Sections 3.7.7 and 3.8), as well as the dearth of empirical research into narrative therapy process and outcomes (see Sections 5.4 and 2.5.5). This research is founded on specified philosophical and methodological arguments about psychotherapy and research (see Chapter 2). The purpose of this chapter is to introduce the current study. After providing a research rationale, the research aims and questions are stated. Description of the design of the overall research then delineates how this study addressed the research questions. Finally, the primary research hypotheses and their rationales are proposed.

7.2 Rationale for the Current Research

One omission in the area of psychotherapy is that there currently exists no comprehensive synthesis of theorised dialogical processes, narrative research and narrative therapy as commonly practiced. Nor is there rigorous empirical research into processes of therapeutic change in narrative therapy. There also exists no rigorous empirical research investigating the outcomes of narrative therapy, specifically in the treatment of adults with major depressive disorder. Research into the process and outcome of narrative therapy for depression is required to gain an understanding of narrative processes of therapeutic change and to provide clinicians with a broader evidence base for the practice of narrative therapy than currently exists.

Dialogical narrative theorists employ the notion of dialogue, rather than story and emphasise inter-subjective processes (e.g., Hermans & Kempen, 1993). Research

into therapeutic change processes proposed by dialogical narrative theorists, has the potential to contribute to our understanding of therapeutic change processes that underpin narrative practice, with possible implications for understanding psychotherapeutic processes overall.

Dialogical theorists contend that the client engages with his or her self and others in dialogical conversations in order to access multiple personal dimensions of self that give meaning to experience. From this perspective, psychotherapy involves inter-subjective and dialogical processes whereby the self speaks with the self (and with others as aspects of the self) so that experience integrates with meaning. That is to say, psychotherapy involves intra-personal and inter-personal processes. The *otherness* that comes with such multiplicity provides varied perspectives through which dialogues occur and new meanings are created, discernible in richer, more complex dialogues (Gonçalves et al., 2002; Hermans, 2006; Lysaker & Lysaker, 2002).

The Narrative Processes Model (Angus et al., 1999) proposed that therapists facilitate therapeutic change by shifting therapy conversations across external, internal and reflexive modes of discourse. Research utilising the NPCS (Angus et al., 1996), developed from the Narrative Processes Model, suggests that the process of reflexivity, the integration of external and internal experience with meaning, is central to psychological well-being and therapeutic change.

According to narrative therapists, narratives associated with psychological distress, are discernible in thin and impoverished stories (White & Epston, 1990). Informed by social constructionist and constructivist assumptions, a significant element of narrative practice is to assist clients to make meaning of their experience through conversations that traverse landscapes of action and identity, resulting in richer stories that open up possibilities (White, 2007). Although narrative therapists generally evoke a

story metaphor to explain processes of therapeutic change, in practice narrative therapy focuses on conversations involving dialogical rather than monlogical processes (White, 2007). Further, although narrative therapists emphasise inter-personal dimensions of therapy (White, 2007), narrative theorists hold that intra-personal and inter-personal dimensions are reciprocally embedded within inter-subjective narrative processes (e.g., Vygotsky, 1934/1987; Wittgenstein, 1958).

This thesis sought to articulate a synthesis of narrative theory, research and practice. The integration of experience with meaning is common to dialogical narrative theory (Hermans & Kempen, 1993), narrative theory and research of the NPCS (Angus et al., 1999; Angus et al., 1996) and narrative therapy (White, 2004). Across these three narrative domains, the integration of experience with meaning can be conceptualised as involving the process of narrative reflexivity, a creative, inter-subjective and dialogical process, with inter-personal and intra-personal dimensions, through which individuals engage with their selves and others. Further, narrative reflexivity is discernible in individuals' dialogues, and the NPCS offers a metric for examining change in narrative reflexivity in the context of narrative therapy for depression in adults.

Based on dialogical narrative theory, the therapeutic relationship is a pivotal inter-personal element of this inter-subjective process. The therapist provides an *other*, who engages in dialogue with the client. From a narrative practice perspective, each member of the therapeutic dyad brings expertise to therapeutic conversations, influencing the understandings of the other in inter-personal inter-change (Anderson, 1997). Through "transformative dialogue" (Gergen & McNamee, 2000, p. 343), new meanings and new stories are constructed, creating a richer self, a richer narrative, and opening up new possibilities of being-in-the-world (Anderson & Goolishian, 1990). Considering the role of the therapeutic relationship in facilitating transformative

dialogues, it would be reasonable to expect relationships between the therapeutic alliance and outcomes.

Outcome research into psychotherapies that lend themselves to objective methodologies predominate the psychotherapy outcome literature. Research suggests *bone fide* therapies are likely to produce similar outcomes (Wampold et al., 2002). Inspired by narrative ideas, researchers who have investigated narrative therapy, however, have generally rejected the use of objective research designs (Kelley, 1998). This thesis argues that rejecting the knowledge that emanates from inductive thought is not congruent with fundamental assumptions of post-modernism. Although some studies have used quantitative methods to investigate narrative therapy, the measures and statistical analyses used were not consistent with traditional psychotherapy outcome trials, limiting comparison with outcomes from standard psychotherapies. Research investigating narrative therapy in the treatment of adult depression, utilising objective methods and widely used outcome measures, would enable therapists to compare processes and outcomes of narrative therapy with those from alternative approaches. Such comparison would complement the qualitative and case study research that currently comprises the evidence base for narrative therapy, and would contribute to the wider-evidence base required to justify the implementation of narrative therapy in clinical practice.

One way of investigating the process of narrative therapy is to examine the level of narrative reflexivity in therapy dialogues and to investigate how narrative reflexivity relates to successful and unsuccessful therapeutic outcomes in terms of depressive symptomatology. Another way of examining the process of narrative therapy is to examine the relationship of the therapeutic alliance with therapy outcomes. The perspectives that dialogical narrative theories have contributed, specifically the

interpretation of a self as multiple, inter-subjective, dialogical and reflexive, presents a construal of self that may assist our understanding of change processes in narrative therapy, so that therapists may shape the course of therapy to enhance the effectiveness of treatment.

7.3 Research Aims and Objectives

Given the potential utility of examining the process of therapeutic change from a dialogical narrative perspective, and given the dearth of empirical research into narrative therapy for adult depression, the overall aim of this research was to investigate the process and outcome of narrative therapy in the treatment of major depressive disorder in adults. This over-arching aim comprised three major objectives, as follows, in the context of narrative therapy for adults with major depressive disorder:

1. Provide a theoretical link integrating theorised dialogical narrative processes of psychotherapeutic change, with narrative research and narrative practice.

2. Examine processes of narrative therapy, specifically narrative reflexivity and the therapeutic alliance and their relation to therapy outcomes.

3. Investigate intra-personal (depressive symptoms) and inter-personal (inter-personal relatedness) outcomes of narrative therapy through analyses of statistical significance, clinical significance and benchmarking.

Towards the first objective, I identified the process of narrative reflexivity as a theoretical construct of meaning-making linking dialogical narrative theory with narrative research into reflexivity and narrative practice (See Chapter 3). The remaining sections of Chapter 7 are concerned with providing empirical support for this theorised synthesis.

7.4 Primary Research Questions

7.4.1 Process of Narrative Therapy in the Treatment of Adults with Major Depressive

Disorder

Two primary research questions into the process of narrative therapy arose from the research aims and objectives. Following the implementation of narrative therapy for adults with major depressive disorder:

1. Comparing least improved and most improved clients, is there a differential change in narrative reflexivity?

2.   Are improvements in the quality of the therapeutic alliance quality related to improved post-therapy depressive symptoms and inter-personal relatedness?

7.4.2   Outcome of Narrative Therapy in the Treatment of Adults with Major

Depressive Disorder

Four primary research questions into the outcome of narrative therapy arose from the research aims and objectives. Considering the clinical context of this research, this thesis specifically delineates enquiries into statistical and clinical significance of change. Following the implementation of narrative therapy for adults with major depressive disorder:

1   Are there statistically significant improvements in depressive symptoms and inter-personal relatedness from pre-therapy to post-therapy?

2   What proportions of clients achieve clinically significant change, as indexed by change in depressive symptoms and inter-personal relatedness from pre-therapy to post-therapy?

3. Are improvements in depressive symptoms and inter-personal relatedness maintained from post-therapy to three-month follow-up?

4. Are pre-therapy to post-therapy gains in depressive symptoms in the current study comparable to those from evidence-based psychotherapies, reported in benchmark research?

7.4.3 Supplementary Research Questions

From the review of the literature, four questions emerged as useful in clarifying outcome results. Empirical investigation of the following questions was exploratory, without hypotheses. After eight sessions of narrative therapy in the treatment of adults with major depressive disorder:

1. Is there a differential change in depressive symptoms from pre-therapy to post-therapy depending on the severity of pre-therapy depressive symptoms?

2. Is depressive symptom outcome, as assessed by the BDI-II, confirmed by an alternative measure of depressive symptomatology?

3. Do clients express satisfaction with narrative therapy?

4. Do completer and non-completer clients differ in pre-therapy depressive symptoms and inter-personal relatedness?

7.5 Overview of Research Design

A clinical trial investigated the process and outcome of narrative therapy in the treatment of major depressive disorder in adults. Simultaneous investigation of process and outcome components enabled evaluation of the process of narrative therapy as it relates to outcome.

Investigation into the processes of narrative therapy used a single-sample repeated measures design. The within-groups independent variable was narrative therapy, operationalised as exposure to eight sessions of manualised narrative therapy. There were two dependent process variables: narrative reflexivity and therapeutic alliance. Narrative reflexivity was assessed at Sessions 1 and 8. Therapeutic alliance was assessed at Sessions 1, 3 and 8. Table 7.1 shows operational definitions of dependent process variables.

The evaluation of narrative therapy outcome used a single-sample repeated-measures design. A benchmarking strategy contributed to the assessment of pre-therapy to post-therapy treatment gains, effect size and clinical significance. The within-groups independent variable was narrative therapy, operationalised as exposure to eight sessions of manualised narrative therapy. There were 10 assessment points: initial assessment, Sessions 1-8 and three-month follow-up[17]. The initial assessment point provided the pre-therapy data. Questionnaires completed after Session 8 provided post-therapy data. The dependent outcome variables were depressive symptoms, interpersonal relatedness and therapy satisfaction. Table 7.1 shows the operational definitions of the dependent outcome variables.

7.6 Hypotheses for Primary Research Questions

7.6.1 Form of Hypotheses

For each primary research question, a brief rationale is presented, followed by a formal hypothesis. Consistent with the advice of Pedhazur and Schmelkin (1991) that, "...hypotheses should refer to the variables of interest, *not* to the specific indicators, or

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[17] Some measures were not administered at all assessment points. Clients completed the BDI-II at pre-therapy, post-therapy and follow-up only and STS-T at post-therapy only.

the specific empirical definition used" (p. 179), formal hypotheses propose relationships between the variables being studied in this research. Table 7.1 provides the operational forms of the relevant variables. Where appropriate, the symbolic forms of the research and null hypotheses are presented. For clarity, symbolic forms of the hypotheses use operational definitions.

7.6.2 Hypotheses for Primary Process Research Questions

7.6.2.1 Primary Process Question 1: Differential Change in Narrative Reflexivity in Least and Most Improved Clients

Since narrative approaches to therapy are informed by the theoretical position (outlined in Sections 3.3 to 3.6) that: (a) improved therapeutic outcome occurs through a dialogical process of meaning-making whereby the person develops a richer narrative, and (b) richer narratives contain a higher proportion of reflexive dialogue, it was predicted that:

H_1: In the narrative treatment of depression, change (from Session 1 to Session 8) in the mean proportion of reflexive discourse would be greater in most improved clients than in least improved clients, with improvement indexed by BDI-II scores.

H_1: $\mu_{\text{\% of reflexive discourse in most improved clients}} > \mu_{\text{\% of reflexive discourse in least improved clients}}$

H_{01}: $\mu_{\text{\% of reflexive discourse in most improved clients}} \leq \mu_{\text{\% of reflexive discourse in least improved clients}}$

Table 7.1

Operationalisation of Dependent Outcome and Process Variables

Dependent Variables	Operational Definitions (scores)	Acronym	Authors
Outcome			
Depressive Symptoms	Beck Depression Inventory II	BDI-II	Beck et al., 1996
	Depression Anxiety Stress Scale-Depression Subscale	DASS-D [a]	Lovibond & Lovibond, 1995
Interpersonal Relatedness	Outcome Questionnaire 45.2-Interpersonal Relations Subscale	OQ45.2IR [a]	Lambert et al., 1999
Satisfaction with Therapy	Satisfaction with Therapy and Therapist Scale-Therapy Subscale	STS-T	Oei & Shuttlewood, 1999
Process			
Narrative Reflexivity	Narrative Processes Coding System[a]	NPCS [b]	Angus, Hardtke, & Levitt, 1996
Therapeutic Alliance	Working Alliance Inventory- Short Form	WAI-S[c]	Tracey & Kokotovic, 1989

[a] Clients completed the DASS-D and OQ-45.2 IR at initial assessment, after each therapy session and at three-month follow-up. [b]NPCS is coded, then scored. [c]Clients completed the WAI-S at Session 1, 3, 8.

7.6.2.2 Primary Process Question 2: Relationship of the Therapeutic Alliance with

Post-therapy Depressive Symptoms and Inter-personal Relatedness

Based on previous research indicating the therapeutic alliance predicts outcome across different therapy modalities (Sections 3.7.4 to 3.7.5) and based on the centrality of the therapeutic relationship theorised by proponents of narrative therapy (Section 3.7.7), it was predicted that:

H_2:   After eight sessions of narrative therapy, mean pre-therapy to post-therapy depressive symptom change would be negatively correlated with mean therapeutic alliance change from Session 1 to 8.

H_2: $r_{xy} \neq 0$

H_{02}: $r_{xy} = 0$

Where: x = mean BDI-II decrease from pre-therapy to post-therapy

     y = mean WAI-S increase from Session 1 to 8

H_3:   After eight sessions of narrative therapy, mean pre-therapy to post-therapy interpersonal relatedness change would be negatively correlated with mean therapeutic alliance change from Session 1 to 8.

H_3: $r_{xy} \neq 0$

H_3: $r_{xy} = 0$

where x = mean OQ 45.2 IR decrease from pre-therapy to post-therapy

     y = mean WAI-S increase from Session 1 to 8

7.6.3 Hypotheses for Primary Outcome Research Questions

7.6.3.1 Primary Outcome Question 1: The Statistical Significance of Depressive Symptom and Inter-personal Relatedness Outcomes

Based on previous research (outlined in Section 5.2) indicating that standard psychotherapies were effective in the treatment of adult depression, and on previous research (outlined in Section 5.3) that psychotherapies appear to produce broadly equivalent outcomes, it was predicted that:

H_4:   After eight sessions of narrative therapy, mean depressive symptoms would be significantly lower at post-therapy than pre-therapy.

H_4: μ post-therapy BDI-II scores $<$ μ pre-therapy BDI-II scores

H_{04}: μ post-therapy BDI-II scores $\geq$ μ pre-therapy BDI-II scores

Based on theoretical notions of psychotherapy as a process of inter-subjective change (outlined in Section 2.4.3), it was predicted that:

H_5:   After eight sessions of narrative therapy, mean inter-personal relatedness problems would be significantly lower at post-therapy than pre-therapy.

H_5: μ post-therapy OQ45.2 IR scores $<$ μ pre-therapy OQ45.2 IR scores

H_{05}: μ post-therapy OQ45.2IR scores $\geq$ μ pre-therapy OQ45.2 IR scores

7.6.3.2 Primary Outcome Question 2: The Clinical Significance of Depressive Symptom and Inter-personal Relatedness Outcomes

Based on previous research indicating that psychotherapy produced clinically significant change in over 50% of clients experiencing depression (outlined in Section 6.3.6), and that psychotherapies appear to produce broadly equivalent outcomes (outlined in Section 5.4.3), it was predicted that:

H$_6$:   After eight sessions of narrative therapy, the percentage of clients achieving

clinically significant change, as indexed by BDI score change from pre-therapy

to post-therapy, would be equal to or over 50%.

H$_6$:   %$_{\text{clinical significance of BDI-II change from Pre-therapy to Post-therapy}} \geq 50\%$

H$_{06}$:   %$_{\text{clinical significance of BDI-II change from Pre-therapy to Post-therapy}} < 50\%$

Since, to my knowledge, there exists no research examining the proportion of clients

achieving clinically significant change in inter-personal relatedness from pre-therapy to

post-therapy in the context of psychotherapy for depression, this part of the second

research question was exploratory and no hypothesis was proposed.

7.6.3.3 Primary Outcome Question 3: Maintenance of Depressive Symptom and Inter-personal Relatedness Outcomes at Three-month Follow-up

Based on previous research of standard psychotherapies (outlined in Section

5.2.5) which found maintenance of post-therapy gains at three-month follow-up, it was

predicted that:

H$_7$:   After eight sessions of narrative therapy, the mean three-month follow-up scores

for depressive symptoms would not differ from mean post-therapy scores.

H$_7$: $\mu_{\text{three-month follow-up BDI-II scores}} = \mu_{\text{post-therapy BDI-II scores}}$

H$_{07}$: $\mu_{\text{three-month follow-up BDI-II scores}} \neq \mu_{\text{post-therapy BDI-II scores}}$

H$_8$:   After eight sessions of narrative therapy, the mean three-month follow-up scores

for inter-personal relatedness would not differ from mean post-therapy scores.

H$_8$: $\mu_{\text{three-month follow-up OQ45.2 IR scores}} = \mu_{\text{post-therapy OQ45.2 IR scores}}$

H$_{08}$: $\mu_{\text{three-month follow-up OQ45.2 IR scores}} \neq \mu_{\text{post-therapy OQ45.2IR scores}}$

7.6.3.4 Primary Outcome Question 4: Comparability of Narrative Therapy Depressive

Symptom Outcome with Evidence-Based Psychotherapies

Based on previous research (outlined in Section 5.3) that psychotherapies appear to produce broadly equivalent outcomes, it was predicted that:

H_9:   Pre-therapy to post-therapy gains in mean depressive symptoms following

narrative therapy would equal those of evidence-based psychotherapies.

H_9: μ BDI-II pre-post gain scores from NT $=$ μ BDI-II pre-post gain scores evidence-based psychotherapies

H_{09}: μ BDI-II pre-post gain scores from NT $\neq$ μ BDI-II pre-post gain scores evidence-based psychotherapies

7.7 Concluding Comments

The purpose of this chapter was to introduce the current research, setting the context for the subsequent three chapters (Chapters 8, 9, and 10) which address the research program, the research method and the research findings respectively. As such, the research rationale, aims, objectives, primary research questions, supplementary questions, research design, and hypotheses were proposed.

CHAPTER 8

RESEARCH PROGRAM

8.1 The Overall Research Program

The purpose of this chapter is to situate the process-outcome trial in the overall
research program (Figure 8.1). The implementation of the process-outcome trial of
narrative therapy in the treatment of major depressive disorder in adults required 10
preparatory stages. Chapter 9, the following chapter, details the method of the clinical
trial. To address the research questions, data analyses followed the process-outcome
trial.

This chapter describes the 10 preparatory stages for the conduct of the clinical
trial into the process and outcome of narrative therapy, providing rationales and
research evidence for research decisions where appropriate. Preparatory stages
comprised: ethical clearance; development of the manualised narrative therapy
intervention and narrative therapy integrity measure; development of a narrative therapy
training video and training program; recruitment of adherence raters and therapists;
training in manualised narrative therapy; training raters to implement the therapy
integrity measure, and; recruitment and training of a coder to evaluate narrative
reflexivity. The final section of the chapter describes protocols used to evaluate
narrative outcome and process, with particular attention to the benchmarking strategy
used to evaluate outcome analyses.

The delineation of these steps aims to situate the process-outcome trial in the
overall research program and to illustrate how this research investigated the outcome of
narrative therapy and theorised processes of therapeutic change in a population of adults
with major depressive disorder.
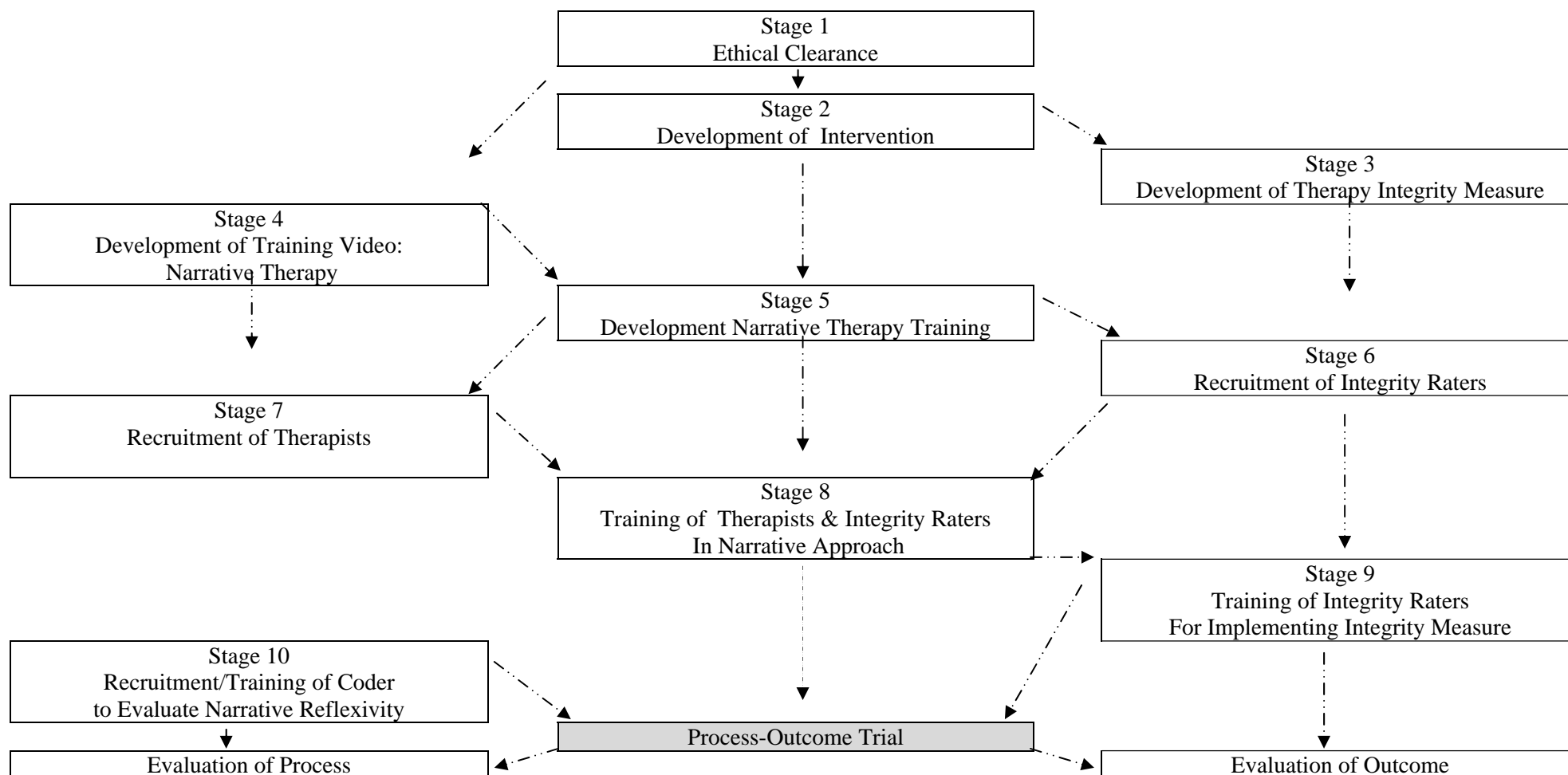
Figure 8.1. Overview of the research program, situating the process-outcome trial in relation to the preparatory stages and process-outcome evaluation. Stages are numbered in chronological order. Arrows show inter-relations between stages.

8.2 Preparatory Stages

8.2.1 Ethical Clearance

The research involved human participants in the context of a psychological treatment involving an innovative intervention and clinical trial. The first stage (Figure 8.1) involved acquiring ethical clearance for the conduct of the clinical trial. As such, the research program required that the researcher apply for and be granted full approval to undertake research involving human participants from the Queensland University of Technology (QUT) University Human Research Ethics Committee (UHREC). The UHREC granted ethical approval (QUT Reference number 3323H), ratified on the 17th February 2004.

8.2.2 Development of the Narrative Intervention

8.2.2.1 Development of a Narrative Manual

The second stage (Figure 8.1) was the development of a manualised narrative therapy intervention titled, A Narrative Approach to Therapy: Guiding Principles and Practice (Appendix A). Research treatment manuals specify therapy so that a specific research intervention is consistent with the principles and theory underpinning the nominated therapy orientation and clinical practice, and consistent across therapists participating in the research trial. Two therapists, with acknowledged expertise in narrative therapy reviewed the manual as being consistent with a narrative approach.

Manualisation of post-modern therapies for the purpose of research is rare. Prescriptive therapy is inconsistent with the assumptions and theory underpinning post-modern therapies (Pote, Stratton, Cottrell, Shapiro, & Boston, 2003). One notable exception is the Systemic Family Therapy Manual that was developed by the Leeds Family Therapy and Research Centre (Pote et al., 2000). To my knowledge, a research manual for narrative therapy did not exist prior to the current study.

Given the absence of a research manual for narrative therapy, the empirical nature of the current research required developing a narrative therapy manual. Given that this thesis challenged the notion that objective methodologies are inconsistent with narrative theory (see Section 2.6), a manualised narrative approach is coherent, but with the caveat that this manual does not profess to represent the only approach to narrative therapy. To provide a singular account of narrative therapy would be inconsistent with the notion of multiplicity that underpins narrative philosophy. Utilisation of a research treatment manual allowed a credible comparison with outcomes from comparison manualised interventions.

In this thesis, I use the term *manual* to be consistent with empirical psychotherapy literature, but with the qualification that I use the term with its least prescriptive meaning. In developing the manual, the tension between modern and post-modern frameworks needed to be recognised. The primary intention was to specify a narrative approach that was consistent with narrative therapy, as commonly practiced, and true to the spirit and ethos of the narrative world-view, but at the same time could be standardised across research therapists.

Workshop attendance and intensive review of narrative literature largely informed the development of the manual. Techniques and knowledge gained by attendance at an intensive one-week workshop in the practical implementation of narrative therapy facilitated by Michael White strongly influenced the overall structure and tone of the manual. Consistent with the primary intention of developing a manual that was consistent with the clinical practice of narrative therapy, Michael White is widely recognised for interpreting narrative theory in the context of therapy practice and many practicing narrative clinicians follow his framework (Gergen & Gergen, 2006). The manual was also influenced by an in-depth review of literature about narrative

theory and practice (e.g., Anderson, 1997; Angus, Levitt, & Hardtke, 1999; Bruner, 1986; Freedman & Coombs, 1996; Gergen, 1985a; McLeod, 1997; Monk, Winslade, Crocket, & Epston, 1997; Morgan, 2000; Omer, 1993; Payne, 2000; Sarbin, 1986; Schafer, 1976; Spence, 1983; White & Epston, 1990).

The manual acknowledged the heterogeneity of depression, conceiving the categorisation of depression as a heuristic, helpful in communication, but essentially constructed by society. Instead of assuming that the difficulties each person brings to therapy have a preconceived aetiology and course, the manual, and therefore the intervention, focused on the personal meaning of stories that each person brought to the therapy session. That is not to say that the experience of depression does not exist; this thesis has argued that the linguistic processes of self, associated with psychological distress, are embodied.

After a general introduction, the manual comprised eight training modules.The first three modules provided the theory underpinning narrative practice. The first module outlined the key assumptions that inform the practice of narrative approaches. Matters addressed included: post-modern ideology; narrative construction of reality; narrative as a way of knowing; meaning-making; landscapes of action and consciousness, and; self as multiple and relational. The second module delineated the narrative approach to problems and therapeutic change. Issues addressed included: the narrative conceptualisation of problems; the role of dominant problem stories and powerful discourses; the presence of alternative stories; the notion of deconstruction; making new meaning, and; transformative dialogues. The third module provided a very general framework for narrative sessions.

The five training modules that followed presented five phases of narrative therapy. A narrative world-view, which acknowledges a relational context, was

emphasised throughout the manual. A prescriptive approach was minimised in recognition of the constructionist paradigm underlying narrative therapy. Narrative theorists consider that narrative therapy continues to evolve (McLeod, 1997), and the notion of narrative therapy as a cohesive whole, with a recipe for applying techniques would be anathema to narrative-informed therapists. Instead, the manual presented five broad phases that encompass key concepts of narrative theory and practice, but is highly flexible within the phases. The five phases comprised: (a) developing a therapeutic relationship; (b) eliciting problem stories; (c) deconstructing dominant stories; (d) embracing preferred stories, and; (e) living enriched stories. Section 2.5.4 outlined these key phases, which are detailed in the manual (Appendix A).

The manual contained no linear session-by-session instructions. The approach advocates an iterative and recursive interweaving of the five phases. Emphasis on the broad processes of therapy, rather than techniques, provided specific criteria for implementing a narrative approach. For each of the five phases, the manual provided key principles, and offered strategies and examples of how these principles may be applied. The initial overview of the assumptions and theory of narrative therapy and therapeutic change were intended to colour the way in which the phases were implemented. Within the broad phases, the strategies offered are couched in terms of their underpinning theoretical principles. The recursive and flexible nature of the manualised approach allowed for the contributions of both therapists and clients.

The final section of the manual contained a list of proscribed practices. It is important to note that the list of proscribed practices did not include specific techniques found in other therapeutic orientations. Therapeutic techniques are considered valid if incorporated within a narrative framework.

8.2.2.2 Therapy Dose

Establishing the number of sessions, or therapy dose, was important when developing the research intervention. Primarily, adoption of an eight-session intervention addressed ethical concerns about maintaining potentially vulnerable individuals on a previously empirically untested treatment for an extended period (see Sections 4.6 and 6.5). An eight-session intervention was pragmatic in terms of time, resources and costs, but also aligned with the realities of clinical practice and previous research that supports brief therapy as effective.

8.2.3 Development of a Therapy Integrity Measure

8.2.3.1 Rationale in the Development of the Narrative Therapy Integrity Schedule

During the third stage of the research program, the investigator developed a measure to evaluate the integrity of the narrative therapy intervention (Figure 8.1). Use of the Narrative Therapy Integrity Schedule (N-TIS; Appendix B) provided a manipulation check on the construct validity of the independent variable, the narrative therapy intervention. The N-TIS is an observer-rated measure (applied to video or audio taped therapy sessions) that examines intervention therapy integrity by evaluating therapists' adherence to the manualised approach and therapists' competence in delivering the approach.

8.2.3.2 Adequate Therapy Integrity

In the current study, adequate intervention integrity required progression through the five prescribed phases over three sessions, with minimal use of proscribed practices. Methods of measuring therapy integrity in research trials comprise an array of diverse methods, without a widely accepted methodology (Hogue & Liddle, 1996). The current study followed several suggestions proposed by Waltz, Addis, Koerner, and

Jacobson (1993), as well as those of Perepletchikova and Kazdin (2005), who outlined

limitations in the current literature and offered specific recommendations.

There appears to be no criteria in narrative literature delineating adequate

integrity to narrative therapy. The investigator considered that the five broad phases of

the manualised narrative approach were fundamental to the narrative theory of change,

either providing the necessary context or actively contributing the therapeutic change

processes. At the same time, considerable movement within the five broad phases was

possible. The structure of the N-TIS reflects the flexible delivery of the five broad

narrative phases of the narrative manual. Recognising the non-prescriptive and recursive

nature of narrative therapy, the unit of analysis was three full therapy sessions: an early

session, a middle session and a late session. To minimise the cost of video tapes, the

current study used Session 1 tapes to represent early session tapes and Session 8 tapes to

represent late session tapes since these were required for the analyses of therapy

process. Therapists taped a middle session at random (any one of Sessions 2, 3, 4, 5, 6,

7). Where a video or audio tape of a session was unavailable or inaudible because of

technical problems, adherence was calculated from the remaining two sessions.

8.2.3.3 Therapy Adherence

According to Waltz, Addis, Koerner, and Jacobson (1993), therapy adherence

refers to "the extent to which a therapist used interventions and approaches prescribed

by the treatment manual and avoided the use of intervention procedures proscribed by

the manual" (p. 620). N-TIS comprised items that corresponded closely with the

intervention manual developed for the research, and measured both positive and

negative adherence. Items applied to therapist behaviours only. Positive adherence items

(items 1-15) evaluated whether therapists performed behaviours prescribed by the

intervention manual. The N-TIS grouped positive items according to five manual phases

(each phase with three items). Negative adherence items (items 16-18) evaluated whether therapists performed behaviours proscribed by the intervention manual.

8.2.3.4 Therapist Competence

The N-TIS also indexed therapist competence. According to Waltz et al. (1993), competence refers to,

> …the level of skill shown by the therapist in delivering the treatment. By skill, we mean the extent to which the therapists conducting the interventions took the relevant aspects of the therapeutic context into account and responded to these contextual variables appropriately. (p. 620)

For each item, integrity raters allocated an extra point, above the point available for adherence, if the therapist implemented the item appropriately, indicating therapy competence.

8.2.3.5 Implementing and Scoring the Narrative Therapy Integrity Schedule

For prescribed items (items 1-15), each therapist's adherence to the prescriptive behaviours were scored according to occurrence or non-occurrence, rather than frequency, since frequency was not relevant to all items. Evaluation of therapy adherence was therefore largely objective.

The therapist achieves an additional mark if the therapist implemented the behaviour appropriately, indexing therapist competence. While the frequency of a behaviour may be a factor of appropriate implementation, appropriate implementation does not equate to frequent implementation. There was therefore a subjective aspect to therapist ratings of adherence.

A Not Applicable (N/A) option was available for occasions where an item was not appropriate for the specific therapy session, for example, where raters applied the N-TIS to an initial session and the question addressed a last-session strategy. Response

options for prescribed items included Not Present (0), Present (1), Appropriately Applied (2), and Not Applicable (N/A). Raters circled the number above the response that closely corresponded with the degree to which they evaluated therapy integrity. When items scores within a phase were averaged, mean item scores closer to 0 indicated less therapist adherence, closer to 1 indicated greater therapist adherence, and closer to 2 indicated greater therapy integrity.

For proscribed items (items 16 to 18) response options were Not Present (2) and Present (0). When item scores within the proscribed category were averaged, mean item scores closer to 0 indicated less therapy adherence, and closer to 2 indicated greater therapy integrity.

8.2.4 Development of a Training Video: Narrative Therapy

Stage 4 involved the development of a training video, used in the research to illustrate important aspects of implementing narrative therapy to therapists (Figure 8.1). A paid professional actor agreed to act as a client at an initial therapy session. The actor researched depression and created a character, behaviour and "story", consistent with a person experiencing depression. An experienced narrative therapist agreed to be video taped while implementing the narrative approach. After reviewing the research manual and familiarising herself with its contents, the therapist agreed to implement the approach, demonstrating the manualised strategies as she deemed appropriate to the client's situation and for an initial session. The scenario was unscripted and the therapist was naïve to the actor's (client's) story, avoiding a wooden portrayal of the narrative approach and portraying the spontaneity of an initial narrative therapy session. The video was used to orient therapists and adherence raters in the implementation of narrative therapy and to provide stimulus for training exercises wherein trainees were required to identify and discuss the use of manualised strategies in the video.

8.2.5 Development of a Narrative Training Program

Stage 5 (Figure 8.1) required the development of a narrative training program (Appendix C provides a brief schedule of the program[18]) to inform and skill trainees in the manualised narrative therapy over a two-day period. The training program comprised two major components: (a) training in the manualised narrative intervention; and (b) provision of information on details of the research protocol of direct relevance to the trainees should they participate in the research.

Training in the manualised narrative intervention closely corresponded with the treatment manual. Training contained both didactic and experiential components and comprised lectures, discussion, examples, viewing the training video, exercises and role-plays. Wherever practicable, the general format for each topic was to inform, to discuss, to provide examples (in terms of therapy dialogue and video dialogue) and to practice exercises or role-plays.

Research protocol topics raised included clinical issues such as confidentiality, supervision and procedures for client deterioration or suicidality. Operational matters included video taping, therapy locations and administration of research materials.

8.2.6 Recruitment of Independent Raters to Evaluate Therapy Integrity

At Stage 6 (Figure 8.1), two students provided informed consent (Appendix D) to: (a) participate in the narrative training program; (b) participate in the N-TIS training; and (c) rate taped (video or audio) therapy sessions according to the N-TIS. One rater was an undergraduate psychology student and the other was a Master's in Counselling student. The independent raters were naïve to client outcomes and to research hypotheses. Use of independent rates minimised problems of investigator bias.

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[18] A more comprehensive copy of the narrative therapy training program is available from the author.

8.2.7 Recruitment of Therapists to Implement Narrative Therapy

8.2.7.1 Advertisement for Therapists

Therapists were invited to participate in the research narrative therapy training program through poster and email contact (Appendix E) with government, university and community mental health agencies (Stage 7; Figure 8.1)**.** There were four therapist intake occasions over a five-month period.

8.2.7.2 Therapist Inclusion Criteria

Minimum requirements for therapists were: (a) a recognised graduate qualification in the field of mental-health; (b) at least one year graduate experience providing psychotherapy to clients; (c) successful completion of the 16-hour manualised narrative therapy training program developed for the research; and (d) commitment to implement the manualised narrative approach with two clients.

8.2.7.3 Research into Therapist Discipline and Experience

Research into therapist experience is mixed. A review of graduate training in psychotherapy by Stein and Lambert (1995) found that, in comparison to more experienced therapists, less experience in therapists was associated with less improvement in symptom severity. In support of the findings by Stein and Lambert, a recent clinical trial by DeRubeis et al. (2005), comparing paroxetine to CT, found both treatments were equally superior to pill placebo, especially when implemented by experienced cognitive therapists. In contrast, wider research indicates that neither the therapist's years of experience nor type of mental health qualification impact on treatment outcome (Bright, Baker, Neimeyer, 1999; Clementel-Jones et al., 1990; Crits-Christoph et al., 1991; Smith & Glass, 1977; Wierbicki & Pekarik, 1993).

8.2.7.4 Number of Therapists

In the light of the recent debate on therapist effects (see Section 6.7.2), recent research by Okiishi et al.(2003; 2006) demonstrated wide variability in psychotherapy outcome dependent on the therapist. So that outcome results were not an artefact of the effect of a particular therapist or particular therapists, clients were distributed across many therapists relatively evenly. Therapists were allocated one, two or three clients (see Section 9.3.3.3).

8.2.7.5 Therapist Allegiance

Therapist allegiance refers to "the degree to which the therapists delivering the treatment believes that the therapy is efficacious" (Wampold, 2000, p. 159). Although research therapists were naïve to research hypotheses they were aware the research was investigating the process and outcome of narrative therapy. The chief investigator offered training in narrative therapy in return for participation in the research. Therapists who applied to participate in the research were therefore likely to have, at least, an interest in narrative approaches to therapy and the majority (see Section 9.2) indicated that they believed narrative therapy was efficacious in the treatment of depression. Several meta-analyses have found that allegiance to a particular therapy contributed strongly to therapy outcome in research trials, with the effect size of therapy allegiance ranging from 0.29-0.85 (e.g., Berman, Miller & Massman, 1985; Dush, Hirt, & Schroeder, 1983; Luborsky et al., 1999).

8.2.8 Training in Narrative Therapy:

Therapists and Integrity Raters

The investigator trained therapists and two adherence raters in the manualised narrative intervention during Stage 8 (Figure 8.1) of the research program. The training schedule followed the training program developed (Appendix C). Four separate training

sessions corresponded to the four earlier therapist intake occasions. To avoid the imposition of excessive travel on therapists, narrative training was intensive, totalling 16 hours over a two-day period. To decrease the likelihood that the research would interfere with therapists' work commitments, each set of training was held on two consecutive Saturdays at the research site (QUT). A two-day training period is consistent with the research by Bright, Baker and Neimeyer (1999) that compared professional and paraprofessional groups in the implementation of CBT or mutual support group therapy (Mallory, 1984) to depressed outpatients.

The first day of training addressed the definition of narrative, the research manual, key assumptions of narrative therapy, the narrative approach to problems and therapeutic change, and the first three phases of narrative therapy. The second day of training covered the remaining two phases of narrative therapy, the phenomenon of depression, the framework of narrative sessions, proscribed practices and areas of the research protocol relevant to therapists. Trainees also received references for articles covering important elements of narrative therapy. All trainees who completed training received QUT accreditation for workshop attendance.

Therapists, judged by the investigator as competent in implementing the approach (by observation of competency across role-plays), were invited to participate in the implementation phase of the research. Of the 41 therapists who completed the workshop, 24 of those considered eligible agreed to implement the narrative intervention.

8.2.9 Training Independent Therapy Integrity Rater:
The Narrative Therapy Integrity Schedule

The investigator trained two integrity raters in the implementation of the N-TIS (Stage 9; Figure 8.1) after raters had completed training in the narrative intervention.

The aim of N-TIS training was to skill raters in evaluating taped therapy sessions for therapy integrity to the manualised narrative intervention.

After reading and discussing the protocol for implementing the N-TIS with the investigator, raters achieved rating experience through approximately nine hours of evaluating three example video tapes of narrative therapy with the N-TIS independently, then discussing rating discrepancies together in the presence of the investigator. The training tape developed for the current research, and video tapes of narrative therapy by Steve Madigan (Madigan, 2000) and Michael White (1994) comprised the training videos.

8.2.10 Recruitment and Training of Independent Coder:

Narrative Processes Coding System

Stage 10 (Figure 8.1) involved the recruitment and training of an independent coder for evaluating therapy transcripts with the Narrative Processes Coding system (NPCS; Angus et al., 1996). The intention of using an independent coder was to minimise investigator bias (see Section 5.3.3). The coder was naïve to the research hypotheses and client outcomes; session content often revealed whether Session 1 or 8.

One social work undergraduate volunteered to code 20 selected therapy transcripts for narrative complexity by applying the NPCS to transcripts from Sessions 1 and 8 from the five most improved clients and five least improved clients (according to change in BDI-II scores from pre-therapy to post-therapy).

After gaining an understanding of the basic principles underpinning the NPCS, as articulated in the NPCS manual by Angus et al. (1996), the coder progressed through the practical stages of the NPCS by coding exemplar transcripts, gaining experience in distinguishing (a) topic segments; (b) external discourse; (c) internal discourse, and; (d) reflexive discourse. Training was for 24 hours across three days. The investigator and

the coder discussed ambiguities in coding and inconsistent coding during the learning process in order to reach consensus for future coding decisions. Evaluation of inter-rater agreement for the NPCS compared the judgments on topic segments and ratings for narrative modes against those of the investigator for two (10%) of the transcripts.

8.3 The Process-Outcome Trial

The ten preparatory stages laid the foundations for the conduct of the process-outcome trial to investigate narrative therapy in the treatment of major depressive disorder in adults. Chapter 9 details the method of the process-outcome trial.

8.4 Outcome Evaluation

8.4.1Outcome Evaluation Analyses

Evaluation of outcome data from narrative therapy in the treatment of adult depression utilised four strategies: calculation of statistical significance, effect size, clinical significance and benchmarking. The benchmarking strategy incorporated results from the other three analyses. Use of these four strategies provided a parsimonious protocol for evaluating the outcome of narrative therapy, avoiding some of the practical and ethical limitations of RCT designs (see Section 6.2). Rather than using within-trial controls or alternative therapies, analyses of clinical significance provided normative comparisons. Benchmarked reference points provided evidence-based comparisons. The first two strategies were relatively straightforward, and are reported in the Results section (Chapter 10). Section 6.3 detailed methodology for the calculation of clinical significance. Section 8.4.2 below describes the procedure for the fourth strategy, benchmarking.

8.4.2 Benchmarking Procedure

8.4.2.1 Benchmarking Steps

The benchmarking strategy was based on benchmarking protocols reported by Merrill et al. (2003) and Weersing and Weisz (2002). The strategy comprised seven steps that required the investigator to:

(1) Identify empirically supported treatment for adult depression.

(2) Select previous clinical trials that provided outcome data of empirically-supported treatment of adult depression.

(3) Assess the demographic comparability of the current client sample with client samples from benchmark research.

(4) Assess the clinical comparability of the current client sample with client samples from benchmark research.

(5) Compare the treatment protocol of the current study with the treatment protocols of benchmark research.

(6) Compare symptom outcome (as assessed by mean BDI scores) in the current study with benchmark research, measured by mean scores and effect size from pre-therapy to post-therapy and from pre-therapy to three-month follow-up.

(7) Compare symptom outcome (as assessed by individual BDI-II scores from pre-therapy to post-therapy) in the current study with benchmark research, measured by reliable change and clinical significance.

The first two steps of the benchmarking strategy are described in the two sections following (8.4.2.2 and 8.4.2.3). The five last steps comparing the current study with benchmark studies are discussed in Chapter 10 in Section 10.5.4 of the Results.

8.4.2.2 Empirically Supported Psychotherapy for Depression in Adults

Review of depression psychotherapy outcome research (Chapter 5) revealed that research evidence supports a number of *bone fide* psychotherapies as useful in treating depression, with the caveat that debate on the specificity of psychotherapy for different sub-types of depressed individuals continues.

Professional psychiatric and psychological associations have provided their own treatment guidelines based on specified criteria. The Australian Psychological Society (2005) recommended CBT and IPT as psychotherapies of choice in the treatment of adult depression. The Australian Psychological Society also cited guidelines from the Royal Australian and New Zealand College of Psychiatrists (RANZP). The RANZP (2005) advised that CBT and IPT were the most effective psychotherapies for adult depression, except where depression was severe and associated with melancholia and psychosis. The American Psychiatric Association (Fochtmann & Gelenberg, 2005) cites CBT as subjected to more research, but recognised evidence for other bone-fide psychotherapies have efficacy comparable with CBT in treating adult depression. The current study therefore selected research that utilised CBT or IPT in the context of well-conducted RCTs.

8.4.2.3 Selection of Benchmark Research

Clinical trials into psychotherapy for adult depression were sourced through computer search[19] of PsycINFO, PsycEXTRA, PsychARTICLES, Medline, Science Direct, as well as reference lists from relevant articles, book chapters, and meta-

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[19] Computer search terms were *psychotherapy, depression, outcome*, *major depressive disorder, trials, RCT, adult, Outcome questionnaire 45.2, Beck Depression Inventory-II.*

analyses. Focus was on clinical trials that used control or comparison groups, and used the BDI as an outcome measures. The BDI is a well-validated measure, used extensively in previous psychotherapy research into adult depression. As such, several analyses of the statistical significance, effect size and clinical significance of psychotherapy have used the BDI, providing comparison data.

Through a review of the peer-reviewed studies sourced, the Second Sheffield Psychotherapy Project (Shapiro et al., 1994) emerged as a large ($n = 117$), well-controlled trial and well-designed trial that was likely to demonstrate representative outcome results (see Chapter 5 for a more detailed description of the study) of psychotherapy into adult depression. Consistent with the current study, Shapiro et al. provided pre-therapy, post-therapy and three-month follow-up mean BDI scores for CBT and IPT conditions combined, enabling comparison with the current research. Although Shapiro et al. reported outcomes from 8-session and 16-session conditions, I have selected outcome data from the 8-session condition for comparison, as this was comparable with the current study.

A second comparison trial by Watson, Gordon, Stermac, Kalogerakos, and Steckley (2003), comparing process-experiential and CBT in the treatment of adult depression with 16 weekly sessions, was selected as a benchmark comparison. I selected the research by Watson et al. because the level of therapist experience was comparable to the current study. As a recent well-designed study that addressed researcher allegiance, it provided valid pre-therapy and post-therapy mean BDI scores for comparison.

A third comparison study, by Ogles, Lambert, and Sawyer (1995) evaluated the clinical significance of results from the NIMH Treatment of Depression Collaborative Research Program (Elkin et al., 1989; see Chapter 5) based on BDI scores from

individuals who had completed 12 sessions and 15 weeks of CBT or IPT. I selected this research because it was the only study of psychotherapy into adult depression found that offered comprehensive comparison data on individual BDI scores grouped into categories according to rigorous calculation of reliable change indices and clinically significant cut-off points.

8.5 Process Evaluation

8.5.1 Therapeutic Processes Investigated

The current research investigated two proposed processes of narrative therapy: narrative reflexivity and the therapeutic alliance. The research examined narrative reflexivity and therapeutic change, by comparing narrative reflexivity in the five least improved clients with that of the five most improved clients (as assessed by change in BDI-II scores) and by examining the relationship of narrative reflexivity with depressive symptom and inter-personal relatedness. Qualitative coding of therapeutic conversations at Sessions 1 and 8 with the NPCS (Angus et al., 1996) provided empirical data on the percentage reflexive discourse, compared to external and internal discourse present. The research examined the relationship between the therapeutic alliance and depressive symptom and inter-personal relatedness outcomes. The self-report battery that clients completed after each of the eight therapy sessions included an empirical measure of the quality of the therapeutic relationship (WAI-S; Tracey & Kokotovic, 1989).

8.9 Concluding Comments

This chapter aimed to situate the process-outcome trial in the overall research program (Figure 8.1). The descriptions and reasoning for the preparatory stages provided the foundations for the process-outcome trial described in the following chapter on method. The protocols and associated rationales for evaluating the outcome

and process data aimed to clarify how the current study addressed the research

questions.

CHAPTER 9

PROCESS-OUTCOME TRIAL METHOD

9.1 Participants

9.1.1 Clients

9.1.1.1 Client Inclusion Criteria

Inclusion criteria required clients to be aged between 18 and 60 years and experiencing a current major depressive episode, as diagnosed by the research investigator according to the Mini International Neuropsychiatric Interview 5.0.0 (M.I.N.I-5.0.0; Sheehan et al., 2000). To achieve a more representative sample, the research included individuals with co-morbid Axis I and Axis II disorders, with the exception of diagnoses specified in the exclusion criteria. Current use of antidepressant medication was accepted if use had commenced prior to the previous 12-week period**.** The 12-week cut-off criteria for anti-depressants increased the likelihood that treatment gains were attributable to therapy.

9.1.1.2 Client Exclusion Criteria

Exclusion criteria applied where the initial interview and questionnaire assessment indicated: (a) current psychosis, manic episode, anorexia or bulimia according to the MINI-5.0.0 (Sheehan et al., 2000); (b) antisocial, borderline or schizo-typal personality disorder, according to the Structured Clinical Interview for DSM-IV Axis II Personality Disorders (SCID-II-IV; First, Gibbon, Spitzer, William, & Benjamin, 1997); (c) concurrent psychotherapy for depression; (d) high suicide risk as determined by the M.I.N.I-5.0.0; (e) language difficulties which would prevent completion of questionnaires; (f) depression was a direct consequence of a physiological condition (e.g., multiple sclerosis, stroke, hypothyroidism, or; (g) current use of anti-depressant medication commenced within the previous 12-week period.

9.1.1.3 Client Demographic Characteristics

Clients comprised 47 adults, who: (a) responded to media advertisement for volunteers experiencing depression, (b) provided informed written consent to participate in the study (Appendix F), and (c) met research criteria[20]. Of these individuals, 29.80% (14) were males and 70.20% (33) females. Client age ranged from 22 to 60 years ($M = 41.19$; $SD = 10.32$). Table 9.1 shows that all clients had achieved secondary education or beyond and the majority were in paid employment or cared for family at home. All clients described themselves as Caucasian.

Table 9.1

Client Education and Work Status

Characteristic	Category	*N*	%
Education Level	Primary Education	00	00
	Secondary Education	16	34
	Trade Qualification	08	17
	Tertiary Qualification	23	49
Work Status	Paid Employment (Full-time or Part-time)	25	53
	Student	00	00
	Cares for Family at Home	10	21
	Voluntary Work	01	02
	Unemployed or Seeking Employment	08	17
	Sick Leave or Disability Pension	03	06

Note. $N = 47$

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[20] The clients described comprised the intent-to-treat sample. See Appendix G for client characteristics of the completer sample.

9.1.1.4 Client Clinical Characteristics

Twenty-six clients (55%) were taking antidepressant medication at initial assessment. Most of the clients had experienced prior depressive episodes. Thirteen (28%) clients reported that they had experienced one to three previous depression episodes and 20 (42%) reported that they had experienced four or more previous depression episodes. Only eight (17%) of the clients reported that they had no previous episodes of depression. Six clients (13%) did not respond to the question about the number of previous episodes of depression experienced. Table 9.2 shows the frequency and proportion of clients' Axis I co-morbidity, as assessed by the MINI-5.0.0 (Sheehan et al., 2000).

Table 9.2

Frequency and Proportion of Clients with Co-morbidity across Axis I Diagnostic Categories

Major Classification	Axis 1 Category	N	%
Mood Disorders	Dysthymia	18	38
Anxiety Disorders	Panic Disorder	19	40
	Agoraphobia	19	40
	Social Phobia	14	30
	Obsessive-Compulsive Disorder	07	15
	Post-Traumatic Stress Disorder	09	19
	Generalized Anxiety Disorder	28	60
Substance Related Disorders	Alcohol Dependence	10	21
	Non-Alcohol Drug Dependence	02	04

Note. $N = 47$

Table 9.3 shows the frequency and proportion of clients' Axis II co-morbidity, as assessed by the SCID-II-IV (First et al., 1997). According to the SCID-II-IV, 29 clients had no personality disorder, 10 clients had 1 personality disorder, 6 clients had 2 personality disorders, 1 client has 3 personality disorders and 1 client had 4 personality disorders.

Table 9.3

Number and Proportion of Clients with Co-morbidity across Axis II Diagnostic Categories

Cluster	Axis II Category	*N*	*%*
Cluster A Personality Disorders	Paranoid	04	09
	Schizoid	00	00
Cluster B Personality Disorders	Histrionic	00	00
	Narcissistic	01	02
Cluster C Personality Disorders	Avoidant	11	23
	Dependent	03	06
	Obsessive-Compulsive	02	04
	Passive-Aggressive	02	04
	Depressive	07	15

Note. N = 47

9.1.2 Therapists

9.1.2.1 Therapist Characteristics

Therapists were 24 individuals, invited to participate in the research by the investigator through poster and email contact with government, university and community mental health and counselling agencies (see Section 8.2.7.1), who provided informed written consent to participate in the study (Appendix H). Therapist age ranged

between 26 and 70 years old ($M = 47.45$; $SD = 12.24$). Of the 24 therapists, 8 % (2) were males and 92 % (22) were female.

Therapists varied in their therapeutic discipline and qualifications (Table 9.4) and in their years of counselling experience and years of experience using narrative therapy. Experience in psychotherapy ranged from 12 months to 15 years ($M = 4.8$ years; $SD = 3.9$ years). Experience in narrative therapy ranged from 0 to 8 years ($M = 22.96$ months; $SD = 24.29$ months).

Table 9.4

Frequency and Proportion of Therapists across Mental Health Disciplines and Qualification Levels

Demographic Characteristic	Category	*N*	%
Mental Health Discipline	Counselling	10	42
	Psychology	08	33
	Social Work	05	21
	Nursing	01	04
Level of Qualification	Masters	10	42
	Degree	10	42
	Diploma	03	13
	Doctorate/PhD	01	04

9.1.2.2 Therapist Allegiance

Of the 20 therapists that responded to questionnaire items directly after session 1, all either agreed or strongly agreed that the philosophy and assumptions underpinning narrative therapy were consistent with their view of the world. The majority ($n = 19$) agreed or strongly agreed that narrative therapy was consistent with their beliefs about

what brings about therapeutic change. Three therapists strongly agreed and twelve therapists agreed that they were confident to implement narrative therapy. Two therapists remained neutral, two disagreed and one strongly disagreed that they felt confident in implementing narrative therapy. Of the 24 therapists that responded, many ($n = 15$) agreed or strongly agreed that narrative therapy was efficacious in the treatment of depression, although a substantial number ($n = 8$) remained neutral and one therapist disagreed.

9.2 Materials

9.2.1 Treatment Intervention

The treatment intervention comprised eight 50-minute individual psychotherapy sessions, based on the manualised narrative approach to therapy (A Narrative Approach to Therapy: Guiding Principles and Practice), developed for the research (See Section 8.2.2.1). The manual specified a narrative approach to therapy that had fidelity to its founding principles and clinical practice, and was at the same time standardised for the purpose of research.

9.2.2 Treatment Integrity Measure: Narrative Therapy Integrity Schedule

The Narrative Therapy Integrity Schedule (N-TIS), developed for the research, evaluated the extent to which therapists adhered to, and were competent in implementing the manualised narrative approach. The N-TIS is an 18-item, observer-rated scale, applied to entire therapy sessions across an early, middle and late session. Section 8.2.3 details the development, structure and scoring of the N-TIS. In this study, inter-rater reliability was acceptable with an intra-class correlation of .88.

9.2.3 Assessment Instruments

9.2.3.1 Mini International Neuropsychiatric Interview 5.0.0

The Mini International Neuropsychiatric Interview 5.0.0 (M.I.N.I. 5.0.0; Sheehan et al., 2000) is a brief structured interview for 17 major Axis I disorders described in DSM-IV (APA, 1994) and International Classification of Diseases 10 (World Health Organisation, 1990). One Axis-II disorder and a suicidality module are included. The investigator administered the M.I.N.I. 5.0.0 as part of the initial assessment to determine whether potential clients met inclusion and exclusion criteria and to identify the presence of Axis I disorders co-morbid with major depressive disorder.

With a focus on current disorder, the M.I.N.I. 5.0.0 is structured into diagnostic modules. For each module, a positive response to one or two initial screening questions leads to further questions, but a negative response excludes the specified diagnosis. Questions require a *Yes* or *No* response. Median administration time is 15 minutes (mean 18.7 ± 11.6 minutes).

Research indicates the M.I.N.I. 5.0.0 (Sheehan et al., 2000) has good test-retest and inter-rater reliability across the diagnostic categories. In a sample of 42 individuals, Lecrubier et al. (1997) found good two-day test re-test reliability for diagnostic categories, ranging from .76 to .93; inter-rater reliabilities ranged from .88 to 1.0. In a study of 84 clients, Sheehan et al. (1997) found that all test re-test (one or two days) kappa values were above .75, except current mania, which was .40. Inter-rater reliabilities had kappa values above .75 with the majority .90 or higher.

Research supports the validity of the M.I.N.I.5.0.0. (Sheehan et al., 2000). Sheehan et al. (1998) consolidated results from 636 psychiatric patients and control individuals from two parallel studies comparing the M.I.N.I..5.0.0 with the Composite

International Diagnostic Interview (CIDI; World Health Organisation, 1990) and the
Structured Clinical Interview for DSM-III-R Disorders (SCID-I; First, Spitzer, Gibbon,
& Williams, 1997). Sheehan et al. (1998) reported that clinician-rated M.I.N.I. 5.0.0
diagnoses were concordant with SCID-I diagnoses, with good or very good kappa
values, excepting current drug dependence, which was below .50. Comparison of
M.I.N.I. 5.0.0 and CIDI diagnoses found kappa values were good or very good, except
for simple phobia and generalised anxiety disorder, which were below 0.5.

9.2.3.2 Structured Clinical Interview for DSM-IV Axis II Personality Disorders

The Structured Clinical Interview for DSM-IV Axis II Personality Disorders
(SCID-II-IV; First, Gibbon, Spitzer, William, & Benjamin, 1997) was used to
investigate the presence or absence of 13 DSM-IV Axis II personality disorders in order
to determine whether clients met exclusion criteria and to identify personality disorders
co-morbid with major depressive disorder. The investigator administered the SCID-II-
IV at the initial assessment interview to all prospective participants.

The SCID-II-IV (First et al., 1997) directly links with DSM-IV criteria (APA,
1994). To shorten the process, clients first respond "yes" or "no" to items on the
preliminary SCID-II Personality Questionnaire (completion time approximately 20
minutes). The interviewer then uses the semi-structured diagnostic interview questions
to inquire further into items that the client marked "yes". Responses are rated according
to the following: ? = inadequate information, 1 = absent, 2 = sub-threshold, and 3 =
meets or surpasses DSM-IV criteria.

The SCID-II-IV (First et al., 1997) has demonstrated acceptable internal
consistency, inter-rater reliability and test-retest reliability. Investigating the
psychometric properties of the SCID-II-IV in a population of 149 psychotropic
medication-free individuals, Farmer and Chapman (2002) found internal consistency

was ≥ .60 for all personality disorder categories except obsessive-compulsive disorder

(α = .53). Maffei et al. (1997) also reported good internal consistency within SCID-II

diagnostic categories. Farmer and Chapman (2002) found excellent inter-rater

reliability, with a median kappa value of .90 (ranging from .85 to .95). Findings from

Farmer and Chapman are consistent with other studies which have found good to very

good inter-rater reliability for the SCID-II (e.g., Dreessen & Arntz, 1998; Fogelson,

Neuchterlein, Asarnow, Subotnik, & Talovic, 1998; Maffei et al. 1997). Research

indicates moderate test-re-test reliability (e.g., Weiss, Najavits, Muenz, & Hufford,

1995). For example, one multi-site study by First, Spritzer, et al. (1997) found kappa

coefficients of .53 (.24 to .74) for patient and .38 (.12 to .59) for non-patient populations

for time intervals ranging from one day to two weeks in a population of 284 individuals.

Findings on the validity of the SCID-II are mixed. Research indicates that use of

the SCID-II Personality Questionnaire results in a low percentage of false negatives

across all categories, with a higher percentage of false-positives (Farmer & Chapman,

2002; Jacobsberg, Perry, & Frances, 1995; Nussbaum & Rogers, 1992). When

compared to the Personality Disorder Examination in a population of 100 psychiatric

inpatients, Skodol, Rosnick, Kellman, Oldham, and Hyler (1991) found an average

kappa coefficient of .50, ranging from .14 to .66, across 11 personality disorders. In

contrast, Skodol, Rosnock, Kellman, Oldham, and Hyler (1988) found moderate to high

diagnostic agreement (from .45 to.95 across the personality disorder categories)

between the SCID-II and longitudinal expert evaluation that used all data. Despite

mixed findings, the SCID-II is widely used in the evaluation of personality disorder in

clinical and research domains.

9.2.3.3 Demographic Questionnaires for Clients and Therapists

The investigator used the Client Demographic Questionnaire (CDQ; Appendix I), developed for the research, to enquire into clients' age, gender, English proficiency, educational status, vocational status, psychiatric diagnosis, major medical problems, and episodes of depression at the initial telephone assessment.

A Therapist Demographic Questionnaire (TDQ; Appendix J), developed for the research, enquired into therapists' age, gender, mental health discipline, level of qualification, counselling experience, and narrative counselling experience. Considering evidence supporting the importance of therapist allegiance (up to 10% of the outcome variance) to the modality under investigation (Robinson et al., 1990), the TDQ also requested that therapists respond to four statements related to their beliefs about narrative therapy, aimed to determine therapists' allegiance to narrative therapy and confidence in implementing the approach. Therapists completed the TDQ directly after Session 1.

9.2.3.4 Health-Care Contact Monitors

The Health-Care Contact Monitor (Appendix K) enquired into medication use and contact with health professionals. Clients completed appropriate versions of the Health-Care Contact Monitor at the initial assessment interview, Session 8 and three months following therapy.

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9.2.4 Process Instruments

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9.2.4.1 Narrative Processes Coding System

The Narrative Processes Coding System (NPCS; Angus, Hardtke, & Levitt, 1996) provides an empirical evaluation of narrative complexity, and in this study is used to determine the proportion of narrative reflexivity in therapy narratives (tapping into self) at Sessions 1 and 8. Table 9.5 shows assessment points for process instruments.

Table 9.5

Assessment Points for Process Instruments

Process Instrument	Session							
	1	2	3	4	5	6	7	8
NPCS	X							X
WAI-S	X		X					X

Note. NPCS = Narrative Processes Coding System; WAI-S = Working Alliance Inventory-Short Form.

Following the recording and transcription of therapy sessions, the NPCS comprises two stages. Coders first derive units of analysis by dividing therapy transcripts into topic segments. The start of a topic segment is determined by a change in the topic theme. The coder then codes topic segments qualitatively into one of the three narrative process modes considered by Angus et al. (1999) as fundamental elements of the therapeutic process common across therapeutic modalities: external, internal, and reflexive. Researchers calculate each of the process modes as a percentage of the total transcript discourse.

Angus et al. (1996) described the external narrative mode of discourse as comprising descriptions of actual or imagined past, present and/ or future events (e.g., "My daughter had been smoking pot …she couldn't think straight…"). The internal narrative mode comprises subjective and emotion-related descriptions of experience (e.g., "The more she accused me of being too strict, the sadder I felt …"). The reflexive narrative mode involves interpretive processes in relation to beliefs, actions and emotions, involving past, present and/or future events, which give meaning to events

(e.g., "I suddenly realised that I began drinking to escape my own mother's control…seems like we both can't tolerate being controlled…").

Supporting the construct validity of the NPCS, Levitt (1993) reported that the narrative processes of a given therapy were consistent with therapy orientation. Levitt found that cognitively based therapies that emphasised interpretation comprised more reflexive modes of discourse. Content validity is inherent to the design of the NPCS. For example, rather than tapping into a person's experience of depression through a rigid set of items, topic segments reflect a person's personal experience of depression.

Inter-rater reliability for the identification of topic segments in transcripts from 270 therapy sessions of 9 good outcome therapy dyads (Angus, Levitt, & Hardtke, 1999) found a Cohen's Kappa of .78 in raters with 20-25 hours training in the NPCS. For the coding of discourse modes, Angus, Hardtke, Pedersen, and Grant (1991) reported inter-rater reliability of 88%, with a Cohen's Kappa of .75 for 18 transcripts from six therapy dyads. From five therapy transcripts, Angus, Levitt, and Hardtke (1999) reported a Cohen's Kappa of .75.

9.2.4.2 *Client-Rated Working Alliance Inventory-Short Form*

The short form of the Working Alliance Inventory (WAI-S; Tracey & Kokotovic, 1989) is a self-report index of the quality of the therapeutic alliance between the therapist and client. The WAI-S derives from the full 36-item version WAI (Horvath & Greenberg, 1989). Based on Bordin's (1979, 1994) conception of a pan-theoretical construct that comprises three dimensions, the WAI and WAI-S comprise three sub-scales to assess: the client-therapist bond, agreement on tasks, and agreement on goals. There are several forms of WAI-S, including therapist and observer rated versions. The current study used the client form of the WAI-S, completed immediately after therapy Sessions 1, 3 and 8 (Table 9.5).

The WAI-S (Tracey & Kokotovic) is a 12-item inventory rated on a 7-point Likert scale (1 = Never, 2 = Rarely, 3 = Occasionally, 4 = Sometimes, 5 = Often, 6 = Very Often, 7 = Always). Instructions request clients to circle the number above the statement that describes the way they think or feel about their therapist. Items 4 and 10 of the goal subscale are reverse coded. The lowest possible score is 12 and the highest possible score is 84. Higher scores indicate higher alliance quality.

Research by Busseri and Tyler (2003) suggested that scores from the WAI-S are interchangeable with the WAI. Comparing fourth session ratings from the WAI-S and WAI from 54 university counselling centre therapeutic dyads, Busseri and Tyler found comparable means, standard deviations, internal consistency, sub-scale inter-correlations and predictive validity for the two measures. Consistent with previous research (e.g., Horvath & Greenberg, 1989) that found moderate to strong correlations among WAI sub-scales, Busseri and Tyler (2003) found that the total and sub-scale scores from the WAI-S and WAI were highly correlated.

The psychometric properties of the WAI are established. Busseri and Tyler found high internal consistency for the total WAI-S scale scores, with $\alpha = .91$, and high alphas of .86, .73 and .80 for the task, goal and bond subscales respectively. Results from Horvath (1994) demonstrated convergent and discriminant validity. Research supports the concurrent validity of the WAI. Horvath and Greenberg (1989) found strong associations between the WAI and the Counselor Rating Form (LaCrosse & Barak, 1976; 6- 40% of common variance) and the Empathy scale (48- 52% of common variance) of the Relationship Inventory (Barrett-Lennard, 1962) suggesting convergent validity.

9.2.5 Outcome Instruments

9.2.5.1 Beck Depression Inventory-II

The Beck Depression Inventory (BDI-II; Beck, Steer, & Brown, 1996) is a widely used 21-item inventory, assessing depression severity in individuals aged 13 years and over, administered orally or by self-report. Clients completed the BDI-II at the pre-therapy (initial assessment interview), post-therapy (immediately after session 8) and at three-month follow-up (Table 9.6).

Each item has four statements. Respondents circle the number that corresponds to the statement that best describes their mood over the past two weeks, ranging on a 4-point scale from 0 (normal) to 3 (most severe). The BDI takes approximately 5 to 10 minutes to complete, depending on reading ability and depression severity. Summing individual item scores calculates the total BDI score, with a possible minimum score of zero and a maximum score of 63. The BDI-II manual recommends the following severity cut-off scores: minimal (0-13); mild (14-19); moderate (20-28); severe (29-63).

Research suggests that the BDI is a reliable measure. Beck et al. (1996) examined the psychometric characteristics of the BDI-II in outpatient ($n = 500$) and student ($n = 120$) samples, finding a high internal consistency, with a mean Chronbach's α of .92 for the outpatient sample and .93 for college students. Based on a sub-sample of outpatients, Beck et al. reported a one-week test-retest reliability of .93.

Research supports the validity of the BDI-II. Beck et al. (1996) reported that the BDI-II was positively correlated with the Hamilton Rating Scale for Depression ($r = .71$; HRSD, Hamilton, 1960) and the Beck Hopelessness Scale ($r = .68$; Beck & Steer, 1988) demonstrating convergent validity. In contrast, the correlation between the BDI-II and the Revised Hamilton Anxiety Rating Scale was .47, demonstrating discriminant validity.

Table 9.6

Assessment Points for Outcome Instruments

		Assessment Points									
		Sessions									
Outcome Instrument	IA[a]	1	2	3	4	5	6	7	8	FU[b]
BDI-II	X								X	X
DASS-D	X	X	X	X	X	X	X	X	X	X
OQ-45.2 IR	X	X	X	X	X	X	X	X	X	X
STS-T									X	

Note. BDI-II = Beck Depression Inventory II; DASS-D = Depression Anxiety Stress Scale-Depression Subscale; OQ-45.2 IR = Outcome Questionnaire 45.2 Interpersonal Relations Subscale; STS = Satisfaction with Therapy Sub-Scale.

[a] Initial Assessment interview. [b] three-month Follow-up.

9.2.5.2 Depression, Anxiety, Stress Scale-Depression Subscale

The Depression Subscale of the Depression Anxiety Stress Scale (DASS-D; Lovibond & Lovibond, 1995), one of three subscales of the 42-item DASS, is a 14-item self-report measure of depressive states, including "…dysphoria, hopelessness, devaluation of life, self-depreciation, lack of interest/ involvement, anhedonia, and inertia" (Lovibond & Lovibond, 1995, p. 1). The DASS-D is free-to-use measure, and in the current study was utilised to substantiate BDI-II scores and to measure depressive symptoms at all assessment points (Table 9.6), without the expense associated with multiple administrations of the BDI-II.

Respondents rate the extent to which they have experienced symptoms of depression in the past week on a 4-point severity/frequency scale from 0 to 3. Summing

item scores provides the DASS-D score. Possible scores range between 0 and 42. According to the DASS manual (Lovibond & Lovibond, 1995), scores between 10 and 13 indicate mild depression, scores between 14 and 20 indicate moderate depression, and between 21 and 27 indicate severe depression. Scores of 28 and over indicate extremely severe depression.

Research supports the DASS-D as a reliable measure. Examining the psychometric characteristics of DASS, Lovibond and Lovibond (1995) found an internal consistency coefficient for the depression subscale of .91 in a sample of 1044 males and 1870 females from 17 to 69 years old, which was consistent with the alpha of .95 found by Crawford and Henry (2003).

Research indicates the DASS-D is a valid measure of depression. Lovibond and Lovibond (1995) reported a comparison of the DASS subscales with the BDI and the Beck Anxiety Inventory in a sample of 717 first-year psychology students. The DASS-D was found to have a positive high correlation with the BDI ($r = .74$), and a weaker correlation ($r = .54$) with the Beck Anxiety Inventory, demonstrating construct validity.

9.2.5.3 Outcome Questionnaire 45.2 Inter-personal Relations Sub-scale

The Outcome Questionnaire 45.2 (OQ-45.2 Lambert, Hansen, Umpress, Lunnen, Okiishi, & Burlingame, 1999) is a brief (45-item) self-report outcome measure of clients' progress over the duration of therapy. The OQ-45.2 enquires into clients' subjective experience in three domains of functioning: subjective discomfort, interpersonal relationships and social role performance. Completion time for the total scale is usually five minutes, ranging from three to twenty minutes. The OQ-45.2 has demonstrated sensitivity to change from psychotherapy (Vermeersch, Lambert, & Burlingame, 2000).

The OQ-45.2 requests that respondents look "…back over the last week, including today…read each item carefully and mark the box under the category which best describes your current situation." Individuals respond to each item on a five-point scale. Most items are scored from 0-4 with: 0 = Never; 1 = Rarely; 2 = Sometimes; 3 = Frequently, and ; 4 = Almost Always.

In the current research, the Interpersonal Relations sub-scale was used to index Interpersonal Relatedness. Clients completed the OQ-45.2 IR at all assessment points (Table 9.6). The OQ-45.2 IR comprises 11 items, four of which are reverse scored. Addition of sub-scale items provides a sub-scale score for Interpersonal Relations. The possible total Inter-personal Relations sub-scale score ranges from 0 to 44. Higher scores indicate higher disturbance. Lambert et al. distinguish scores of 15 and higher as clinically significant and score change of 8 or more as reliable change.

Research indicates that the OQ-45.2 IR is a reliable measure. Lambert, Hansen, Umpress, Lunnen, Okiishe, and Burlingame (1999) found high internal consistency coefficients for both student ($N = 157$) and patient ($N = 298$) samples for the Interpersonal Relations sub-scale ($r = .74$; $r = .74$). When administered to a sample of 157 university students, test-retest reliability (with a three week interval) for the Interpersonal Relations sub-scale was found to be high ($r = .80$).

Several studies support the validity of the OQ-45.2. OQ-45.2 total and sub-scale scores have shown high to moderately high concurrent validity with several measures measuring similar constructs. For example, a validity study by Umphress (1995) using three clinical samples, including clients from a college counselling centre ($n = 53$) and from inpatient ($n = 24$) and outpatient ($n = 106$) settings found that the OQ-45.2 Interpersonal Relations sub-scale scores were positively correlated with the Inventory of Interpersonal Problem (Horowitz et al., 1988) scores (ranging from .49 to .64).

9.2.5.4 Satisfaction with Therapy Sub-Scale

The Satisfaction with Therapy sub-scale (STS-T; Oei & Shuttlewood, 1999) is a 7-item self-report sub-scale of the 12-item Satisfaction with Therapy and Therapist Scale, developed to measure general client satisfaction with therapy provided in individual therapy. The STS-T measures, "…a positive attitude in the client towards therapy as a whole" (Oei & Shuttlewood, 1999, p. 751) and reflects two commonly accepted non-specific factors; acceptance of rationale and benefit expectancy. Clients completed the STS directly after session 8 (Table 9.6).

The STS requests clients to respond to items by circling the number from 1 to 5, which bests describes their experience of therapy (1 = Strongly Disagree, 2 = Disagree, 3 = Neutral, 4 = Disagree, 5 = Strongly Agree). Item scores are summed to provide the STS score, with a possible minimum score of 7 and a possible maximum score of 35. Higher scores indicate higher therapy satisfaction.

Research by Oei and Shuttlewood (1999), examining the responses of 67 clients experiencing depression, indicated that the STS-T has good internal consistency with an Cronbach's alpha of 0.91 for the STS. The STS-T has concurrent validity, correlating significantly with items measuring coping and progress and not correlating with the BDI, the Automatic Thoughts Questionnaire (Hollon & Kendall, 1980) or the Dysfunctional Attitude Scale (Weissman, 1979).

<div align="center">9.3 Procedure</div>

<div align="center">*9.3.1 Client Recruitment*</div>

9.3.1.1 Advertisement

Clients were recruited through advertisement (Appendix L) in local (Brisbane) print media at two intake dates. The advertisement requested that people experiencing depression, interested in volunteering to participate in psychological treatment at no

cost as part of a research project, contact the chief investigator by phone or email for information. Some inclusion and exclusion criteria were specified. One hundred and thirty-nine people (initial intake = 20; second intake = 119) responded to media advertisements. Figure 9.1 shows the progression of the research.

9.3.1.2 Two Client Intakes

There were two client intakes. A second larger client intake followed a smaller initial intake of clients. The purpose of the initial intake ($n = 11$)was to examine the feasibility of the: (a) client recruitment process, (b) initial assessment interview protocol, (d) intervention protocol, (e) outcome materials, (f) process materials, (g) N-TIS , and the (h) NPCS. The procedure of the second intake ($n = 36$) was consistent with the initial intake excepting the following amendment, deemed to improve the capacity of the research design to answer the research questions: (a) the OQ-45.2 IR supplemented the outcome battery at the second intake.

9.3.2 Preliminary Telephone Screening

9.3.2.1 Preliminary Telephone Interview

On initial phone or email contact from 139 respondents, the chief investigator provided details of the research and participant requirements and conducted telephone screening to determine whether respondents met preliminary inclusion or exclusion criteria (Figure 9.1). At the preliminary telephone interview the chief investigator enquired into: (a) contact details, (b) age, (c) gender, (d) depressive symptoms, (e) antidepressant medication, and (f) current psychotherapy.
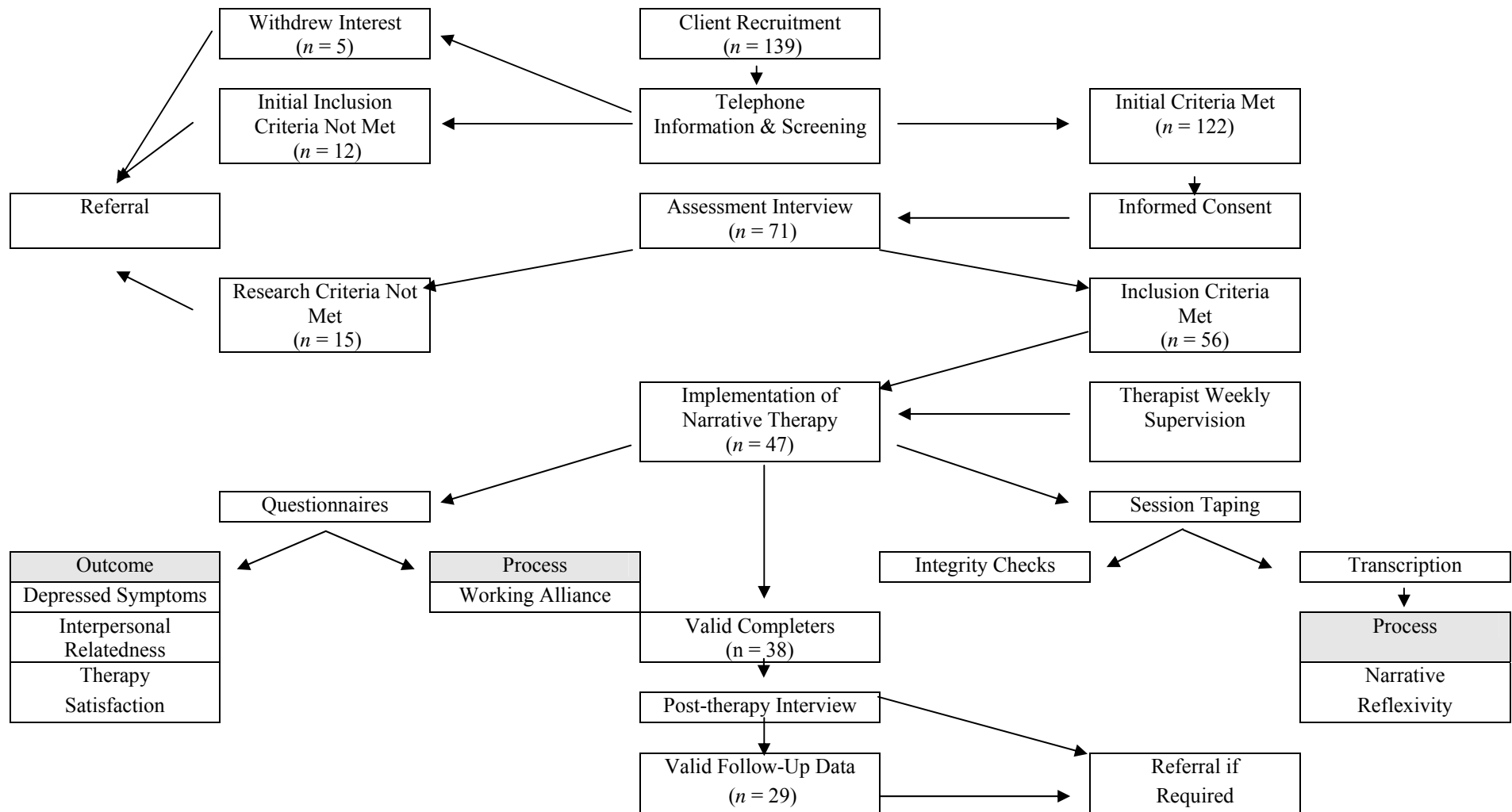
Figure 9.1 Main process-outcome study: Outline of research procedure.

9.3.2.2 Referral: Telephone Respondents

Respondents who applied, but did not meet preliminary inclusion criteria or who met exclusion criteria, were referred to the QUT Psychology and Counselling Clinic to obtain treatment at low cost if appropriate and were advised to contact their general practitioner. Of the 139 people who responded to media advertisement for individuals experiencing depression, telephone screening revealed that 12 did not meet the preliminary inclusion criteria. Five people did not wish to participate in the research after being informed of the research protocol.

9.3.2.3 Informed Consent

The investigator organised an initial assessment interview for, and mailed research information letters and consent forms to 122 individuals for whom preliminary telephone contact indicated that respondents were interested in participating in the research and met preliminary research criteria (Figure 9.1).

9.3.3 Initial Assessment Interview

9.3.3.1 Context and Purpose

The investigator conducted initial assessment interviews at the QUT Psychology and Counselling Clinic (Figure 9.1) for each individual who met preliminary research criteria, provided informed consent to participate in the research and arrived for the designated appointment ($n = 71$). The primary aim of initial assessment interviews was to determine whether respondents met full inclusion criteria or met exclusion criteria. Assessment required approximately 1.5 to 2.5 hours per client. Materials administered at the initial assessment included the: (a) M.I.N.I. 5.0.0 (Sheehan et al., 2000); (b) SCID-II-IV (First et al., 1997); (c) Demographic Questionnaire; (d) Health-Care Contact Monitor; (e) BDI-II; (f) DASS-D (Lovibond & Lovibond, 1995), and the; (g) OQ-45.2 IR (Lambert et al., 1999).

9.3.3.2 Confidentiality: Code Identifiers

Each client and therapist, who participated in the research, developed a code identifier (Appendix M), according to the following stimulus prompts: (a) What is the first letter of your mother's first name?; (b) What is the first letter of your father's first name?, and; (c) what is the year of your birth? The purpose of code identifiers was to maintain the confidentiality of clients and therapists while matching data from questionnaires and tapes over the course of the research. Code identified responses were therefore kept separate from personal identifying information. Stimulus prompts for code identifiers began each battery of questionnaires and the code identifiers of both therapists and clients identified session audio or video tapes.

9.3.3.3 Client Selection, Allocation to Therapists, and Referral

The initial assessment interview revealed that of the 71 people interviewed, 15 did not meet research inclusion criteria or met research exclusion criteria. Six people were unable to attend available therapy sessions because of time or location clashes. Three people withdrew from the study after the initial assessment interview. The investigator invited the remaining 47 (33 females and 14 males) people to participate in therapy sessions.

Preferred time-slot matches with therapists and preferred location matches with therapists determined the allocation of clients to therapists. Two therapists saw one client each; 21 saw two clients each, and; one therapist saw three clients. Individuals who attended the initial assessment interview, but did not continue in the research were referred to the QUT Psychology and Counselling Clinic for treatment at low cost and to their general practitioners.

9.3.4 Implementation of Narrative Therapy

9.3.4.1 Therapy Dose

Research therapists implemented eight fifty-minute sessions of narrative therapy in the context of individual face-to-face therapy over eight to sixteen weeks (Figure 9.1).

9.3.4.2 Therapy Setting

Since the insurance provider for the QUT did not indemnify therapists who were not QUT staff or students to provide therapy on QUT premises, at the outset of the research, an application to adjust QUT indemnity to cover therapists who participated in QUT research both at QUT and other premises was sought and obtained.

The majority of clients were seen at the QUT Psychology and Counselling Clinic. Six clients were seen at Brisbane Centacare, two at Griffith University Psychology Clinic, Brisbane, two at a University of Queensland Psychology Clinic, and two at L'ARCHE, Brisbane. In line with ethical requirements from the QUT Human Research Committee (UHREC), the investigator sought and obtained consent from the organisations involved for the use of their premises for QUT research purposes.

9.3.4.3 Therapist Supervision

In order to prevent drift away from the intended therapy program and to facilitate the integrity of therapy implementation, four therapist supervisors (three males and one female) offered therapists weekly group supervision (Figure 9.1). Therapist supervisors participated in the research at the invitation of the investigator. Therapist supervisors were therapists who: (a) were experienced in a narrative approach to therapy, (b) were experienced in providing supervision to post-graduates

(c) agreed to oversee a manualised treatment process, and (c) were current QUT staff. All but one supervisor were unpaid.

Supervisors conducted group supervision sessions at the QUT. Each supervisor was available for one to 1 and 1/2 hours of supervision per week over the course of the therapy implementation. The investigator also supervised therapists, and attended and contributed to the supervision sessions of other supervisors. Therapists attended at convenient sessions and times. Where scheduling problems meant that therapists could not attend group supervision sessions at the QUT, the investigator met with therapists at the QUT or other suitable location (e.g., three therapists were seen at Centacare clinic rooms) so that therapists could access supervision. Telephone supervision was available when required by therapists.

Although supervision style varied according to the mode preferred by each supervisor, supervisors and therapists discussed clients in the context of a narrative therapeutic approach. Supervision was informed by narrative theory and supervisors encouraged therapists' reflection on their practice and on the practice of others in their group.

9.3.4.4 Outcome and Process Questionnaires

Research therapists and clients completed questionnaires (Figure 9.1). The chief investigator provided each therapist with a research pack for each of the therapist's clients. Each pack contained:

1. Instructions for therapists (Appendix N).

2. A three-hour blank video tape (audio tapes were used for two clients to meet the preference of the therapist). Extra videos were always available from the investigator.

3.   Eight manila envelopes, labelled from Session 1 to Session 8, addressed to the investigator.

4.   In each envelope: A battery of questionnaires, specific to the session (e.g., Session 1, Session 2, ….Session 8) for the client to complete directly after the appropriate session.

5.   In the envelope marked Session 1: A demographic questionnaire for the therapist to complete directly after session one.

To maintain confidentiality, therapists and clients placed questionnaires in manila envelopes provided by the investigator. Manila envelopes were marked only with the session number and investigators name.

9.3.4.5 Session Taping

Following written consent from clients and therapists to audio or video tape therapy sessions, Sessions 1 and 8 and a middle session (at random) were audio or video taped (Figure 9.1) to assist the assessment of therapy integrity and to provide data for determining narrative reflexivity. To maintain confidentiality, therapists and clients labelled session tapes with their own code identifiers prior to placing the tape with session questionnaires in manila envelopes provided by the investigator. Envelopes were sealed in the view of the client and therapist involved and placed in a locked box in the QUT Psychology and Counselling Clinic reception area.

9.3.5 Evaluation of Therapy Integrity

For each therapist-client dyad assessed, three video taped therapy sessions (Session 1, Session 8; and a middle session at random) provided data to calculate therapy integrity with the N-TIS. An independent rater evaluated therapy integrity from a random 18 (47.37%) of the therapist-client dyads. Where a video or audio tape was unavailable or inaudible because of technical difficulties, calculation of therapy

integrity was derived from the remaining two sessions, providing a conservative estimate of therapy integrity. A second independent rater evaluated 13 (11%) of the session tapes to provide data for the calculation of N-TIS inter-rater reliability.

9.3.6 Tape Transcription

Video tapes from the first and eighth therapy sessions from the five least improved and five most improved clients (according to change in BDI-II scores) were selected. A professional sound technician transferred the 20 video taped therapy sessions into a digital audio format. Since tapes were labelled with code identifiers, not names, and since the technical process required no viewing of tapes, the confidentiality of research participants was maintained. A professional transcriber transcribed the 20 therapy sessions from the digital audiotapes (Figure 9.1) to provide data for coders to code and evaluate the proportion of narrative reflexivity in therapy sessions.

9.3.7 Post-Therapy Interview

Post-therapy interviews with clients who completed the eight-session intervention by the investigator occurred as soon as possible after each client completed the eight-session narrative intervention (Figure 9.1). Two purposes underpinned the post-therapy interviews. Firstly, the interviews offered an opportunity for clients to meet with the investigator to voice their experience of the therapy sessions and research, potentially providing a sense of closure. Secondly, the post-therapy interview provided the investigator an opportunity to listen to the concerns of each client individually and review his or her situation. Clients who therapists considered to need additional therapeutic contact or who indicated they wanted to access additional treatment, were referred to their general practitioner or to the QUT

Psychology Clinic for treatment at low cost or were otherwise referred as appropriate (Figure 9.1).

9.3.8 Suicide Risk Protocol and Post-Treatment Referral

The investigator provided research therapists with a suicide risk assessment protocol with relevant contact information, and requested that therapists be alert to the mood and situation of their clients throughout the treatment trial.

9.3.9 Three-Month Follow-Up

Three months after each client completed the eight-session intervention, the investigator sent envelopes containing outcome measures (Table 9.5) by mail to clients who completed eight sessions of the narrative intervention, to be completed by each client and sent back in a stamped envelope provided, addressed to the investigator at the QUT (Figure 9.1).

CHAPTER 10

RESULTS

10.1 Reliability Analyses

10.1.1 Internal Consistency of Dependent Variable Scales

Examination of dependent variables' internal consistency used the R*eliability*

Analysis function SPSS 14.0.0 (Statistical Package for Social Sciences 14.0.0 for

Windows, 2005)[21]. Table 10.1 presents Cronbach's alpha coefficients for dependent

variable scales and sub-scales employed in the research, calculated from the completer

sample at Session 8. Reliability scores ranged from .70 to .97, suggesting that scores

were reasonably reliable for participants in the current study (Tabchnick & Fidell,

2001).

Table 10.1

Cronbach's Alpha Coefficients for Dependent Variable Scales

Scale	Cronbach's α
Beck Depression Inventory-II	.94
Depression Anxiety Stress Scale, Depression Subscale	.97
Outcome Questionnaire-45.2 Interpersonal Relations Subscale	.84
Working Alliance Inventory Total Score	.95
Working Alliance Inventory Task Subscale	.95
Working Alliance Inventory Bond Subscale	.95
Working Alliance Inventory Goal Subscale	.72
Satisfaction with Therapy Subscale	.91

Note. Calculated from the completer sample at session eight.

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[21] Henceforth, this thesis refers to Statistical Package for Social Sciences 14.0 for Windows (SPSS 14.0, 2005) as SPSS.

10.1.2 Narrative Processes Coding System: Inter-Rater Agreement

Inter-rater reliability for the NPCS was examined by comparing the judgements of the independent NPCS coder against those of the investigator for a sample (10%) of the transcripts. Agreement on two elements of the NPCS were examined: (a) agreement in distinguishing topic segments, and; (b) agreement in identifying narrative discourse modes within previously distinguished topic segments. In distinguishing the beginning and end of topic segments, the two raters agreed 92.47% of the time; insufficient variability excluded calculation of Cohen's Kappa. Cohen's Kappa was used to evaluate inter-rater agreement for categorising previously distinguished topic segments into narrative sequences, while correcting for chance agreements. Using the *Crosstabs* function of SPSS, raters achieved acceptable inter-rater agreement (Cohen's Kappa = .69) in distinguishing discourse modes as (a) external; (b) internal, and; (c) reflexive, with raters agreeing 86.17% of the time.

10.1.3 Narrative Therapy Integrity Schedule: Inter-Rater Relibility

For each therapist-client dyad assessed, three video or audio taped therapy sessions (Session 1, a middle session at random, Session 8) provided data to calculate therapy integrity using the N-TIS. Two independent raters evaluated therapy integrity from a random 13 (11%) of the taped therapy sessions. Analysis of intra-class correlation (ICC) assessed inter-rater reliability (Shrout & Fleiss, 1979) for N-TIS scores using the SPSS *Scale* function. Using a two-way mixed model and examining absolute agreement, the single measure ICC was .88[22], significant at $p < .01$, with a 95% confidence interval between 0.84 and 0.90.

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[22] The value of the ICC equals one when there is no variation between raters in judging items.

10.2 Evaluation of Intervention Integrity Using the Narrative Therapy Integrity

Schedule

One independent rater used the N-TIS to evaluate integrity from a random 47%
of the therapist-client dyads. The *Frequencies* function of SPSS provided mean item
scores averaged across clients per session. Averaging the three items within each
category provided the mean item score for each N-TIS category for first, middle and last
sessions. Averaging session mean item scores then provided an index of the mean item
score for each category. Table 10.2 shows mean item scores according to each N-TIS
category.

Table 10.2

Narrative Intervention Integrity: Mean Item Scores for Sessions According to N-TIS
Categories

N-TIS Category	Items	Mean Item Score			
		S1[a]	Mid[b]	S8[c]	Tot[d]
Developing a Therapeutic Relationship	1-3	1.70	1.70	1.70	1.70
Eliciting Problem Stories	4-6	1.40	1.50	1.40	1.43
Deconstructing Dominant Problem Stories	7-9	1.00	1.57	1.17	1.25
Embracing Preferred Stories	10-12	0.43	0.80	1.20	0.81
Living Enriched Stories	13-15	0.70	1.20	1.50	1.13
Proscribed Practices	16-18	1.80	1.80	1.90	1.83

Note. Maximum score for each category = 2. Higher scores indicate higher therapy
integrity.

[a]Session 1. [b]Middle Session (one of Sessions 2-7). [c]Session 8. [d]Mean item score
averaged across first, middle and last sessions.

Scores near 0 (0%) indicated no therapy adherence or therapy competence. Scores near 1 (50%) indicated therapy adherence and scores near 2 (100%) indicated therapy integrity (adherence and competence). When taken across therapists and categories, therapists achieved an adherence score of 96.83% and an integrity score of 67.92%. Therapists implemented the 'embracing preferred stories' phase with least adherence and competence, achieving an average integrity score of 40.5%.

10.3 Preliminary Data Management for Process-Outcome Research

10.3.1 Data Screening and Accuracy

Prior to the main analyses, data entry accuracy was assessed utilising the *Descriptive Statistics, Frequencies and Explore* functions of SPSS. Perusal of the number and range of scores for each dependent variable suggested the data was accurate.

10.3.2 Treatment of Univariate Outliers and Extreme Points

Box-plots in the *Explore* function of SPSS identified outliers in OQ-45.2 IR and WAI-S distributions. Outliers were confirmed as genuine scores. Examination of the 5% *Trimmed Mean* statistics revealed that none of the identified outliers influenced the mean scores greatly. Outliers were retained because they were part of the intended populations and did not substantially influence means. Investigation for univariate outliers in dependent variable distributions found one extreme point. Treatment of the extreme point in the pre-therapy BDI-II distribution for mildly depressed individuals is discussed in the relevant section (10.6.1).

10.3.3 Missing Data Treatment

Missing data was managed according to manual protocols where provided. Where a manual provided no protocol for missing data, the investigator substituted an estimation of unweighted means (Winer, Brown, & Michels, 1991). Where possible,

remaining items from the relevant sub-scale were averaged to calculate the unweighted means estimate. Where there were no sub-scales, scores from the total scale were averaged to calculate the estimate. Since the scales used had good internal consistency, bias resulting from using mean scores was likely to be minor (Schafer & Graham, 2002). Replacement of these randomly missing data ensured adequate statistical power.

10.3.4 Attrition and Invalid Data

Forty-seven clients (33 females; 14 males), the ITT sample set, commenced therapy. Figure 10.1 depicts a flow chart of client attrition and invalid data, showing intent-to-treat, completer and follow-up data sets. Of clients that commenced therapy, six (13%) did not complete eight therapy sessions: three clients completed one session; two clients completed two sessions, and; one client completed three sessions. Although there is considerable variation in attrition rates in the psychotherapy literature, attrition in the current study is lower than the estimated 20% proposed by Mason (1999) from previous outcome studies.

Forty-one clients completed the eight therapy sessions. One of the 41 clients, who completed eight sessions, responded to the first six questionnaires only: The client did attend the post-therapy interview. The post-therapy Health Care Monitor distinguished that two people had commenced antidepressants during the eight-session intervention, and their data was excluded from the completer sample analyses. Based on ethical grounds, no directions were provided to clients in relation to commencing medication during the trial. There was therefore valid data for the eight-session intervention for 38 clients (27 females; 11 males), comprising the completer sample set.
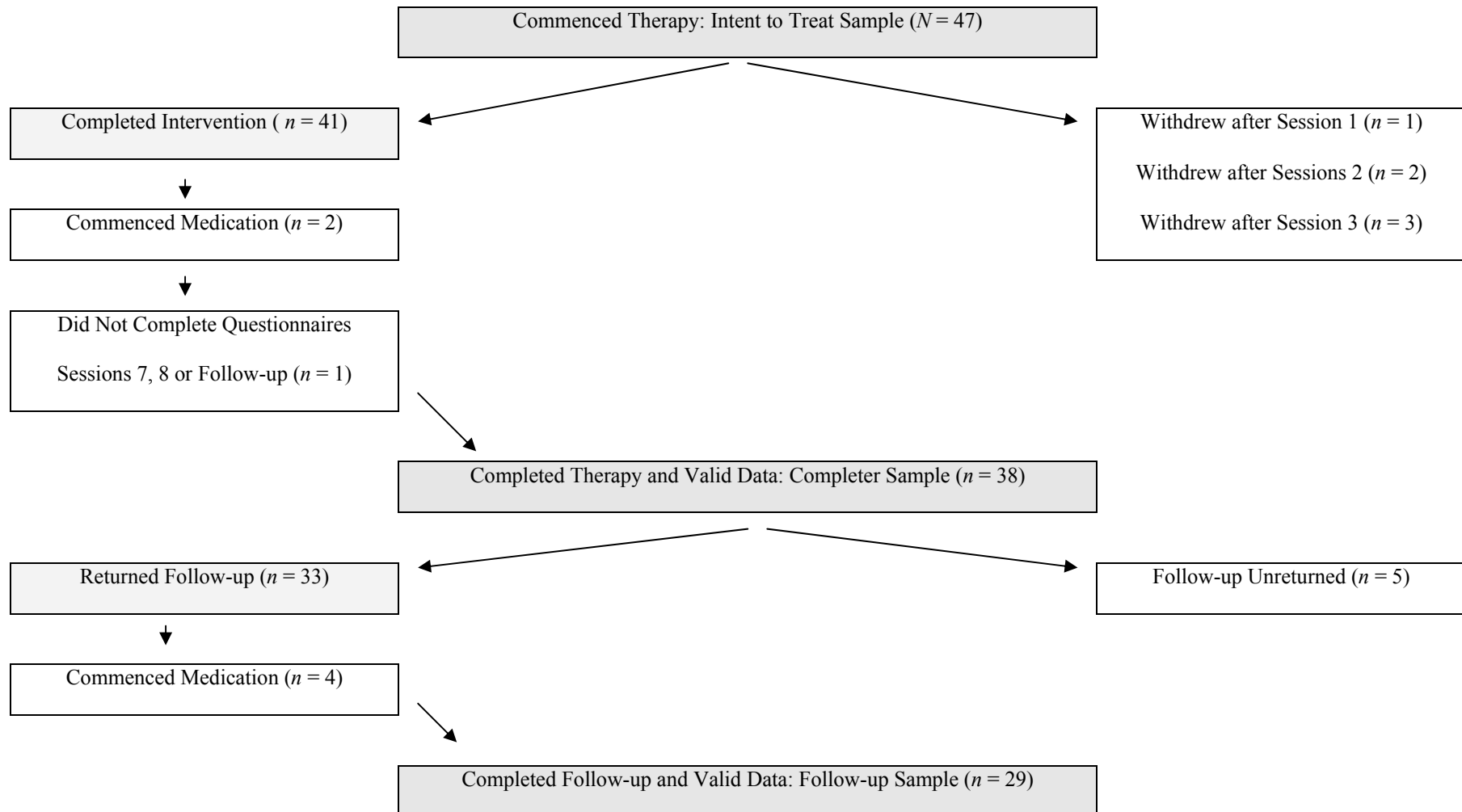
Figure 10.1. CONSORT flow chart of client attrition and invalid data showing major data sets.

Five of the 38 completer clients did not return three-month follow-up questionnaires. Responses indicated that four of the 33 people who returned follow-up questionnaires commenced medication during the three-month follow-up period. At three-month follow-up, there was therefore valid data for 29 clients.

The current study reports analyses of statistical significance and effect size for both ITT and completer samples. Report of ITT analyses is consistent with CONSORT guidelines ((Moher, Schulz, & Altman, 2001; see Section 5.6). Report of completer sample analyses is congruent with common practice in psychotherapy research. Of note, however, the ITT sample contained individuals who had commenced medication or withdrawn early. Analysis of clinical significance evaluated the completer sample to be consistent with the benchmark comparison trial.

10.3.5 Assumption Testing

Relevant data were assessed for possible violations of assumptions underlying the statistical techniques used including t-tests, correlations and split-plot analysis of variance (SPANOVA).

Assumptions for t-tests included: (a) random sampling; (b) independence of observation; (c) normality; (d) normality of difference scores, and; (e) homogeneity of variance. Assumptions (a) and (b) were built into the research design. Assessment of normality utilised the *Explore* function of SPSS to visually examine normality plots, de-trended normal plots and histograms. This function also enabled examination of the Kolmogorov-Smirnov statistic and values for skewness and kurtosis. Assessment of homogeneity of variances used Levene's Test for Equality of Variances.

Assumptions for correlation analyses included: (a) normality; (b) linearity, and; (c) homoscedasticity. Independence of observations was required to determine the statistical significance of correlations. Assessment of linearity and homoscedasticity used the G*raphs* function of SPSS to generate scatterplots for pairs of variables

Assumptions for SPANOVA included: (a) random sampling; (b) independence of observations (c) normality; (d) homogeneity of variance, and ; (e) homogeneity of inter-correlations. The Box M statistic, examining the variance-co-variance matrices, was used to examine homogeneity of inter-correlations.

10.3.6 Data Transformations

Data Transformations were conducted, where relevant, using the T*ransform* function of SPSS to (a) recode reverse-scored items in WAI-S data (b) compute total scale scores for the BDI and WAI-S (c) compute sub-scale scores for the OQ-45.2 IR, WAI-S Bond, Task and Goal, DASS-D and SWT-T sub-scales, and (d) transform skewed variables.

Where variables were not normally distributed, data transformations conducted to address skew and improve distribution normality, are discussed in the relevant sections. In these cases, analyses were performed with and without transformations; if transformation did not impact substantive interpretations, then statistics for untransformed analyses were reported.

10.4 Primary Process Analyses

10.4.1 Primary Process Question 1:

Differential Change in Narrative Reflexivity: Comparing Least Improved and Most Improved Clients

The first process research question asked whether there would be a differential change in narrative reflexivity in least improved compared to most improved clients. Hypothesis 1 predicted that change in the mean proportion of reflexive sequences would be greater in most improved clients than in least improved clients.

The five least improved clients and the five most improved clients were selected according to pre-therapy to post-therapy BDI-II change scores (Table 10.3), as the BDI-II is a widely used and reliable measure of therapy outcome in depression treatment. For the least improved clients, pre-therapy BDI-II scores ranged from minimally depressed ($n = 1$) to mildly depressed ($n = 2$) and severely depressed ($n = 2$). For the most improved clients, pre-therapy BDI-II scores ranged from moderately depressed ($n = 1$) to severely depressed ($n = 4$).

At post-therapy, BDI-II scores had increased in three of the least improved clients and decreased in two clients, ranging from minimally depressed ($n = 1$) to mildly depressed ($n = 1$) to severely depressed ($n = 3$). At post-therapy, all five of the most improved clients achieved BDI-II scores in the minimally depressed range. The NPCS (Angus et al., 1999) coder evaluated entire therapy transcripts from videoed Sessions 1 and 8 for each selected client. The coder first divided transcripts into topic segments, then sub-divided topic segments into external, internal and reflexive sequences. For each session, external, internal and reflexive sequences were calculated as a proportion of total sequences.

Table 10.3

Change in Beck Depression Inventory II Scores and Percentage of Reflexive Sequences in Most and Least Improved Clients

Client		BDI-II Scores Change	Reflexive Sequences (%) Change
Most Improved	A	-30.00	+23.42
	B	-29.00	+22.70
	C	-28.00	+25.07
	D	-27.00	+27.27
	E	-27.00	+21.08
Least Improved	F	-08.00	+26.71
	G	-02.00	+18.21
	H	+01.00	-00.61
	I	+09.00	+9.33
	J	+14.00	-07.27

Table 10.3 shows change in the proportion of reflexive discourse sequences for least and most improved clients. Figures 10.2 and 10.3 depict the proportion of reflexive sequences for Sessions 1 and Session 8 in relation to external and internal sequences, averaged across the five most improved clients and across the five least improved clients.

Calculation of reflexive sequences in therapeutic discourse (Table 10.3) provided continuous data to evaluate the effects of outcome and assessment point on narrative reflexivity for the five least improved and five most improved clients. Table 10.4 shows the means and standard deviations of reflexive sequences in therapeutic discourse for the least improved and most improved clients at Sessions 1 and 8.

Table 10.4

Mean Percentage of Reflexive Discourse at Sessions 1 and 8: Least Improved and Most

Improved Clients

Outcome	% Reflexive Discourse Session 1		% Reflexive Discourse Session 8	
	M	SD	M	SD
Least Improved	21.49	07.33	30.77	10.48
Most Improved	27.71	05.74	51.61	06.77
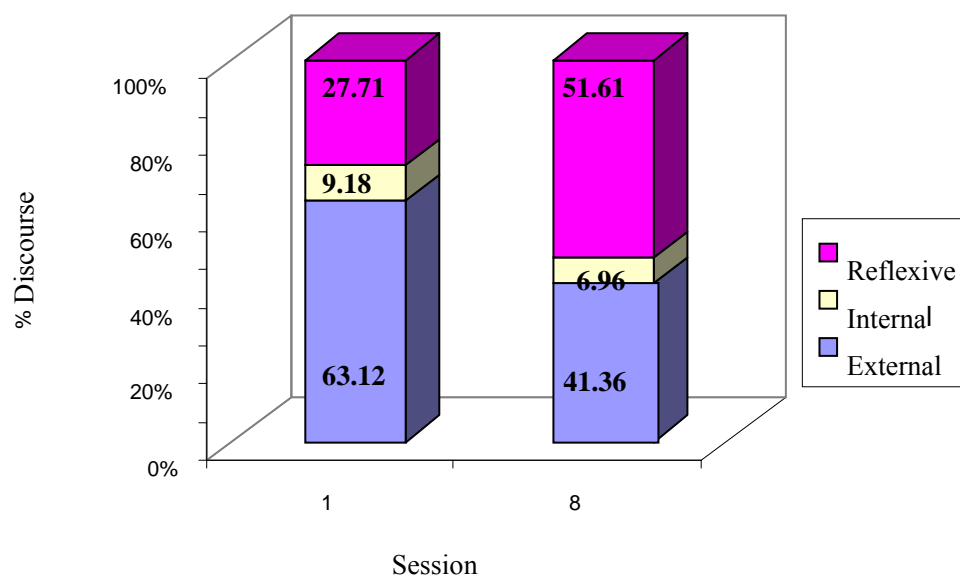
Figure 10.2. Percentage of external, internal and reflexive discourse in Sessions 1 and 8 averaged across five most improved clients.
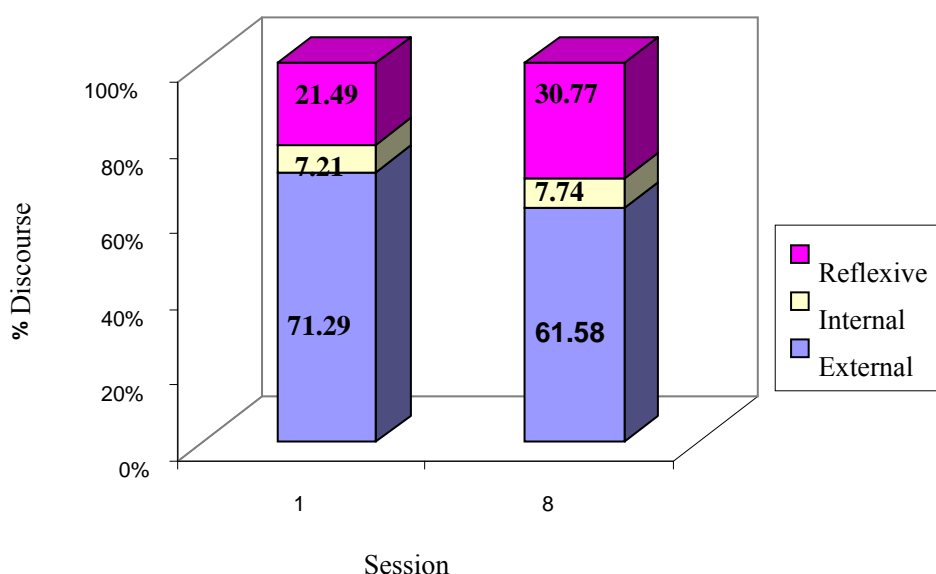
Figure 10.3. Percentage of external, internal and reflexive discourse in Sessions 1 and 8 averaged across five least improved clients.

A two-way (2 x 2) mixed analysis of variance (SPANOVA)[23] was conducted on the percentage of reflexive sequences (narrative reflexivity) in therapeutic discourse using the General Linear Model function of SPSS. The independent variables were outcome, a between-groups variable with two levels (least improved and most improved clients), and assessment point, a within subjects variable, with two levels (Sessions 1 and 8). There was a significant main effect for outcome, $F(1, 8) = 12.61$, $p < .01$, partial $\eta^2 = .61$, and a significant main effect for assessment point, $\Lambda = .22$, $F(1, 8) = 28.32$, $p < .01$, multivariate partial $\eta^2 = .78$. There was a significant effect for the interaction between outcome and assessment point, $\Lambda = .59$, $F(1, 8) = 5.51$, $p < .05$, multivariate partial $\eta^2 = .41$ (Figure 10.4).

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[23] A binary logistic regression, using narrative reflexivity as the independent variable and outcome as the dependent variable, was considered, but rejected because of sample size requirements (Grimm & Yarnold, 1995).

Since there was a significant interaction between outcome and assessment point, I chose to ignore the significant main effects for outcome and assessment point and examined pre-therapy to post-therapy change for the two groups (least improved clients and most improved clients) separately. Two follow-up pair-wise comparisons of group means were conducted. To control for Type 1 error, I set alpha for each at .025 (.05/2 = .025).

A one-way between-groups analysis of variance was conducted to compare the mean percentage of reflexive discourse (the dependent variable) in the therapeutic conversations of least improved clients with those of most improved clients at Session 1 (the independent variable). At Session 1, there was no statistical difference, $F(1, 8) = 2.23$, $p = .17$, in the percentage of reflexive discourse between least improved clients ($M = 21.49$; $SD = 7.33$) and most improved clients ($M = 27.71$; $SD = 5.74$). Eta squared (η^2) indicated that outcome (least or most improved group) accounted for 22% of the variance in the percentage of reflexive sequences in the discourse of clients at Session 1.
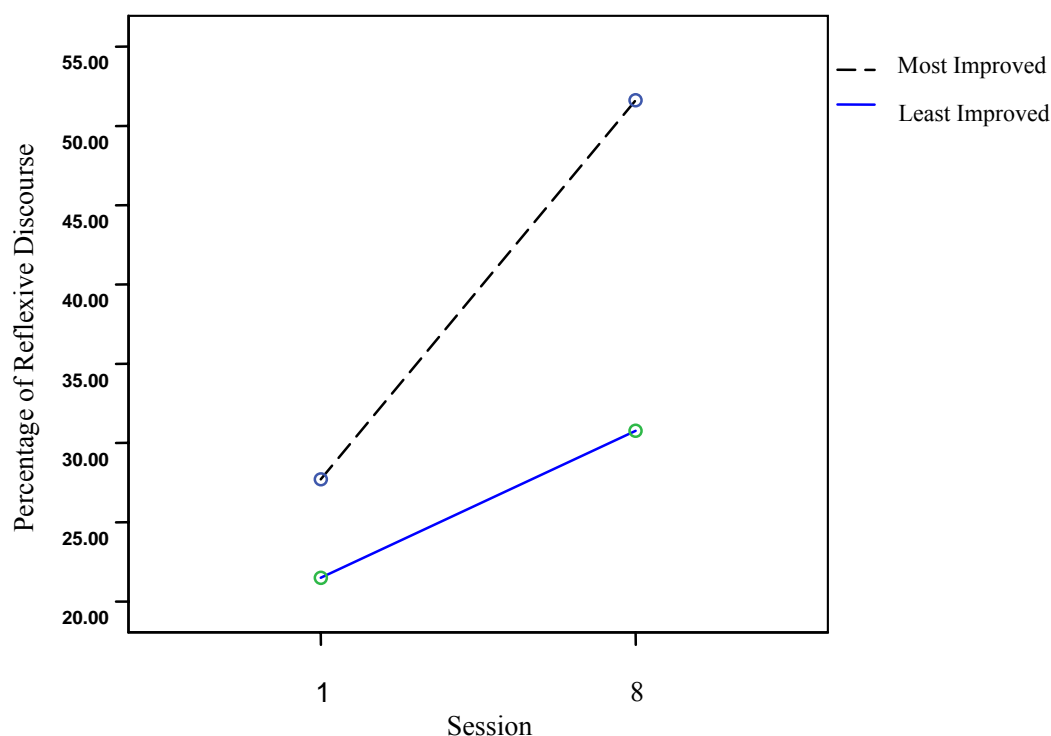
Figure 10.4. Interaction of outcome and assessment point demonstrating change in reflexive discourse from Session 1 to 8 for least and most improved clients

A one-way between-groups analysis of variance was conducted to compare the percentage of reflexive discourse (the dependent variable) in the therapeutic conversations of least improved clients with those of most improved clients at Session 8 (the independent variable). In support of Hypothesis 7, at Session 8, there was a statistically higher percentage of reflexive sequences, $F(1, 8) = 13.96$, $p = .01$, in the discourse of most improved clients ($M = 51.61$; $SD = 6.77$) compared to least improved clients ($M = 30.77$; $SD = 10.48$). Eta squared (η^2) indicated that outcome accounted for 64% of the variance in the percentage of reflexive sequences in the discourse of clients at Session 8.

There was a medium negative correlation ($r = -.44$) between narrative reflexivity and inter-personal relatedness in the sub-sample of clients who provided reflexivity scores. Requirements for independence of observations excluded calculation of the statistical significance of this correlation.

10.4.2 Primary Process Question 2: Relationship of Working Alliance with Depressive Symptom and Inter-personal Relatedness Outcomes

The second process research question enquired into the relationship between Session 1 to 8 improvement in therapeutic alliance quality and pre-therapy to post-therapy improvements in depressive symptoms and inter-personal relatedness. Hypothesis 2 predicted that mean Session 1 to 8 WAI-S change would be negatively correlated with mean pre-therapy to post-therapy BDI-II change, such that improved (increased) alliance would be associated with improved (decreased) depressive symptoms. Hypothesis 3 predicted that mean Session 1 to 8 WAI-S change would be negatively correlated with mean pre-therapy to post-therapy OQ-45.2 IR change, such that improved (increased) alliance would be associated with improved (decreased) inter-personal relatedness.

Table 10.5 displays the means and standard deviations for WAI-S total and subscale scores at Sessions 1, 3 and 8. Averaged across the 12 items, the mean total scores were 5.14 for Session 1, 5.59 for Session 3, and 5.86 for Session 8. The highest possible score was 7.

Paired-samples t-tests, conducted on completer sample scores, evaluated whether mean total WAI-S scores changed over time. With alpha set at .05, mean WAI-S scores increased significantly from Session 1 to Session 3, $t(37) = -3.50$, $p < .001$, with a 95% confidence interval for mean difference from -8.19 to -2.18. Mean WAI-S

scores also increased significantly from Session 3 to Session 8, t (37) = -3.03, p < .004, with a 95% confidence interval for mean difference from -5.93 to -1.18.

Table 10.5

Working Alliance Inventory Short Form Means and Standard Deviations for Total and Subscale Scores: Completer Sample (n = 38)

	Assessment Point					
	Session 1		Session 3		Session 8	
WAI-S	*M*	*SD*	*M*	*SD*	*M*	*SD*
Total	61.63	09.92	66.82	08.79	70.37	09.02
Task	19.76	04.41	22.32	03.11	23.60	03.10
Bond	21.45	03.73	22.00	03.59	23.24	03.37
Goal	20.42	04.18	22.50	03.15	23.53	03.17

Using the *Correlate* function of SPSS to calculate Pearson product moment correlations on completer sample data, correlations of improving alliances with depressive symptom and inter-personal relatedness improvements were calculated. In support of Hypothesis 2 and 3, Session 1 to 8 WAI-S gain scores were significantly negatively correlated with pre-therapy to post-therapy BDI-II gain scores, r (37) = -.34, p = .04, and OQ 45.2 IR gain scores, r (29) = -.43, p = .02, with improvements in client-rated alliance associated with improvements in depressive symptoms and inter-personal relatedness**.**

Pre-therapy BDI-II scores were significantly correlated with BDI-II (pre-therapy to post-therapy) gain scores, r (37) = .42, p = .009, and pre-therapy OQ 45.2 IR scores were correlated with OQ 45.2 IR (pre-therapy to post-therapy) gain scores, r (29) = .39, p = .03. To control for pre-therapy scores and measurement error inherent to repeated

use of measures, residual gain scores[24] were calculated for BDI-II and OQ 45.2 IR scores (Steketee & Chambless, 1992). Pearson product moment correlations of total WAI-S gain scores (Session 1 to 8) with BDI-II residualised gain scores and OQ 45.2 IR residualised gain scores were then calculated. WAI-S gain scores were significantly correlated with BDI-II residualised gain scores, r (37) = .44, p = .006 and with OQ 45.2 IR residualised gain scores, r (29) = .42, p = .02.

Given previous research, showing early client-rated alliance predicted outcome (Horvath & Bedi, 2002), Pearson product moment correlations evaluated whether clients' early ratings of alliance were correlated with improved depressive symptoms and inter-personal relatedness. Session 3 WAI-S scores were significantly correlated with BDI-II residualised gain scores, r (37) = -.48, p = .002, and OQ 45.2 residualised gain scores, r (29) = -.47, p = .008, with Session 3 client-rated alliance associated with pre-therapy to post-therapy improvements in depressive symptoms and inter-personal relatedness.

To examine relationships of the working alliance with depressive symptom and inter-personal relatedness scores over time, correlations of WAI-S scores at Session 1, 3 and 8 with post-therapy BDI-II and OQ 45.2 IR scores were investigated. Assessment of the assumptions underpinning correlation analyses revealed that BDI-II scores were positively skewed at Session 8 and WAI-S Task scores were negatively skewed at Session 1. A square root transformation of Session 8 BDI-II scores and a reflect and square root transformation of Session 1 WAI-S Task scores were carried out. Analyses were conducted with and without transformed scores. Since transformations did not influence substantive interpretations, results are reported for untransformed variables.

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[24] Residual gain score = $(Z_2 - Z_1 r_{12})$, where Z_2 is the standardised post-therapy score, Z_1 is the standardised pre-therapy score, and r_{12} is the correlation between pre-therapy and post-therapy scores.

As shown in Table 10.6, Session 1 WAI-S scores were not significantly correlated with post-therapy BDI-II scores, but there were medium to large negative correlations of BDI-II scores with Session 3 and 8 WAI-S scores, excepting the Session 3 WAI-S Goal subscale scores.

Table 10.6

Pearson Product Moment Correlations of Working Alliance Inventory-Short Form Scores at Sessions 1, 3 and 8 with Post-therapy Beck Depression Inventory II Scores: Completer Sample

| Session | Working Alliance Inventory-Short Form | | | |
	Total	Task	Bond	Goal
1	-.10	.05	-.16	-.13
3	-.47**	-.49**	-.55**	-.21
8	-.52**	-.47**	-.55**	-.44**

Note. n = 38. **

p < .01

To determine whether the working alliance-post-therapy depressive symptom correlation differed from Session 3 to 8, the difference between the two non-independent correlations was calculated using Steiger's (1980) formula[25] to account for the correlation between WAI-S scores at Sessions 3 and 8 (r = .67). With 35 degrees of freedom (N-3), t_{obtained} = 0.43, which was not significant at p < .05, indicating there was

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[25] $t_{\text{obtained}} = (r_{12} - r_{13}) \sqrt{[\{(N - 1)(1 + r_{23})\}/ 2(N-1/N-3)|R| + \{(r_{12} + r_{13})^2\}/4(1 - r_{23})^3]}$

where $|R| = (1 - r^2_{12} - r^2_{13} - r^2_{23}) + (2 r_{12} r_{13} r_{23})$

no significant difference in the correlation between WAI-S and post-therapy BDI-II scores at Sessions 3 and 8.

As shown in Table 10.7, Session 1 WAI-S scores were not significantly correlated with post-therapy OQ 45.2 IR scores. There were medium negative correlations between Session 3 WAI-S and post-therapy OQ 45.2 IR scores, except for the Goal subscale, and large negative correlations between Session 8 WAI-S total and subscale scores with post-therapy OQ 45.2 IR scores.

Table 10.7

Pearson Product Moment Correlations of Working Alliance Inventory-Short Form Scores at Sessions 1, 3 and 8 with Post-therapy Outcome Questionnaire 45.2 Inter-personal Relations Scores: Completer Sample

	Working Alliance Inventory-Short Form			
Session	Total	Task	Bond	Goal
1	-.29	-.14	-.28	-.27
3	-.41*	-.47**	-.39*	-.17
8	-.60**	-.57**	-.60**	-.50**

Note. $n = 30$

*$p < .05$ ** $p < .01$ (2-tailed)

To determine whether the working alliance-post-therapy inter-personal relatedness correlation differed from Session 3 to Session 8, the difference between the two non-independent correlations was calculated using Steiger's (1980) formula to account for the correlation between WAI-S scores at Sessions 3 and 8 ($r = .67$). Using 27 degrees of freedom ($N-3$), $t_{obtained} = 1.52$, which was not significant at $p < .05$,

indicating there was no significant difference in the correlation between WAI-S and post-therapy OQ 45.2 IR scores at Sessions 3 and 8.

10.5 Primary Outcome Analyses

10.5.1 Primary Outcome Question 1:

The Statistical Significance of Depressive Symptom and Inter-personal Relatedness

Outcomes

The first outcome research question asked whether there were statistically significant improvements in depressive symptoms and inter-personal relatedness from pre-therapy to post-therapy. Hypothesis 4 predicted that mean BDI-II scores (depressive symptoms) would be significantly lower (improved) at post-therapy compared to pre-therapy. Hypothesis 5 predicted that mean OQ-45.2 IR scores (inter-personal relatedness) would be significantly lower (improved) at post-therapy compared to pre-therapy.

Paired-samples t-tests, conducted on completer and ITT sample data, evaluated the impact of narrative therapy on BDI-II scores from pre-therapy to post-therapy. Analysis focused on mean raw score change rather than residualised gains, to enable comparison of statistics with previous psychotherapy outcome research. Assessment of normality revealed a positive skew in post-therapy BDI-II scores in the ITT and completer sample sets. Square root transformations were conducted on relevant BDI-II scores in the ITT and completer sample sets to improve distribution normality. Since substantive interpretations of analyses with transformed and untransformed scores did not differ, I report results for untransformed BDI-II scores.

Table 10.8 presents the means and standard deviations for pre-therapy and post-therapy BDI-II scores in the completer and ITT samples. The ITT analysis used the LOCF method to substitute for missing data. Since BDI-II assessment occurred at pre-

therapy, post-therapy and follow-up only; pre-therapy values substituted missing post-therapy values.

Table 10.8

Means and Standard Deviations for Beck Depression Inventory II Scores at Pre-therapy and Post-therapy: Completer and Intent-To-Treat Samples

Sample	Assessment Point	N	Mean	Standard Deviation
Completer	Pre-therapy	38	27.71	09.95
	Post-therapy	38	13.29	11.19
Intent-To-Treat	Pre-therapy	47	28.87	09.98
	Post-therapy	47	16.83	13.47

In support of Hypothesis 4, with alpha set at .05, mean BDI-II scores in the completer sample decreased significantly from pre-therapy to post-therapy, $t(37) = 8.23$, $p < .001$, with a 95% confidence interval for mean difference from 10.87 to 17.97. In the ITT sample, mean BDI-II scores decreased significantly, $t(46) = 7.32$, $p < .001$, from pre-therapy to post-therapy, with a 95% confidence interval for mean difference from 8.73 to 15.35.

Calculation of the magnitude of the effect of narrative therapy utilised the standardised effect size index, *d*, calculated from BDI-II mean scores and standard deviations from pre-therapy to post-therapy. Results (Table 10.9) indicated large effect sizes for BDI-II score change in both completer and ITT samples.

Table 10.9

Effect Size, d, of Pre-therapy to Post-therapy Change According to Beck Depression Inventory II Scores: Completer and Intent-to-Treat Samples

Sample Set	Beck Depression Inventory II
Completer	1.36
Intent-to-Treat	1.10

Paired-samples t-tests, conducted on completer and ITT sample data, evaluated the impact of narrative therapy on OQ 45.2 IR scores from pre-therapy to post-therapy. Table 10.10 presents the means and standard deviations for OQ 45.2 IR scores from the completer and ITT samples. ITT analysis used the LOCF method. OQ-45.2 IR questionnaires were completed at pre-therapy, after each session and at follow-up. Initial intake clients did not complete the OQ-45.2 IR.

Table 10.10

Means and Standard Deviations for Outcome Questionnaire 45.2 Inter-personal Relations Scores at Pre-therapy and Post-therapy: Completer and Intent-to Treat Sample

Sample	Assessment Point	N	Mean	Standard Deviation
Completer	Pre-therapy	30	20.80	5.85
	Post-therapy	30	16.97	6.45
Intent-To-Treat	Pre-therapy	36	20.92	5.43
	Post-therapy	36	17.83	6.52

In support of Hypothesis 5, with alpha set at .05, mean OQ 45.2 IR scores in the completer sample decreased significantly from pre-therapy to post-therapy, $t(29) = 3.60$, $p < .01$, with a 95% confidence interval from 1.66 to 6.01. Mean OQ45.2 IR scores in the ITT sample decreased significantly, $t(35) = 3.14$, $p < .01$, from pre-therapy to post-therapy. The 95% confidence interval for mean difference between the two scores was 1.09 to 5.08.

Calculations on the magnitude of the effect of narrative therapy for depression in adults, utilised the standardised effect size index, d, calculated from OQ 45.2 IR mean scores and standard deviations from pre-therapy to post-therapy. Results (Table 10.11) indicated medium effect sizes for change in mean OQ 45.2 IR scores in both completer and ITT samples.

Table 10.11

Effect Size, d, of Pre-therapy to Post-therapy Change According to Outcome Questionnaire 45.2 Inter-personal Relations Scores: Completer and Intent to Treat Samples

Sample Set	OQ 45.2 Interpersonal Relatedness
Completer	0.62
Intent-to-Treat	0.52

Pearson product moment bivariate correlations (2-tailed) between BDI-II and OQ 45.2 IR gain scores, $r(29) = .71$, $p < .001$, and between BDI-II and OQ 45.2 IR residualised gain scores, $r(29) = .71$, $p < .001$, revealed gains in inter-personal relatedness were related to gains in depressive symptoms.

10.5.2 Primary Outcome Question 2:

The Clinical Significance of Depressive Symptom and Inter-personal Relatedness

Outcomes

The second research question enquired into the proportion of clients, who achieved clinically significant change following narrative therapy, as indexed by change in depressive symptoms and inter-personal relatedness from pre-therapy to post-therapy. Hypothesis 6 predicted that after eight sessions of narrative therapy, the percentage of clients achieving clinically significant change, as indexed by decrease in BDI-II scores (depressive symptoms) from pre-therapy to post-therapy would be equal to or over 50%. Enquiry into the clinical significance of change in OQ 45.2 IR scores (inter-personal relatedness) was exploratory.

Analyses of the clinical significance of BDI-II change, conducted on the completer sample, evaluated the proportion of clients who reliably improved, reliably deteriorated, moved into the functional population, and achieved clinically significant change from pre-therapy to post-therapy. Cut-off scores delineating reliable change and movement into the functional population were sourced from Seggar et al. (2002), who calculated normative data specifically for the purpose of research comparisons (See Section 6.3.6). Symptom change indices included: reliable improvement (defined as decrease in BDI-II scores of 8.46 or higher); reliable deterioration (defined as increase in BDI-II scores of 8.46 and higher); movement into the functional population (defined by BDI-II scores of less than 14.29), and; clinically significant change (defined as reliable change and movement into the functional population). Table 10.12 shows the frequency and percentage of clients grouped into each category. In support of Hypothesis 6, over 50% of clients achieved clinically significant change.

Table 10.12

Frequency and Percentage of Client Reliable Improvement, Reliable Deterioration,
Movement into the Functional Population and Clinically Significant Change According
to Beck Depression Inventory II Scores: Completer Sample

Category According to BDI-II Scores	Number of Clients	% Clients
Reliable Improvement	28	73.68
Reliable Deterioration	02	05.26
Functional Population	23	60.53
Clinical Significance	20	52.63

Note. n = 38.

Analyses of the clinical significance of OQ-45.2 IR change, conducted on the completer sample, evaluated the proportion of clients who reliably improved, reliably deteriorated, moved into the functional population, and achieved clinically significant change from pre-therapy to post-therapy. Cut-off scores delineating reliable change and movement into the functional population for the OQ-45.2 IR were sourced from the OQ-45.2 manual (Lambert et al., 1996). OQ-45.2 IR indices included: reliable improvement (defined as a decrease in OQ-45.2 IR scores of 8 or higher); reliable deterioration (defined as an increase in OQ-45.2 IR scores of 8 or higher); movement into the functional (community) population (defined by scores of less than 15), and; clinically significant change (defined as reliable change and movement into the functional population). Table 10.13 shows the frequency and percentage of clients grouped into each category.

Table 10.13

Frequency and Percentage of Client Reliable Improvement, Reliable Deterioration, Movement into the Functional Population and Clinically Significant Change According to Outcome Questionnaire 45.2 Interpersonal Relations Scores: Completer Sample

Category According to OQ.45.2 IR Scores	Number of Clients	% Clients
Reliable Improvement	09	30
Reliable Deterioration	01	03
Functional Population	09	30
Clinical Significance	07	23

Note. n = 30

10.5.3 Primary Outcome Question 3:

Maintenance of Depressive Symptom and Inter-personal Relatedness Outcomes at Three-Month Follow-up

The third primary outcome research question asked whether improvements in clients' depressive symptoms and inter-personal relatedness were maintained from post-therapy to three-month follow-up. Hypothesis 7 predicted that after eight sessions of narrative therapy, clients' mean follow-up BDI-II scores (depressive symptoms) would not differ from mean post-therapy scores. Hypothesis 8 predicted that clients' mean follow-up OQ 45.2 IR (inter-personal relatedness) scores would not differ from mean post-therapy scores.

Paired-samples t-tests, conducted on follow-up and ITT samples, evaluated change in mean BDI-II scores from post-therapy to follow-up and from pre-therapy to follow-up. Assessment of normality revealed the presence of positive skew in post-therapy BDI-II scores in the ITT and follow-up sample sets. Square root transformations, conducted on relevant BDI-II scores in the follow-up and ITT samples,

improved distribution normality for repeated measures analysis. Analyses were conducted with transformed and untransformed scores. Since substantive interpretations from analyses on transformed and untransformed scores did not differ, I report results for untransformed BDI-II scores.

Table 10.14 presents the means and standard deviations for BDI-II scores at pre-therapy, post-therapy and follow-up in the follow-up and intent-to-treat samples. The ITT analysis used the LOCF method to substitute for missing data. BDI-II assessment occurred at pre-therapy, post-therapy and follow-up only.

Table 10.14

Means and Standard Deviations for Beck Depression Inventory Scores II at Pre-therapy, Post-therapy and Follow-up: Follow-up and Intent-to-Treat Samples

Sample	Assessment Point	*N*	Mean	Standard Deviation
Follow-up	Pre-therapy	29	27.62	09.06
	Post-therapy	29	12.10	11.49
	Follow-up	29	14.69	10.82
Intent-To-Treat	Pre-therapy	47	28.87	09.98
	Post-therapy	47	16.83	13.47
	Follow-up	47	18.64	12.74

In support of Hypothesis 7, with alpha set at .05, mean BDI-II scores in the follow-up sample did not change significantly from post-therapy to follow-up, $t(28) = -1.62$, $p = .12$, with a 95% confidence interval of -5.85 to 0.68. Mean BDI-II scores in the follow-up sample were significantly lower at follow-up than at pre-therapy, $t(28) = 7.53$, $p < .001$, with a 95% confidence interval of 9.42 to 16.45.

Also supporting Hypothesis 7, mean BDI-II scores in the ITT sample did not change significantly from post-therapy to follow-up, $t(46) = -1.37$, $p = .18$, with a 95% confidence interval of -4.47 to 0.85. Mean BDI-II scores in the ITT sample were significantly lower at follow-up than at pre-therapy, $t(46) = 6.22$, $p < .001$, with a 95% confidence interval of 6.92 to 13.55.

Calculations on the magnitude of the effect of narrative therapy on depressive symptoms from pre-therapy to follow-up and from post-therapy to follow-up utilised the standardised effect size index, d, calculated from mean scores and standard deviations on BDI-II scores at pre-therapy, post-therapy and follow-up in the follow-up and ITT sample sets. According to mean BDI-II scores, results (Table 10.15) indicated large effect sizes for change in depressive symptoms from pre-therapy to follow-up, and small effect sizes for depressive symptom deterioration from post-therapy to follow-up in both follow-up and ITT samples.

Table 10.15

Effect Size, d, of Pre-therapy to Follow-up Change and Post-therapy to Follow-up Change According to Beck Depression Inventory II Scores: Follow-up and Intent to Treat Samples

	Effect Size (d)	
Sample Set	Pre-therapy to Follow-up	Post-therapy to Follow-up
Follow-up ($n = 29$)	1.40	-0.23
Intent-to-Treat ($n = 47$)	0.89	-0.14

Paired-samples t-tests, conducted on follow-up and ITT samples, evaluated change in mean OQ 45.2 IR scores from post-therapy to follow-up and from pre-therapy to follow-up. Table 10.16 presents the means and standard deviations for pre-therapy, post-therapy and follow-up OQ 45.2 IR scores for the follow-up and ITT samples. ITT analysis used the LOCF method to substitute missing OQ 45.2 IR scores. OQ 45.2 assessment occurred at pre-therapy, Sessions 1-8 and follow-up for the second intake of clients only.

Table 10.16

Means and Standard Deviations for Outcome Questionnaire 45.2 Inter-personal Relations Scores at Pre-therapy, Post-therapy and Follow-up: Follow-up and Intent-To-Treat Samples

Sample	Assessment Point	*N*	Mean	Standard Deviation
Follow-up	Pre-therapy	26	21.46	5.09
	Post-therapy	26	16.31	5.68
	Follow-up	26	18.12	5.83
Intent-To-Treat	Pre-therapy	36	20.92	5.43
	Post-therapy	36	17.83	6.52
	Follow-up	36	18.50	6.53

Results from the follow-up sample did not support Hypothesis 8, but results from the ITT sample did support Hypothesis 8. With alpha set at .05, results indicated that mean OQ 45.2 IR scores increased significantly (deteriorated) from post-therapy to follow-up, $t(25) = -2.33$, $p = .03$, in the follow-up sample, with a confidence interval between -3.41 and -0.21. Mean OQ 45.2 IR scores in the follow-up sample remained significantly lower at follow-up than at pre-therapy, $t(25) = 3.02$, $p < .01$, with a

confidence interval between 1.07 and 5.63. In the ITT sample, mean OQ-45.2 IR scores at follow-up did not differ significantly from post-therapy scores, $t(35) = -.80$, $p = .43$, with a 95% confidence interval from -2.37 to 1.03. Mean OQ-45.2 IR scores in the ITT sample remained significantly lower at follow-up than at pre-therapy, $t(35) = 2.38$, $p = .02$, with a 95% confidence interval between .35 and 4.48.

Calculations on the magnitude of the effect of narrative therapy on inter-personal relatedness from pre-therapy to follow-up and from post-therapy to follow-up, utilised the standardised effect size index, d, calculated from mean scores and standard deviations on OQ-45.2 IR at pre-therapy, post-therapy and follow-up in follow-up and ITT samples. According to mean OQ-45.2 IR scores, results (Table 10.17) indicated medium effect sizes for change in inter-personal relatedness from pre-therapy to follow-up and small effect sizes for deterioration in inter-personal relatedness from post-therapy to follow-up in both follow-up and ITT samples.

Table 10.17

Effect Size, d, of Pre-therapy to Follow-up Change and Post-therapy to Follow-up Change According to Outcome Questionnaire 45.2 Inter-personal Relations Scores: Follow-up and Intent-to-Treat Samples

	Effect Size (d)	
Sample Set	Pre-therapy to Follow-up	Session 8 to Follow-up
Follow-up ($n = 26$)	0.59	-0.46
Intent to Treat ($n = 36$)	0.40	-0.10

10.5.4 Primary Outcome Question 4:

Benchmarking Depressive Symptom Outcome from Narrative Therapy against

Evidence-Based Psychotherapies

10.5.4.1 Overview of Benchmarking Analysis

The fourth outcome research question asked whether pre-therapy to post-therapy depressive symptom change resulting from narrative therapy was comparable to that found in evidence-based psychotherapies reported in selected research. Hypothesis 9 predicted that improvement in BDI-II scores (depressive symptoms) at post-therapy would equal improvement in BDI-II scores following evidence-based psychotherapies, as found in selected benchmark studies.

To investigate this hypothesis, mean raw BDI-II score pre-therapy to post-therapy gains in the completer sample of the current study were benchmarked against results from completer clients in benchmark research. Additional analysis compared results from the clinical significance analysis in the current study with benchmark research.

The first two steps of the benchmarking analysis, described in Sections 8.4.2.2 and 8.4.2.3, were to (a) identify empirically supported treatment for adult depression, and (b) select previous clinical trials that provided outcome data of empirically-supported treatment of adult depression. In essence, randomised controlled trials of psychotherapy for adult depression by Shapiro et al. (1994) and Watson et al. (2003) provided BDI raw score data for comparison. Analysis of data from the NIMH TDCRP research (Elkin et al., 1989) by Ogles et al. (1995) provided data for comparison of clinical significance.

The remaining sections of 10.5.4 report the last five steps of the benchmarking analysis, which compares the current study with benchmark studies on (a) client demographic characteristics (b) client clinical characteristics (c) research protocols (d) symptom outcomes in terms of mean gain scores and effect size, and (e) symptom outcomes in terms of reliable change and clinical significance. Demographic and clinical data from Shapiro et al. (1994) are for the entire sample of 177 clients, rather than the 59 that completed eight sessions.

10.5.4.2 The Demographic Comparability of Current and Benchmark Client Samples

Demographic characteristics of the clients in the current research into narrative therapy were similar to benchmark samples (Table 10.18). The mean age of the narrative therapy sample was similar to those of the benchmark studies, although slightly less than the mean age reported by Ogles et al. (1995). The percentage of females is similar to proportions reported in benchmark studies, excepting Shapiro et al. (1994), who reported a figure 19% less than the narrative study. All studies reported that a large proportion of clients were of Caucasian descent. The proportion of clients who reported their highest level of education as primary school in the Ogles et al. sample differed markedly from the narrative study where no clients fell into the category. The proportion of clients reporting university education in the Watson et al. (2003) study (76%) was larger than that of the narrative study (48%).

Table 10.18

Client Demographic Characteristics: Comparing the Current Research into Narrative Therapy with Research by Shapiro et al. (1994), Watson et al. (2003) and Ogles et al. (1995)

Variable	Narrative Therapy $N = 38$	Shapiro et al. (1994) $N = 117$	Watson et al. (2003) $N = 66$ [a]	Ogles et al. (1995) $N = 162$ [b]
Mean Age: Years (*SD*)	40.63 (9.44)	40.50 (9.5)	41.52 (10.82)	35 (8.5)
Gender: % female	71	52	67	70
Race: % Caucasian	100	- [c]	91 [d]	89 [e]
Education Completed:				
Primary or Less	0	-	0	25 [f]
Secondary	37	44 [g]	24	35 [h]
University	48	46 [i]	76	40 [j]

Note. Percentages may not sum to 100% because of missing data. Dashes indicate data is unavailable.

[a]Demographic statistics for entire *N*. [b]Clients completed 12 sessions and 15 weeks of therapy.

[c]Predominantly white Anglo-Saxon. [d]6% Asian; 3% Middle Eastern. [e]Other not reported. [f] High school or less. [g]Completed education by 18. [h]Some college education. [i]Held professional qualifications. [j]College graduates.

10.5.4.3 Clinical Comparability of Current and Benchmark Client Samples

Table 10.19 shows clinical characteristics of clients in the current sample in comparison to benchmark samples. The narrative sample differed from the three other samples in permitting and recording antidepressant use if commenced at least 12 weeks prior to therapy. Watson et al. (2003) and Ogles et al. (1995) excluded antidepressant use and the proportion of clients taking antidepressants was substantially less in the research by Shapiro et al. (1994). Compared to the narrative study, Watson et al. reported a lower percentage of clients with no Axis II disorders and a greater percentage of clients with two Axis II disorders.

10.5.4.4 Treatment Comparability: Comparison of Narrative Therapy and Benchmark Research Protocols

To be comparable with previous outcome research, the design of the narrative study followed efficacy protocols. The current research utilised inclusion and exclusion criteria, manualised treatment intervention, manipulation check on the independent variable (narrative therapy), standardised measures of outcome, and therapists, raters and a coder who were naive to hypotheses. By design, the narrative intervention differed from benchmark studies in orientation. Shapiro et al. (1994) examined CBT and PI. Watson et al. (2003) examined CBT and PET and Ogles et al. (1995) examined CBT and IPT. Treatment dose in the current study (eight sessions) was consistent with that of Shapiro et al. (1994) but was less than two of the benchmark studies. Ogles et al. (1995) analysed data from clients who had received 12 sessions and 15 weeks of psychotherapy. Clients in the research by Watson et al. (2003) received 16 weekly sessions. Therapists' demographic characteristics varied across the current and benchmark studies (Table 10.20), as did therapist characteristics relevant to the specific therapeutic modality implemented (Table 10.21).

Table 10.19

Client Clinical Characteristics: Comparing Proportions in Current and Benchmark Samples

Variable		Narrative Therapy	Sheffield et al. (1994)	Watson et al. (2003)	Ogles et al. (1995)
Antidepressant Use %		52.6	21[a]	0[b]	0[b]
Previous Episodes:	0	16	-	06	36
	1 to 3	29	-	26	34[c]
	4 or greater	42	-	62	30[d]
Axis II Diagnoses:	0	63	-	48	-
	1	26	-	29	-
	2	08	-	20	-
	3	03	-	03	-

Note. Dashes indicate no data provided.

[a]Antidepressants, hypnotics, or anxiolytics.[b]Concurrent medication excluded.[c]One or two previous episodes. [d]Three or more previous episodes.

Table 10.20

Therapist Demographic Statistics: Comparing the Current Research into Narrative Therapy with Benchmark Research

Variable	Narrative Therapy	Sheffield et al. (1994)	Watson et al. (2003)	Ogles et al. (1995)
Number of Therapists	24	5 (CBT and PI)	15 (8 CBT; 7 PET)	18 (8 CBT; 10 IPT)
Number of Clients	38	117	66a	162
Discipline	Counselling Psychology Social Work Nursing	Psychology	Psychology	Psychology Psychiatry
Qualification	Diploma Degree Masters PhD	Clinical Psychologists	Counselling Master's Candidates Counselling Psychologist Doctoral Candidates	Psychologists: PhD and clinical internship Psychiatrists: MD and psychiatric residency
Clinical Experience: *M* (Range) years	4.8 (1 – 15)	4.6 (0- 17)	5.23 (1 – 15)	11.4 (2 – 27)

Note. CBT= cognitive behaviour therapy; PI = Psychodynamic interpersonal therapy; PET = Process experiential therapy; IPT = Interpersonal Therapy

Table 10.21

Therapists' Statistics for Implemented Modality: Comparing the Current Research into Narrative Therapy with Benchmark Research

Implemented Therapy	Narrative Therapy	Sheffield et al. (1994)	Watson et al. (2003)	Ogles et al. (1995)
Experience	Mean = 1 year Range = 0 – 8 yr	CBT: Dominant pre-qualification training for all therapists PI: 2 therapists previously trained	Statistics not provided	IPT-Previous psychodynamic training CBT-Cognitive/ behavioural background
Training for Research	16 hours by investigator	64 training cases, with supervision	32 hours by expert in modality	Initial intensive training (2 weeks for CBT by Dr Beck; IPT by Dr Weissman's group) then 2 months supervision with at least 3 clients
Allegiance	All agreed in principles 63% agreed efficacious	Allegiance to both CBT and PI required	All reported allegiance to orientation implemented	Commitment to and special interest in orientation required

Note. CBT= cognitive behaviour therapy; PI = Psychodynamic interpersonal therapy; IPT = Interpersonal Therapy

10.5.4.5 Symptom Outcome as Assessed by BDI-II Scores and Effect Size: Comparison
  of Narrative Therapy and Benchmark Research

Table 10.22 shows clients' mean BDI scores at pre-therapy, post- therapy and

follow-up, comparing results from the current study into narrative therapy with the

benchmark research from Shapiro et al. (1994) and Watson et al. (2003). In narrative

therapy and comparison studies, pre-therapy BDI-II scores were in the moderately

depressed range and post-therapy scores were in the minimally depressed range.

Examination of follow-up BDI-II scores revealed scores in the minimally depressed

range following CBT and PI in the research by Shapiro et al. and in the mildly

depressed range following narrative therapy.

One-sample t-tests, conducted on completer sample BDI-II pre-therapy to post-

therapy gain scores, evaluated whether BDI-II pre-therapy to post-therapy gains differed

from mean gain scores reported by Shapiro et al. (1994) and Watson et al.(2003). In

support of Hypothesis 9, the narrative therapy sample mean gain score of 14.42 (SD =

10.80) did not differ significantly from the mean gain score from CBT (M = 12.02), t

(37) = 1.37, p = .18. In contrast, the NT gain score was significantly higher than the

mean gain score from PI (M = 7.94), t (37) = 3.7, p < .001, reported by Shapiro et al.

1994. The narrative therapy sample mean gain score of 14.42 (SD = 10.80) did not

differ significantly from the mean gain score from CBT (M = 15.73), t (37) = - 0.75, p =

.46, and PE (M = 14.21), t (37) = 0.12, p = .91, reported by Watson et al. (2003).

In additional analyses, one-sample t-tests, conducted on follow-up sample post-

therapy to follow-up scores, evaluated whether BDI-II post-therapy to follow-up mean

change differed significantly from mean change reported by Shapiro et al. (1994). The

narrative therapy sample mean change (deterioration) of -2.57 (SD = 8.58) was not

significantly different from change (deterioration) in CBT (M = -0.78), t (28) = -1.13,

Table 10.22

Client Mean BDI Scores at Pre-therapy, Post-therapy and Follow-up: Comparison of Narrative Therapy with Benchmark Research

Assessment Point	Current Study		Shapiro et al. (1994)				Watson et al. (2003)			
	NT [a]		CBT [c]		PI [d]		CBT [c]		PE [e]	
	$n= 38$ [b]		$n = 29$		$n = 30$		$n = 33$		$n = 33$	
	M	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*
Pre-therapy	27.71	09.95	20.86	03.55	20.14	04.40	26.00	09.03	23.24	07.81
Post-therapy	13.29	11.19	08.84	07.53	12.20	08.08	10.27	09.62	09.03	08.63
Follow-up	14.69	10.82	09.62	08.94	11.22	08.03	-	-	-	-

Note. Watson et al. did not provide follow-up data.

[a] narrative therapy. [b] Excepting follow-up data, where *n* =29. [c] cognitive-behavior therapy. [d] psychodynamic interpersonal therapy. [e] process-experiential therapy.

p =.27, but was significantly different from change (improvement) following PI (*M* =

0.98), *t* (28) = -2.24, *p* = .03.

Since the sample sizes of studies being compared were unequal, pre-therapy to

post-therapy effect size indices (*d*) were calculated from means and standard deviations

reported, then compared to evaluate whether symptom change in narrative therapy

differed from benchmark research (Table 10.23).

Table 10.23

Effect Size (d) from Completer Samples as Assessed by Beck Depression Inventory

Scores: Comparison of Narrative and Benchmark Research

Assessment Points		Shapiro et al. (1994)			Watson et al. (2003)	
	NT[a]	CBT[b]	PI[c]		CBT[b]	PE[d]
Pre to Post-therapy (*n*)	1.36 (38)	2.04 (29)	1.22 (29)		1.69 (33)	1.73 (33)
Post-Follow-up (*n*)	-0.23 (29)	-0.09 (29)	0.12 (29)		-[e]	-[e]

[a]narrative therapy. [b]cognitive behaviour therapy. [c]psychodynamic interpersonal therapy.
[d]process experiential therapy. [e]Watson et al. did not provide follow-up data.

As indexed by BDI-II scores, pre-therapy to post-therapy effect size was large in all

studies. Effect size from narrative therapy was larger than that of PI (Shapiro et al.,

1994), but smaller than that of CBT (Shapiro et al.; Watson et al., 2003) and PE

(Watson et al.). Post-therapy to follow-up effect sizes were small in all therapies, with

all therapies except PI showing small increases in depressive symptomatology at

follow-up.

10.5.4.6 Clinical Significance of Symptom Outcome as Assessed by BDI-II Scores:

Comparison of Narrative Therapy and Benchmark Research

The proportion of clients who attained reliable improvement, reliable

deterioration, who moved into the functional population or achieved clinically

significant improvement following narrative therapy were calculated according to the

RCI (8.46 and greater) and clinical cut-off (less than 14.29) scores for the BDI-II

developed by Seggar et al. (2002). Proportions of clients in each category were

compared (Table 10.24) against research by Ogles et al. (1995), which used slightly

Table 10.24

Percentage of Clients Attaining Change as Indexed by BDI Scores: Comparing

Narrative Therapy with Benchmark Research (Ogles et al., 1995)

This table is not available online.
Please consult the hardcopy thesis
available from the QUT Library

different RCI (9 points and greater) scores and cut-off (13.46 or less) scores to evaluate the clinical significance of results from the TDCRP (Elkin et al., 1989) based on BDI scores from the completer sample (individuals who had completed 12 sessions and 15 weeks of CBT or IPT).

When compared to the benchmark research by Ogles et al. (1995), the proportion of clients who achieved clinically significant change was considerably larger in IPT than in narrative therapy. The proportion of clients who demonstrated reliable change was larger in narrative therapy than in CBT and IPT.

10.6 Supplementary Analyses

10.6.1 Supplementary Question 1:

Influence of Pre-therapy Depressive Symptom Severity on Post-Therapy Depressive Symptom Outcome

The first supplementary research question asked whether post-therapy depressive symptom outcome differed depending on pre-therapy depressive symptom severity. Clients in the completer sample were categorised into three groups according to pre-therapy BDI-II scores: mild, moderate and severe. Possible scores on the BDI-II range from 0 to 63. The current study categorised clients with initial BDI-II scores of 19 and below as mildly depressed, clients in the moderate category had scores from 20 to 28 and clients in the severe condition had scores 29 and above. Table 10.25 shows BDI-II means and standard deviations for the three groups at pre-therapy and post-therapy.

A two-way (2 x 2) mixed analysis of variance (SPANOVA) was conducted on post-therapy BDI-II scores (the dependent variable), using the General Linear Model function of SPSS 14.0. The independent variables included one between-groups variable, pre-therapy depressive symptom severity, with three levels (mild, moderate,

severe) and one within-subjects variable, assessment point, with two levels (pre-therapy, post-therapy).

Table 10.25

Means and Standard Deviations for Pre-therapy and Post-therapy Beck Depression Inventory II Scores: Mildly, Moderately and Severely Depressed Groups

Assessment Point	Mild ($n = 8$)		Moderate ($n = 13$)		Severe ($n = 17$)	
	M	*SD*	*M*	*SD*	*M*	*SD*
Pre-therapy	15.13	03.98	23.92	02.87	36.53	06.52
Post-therapy	10.00	10.10	10.00	08.26	17.35	12.73

Assessment of the assumptions underpinning SPANOVA revealed that the pre-therapy BDI-II distribution of the mildly depressed group was negatively skewed and there was one extreme point (BDI-II score of 6) in the group. Examination of the trimmed mean revealed that the low score had little impact on the group mean. Removal of the extreme score resulted in adequate normality. SPANOVA and follow-up comparison analyses were conducted with and without the extreme score. Since removal of the extreme score from analyses did not change substantive interpretations, results are reported with the extreme score included as this was a genuine score.

There were significant main effects for initial depressive symptom severity, $F(1, 35) = 14.13$, $p < .001$, partial $\eta^2 = .45$, assessment point, $\Lambda = .37$, $F(1, 35) = 60.64$, $p < .001$, multivariate partial $\eta^2 = .63$, and the interaction between severity and assessment point, $\Lambda = .75$, $F(2, 35) = 5.84$, $p < .01$, multivariate partial $\eta^2 = .25$ (Figure 10.5).
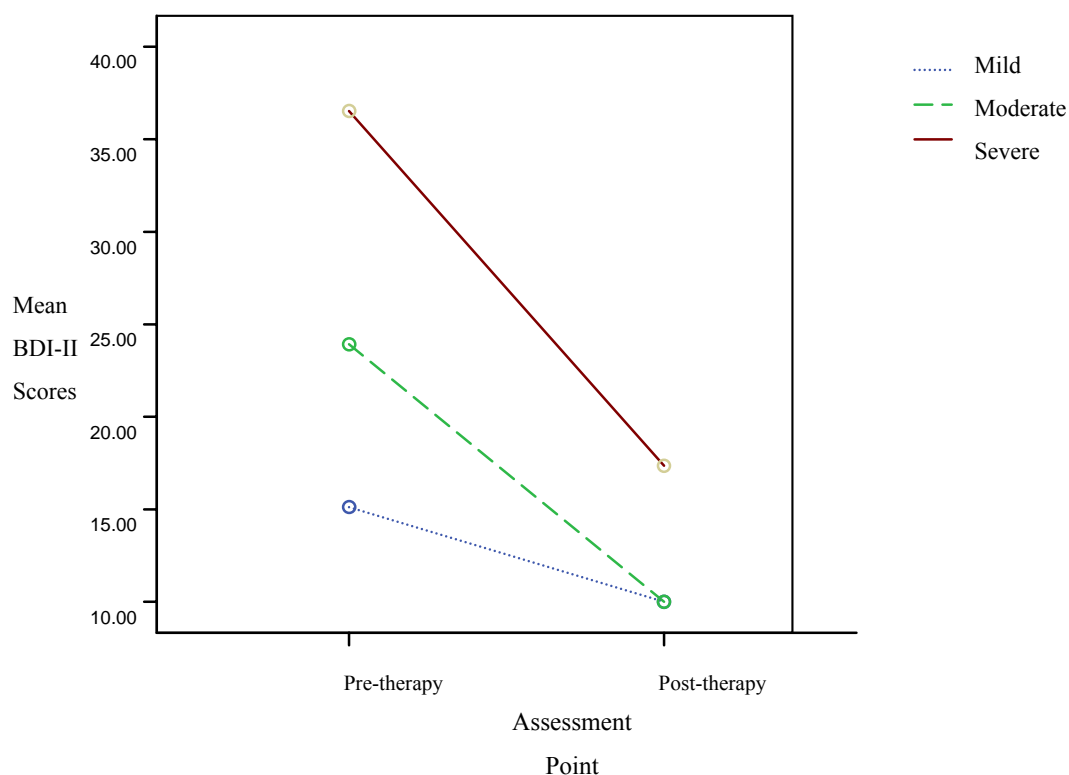
Figure 10.5. Interaction of pre-therapy depressive symptom severity and assessment point demonstrating change in BDI-II scores from pre-therapy to post-therapy for clients with pre-therapy mild, moderate and severe BDI-II scores.

Since there was a significant interaction between initial depressive symptom severity and assessment point, I chose to ignore the significant main effects for initial depressive symptom severity and assessment point and instead examined pre-therapy to post-therapy change for the three initial depressive symptom severity groups (mild, moderate, severe) separately. Three follow-up pair-wise comparisons of group means were conducted. To control for Type 1 error, I set alpha for each at .017 (.05/3 = .017).

Three paired-samples t-tests were conducted to examine BDI-II change from pre-therapy to post-therapy for individuals with mild, moderate and severe pre-therapy

depressive symptoms separately. There was no significant difference in BDI-II scores from pre-therapy to post-therapy in clients with mild pre-therapy depressive symptoms, $t(7) = 1.26$, $p = .25$, with a 95% confidence interval of -4.51 to 14.76. For clients with moderate pre-therapy depressive symptoms, BDI-II scores at post-therapy were significantly lower than at pre-therapy, $t(12) = 6.55$, $p < .001$. For clients with severe pre-therapy depressive symptoms, BDI-II scores were significantly lower at post-therapy than pre-therapy, t (16) = 7.91, p < .001.

10.6.2 Supplementary Question 2:

Outcome as Assessed by the Depression Subscale of the Depression Anxiety Stress Scale

The second supplementary research question asked whether an alternative measure of depressive symptom outcome confirmed BDI-II results. Paired-samples t-tests were conducted on the completer sample to evaluate the impact of narrative therapy on DASS-D scores from pre-therapy to post-therapy, on the follow-up sample set to evaluate whether depressive symptom improvements were maintained at three-month follow-up, and on the ITT sample set to evaluate the impact of narrative therapy at post-therapy and follow-up.

Assessment of normality revealed a positive skew in post-therapy DASS-D scores in the completer set, a positive skew in the post-therapy and follow-up DASS-D scores in the follow-up sample set, and a positive skew in post-therapy and follow-up DASS-D scores in the ITT sample set. Relevant square root transformations on DASS-D scores to improve distribution normality were conducted for completer, follow-up and ITT sample sets. Since substantive interpretations did not differ in analyses of transformed and untransformed scores, I report results for untransformed DASS-D scores.

Table 10.26 presents the means and standard deviations for completer sample pre-therapy and post-therapy DASS-D scores. With alpha set at .05, mean DASS-D scores decreased significantly from pre-therapy to post-therapy, $t(37) = 7.41, p < .001$. The 95% confidence interval for mean difference between the two scores was 9.50 to 16.66.

Table 10.26

Means and Standard Deviations for Depression Anxiety Stress Scale-Depression Subscale Scores at Pre-therapy and Post-therapy: Completer Sample

Assessment Points	Sample Number	Mean	Standard Deviation
Pre-therapy	38	23.16	9.87
Post-therapy	38	10.08	9.88

Table 10.27 presents the means and standard deviations for post-therapy and follow-up DASS-D scores in the follow-up sample. With alpha set at .05, results indicated there was no significant difference in DASS-D scores from post-therapy to three-month follow-up, $t(28) = -1.12, p = .27$. The 95% confidence interval for mean difference between the two scores was -4.79 to 1.41.

Table 10.27

Means and Standard Deviations for Depression Anxiety Stress Scale-Depression Subscale Scores at Post-therapy and follow-up: Follow-up Sample

Assessment Points	Sample Number	Mean	Standard Deviation
Post-therapy	29	09.21	08.27
Follow-up	29	10.90	08.99

Table 10.28 presents the means and standard deviations for pre-therapy, post-therapy and follow-up DASS-D scores in the ITT sample. With alpha set at .05, results indicated that DASS-D scores decreased significantly from pre-therapy to post-therapy, t (46) = 6.85, p < .001, with a 95% confidence interval of 8.08 to 14.81. There was no significant difference in DASS-D scores from post-therapy to three-month follow-up, t (46) = -.41, p = .68, with a 95% confidence interval of -3.12 to 2.06.

Table 10.28

Means and Standard Deviations for Depression Anxiety Stress Scale-Depression Subscale Scores at Pre-therapy, Post-therapy and Follow-up: Intention-to-Treat Sample

Assessment Points	Sample Number	Mean	Standard Deviation
Pre-therapy	47	24.00	10.14
Post-therapy	47	12.55	11.64
Follow-up	47	13.09	11.21

Tables 10.29 and 10.30 compare the treatment effect size of narrative therapy for adults with depression, comparing effect (*d*) as assessed by the BDI-II and DASS-D for pre-therapy to post-therapy change and post-therapy to follow-up change respectively.

Figure 10.6 shows the mean DASS-D score trajectory from pre-therapy to Session 8 for the completer sample set. The mean DASS-D score at follow-up is taken from the follow-up sample set. Figure 10.7 shows the mean DASS-D score trajectory from pre-therapy to follow-up for the ITT sample set.

Table 10.29

Effect Size (d), as Assessed by the Beck Depression Inventory II and the Depression Sub-scale of the Depression, Anxiety Stress Scale: Pre-therapy to Post-therapy Change in Completer and Intent-To-Treat Samples

Sample Set	BDI-II	DASS-D
Completer (*n* = 38)	1.36	1.32
Intent-To-Treat (*N* = 47)	1.10	1.05

Table 10.30

Effect Size (d), as Assessed by the Beck Depression Inventory II and the Depression Sub-scale of the Depression, Anxiety Stress Scale: Post-therapy to Follow-up Change in Completer and Intent-To-Treat Samples

Sample Set	BDI-II	DASS-D
Follow-up (*n* = 29)	-0.23	-0.20
Intent-to-Treat (*N* = 47)	-0.14	-0.05
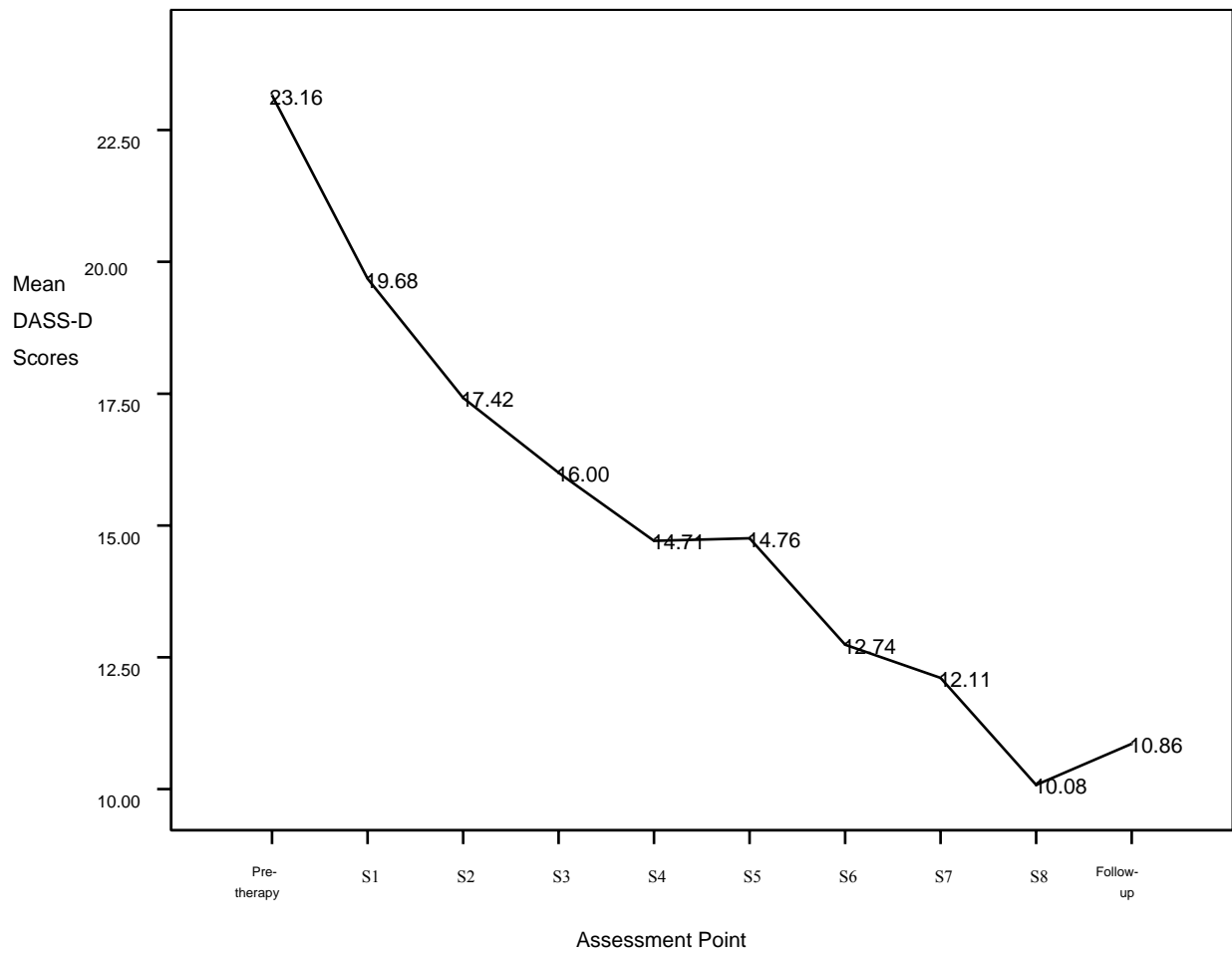
Figure 10.6. Trajectory of scores from pre-therapy to three-month follow-up:

Depression, Anxiety, Stress Scale-Depression subscale: Completer and follow-up
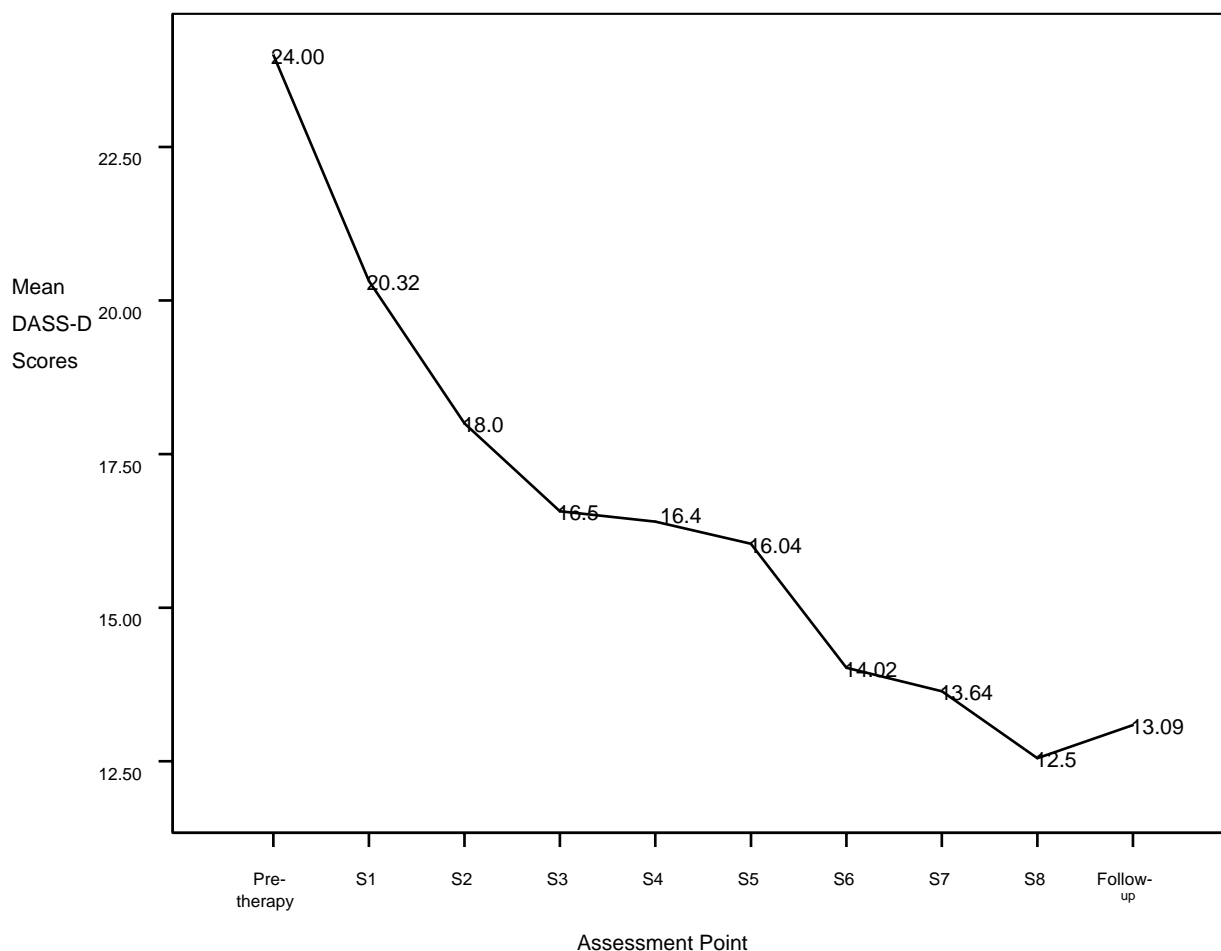
sample.

Figure 10.7. Trajectory of scores from pre-therapy to three-month follow-up:

Depression, Anxiety, Stress Scale-Depression subscale: Intention-to-Treat sample.

10.6.3 Supplementary Question 3:

Client Satisfaction with Narrative Therapy

Client Satisfaction with therapy was examined using the Explore function of

SPSS to investigate the ratings of completers and non-completers. The depressive

symptoms of the one client from the completer sample, who did not respond to the

questionnaire, improved from the moderately depressed range to the minimally

depressed range. Responses are available from only two clients from the non-completer

sample. Both non-completers who responded were excluded from the completer data analysis because they commenced antidepressants during the course of the eight-session intervention.

The total score possible for the SWT scale is 35. for each of the seven items, clients rated responses from 1 to 5, from 1 = "strongly disagree" to 5 = "strongly agree". The mean total score of the Satisfaction with Therapy scale was 31.35 ($SD = 3.34$) for completers and 32.50 ($SD = 2.12$) for non-completers. For all items, the mean score ranged between 4 and 5 for completers and non-completers.

Supplementary Outcome Question 4:

Differences between Completer and Non-completer Clients on the Primary Dependent

Variables

This section compares client completers with non-completers on the pre-therapy scores of the primary dependent variables, BDI-II and OQ-45.2 IR. The ITT sample included all clients who completed at least one session of therapy, comprising clients who completed the eight-session intervention and provided valid data (the completer sample) with clients who did not complete the eight therapy intervention or did not provide valid data (the non-completer sample). Table 10.31 presents means and standard deviations for pre-therapy BDI-II and OQ 45.2 IR scores for completers and non-completers.

An independent-samples t-test was conducted to compare pre-therapy BDI-II scores for the completer and non-completer samples. With alpha set at .05, there was no significant difference in pre-therapy BDI-II scores for completers and non-completers, t (45) = 1.67, p = .10. The 95% confidence interval for mean difference between the two scores was -1.24 to 13.38. The effect size, d = .62, indicates a medium difference between the two means.

Table 10.31

Means and Standard Deviations for Beck Depression Inventory II and Outcome

Questionnaire 45.2 Interpersonal Relations Scores at Pre-therapy: Comparing

Completers and Non-completers

Scale	Sample Set	*N*	*M*	*SD*
BDI-II	Completers	38	27.71	09.95
	Non-completers	09	33.78	08.99
OQ 45.2 IR	Completers	30	20.80	05.85
	Non-completers	06	21.50	02.74

An independent-samples t-test compared pre-therapy OQ-45.2 IR scores for

completer and non-completer samples. With alpha set at .05, there was no significant

difference in scores for completers and non-completers, $t(34) = -0.28$, $p = .78$. The 95%

confidence interval for mean difference between the two scores was -5.70 to -3.98. The

effect size, $d = 0.15$, indicates a small difference between the means of the two samples.

CHAPTER 11

DISCUSSION

11.1 Research Aims and Objectives Restated

The overall aim of this thesis was to investigate the process and outcome of narrative therapy in the treatment of adults with major depressive disorder. This aim comprised theoretical and empirical elements and entailed three major objectives.

The first objective was to articulate a synthesis of dialogical narrative theory (Hermans & Kempen, 1993; Cooper, 2004, narrative research (Angus et al., 1999; Levitt & Angus, 1999), and narrative therapy (White & Epston, 1990; White, 2007), as commonly practiced in Australia. Towards this end, I have identified the meaning-making process of narrative reflexivity as a theoretical construct linking narrative theory, research and therapy and have highlighted the dialogical and inter-subjective nature of narrative practice.

The second objective was to substantiate this synthesis empirically, by examining the processes of narrative therapy, specifically narrative reflexivity and the therapeutic alliance and their relation to therapy outcomes. To address this objective, a process-outcome trial of an eight-session narrative intervention investigated associations of narrative reflexivity and working alliance with depressive symptom and inter-personal outcomes in the treatment of adults with major depressive disorder.

The third objective was to support the theoretical synthesis and provide quantitative evidence for the utility of narrative therapy for major depressive disorder in adults. Towards this objective, analyses of the statistical significance, effect size and clinical significance of narrative therapy depressive symptom outcomes were evaluated and benchmarked against outcomes from evidence-based psychotherapies.

This chapter first provides a synopsis of the study's most important empirical findings, then addresses the primary process and outcome research questions in turn, reviewing support for each hypothesis and discussing results in the context of previous research and theory. Results from supplementary research questions clarify findings where appropriate. Focus then shifts to the theoretical contribution and practical implications of the process-outcome findings. Finally, the discussion turns to the limitations and strengths of the current study and potentials for future research.

11.2 The Process-Outcome Trial of Narrative Therapy: Synopsis of Empirical Findings

All but one of the hypotheses were supported. Research results provided support that improvement in depressive symptoms is associated with the process of narrative reflexivity, finding that greater symptom alleviation was associated with higher narrative reflexivity. A sub-sample of clients was categorised into five least-improved and five most-improved outcome groups, according to depressive symptom improvement. There was a significantly higher percentage of reflexive sequences in the discourse of most-improved clients compared to least-improved clients, with outcome and narrative reflexivity sharing 64% of variance. Improvements in the quality of the therapeutic alliance were associated with pre-therapy to post-therapy depressive symptom and inter-personal relatedness improvements. Session 1 to 8 improvement in the working alliance shared 19% of the variance in depressive symptom improvement and 17% of the variance in inter-personal relatedness improvement.

Outcome results from the clinical trial provided empirical support for the utility of narrative therapy in improving depressive symptoms and inter-personal relatedness from pre-therapy to post-therapy: the magnitude of change indicating large effect sizes

(1.10 to 1.36) for depressive symptoms and medium effect sizes (.52 to .62) for inter-personal relatedness. Therapy was effective in reducing depressive symptoms in clients with moderate and severe, but not mild pre-therapy depressive symptom severity. Improvements in depressive symptoms, but not inter-personal relatedness, were maintained three-months following therapy. The reduction in depressive symptoms and the proportion of clients who achieved clinically significant improvement in depressive symptoms at post-therapy were comparable to improvements from standard psychotherapies, reported in benchmark research. While the proportion of clients who achieved clinically significant improvement in inter-personal relatedness was less than for depressive symptoms, improvements in inter-personal relatedness correlated ($r = .71$) with depressive symptom improvement, raising the possibility that inter-personal relatedness may be a factor in recovery from depression.

11.3 Process Findings in the Context of Previous Research and Theory

11.3.1 Process Question 1:

Differential Change in Narrative Reflexivity in Least and Most Improved Clients

In support of the first hypothesis, the percentage of reflexive discourse in therapy conversations of the five least-improved and five most-improved clients did not differ at the first session, but was greater for most-improved clients than least-improved clients at the eighth session. The proportion of reflexive sequences increased from 21% to 31% in least-improved clients and from 28% to 52% in most-improved clients. The proportion of internal sequences changed little from the first to eighth session in least-improved and most-improved clients and did not influence the proportion of reflexive sequences. Instead, the increase in reflexive sequences corresponded to a decrease in external sequences in both least-improved and most-improved clients, with the

proportion of external sequences decreasing from 71% to 62% in least-improved clients and from 63% to 41% in most-improved clients.

An increase in the proportion of narrative reflexivity in the conversations of successful therapy dyads in narrative therapy supports previous research, which suggest that increasing reflexivity is associated with successful therapy outcome in therapies that focus on making meaning. For example, qualitative analysis by Botella et al. (2000) concluded that reflexivity was an important process of process-experiential therapy for a good outcome dyad. Angus et al. (1991) also found that good outcome dyads had a higher percentage of reflexive sequences compared to poor outcome dyads after 15 sessions of brief dynamic therapy (See Figure 3.3). Results from Levitt and Angus (1999) indicated that good outcome dyads in perceptual processing and process experiential approaches engaged in more reflexive conversations by the end of therapy (See Figures 3.4).

Increase in the proportion of narrative reflexivity in the conversations of successful therapy dyads from the first to the last session is consistent with the notion of reflexivity as a process of narrative therapy. During narrative therapy, therapists develop a specific form of therapeutic alliance and engage clients in dialogical conversations that traverse landscapes of action and identity, facilitating meaningful interpretation of experience. Based on the synthesis of narrative theory and research proposed in this thesis, therapeutic conversations across the landscapes of action and identity assisted each client to achieve an ordered self through dialogical and inter-subjective engagement of subjectivities in their entire (*I-Me*) form. This was essentially a narrative and reflexive process of relating to self and others as extensions of the self. Narrative therapy inter-personal strategies included clients' conversations with

therapists, conversations with significant others inside and outside of therapy sessions. Intra-personal processes involved conversations amongst the multiple self-positions of the client and others as extensions of self.

The finding that improvement in clients' depressive symptoms was associated with increased narrative reflexivity consequent to narrative therapy also supports the Narrative Processes Model (Angus et al., 1999), which, as articulated by Angus, Lewin, Bouffard, and Rotondi-Trevisan (2004) proposed that therapeutic change comes about from a "…dialectical interplay of autobiographical memory, emotion and reflexive meaning-making processes" (p. 88).

Interpreted from a dialogical perspective, the high proportion of external speech that marks disengagement from important aspects of self was evident in the conversations of early therapy in both least-improved and most-improved clients. At the initial therapy session, for each client, reflexive engagement with self (or others) was limited, and the client was therefore alienated from those personal aspects that gave meaning to their experience, resulting in an impoverished experience of self and impoverished narratives. Experience of self and others took the form of distant *I-It* relating, manifest in external discourse. Part of the therapy discourse[26], below, from an initial session of a young woman experiencing depression, illustrates the nature of external discourse as she reflects on herself as an object, listing the negative events in her life but containing little of her self in terms of her values, beliefs, motivations and intentions:

Therapist: *Can you tell me something about the reason that brought you here: something about the problem that is affecting you?*

---

[26] Parts of example dialogues have been changed to protect the confidentiality of the research participants.

Client: *I've been diagnosed as being depressed for the last six years. I've had*

               shock treatment, and I've been on Aropax, which I'm not on anymore.

Therapist: *No? Was that effective?*

Client: *I didn't find it effective. I found it…well it did. It allowed me to sort of be*

               normal, but I just find I can't play music. I haven't played for five years.

               I haven't worked much in the last five years, and I've got as baby, too.

               I'm not with him. He left me when I was pregnant…

Therapist: *… you're telling me that you've obviously got talents that lots of people*

               haven't got? Being a musician is not a simple thing, is it?

Client: *I have a PhD in music.*

Therapist: *Yes?*

Client: *…but ever since I graduated, I haven't been able to play, because*

               actually I was suffering from depression when I was doing my PhD. I

               had a really hard time when I was doing it…

Although the least-improved clients made some progress in recovery, they remained largely disengaged from the personal aspects that make experience of self and others interpretable. While the proportion of narrative reflexivity in the conversations of least-improved clients increased by the end of therapy, their dialogue remained dominated by external speech that was outer oriented, resonating with the notion of alienation from self.

In contrast, an increased proportion of narrative reflexivity characterised the conversations of most-improved clients, marking increased access to the inner lives of themselves and others; access that gave meaning to their experience of self and others.

Increasing reflexivity indicated that most-improved clients were not only reflecting on their experience of self and others, but were making sense of their experience; for example, in the context of their past beliefs, their present values and motivations, and their intentions for the future. In comparison to initial session narratives, the session eight narratives of most-improved clients became richer in content, now including previously overlooked stories. Stories also became richer in meaning and self, now including such constructs as beliefs, values and intentions, which underpin their experience of self and others. For example:

Therapist: *So welcome, welcome to out eighth and final session.*

Client: *It just seems to have flown past.*

Therapist: *Not really quite sure where to start. There has been a big change from the first session to now, so I thought I might just touch base or run over perhaps... where you first started, and gradually work to now if that is alright? So I guess one of the things that you were saying in the first session was that it was very important for you to get approval from your Mum...where is that now?*

Client: *Well...I realise now, that me searching for that, well wanting it is one thing, but feeling like I need that now is not something that is big to me... It is not important to me anymore because I realise that even if I was to get her approval it is not going to solve my problems or the way I feel about things. Because it just, that would be just be such a disappointment if I was to get her approval and still felt that I wasn't good enough. So I am focusing more I guess on the things I know that I am, and that my*

> *opinion of me is really what is important. I know me better than anybody*
>
> *else does.*

The therapy conversation above, from a final session of a most-improved client illustrates how the client's different *I* positions engaged in dialogue, examining the difference between wanting and needing, examining which position, whose values, should dominate. The woman eventually articulated an intention; in future, her own standards will dominate her evaluations.

11.3.2 Process Question 2:

The Relationship between the Therapeutic Alliance and Post-therapy Outcomes

Improvements in the quality of therapeutic alliance from Sessions 1 to 8 correlated with pre-therapy to post-therapy improvements in depressive symptoms and inter-personal relatedness, supporting the second and third hypotheses respectively. The quality of the therapeutic alliance increased from Session 1 to 3 and then from Session 3 to 8. Improving alliances were correlated with improvements in depressive symptoms (.44) and interpersonal relatedness (.42), after correcting for pre-therapy scores and measurement error. The current study found medium (-.47 to -.48) relationships between early Session 3 working alliance and pre-therapy to post-therapy improvements in depressive symptom and inter-personal relatedness improvements, supporting research by Horvath and Bedi (2002), which concluded that the strength of the early alliance is a good predictor of outcome.

Results showing a relationship between improving alliance and improved therapeutic outcomes are consistent with research that supports the relationship as robust ($M = .22$ to .26) over a range of disorders, therapeutic orientations and alliance measures (Martin, Garske, & Davis, 2000). Higher alliance-outcome correlations ($r =$

.42 to .44) than the mean alliance-outcome correlation reported by Martin et al. is consistent with several studies finding relatively higher alliance-outcome correlations when treating depression. For example, controlling for pre-treatment severity and type of treatment (including various pharmacotherapy and CT combinations), Castonguay, Goldfried, Wiser, Raue and Hayes (1996) reported post-treatment alliance-outcomes between -.42 and -.59, and Raue, Castonguay, and Goldfried (1993) found alliance-outcome correlations between -.32 and -.64 for cognitive-behavioral and psychodynamic inter-personal approaches respectively. Higher alliance-outcome relationships in depression may reflect the significance of inter-personal relatedness to depression.

Although evidence indicating an alliance-outcome relationship is robust, a cause and effect relationship remains unconfirmed. We know little about how the alliance connects with the relational elements of therapy to bring about change. The current research finding that better inter-personal relatedness was associated with a higher quality of therapeutic alliance is consistent with previous research, which found that the quality of past and current inter-personal relationships was associated with the therapeutic alliance (Mallinckrodt, 1991; Marmar, Weiss, & Gaston, 1989). The high magnitude of the alliance-outcome relationship (-.64) found by Raue et al. for interpersonal psychodynamic therapy, a therapy that emphasises the inter-personal nature of psychotherapy change, supports the notion that inter-personal mechanisms are involved in psychotherapy change. Results from the current study suggest the form and quality of the therapeutic alliance is an important aspect of narrative therapy, associated with successful outcome. However, research indicates that intra-personal relatedness is also associated with the therapeutic alliance (Mallinckrodt, Cobble, & Grant, 1995;

Marmar, Horowitz, Weiss, & Marziali, 1986; Marziali, 1984). Although the significance of the relationship between narrative reflexivity and inter-personal relatedness could not be examined in the current study because of the requirement for independence of observations, examination of the data from the sub-sample of clients who provided scores on reflexivity revealed a medium correlation (-.44) between narrative reflexivity and inter-personal relatedness. Although possible that the therapeutic alliance in narrative therapy is the mechanism of change, I would like to suggest that its role may well be one that fosters narrative reflexivity as the pivotal therapeutic process. That is, the purpose of the bond, the goals and the tasks of the therapeutic alliance in narrative therapy is to facilitate dialogical conversation with a primary emphasis on meaning-making.

The contention that the quality of therapeutic alliance in narrative therapy is necessary for the process of reflexivity is consistent with findings from an investigation of process-experiential therapy in a good outcome dyad (Botella, Pacheco, Herrero, & Corbella, 2000). Qualitative findings suggested that the therapist's reflexive interpretations of the client's reflections enabled the client to reflexively examine her experience and position herself differently. Botella et al. concluded that the quality of the therapeutic relationship was important in fostering clients' narrative reflexivity in process-experiential therapy and speculated on a similar relationship in other therapies that focus on meaning-making.

Narrative therapists emphasise the importance of the quality and form of the therapeutic alliance in narrative therapy. Narrative therapy emphasises the relational nature of meaning making, which this thesis proposed involves inter-subjective processes. As a relational endeavour, the therapeutic relationship is central to narrative

therapy and the dialogue of the therapeutic alliance is pivotal to the process of change. Narrative therapists assume a very specific stance in relation to their clients. Narrative therapists consider power gradients inherent to a pathologising, knower, or curer stance are unhelpful (Anderson, 1997), proposing that each member of the dyad contributes knowledge to the therapeutic endeavour, influencing the understanding of the other. That is to say, the form of the alliance in narrative therapy facilitates dialogues, rather than monologues. Within this alliance, therapists utilise specific modes of questioning to transverse the landscapes of action and identity in order to assist clients to engage in narrative reflexivity. Therapists also make use of externalising conversations and deconstruction to decrease client's engagement with dominant problems. As part of the dialogical interaction that is encouraged throughout the therapeutic process (e.g., with the therapist and significant others), the intention of the dialogue between the therapist and the client is to co-create new meaning. Informed by dialogical narrative theory, I suggest that the quality of the therapeutic relationship is pivotal to the facilitation of reflexive dialogues and therefore therapeutic change in narrative therapy.

11.4   Outcome Findings in the Context of Previous Research and Theory

11.4.1 Outcome Question 1:

The Statistical Significance of Depressive Symptom and Inter-personal Relatedness

Outcomes

Supporting the fourth and fifth hypotheses, following eight sessions of narrative therapy for adults with major depressive disorder, improvements in depressive symptoms and inter-personal relatedness were statistically significant, with large effect sizes found for improvements in depressive symptoms and medium effect sizes found

for improvements in inter-personal relatedness in both completer (Figure 11.1) and ITT samples.
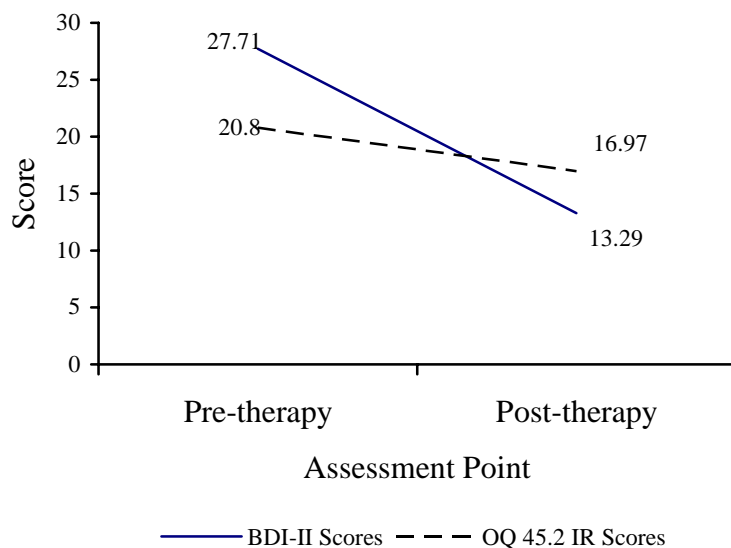
Figure 11.1 Narrative Therapy: Pre-therapy to post-therapy depressive symptom and inter-personal change in the completer clients

Clients improved from the high end of the moderately depressed range at pre-therapy to the minimally depressed (completer sample) and mildly depressed (ITT sample) range at post-therapy, as indexed by mean BDI-II scores. Supplementary investigation of depressive symptom outcomes using the DASS-D confirmed BDI-II results. DASS-D trajectories, showing relatively steep decrease in depressive symptoms from the first to third session, then a less acute decline, corroborate previous findings of decelerating improvements wherein a large proportion of recovery occurs by the third session of therapy (Howard et al., 1986; Barkham et al., 2002).

Reduction in depressive symptoms in the current study is congruent with previous meta-analytic research of psychotherapy for depression. For example, improvement in BDI-II scores in the current study is comparable to that found by

Robinson et al. (1990) in meta-analysis of 58 studies which aggregated results from a range of psychotherapies treating adults for depression (including cognitive, behaviour, cognitive-behaviour and general verbal therapies). Similar to the therapy dose in the current study, the mean number of sessions in the study by Robinson et al. was 8.7. Figure 11.2 depicts mean BDI-II scores of meta-analytic treatment and control conditions from Robinson et al. with completer sample results from the current study.

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Figure 11.2 Comparison of narrative therapy with meta-analytic treatment and control conditions from Robinson et al. (1990): Mean Beck Depression Inventory scores at pre-therapy and post-therapy

The effect size in the narrative therapy completer sample (1.36) was larger than in the ITT sample (1.10), consistent with comparison of completer and ITT sample sets with other therapy orientations (Minami et al., 2007). The large pre-therapy to post-therapy effect sizes of narrative therapy is consistent with meta-analysis of effect sizes

of 12 studies (primarily cognitive, behavioural and inter-personal interventions) by Westen and Morrison (2001). Westen and Morrison calculated a large (2.23) pre-therapy to post-therapy mean effect size across studies. Although the effect size of narrative therapy was smaller than the mean effect size calculated by Westen and Morrison, the standard deviation of 0.78 in the meta-analysis indicated a large variation in effect sizes across the studies examined. I will return to the matter of effect size in later paragraphs.

In the current study, post-therapy depressive symptom outcome differed depending on pre-therapy symptom severity. Statistically significant improvements in depressive symptoms from pre-therapy to post-therapy for clients with moderate and severe pre-therapy symptom severity contrasted with a failure to find statistically significant pre-therapy to post-therapy improvement in depressive symptoms in clients with mild pre-therapy symptom severity. Clients with higher initial depressive symptom severity achieved greater treatment gains. This finding is inconsistent with Beckham (1989), who reported that initial severe symptom severity was associated with poorer response to treatment. Evaluating CBT for 23 clients with depression, Beckham (1989) found that clients with initial severe symptom severity improved less from Session 1 to Session 6 compared to clients less severely depressed at initial intake.

Interpretation of significant improvement in clients with pre-therapy severe symptom severity must consider regression to the mean, that the extreme scores of clients in the severe group may have had an extreme amount of random error. Regression to the mean was unlikely, however, as the current research minimised the effect of regression to the mean by way of two strategies. One reason for selecting the BDI-II to index depressive symptoms was its good reliability, shown to have minimal

random measurement error. Secondly, clients in the study did not have extreme pre-test BDI-II scores. Fifteen of the 17 clients in the severe severity group had pre-test BDI-II scores under 43, 20 points below the highest possible BDI-II score.

Floor effects were unlikely because only one client in the mild pre-therapy symptom severity group achieved a score of zero at post-therapy, the lowest possible score on the BDI-II. Because of the low number of clients in the group ($n = 8$), the scores of each client wielded considerable influence on the group mean. Of the 38 clients that completed the eight therapy sessions, BDI-II scores of two clients indicated deterioration in depressive symptoms. Both of these clients were in the group categorised as pre-therapy mild symptom severity. Despite removal of the data from one of these clients because of an extreme post-therapy score, the substantive interpretation of analysis remained unchanged. Since there was a low number of clients in the remaining group ($n = 7$), the score of the remaining client who deteriorated wielded considerable impact on the group mean, possibly cancelling the treatment effect of other clients.

The larger reduction in depressive symptoms in clients with pre-therapy severe symptom severity (BDI-II mean reduction of 19.18) compared to clients with pre-therapy mild symptom severity (BDI-II mean reduction of 10.13) is consistent with Lambert's (2001) review, which observed that mildly disturbed clients tend to make small improvements because of better existing function. From this perspective, restricting research intake to clients with relatively high initial depressive symptom scores would enable a greater treatment effect size. Meta-analysis of psychotherapy for major depressive disorder in adults by Minami et al. (2007) estimated that higher severity of pre-therapy depression resulted in larger effect sizes.

In the current study, there was no pre-requisite depressive symptom entry score. Many psychotherapy outcome trials require a moderate to high depression score. Despite assessment of major depressive disorder diagnosis by the M.I.N.I 5.0.0 (Sheehan et al., 2000), the initial BDI-II scores of some clients were relatively low. The lowest initial BDI-II score was six, in the minimal depression range. This obviously represents a limitation of the reliance on self-report in the current study. Such assessment anomalies could occur because of distinctive responding characteristics of some clients, perhaps based on self-awareness or personality. The initial BDI-II scores of the other seven clients, grouped as having mild symptom severity, ranged from 14 to 19. Acceptance of clients with low BDI-II pre-therapy scores in the current study may explain lower pre-therapy to post-therapy effect size in comparison to some benchmark research (see Section 11.4.4).

The impact of initial symptom severity may be dependent on treatment. For example, analysis of NIMH data (Elkin et al., 1995) suggested a differential impact of initial symptom severity dependent on the treatment. Results from Elkin et al. indicated antidepressants and IPT were superior to CBT for clients with high initial symptom severity. Antidepressants were superior to IPT for clients with high initial symptom severity and functional impairment. The current study accepted antidepressants if commenced at least 12 weeks prior to initial assessment. Of the 17 clients who were grouped into the pre-therapy severe symptom severity category, 10 were taking antidepressants and 7 were not. Therapy may have constituted an additive effect that would not have occurred unless clients had already commenced medication. In this case, results from the current study support previous research by Keller et al. (2000) and Paykel et al. (1999), which found that psychotherapy improves residual

symptoms when taken in conjunction with antidepressants. Keller et al. found that after 12 weeks of therapy 55% of clients taking antidepressants alone improved, whereas 85% of clients in a combined antidepressant and CBT condition improved. Alternatively, if results reflected additive gains, then treatment gains may have been higher if clients taking medication were excluded.

Since, to my knowledge, this was the first rigorous clinical trial of narrative therapy, comparison with a similar trial of narrative therapy is not possible. Improved outcomes are, however, consistent with case study and qualitative research into narrative therapy for depression (e.g., Wirtz & Harari, 2000). Improvement in depressive symptoms is also consistent with quantitative research by Weber et al. (2006) that reported a reduction in DASS scores from the severe or extremely severe range for depression to the moderate, mild or normal range in seven women with depression and eating problems.

From the integration of narrative theory and practice proposed in this research, narrative therapists engaged clients in conversations that traversed landscapes of action and consciousness (Bruner, 1986), enabling clients to access those parts of their selves such as their emotions, beliefs, values, intentions and purposes, which gave meaning to actions and experience. In doing so, therapists fostered engagement amongst clients' multiple *I-Me* positions. As this self-intimacy increased, new understandings of self emerged, and the manifestations of estrangement (depressive symptoms) decreased.

The clinical significance of inter-personal relatedness at pre-therapy is congruent with previous research by Barrett and Barber (2007), which found that clients with major depressive disorder reported more interpersonal distress than a normative sample, as indexed by the Inventory of Interpersonal Problems (Horowitz, Rosenberg, Baer,

Ureno, & Villasenor, 1988). Soygüt and Savasir (2001) also found that individuals with depressive symptoms are more likely to expect inter-personal difficulties with relatives and friends.

The stories that people experiencing depression bring to therapy are often stories of inter-personal distress. Themes of distance, insensitivity, hurt, betrayal, incomprehension, confusion, indifference and ambiguity, amongst others, characterise the stories of depression. Just as a sense of well-being requires intra-personal engagement amongst multiple selves so that different selves relate to others in their entirety (*I-Me*) and otherness, well-being requires inter-personal engagement. The psychological distress associated with inter-personal relationships is testament to James' (1890) notion of significant other people as extensions of the self. In many respects, the person is not in sympathy with others within his or her inter-personal field. Based on the work of Cooper (2003), rather than the meeting of two subjectivities in the form of *I-I* relating, inter-personal engagement is likely to be of the type whereby the person observes the actions of others and his or her own inter-actions with that person in an *I-It* form of relating.

Improvement in inter-personal relatedness in the current study (OQ 45.2 IR decrease of 3.83) is consistent with findings of Lambert et al. (1999), who reported a mean decrease of 2.68 in OQ 45.2 IR scores in 40 clients suffering primarily from anxiety and depression, who completed seven sessions of therapy. Figure 11.3 depicts mean OQ-45.2 IR sub-scale scores at pre-therapy and post-therapy, comparing results from the narrative therapy completer sample with those reported by Lambert et al. Although clients' inter-personal relatedness improved statistically from pre-therapy to post-therapy in narrative therapy completer and ITT samples, mean post-therapy OQ-

45.2 IR scores above 15 indicated that clients' problems in inter-personal relatedness remained clinically significant (see Section 11.4.2).

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Figure 11.3 Comparison of Outcome Questionnaire 45.2 Inter-personal Relations outcome from narrative therapy with results from Lambert et al. (1999): Completer sample mean pre-therapy and post-therapy scores.

Improvement in inter-personal relatedness consequent to narrative therapy is consistent with the proposal by a number of theoretical orientations that psychological distress and psychotherapy involves inter-personal processes (Blatt, 2006; Muran, 2002) and the contention that people are indivisible from their inter-personal fields, each person's self existing in the context of others (Auerbach & Blatt, 2001). Following from Tappan's (1999) conceptualisation of inter-personal relatedness as a dimension of inter-subjective processes mediated through language, dialogic conversations both within and outside of narrative therapy sessions fostered change

in inter-personal and intra-personal relatedness. During narrative therapy sessions therapists encouraged clients' reflexive conversations, both within and outside of the therapeutic relationship. By enquiring into the perspectives, words, thoughts, emotions, beliefs and values of significant others, in the context of clients' own beliefs and values, therapists fostered conversations that traversed the landscapes of action and identity facilitating the meeting of subjectivities, creating new understandings of self and others.

The reduction in depressive symptoms and inter-personal relatedness consequent to narrative therapy is consistent with the narrative notions of human existence which have underpinned this study (Hermans & Kempen, 1993; James, 1890), and which present a paradoxical self that is at once relational and embodied, with inter-personal and intra-personal dimensions of existence. From these perspectives, each of the multiple self-positions that each person holds are embodied; each having a voice, each voice with an emotional tone. Without reflexive engagement amongst the multiple aspects of self, persons remain alienated from intensely personal values, beliefs and intentions that give meaning to life. According to James (1890), these moral elements of self are "felt", providing a sense of "…inner and subjective being…" (p. 296). I believe depressive symptoms are an embodied manifestation of this estrangement from meaning and feeling, and problems with inter-personal relationships reflect disengagement from the subjectivities of both self and others, corresponding to *I-It* modes of relating.

11.4.2 Outcome Question 2:

The Clinical Significance of Depressive Symptom and Inter-personal Relatedness

Outcomes

Supporting the sixth hypothesis, 53% of clients achieved clinically significant improvement in depressive symptoms by both improving reliably and moving into the

functional population (Figure 11.4). Improvement in the inter-personal relatedness of clients was not as substantial as depressive symptoms, with 23% of clients achieving clinically significant improvement.

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Figure 11.4. Proportion of clients who achieved reliable improvement, movement into the functional population, clinically significant change and reliable deterioration, indexed by Beck Depression Inventory scores: Comparing results from narrative therapy (NT) with cognitive-behavior therapy (CBT) and interpersonal therapy (IPT) from Ogles et al. (1995).

The proportion of clients who achieved clinically significant change in depressive symptoms subsequent to narrative therapy is consistent with results from CBT and IPT in the NIMH TDCRP study (Elkin et al, 1989), as calculated and reported by Ogles, Lambert, and Sawyer (1995). Keeping in mind that Ogles et al. corrected post-therapy outcome for regression to the mean and used slightly different cut-offs for RCI and clinical significance, the proportion of clients who achieved clinically

significant change following narrative therapy was slightly larger than the figure reported by Ogles et al. (1995) for CBT and less than that for IPT.

Considering previous research by Robinson et al. (1990) that indicated clients improve consequent to psychotherapy, but continue to experience residual symptoms, the proportion of clients who move into the functional population or improve reliably are important indicators of comparative effectiveness. In the current study of narrative therapy, the proportion of clients who moved into the functional population was less than proportions reported by Ogles et al. (1995) for IPT and CBT, but the proportion of clients who improved reliably following narrative therapy was larger. The proportion of clients who deteriorated reliably consequent to narrative therapy, larger than figures reported for CBT and IPT, was consistent with the approximation of 5-10% given by Lambert and Ogles (2004) in a review of psychotherapy outcome literature.

Differences in proportions of clients who achieved each category may indicate difference in effectiveness of individual orientations. Alternatively, differences may reflect the pre-therapy scores of individual clients. For example, since the current study did not stipulate a minimum entry BDI-II scores, some clients were already in the functional population and therefore could achieve reliable change but could not achieve clinically significant change as this required both reliable change and a shift to the functional population. Alternatively, differences in proportions may also reflect the therapy dose. Ogles et al. evaluated the clinical significance of results based on BDI scores from individuals who had completed 12 sessions and 15 weeks of CBT or IPT. The current study dose was less, implementing eight sessions

In the current study, the smaller proportions of clients achieving reliable improvement (30%), movement into the functional population (30%) or clinically

significant improvement (23%) in inter-personal relatedness compared to improvements in depressive symptoms are likely to reflect the more persistent nature of inter-personal problems in the lives of individuals experiencing depression. The manner in which a person relates to other people is likely to be relatively ingrained; patterns of inter-relating having occurred for many years. While awareness of these patterns and initial attempts to make changes may have occurred during therapy, it is unlikely that the patterns are going to change substantially over the period of eight therapy sessions. This contention is evidenced by results from research by Barkham et al. (2002) and Barkham et al. (1996), which found that improvement in interpersonal problems was slower than the alleviation in depressive symptoms, requiring more therapy sessions. To my knowledge this is the first study that has evaluated the clinical significance of therapy outcome as indexed by the OQ-45.2 IR.

Slower improvement in inter-personal relatedness supports the proposal that therapy progresses in phases, with acute symptoms associated with subjective well-being alleviating first, followed by improvements in more chronic problems, like those associated with inter-personal relationships (Howard et al.,1993; Kopta et al., 1994). In comparison to depressive symptoms, the smaller proportion of clients achieving clinically significant change in inter-personal relatedness is therefore likely to represent a slower improvement. Despite the smaller or slower improvement, the significant large correlation ($r = .71$) between BDI-II and OQ 45.2 IR pre-therapy to post-therapy change suggest that improvements in inter-personal relatedness were associated with symptomatic recovery, lending support to the notion that inter-personal relatedness is an essential element of processes involved in psychological well-being and disorder.

Smaller gains in inter-personal relatedness, compared to depressive symptoms, may reflect the importance of intra-personal processes to recovery from depression, supporting the notion that change is an inter-subjective process involving inter-personal and intra-personal dimensions. Smaller gains in inter-personal relatedness may also reflect the notion of self and self-stories as co-constructions. Irrespective of client changes, others in the client's inter-personal field may hold past memories or retain past patterns of inter-action with the client, which influence present patterns of relating with the client. That is, inter-personal relatedness requires not one, but at least two people.

In this study, analysis of reliable change provided support for pre-therapy to post-therapy change as reliable. Determining the proportion of clients, who moved into the functional population indexed the clinical meaningfulness of the change. These two elements combined provided stringent criteria for outcome change, important to this study, which did not use a control or alternative therapy comparison. Despite analysis of the statistical significance of pre-therapy to post-therapy change in the current study, giving useful information on the reliability of change, analysis of clinical significance provided information on the clinical meaningfulness of change, more relevant to clinicians.

11.4.3 Outcome Question 3:

Maintenance of Depressive Symptom and Inter-personal Relatedness Outcomes at Three-month Follow-up

In support of Hypothesis 7, client responses indicated that post-therapy treatment gains in depressive symptoms were maintained at three-month follow-up. In contrast, Hypothesis 8 had little support. Treatment gains in inter-personal relatedness were maintained at three-month follow-up in the ITT, but not the follow-up sample.

Figure 11.5 depicts changes in BDI-II and OQ 45.2 IR scores from post-therapy to follow-up in relation to post-therapy gains in the completer sample.
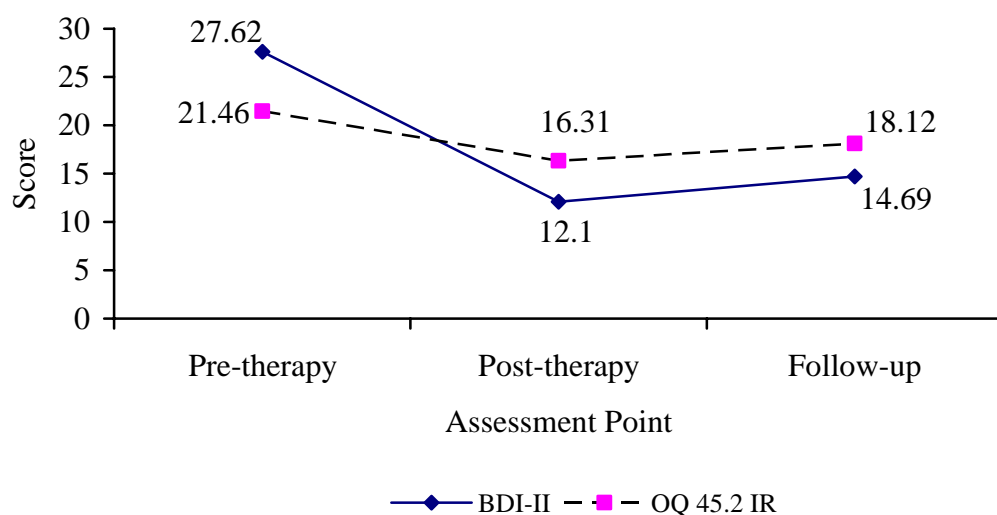
Figure 11.5. Changes in Beck Depression Inventory and Outcome Questionnaire 45.2 Inter-personal Relations scores from post-therapy to follow-up in relation to post-therapy gains in completer clients.

Results from client responses indicated that BDI-II scores did not differ from post-therapy scores three months following the end of the narrative intervention in both follow-up and ITT samples. Depressive symptoms remained significantly improved compared to pre-therapy assessment. Supplementary investigation of depressive symptom outcomes using the DASS-D confirmed BDI-II results in follow-up and ITT samples sets. Maintenance of post-therapy improvement in depressive symptoms is consistent with meta-analyses of 31 follow-up studies of uni-polar depression by Neitzel et al. (1987) that found post-treatment scores remained stable at follow-up, when the

average follow-up period was 16.4 weeks. Meta-analysis of nine studies (with a mean follow-up period of 13 weeks) by Robinson et al. (1990) also found that follow-up effect sizes did not differ from post-treatment effect sizes.

In the current study of narrative therapy, there was a small increase in mean BDI-II scores at three-month follow-up, although not statistically significant. Since the increase was not statistically significant, it is possible that the larger BDI-II scores simply reflected error measurement. Considering the small sample size, however, the increase could portend a trend towards deterioration in depressive symptoms over time. Although follow-up results from the current study cannot be compared convincingly with research that utilised longer follow-up periods, I note that results from Shea et al. (1992) indicated that 33 to 36 % of the NIMH TDCRP clients relapsed by 18 months. Westen and Morrison (2001) and Neitzel et al. (1987) also observed small to moderate decreases in treatment gains over follow-up periods.

Results from the follow-up sample indicated that improvements in inter-personal relatedness were not maintained at three-month follow-up, with deterioration in inter-personal relatedness from post-therapy to follow-up. Nevertheless, the effect size of the change was small and despite deterioration, clients' inter-personal relatedness remained significantly improved compared to initial assessment. Failure to maintain treatment gains in inter-personal relatedness at three-month follow-up in the follow-up sample may reflect the slower treatment gains in inter-personal relatedness by the end of therapy and the persistent nature of patterns of inter-personal relating, discussed in Section 11.4.2. Larger improvement and maintenance of depressive symptomatology compared to inter-personal relatedness speaks to importance if intra-personal processes to psychological well-being.

Inter-personal relatedness results from the ITT sample differed from those of the follow-up sample, with post-therapy improvements maintained at three-month follow-up. Results from the ITT sample, however, do not provide convincing support for Hypothesis 8 as maintenance of inter-personal gains in the ITT sample could simply reflect the extra treatment accessed by members of that group. In the ITT sample set, two people commenced antidepressants during the eight-session intervention and six people commenced medication during the three-month follow-up period.

While change in inter-personal processes may have begun, inter-personal changes made may have been fragile and easily destabilised, impacting on the durability of inter-subjective processes so that inter-personal gains were not maintained. From the perspective of a dialogical self (Hermans, 2006), at treatment end the inter-subjective processes of therapy had enabled a flexible interplay of the diverse perspectives, necessary for each client to fully engage with his or her own self. From the integration of narrative theory and practice, *I* positions (subjectivities) related to other *I* positions and reflected on their respective *me(s)* in an inter-subjective process of reflexivity, diminishing the power of dominant *I* positions implicated in problematic inter-personal relationships, and strengthening alternative positions. The strength of the alternate *I* positions, however, was not fully established. After therapy sessions ceased, the relatively unstable alternate *I* positions were vulnerable, easily subjugated by previously dominant *I* positions so that by three-month follow-up assessment, dominant I position were powerful.

Examination of the results from the intervention integrity measure revealed good therapist adherence to *developing the therapeutic relationship*, *eliciting problem stories*, *deconstructing problem* stories and *living enriched stories*, as well as avoidance of

proscribed practices. Adherence to *embracing preferred stories*, however, was low. In the embracing preferred stories phase, therapists facilitate clients' receptiveness to alternative stories of self, by exploring these stories in-depth, and weaving these stories into other stories of the person and significant others. As alternative stories are told and retold the narrative tapestry of the person's life becomes more richly described, the story becomes more stable and accepted by the person and others in the person's inter-personal field. A greater number of sessions or increased emphasis or training may have improved application of this phase of the intervention, improving gain maintenance.

11.4.4 Outcome Question 4:

Comparability of Narrative Therapy Depressive Symptom Outcome with Evidence-Based Psychotherapies

The current research utilised depressive symptom outcomes from research by Shapiro et al. (1994), Watson et al. (2003) and Ogles et al. (1995) as benchmarks for comparing outcomes from narrative therapy. In support of Hypothesis 9, pre-therapy to post-therapy improvements in depressive symptoms following narrative therapy were comparable to improvements found by research into evidence-based psychotherapies (See Figure 11.6).

Client demographic characteristics in the current study were broadly similar to those in benchmark studies, excepting a higher proportion of clients reported university education in the Watson et al. (2003) study. Client clinical characteristics in the current study differed from benchmark research in permitting antidepressant use if commenced at least 12 weeks prior to therapy. Watson et al. and Ogles et al. (1995) excluded antidepressant use. The proportion of clients taking antidepressants was substantially

less in the research by Shapiro et al. (1994) than in the current study and differences in client co-morbidity were apparent.

Comparable to benchmark research, the current research used an efficacy protocol, but utilised a lower treatment dose (8 sessions) than Ogles et al. (1995), with 12 sessions, or Watson et al. (2003), with 16 sessions. In comparison to the current study, therapists in benchmark studies varied less across qualifications and disciplines and had more training in the therapy implemented. Therapists in the research by Ogles et al. were more clinically experienced.
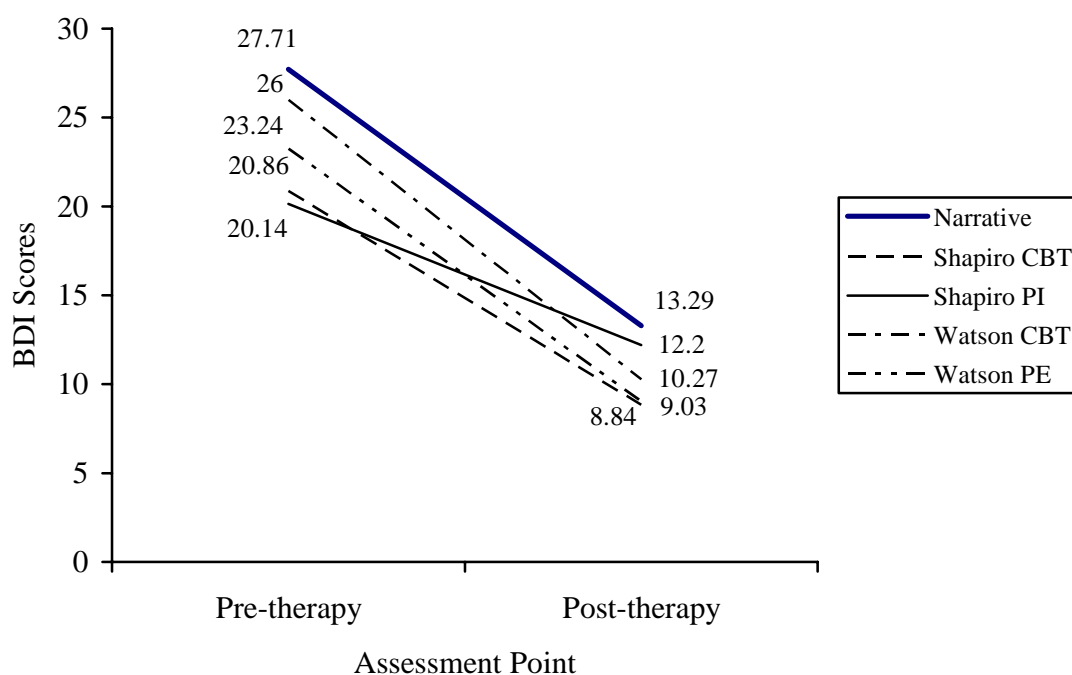
Figure 11.6. Pre-therapy to post-therapy gains from narrative therapy compared to gains reported in benchmark research from cognitive behaviour therapy and psychodynamic therapy (Shapiro et al., 1995) and cognitive behaviour therapy and process experiential therapy (Watson et al., 2003).

Improvement in depressive symptoms in narrative therapy did not differ from improvements reported by Shapiro et al. (1994) in CBT and by Watson et al. (2003) in CBT and PE, but was greater than that reported by Shapiro et al. for PI. As indexed by depressive symptoms, results indicated large effect sizes for narrative and comparison therapies, although the magnitude of effect for narrative therapy was smaller than reported for CBT (Shapiro et al.), and for CBT and PE (Watson et al.).

Comparing the clinical significance of results from the current study to those of Ogles et al. (1995), the proportion of clients who achieved clinically significant improvement in narrative therapy was comparable to CBT, but less than IPT (See Section 11.4.2).

11.5 Process and Outcome of Narrative Therapy:
Theoretical Contributions

11.5.1 A Theoretical Argument to Justify an Empirical Evaluation of Narrative Therapy

The current research articulated a theoretical argument for an empirical evaluation of narrative therapy, that was informed by the writings of Bruner (1986) and Gergen (2001b). Foucault (1980) noted that groups who claim privileged knowledge in a society often have a powerful voice in that society. In our society, the voice of science is particularly strong; psychology's use of empirical methodologies has come with increased credibility. Consequently, psychology has been slow to adopt narrative ideas. In response, incited by the notion of deconstruction, many narrative researchers have privileged narrative ways of knowing the world, excluding paradigmatic methodologies.

This thesis recognised the importance and richness of narrative research methodologies. By excluding empirical methodologies, however, narrative researchers

have effectively withdrawn from mainstream psychology dialogue. Further, if narrative ways of knowing are privileged above paradigmatic ways, then the narrative metaphor is at risk of being positioned as another totalising paradigm.

Reiterating the opinions of Bruner (1986) and Gergen (2001b), that empirical ways of knowing the world complement narrative ways and are necessary to provide a comprehensive understanding of the human condition, this thesis assumed a pluralistic stance. I argued that an empirical investigation of narrative therapy is coherent with theories that underpin narrative therapy, and proposed that an empirical evaluation of narrative therapy, provides valuable information, broadens the evidence base for its use in clinical practice, and positions narrative therapy in dialogue with mainstream psychology.

11.5.2 A Synthesis of Dialogical Narrative Theory, Narrative Research and Narrative Therapy

This thesis conceptualised narrative therapy in the context of dialogical narrative theory (Hermans & Kempen, 1993) and narrative research into reflexivity (Angus et al. 1999; Levitt & Angus, 1999). Rather than the story framework that currently characterises narrative practice, this synthesis proposed that a dialogical framework is more appropriate; the cross-fertilisation of perspectives accounting for the creative and generative process that transforms self and narrative. Although the term "dialogue" is not explicitly used in narrative therapy, it is implicit in references to "therapeutic conversations", "conversations with significant others" and in the turn-taking of reflecting teams and clients. The focus on dialogue in the current thesis contributes to the narrative practice literature by explicitly linking theorised dialogical processes with narrative therapy.

11.5.3 Identified Narrative Reflexivity as a Construct Linking Narrative Theory,

Narrative Research and Narrative Therapy

The process of narrative reflexivity was identified as a theoretical construct linking narrative theory and narrative research with narrative practice contributing to the psychotherapy process literature. By linking the theoretical construct of narrative reflexivity, this thesis proposed that narrative reflexivity is a process of narrative therapy.

Reflexivity is an essential element of the Narrative Processes Model (Angus, Levitt, & Hardtke, 1999). Informed by research on the NPCS (Angus, Hardtke, & Levitt, 1996), which developed from the model, this thesis utilised the NPCS to operationalise narrative reflexivity in the context of narrative therapy.

Although not explicitly named, the process of narrative reflexivity is pivotal to the dialogical narrative theories of Hermans and Kempen (1993) and Cooper (2003). Narrative reflexivity was distinguished as a narrative and inter-subjective process involving inter-personal and intra-personal dialogue, and was linked to the flexible inter-play of *I-Me* inter-personal and intra-personal self-relating, proposed by Hermans and Kempen (1993) to be essential to psychological health. The diverse perspectives (e.g., values, beliefs, and intentions) of the multiple subjectivities (*Is*) engage in dialogue and discuss their respective *Mes.*

This thesis linked the process of narrative reflexivity to strategies employed in narrative therapy. Facilitated by a specific form of therapeutic alliance, which fosters dialogic conversations, narrative therapists assist clients to integrate experience and meaning by scaffolding the therapeutic discourse across Bruner's (1986) landscapes of action and consciousness. That is, narrative therapists facilitate narrative reflexivity,

whereby clients engage in dialogues with their selves, the therapist and others; interpreting experience from diverse perspectives in the context of personal emotions, beliefs, values and intentions. The connection of narrative reflexivity with externalising conversations was also considered.

11.5.4 Identified Intra-personal Processes of Change in Narrative Therapy

By conceptualising narrative therapy as involving dialogical (Hermans & Kempen, 1993) and inter-subjective change processes, this thesis explicitly identified a role for intra-personal processes in narrative therapy. Informed by social constructionist ideas, a great strength of narrative therapy has been an emphasis on the inter-personal, the social and the cultural. This was a central departure from traditional psychology, in which the focus on intra-psychic processes was firmly entrenched. However, just as we lose a means of understanding the human condition by excluding empirical ways of knowing, we lose a means of understanding the human condition if we privilege the inter-personal over the intra-personal. This thesis aligns with theorists who hold that intra-personal and inter-personal dimensions of existence are reciprocally embedded (Auerbach & Blatt, 2001; Hermans, 2004). In their shift away from the intra-psychic and towards the social, proponents of narrative therapy have neglected intra-personal processes of change. Rather than relying on the inter-personal dimension of human existence, I believe the notion of inter-subjectivity is consistent with narrative theory, and provides a richer and more comprehensive narrative account of psychological distress, narrative therapy and psychotherapeutic change.

11.6 Narrative Therapy Process-Outcome Findings:

Practical Implications

11.6.1 The Role of Narrative Reflexivity in Therapist Practice and Training

Findings on narrative reflexivity have potential implications for therapist

practice and training, if results are supported in future studies. Findings from the current

study support a greater emphasis on meaning-making strategies in therapy practice and

when training therapists. Results from narrative research by Angus et al. (1999) and

Levitt and Angus (1999) indicate that different orientations implement different

meaning-making strategies. The meaning-making strategy used by narrative therapy,

traversing landscapes of action and consciousness, may inform other orientations or

integrative practice. A theoretical understanding of how this strategy is involved in

therapeutic change, as articulated in the current research, may assist therapists to

recognise the importance of making meaning to successful therapeutic outcome.

11.6.2 An Empirical Evaluation of Narrative Therapy Supports its Implementation for

Major Depressive Disorder in Adults

To my knowledge, this research was the first rigorous empirical investigation of

narrative therapy. Given that this was an initial clinical trial of narrative therapy and

considering the limitations of the study outlined in Section 11.8, generalising findings

would be premature. Results from the current study, however, suggest that narrative

therapy has utility in the treatment of adults with major depressive disorder in reducing

depressive symptoms and improving inter-personal relations. As such, this research has

contributed to the evidence base for narrative therapy, adding empirical support to the

previous qualitative and case-study support, providing a wider evidence base for

clinicians to justify the use of narrative therapy when treating clients with major

depressive disorder of moderate and high symptom severity. For therapists who hold a post-modern world-view and feel comfortable and authentic using a narrative approach, this is a significant advance, reducing potential tensions in workplaces that interpret evidence-based practice as empirically supported practice and minimising the potential for litigation.

However, analyses of clinical significance of pre-therapy to post-therapy outcomes and follow-up analyses of inter-personal relatedness outcomes suggest treatment dose needs to be more that eight sessions for a substantial proportion of clients. Forty-seven percent of clients did not achieve clinically significant change. Although this figure is consistent with results from CBT, it is lower than the figure of 17% reported for IPT (Ogles et al., 1995) after 12 sessions or 15 weeks of therapy. Although research suggests that improvement proceeds at a decelerating rate, evidence indicates a higher number of therapy sessions is associated with better outcomes (See Section 6.5). Further, findings suggesting there is maintenance of treatment gains in depressive symptoms, but not inter-personal relations three-months after therapy, taken together with slower gains in inter-personal relatedness compared to depressive symptoms, support the view that change in patterns of inter-personal relatedness may require more sessions compared to symptom change.

11.6.3 Contributed to the Psychotherapy Evidence Base on Psychotherapy Outcome, Clinical Significance, Benchmarking and Working Alliance

The current research has contributed to the psychotherapy evidence base in several areas, including the psychotherapy outcome, clinical significance, benchmarking and working alliance literature. The contribution of the current study is particularly

significant in that it informs an empirical evidence base on the outcomes and processes of a post-modern therapy.

The outcome component of the study adds to the wide psychotherapy outcome literature that supports psychotherapy as effective in the treatment of depression in adults. Outcome results also provide support for the numerous studies that have found broad equivalence across psychotherapies and to the dose response literature that indicates phases of psychotherapy change.

Analyses of the clinical significance of depressive symptom outcomes contributes to a growing literature on clinical significance by providing a comprehensive account of outcomes that includes proportions of clients who achieve reliable change, movement into the functional distribution, clinically significant change and reliable deterioration. These proportions add to growing data that provides useful comparison statistics. Further, to my knowledge, this is the first time these proportions have been reported for the OQ-45.2 IR sub-scale, providing future research with useful statistics for comparison of inter-personal change.

This study has added to the benchmarking literature. Weersing and Weisz (2002), contributed to the benchmarking paradigm by using benchmarking for the first time in a comparison trial of two treatments. Like Weersing and Weisz, the current research benchmarked an innovative treatment against RCT research to substantiate the effectiveness of a treatment in a context where an RCT was impracticable.

Results from the current research also contributed to the alliance-outcome literature, providing support for the wide research base that suggests the working

alliance is a common factor of therapy, but also suggesting the importance of relational processes in recovery from depressive disorder.

11.6.4 Manual and Integrity Measure: Potential Utility for Narrative Practice, Training and Research

The narrative manual developed for the current research (A Narrative Approach to Therapy: Guiding Principles and Practice) and the related integrity schedule (N-TIS) has implications for clinical practice, training and future research. Since the current research provided support for the manualised narrative approach as effective in improving outcomes, the manual could be used by therapists to guide their intervention in the treatment of depression in adults. The manual and integrity measure have potential utility in training therapists in narrative therapy, providing a comprehensive framework for practice that is consistent with narrative theory. Used in conjunction with the N-TIS, therapists and therapists-in-training could monitor their own practice. The manual and N-TIS could also be used in future research of narrative therapy for different disorders and with different populations to standardise and validate intervention.

11.6.5 Potential Implications for Future Narrative Practice

As an initial process-outcome study into narrative therapy, conclusions on the efficacy and processes of narrative therapy would be premature. Should future research support the role of narrative reflexivity in therapeutic change in narrative therapy, however, greater emphasis on meaning-making strategies, such as traversing landscapes of action and identity would be warranted. Narrative therapy is commonly associated with externalisation, and therapists frequently emphasise this aspect in their practice.

This thesis recognises the importance of narrative strategies such as externalisation and deconstruction, but highlights the role of conversations that traverse landscapes of action and identity as pivotal to meaning-making and change.

Although current narrative practice emphasises the storied and inter-personal nature of narrative therapy, dialogical and intra-personal processes are implicit. Explicit articulation of these narrative aspects in this thesis may impact future practice, with the potential to enhance therapeutic outcomes of narrative therapy. An understanding of the dialogical and inter-subjective processes of narrative therapy has the potential to assist therapists' conceptualisation of change so that the therapeutic process reflects a greater focus on dialogue and intra-personal experience than currently occurs.

11.7 Research Limitations

11.7.1 Repeated-Measures Design

As this research used a repeated-measures design, potential threats to internal validity must be considered, including maturation, history, instrumentation, regression and mortality. Several strategies were implemented however, to minimise the potential impact of these effects and to maximise the likelihood that the narrative intervention was the sole reason for change in dependent variable scores from pre-therapy to post-therapy.

Constraining the number of sessions to eight reduced the period of the intervention, effectively minimising the potential for clients to change due to the natural progression of their major depressive disorder (maturation) or due to events outside of the narrative intervention (history). The potential for a regression to the mean effect was minimised by using participants who were not extreme scorers. For example, the mean

ITT pre-therapy score on the primary dependent variables were 28.87 (SD = 9.97) out of

a potential 63.00 on the BDI-II and 20.80 (SD = 5.85) out of a potential 44.00 on the

OQ-45.2 IR. Considering that pre-therapy scores were moderate, the error of

measurement was unlikely to be unduly large, therefore reducing the likelihood of

regression to the mean. The use of standardised instruments to operationalise the

dependent variables, with protocols for their implementation, minimised the potential

for changes in the way variables were measured (instrumentation effects) from pre-

therapy to post-therapy. The potential for the over-estimation of treatment effects due to

attrition (mortality effects) was addressed by reporting data from the intent-to-treat

sample for comparison with data from completer and follow-up samples.

Despite the problems inherent to use of a control or comparison group in

psychotherapy research, as discussed in Chapter 6, a control or comparison group may

have increased confidence in relation to the optimal minimisation of systematic effects.

However, control and comparison groups are largely relevant to analyses of statistical

significance. When comparing a treatment group with a control group, researchers can

statistically adjust outcome results to account for control group outcomes. To increase

confidence in outcome results, the current study also conducted analysis of clinical

significance, whereby each client also acts as his or her own control.

11.7.2 Client Sample

Recruiting the client participants through advertisement in local print media may

have biased the sample of clients examined. By limiting the recruitment strategy to the

print media, respondents were likely to be clients that both were financially able to buy

newspapers and were literate enough to read newspapers. In fact, all clients were

relatively well educated; 37% had completed secondary education and 47% had

completed tertiary education. Recruiting the client participants through print media most probably limited the sample to clients who were functioning enough to proactively volunteer; inpatient clients were not represented. Volunteering for research may have reflected a motivational characteristic that would not be present in inpatient clients. Furthermore, all respondents to the advertisement for clients with depression identified themselves as Caucasion. Since this research investigated a well-educated, outpatient Caucasian sample, the question of how the narrative intervention impacts on a culturally diverse sample of clients, clients who are less educated, or who are inpatients, remains untested.

11.7.3 Small Sample Size

Use of a relatively small sample in the current study limits generalisability; a larger sample size would provide greater confidence in results. The decision to constrain the number of research participants was justified by a number of factors.

Ethically, the number of clients used in research should be the minimimum required to demonstrate the hypothesised effect. In this case, a large effect was expected for the repeated-measures design. Despite the small sample size, the study was powerful enough to demonstrate the large effect size expected for symptomatic change.

Considering the population of interest was a clinical and vulnerable population, and suicide was a possibility for clients with major depressive disorder, a relatively small N was appropriate. Apart from this ethical consideration, the financial and time constraints of PhD research dictated a small sample. For example, financial constraints limited the frequency of BDI-II administration, and the finances available for paying raters and coders. Since therapists were required to give their time and expertise without

payment, the number of therapist participants was limited, in turn limiting the number of clients that could commence therapy.

11.7.4 Therapist Experience in Narrative Therapy

The overall level of therapist clinical experience was relatively low ($M = 4.8$ years; $SD = 3.9$ years), and level of experience in narrative therapy even lower ($M = 22.96$ months; $SD = 24.29$ months). Further, therapist training in narrative therapy for the current study was conducted over a relatively short (two days) period. Although the weight of the research appears to support the view that level of experience has little effect, using more experienced therapists and implementing more extensive narrative training may have increased the effect of narrative therapy. On the other hand, results from a trial that has utilised several therapists with a range of experience in the approach under examination, and provided a relatively short period of training in a manualised approach may be more generalisable, and less likely to be due to therapist effects compared to research that used few therapists, very experienced in the approach.

11.7.5 Transcript Analyses

Results from analyses examining narrative reflexivity were based on a small number of clients. Despite the small sample used, differences in narrative reflexivity found between good and poor outcome clients were statistically significant according to the inferential analysis used. Results from such a small number of clients, however, may be unique to the specific clients examined and should be interpreted cautiously. Analysis of the entire set of clients who provided data may have added to the information about the process of narrative reflexivity and its association with therapy process and outcome and provided more confidence in results. This would have required that the first and last therapy sessions of all 47 clients be transcribed and

coded, requiring considerable financial and time resources that were unavailable in the context of a PhD study.

Further, because of resource difficulties in paying a NPCS coder, results for the reliability of the NPCS were based on a small number of transcripts. Reliability analysis on a greater number of transcripts would provide greater confidence in results.

Another limitation involves the neglect of non-verbal communication. The focus on verbal language in the transcript analyses is likely to have lost a considerable amount of information about therapy processes. Since it is likely that the verbal capacity of individuals is compromised when experiencing deep or painful emotion, it is possible that non-verbal communication may have pre-dominated at those times. While the manual suggested that therapists enquire into emotion when it was expressed in therapy sessions, this may not have always occurred. It is possible that the focus on verbal expression in transcript analyses lost emotional content.

11.8 Research Strengths

11.8.1 A Strong Theoretical Foundation for Research Design and Thesis

A strong theoretical foundation underpinned this research, providing a framework for the research questions, research design and the integration of narrative theory and practice. Adopting a pluralistic approach to narrative theory, research and therapy, narrative practice was interpreted according to theoretical notions of narrative, self, inter-subjectivity and dialogical exchange. The wide application of narrative theory across a range of disciplines that are concerned with understanding the human condition, including literature (e.g., Bakhtin), anthropology (e.g., Epston), psychology (e.g., Gergen), social work (e.g., White) philosophy (Archer; Wittgenstein), developmental psychology (Vygotsky) supports its use in this thesis on psychotherapy.

11.8.2 Parsimonious Evaluation of Narrative Therapy Outcomes

The design of the current research complemented analyses of statistical significance with analyses of clinical significance and with a benchmarking strategy in a parsimonious design that was rigorous but without the expense or practical and ethical problems associated with a RCT. Analysis of pre-therapy to post-therapy and post-therapy to follow-up statistical significance supported the reliability of outcomes. Evaluation of the clinical significance of outcomes for clients provided information about the meaningfulness of outcomes, and the benchmarking strategy enabled comparison of narrative therapy outcomes with those from standard evidence-based psychotherapies (including cognitive-behavior therapy, interpersonal, psychodynamic inter-personal and process experiential orientations).

11.8.3 Examination of Psychotherapy Process in the Context of Outcome

The current research examined the process of narrative therapy in the context of outcome. It is likely that the large resources needed for detailed examination of psychotherapy has deterred many researchers from concurrent examination of therapy process when evaluating outcome. In this research, examining the process of narrative therapy as it related to outcome enabled comparison of the process of narrative reflexivity between least and most improved clients, providing more confidence in interpreting narrative reflexivity as a process that occurs in successful therapy.

11.8.4 Internal and External Validity

Although threats to the internal validity of the study need to be considered (see Section 11.8.1), overall the research design was a rigorous clinical trial with acceptable internal validity. The research comprised a standardised intervention, with a manualised

treatment and a manipulation check of the independent variable, therapist training and supervision, standardised assessment of major depressive disorder and com-morbid Axis I and Axis II disorders, and standardised outcome measures.

The external validity of the trial was enhanced by the use of a large number of therapists from a range of disciplines and with a range of clinical experience and experience in narrative therapy. Research indicates therapist effects are important consideration when evaluating therapy outcomes (Elkin, Falconnier, Martinovich, & Mahoney, 2006; Kim, Wampold, & Bolt, 2006). The fewer the number of therapists in a trial, the more likely the mean outcome scores are impacted by the personal characteristics of the therapist and therefore the less externally valid are the results.

11.8.5 Outcome Measures

The BDI is a well-standardised measure that has been, and remains widely used in the research and clinical community. As such, use of the BDI-II in the current research provided statistics that can be compared to previous clinical trials of depression and with future results in clinical and research settings. Considering controversy and anomalies in the literature regarding the specificity of the BDI, however, use of the DASS-D to confirm BDI-II scores afforded greater confidence in concluding depressive symptom improvement. As a standardised and free-to-use measure of depressive symptoms, the DASS-D also enabled evaluation of depressive symptoms at all assessment points. Widely used in Australian research and clinical practice, DASS-D results are particularly relevant to the Australian context. Use of the OQ-45.2 IR and SWT-T provided measures of outcome in addition to depressive symptoms.

11.9 Future Research Directions

As an initial investigation into the processes of narrative reflexivity and the working alliance in narrative therapy and as an initial rigorous empirical evaluation of narrative therapy, results from this study raise several questions for future examination. At the very least, a process-outcome trial into narrative therapy for adults with major depressive disorder should be replicated to confirm findings.

Narrative Reflexivity has emerged as a critical construct, requiring more comprehensive understanding. Although there have been relatively few studies of reflexivity, the association between increasing reflexivity and good outcome found in the current study of narrative therapy has been noted in other therapies, including brief-dynamic, perceptual-processing and process-experiential therapies. While these orientations use different strategies, each therapy assists clients to make meaning from their experience. It is possible that increasing narrative reflexivity is a process occurring in orientations that emphasise making meaning. On the other hand, the process of narrative reflexivity may be a process of all successful psychotherapies. Future research could examine reflexivity in alternative therapies, particularly those that do not posit making meaning as a key therapeutic process.

This research highlighted the narrative therapy strategy of traversing landscapes of action and identity as facilitating narrative reflexivity, based on theoretical reasoning. The link between this strategy and reflexivity was not, however, verified. Future research could examine this link. It is possible that other strategies or processes of narrative therapy are involved.

A causal link between narrative reflexivity and outcome has not been empirically verified; increasingly reflexive dialogue may not be a mechanism of change and may simply be associated with good recovery from depression. Statistical analyses examining reflexivity as a mediating variable may throw some light on this process. Changes in narrative reflexivity in individuals without disorder would provide interesting comparison data in this analysis and may add to our understanding of how narrative reflexivity relates to psychological well-being.

Since examination of reflexivity, involving the transcription and coding of first and last therapy transcripts, in a larger number of clients was beyond the scope of this research, correlations of reflexivity with depressive symptom and inter-personal relatedness outcomes and with the process of working alliance were not rigorously evaluated. The concept of narrative reflexivity as an inter-subjective process raises questions on the inter-play of narrative reflexivity and the working alliance. Considering the robust nature of the relationship between the working alliance and outcome, research investigating the possible interplay of narrative reflexivity and working alliance may provide a better understanding of relational change processes, with the potential to shape the form of the therapeutic relationship in practice.

Further, the theorised inter-subjective processes underpinning this research highlighted inter-personal and intra-personal relatedness. Results on the slower change in inter-personal relatedness consequent to narrative therapy and failure to maintain treatment gains in inter-personal relatedness were consistent with the phase model of therapy (Howard et al., 1993; Kopta et al., 1994). Future research should investigate post-therapy change in inter-personal relatedness and stability of gains in the context of a larger dose of narrative therapy. Further, although the Interpersonal subscale of the

OQ 45.2 proved a sensitive measure of change in inter-personal relatedness in the eight sessions of the current study, a better understanding of the inter-personal and intra-personal processes involved in therapeutic change might be gained by utilising other and more comprehensive measures of inter-personal and intra-personal relating over a longer period. Case study research relating inter-personal and intra-personal findings to processes of working alliance and reflexivity over a longer period might be particularly informative.

Since this was an initial empirical investigation of narrative therapy, evaluation of the utility of narrative therapy in the treatment of major depressive disorder requires confirmation through replication studies, or optimally, with a larger number of participants and a longer period of narrative training for therapists. The narrative manual and Narrative Therapy Integrity Schedule, developed for the current study would assist the conduct of such research. Future research could also focus on the psychometric properties of the integrity measure. Conduct of a number of empirical studies would provide therapists with a wider evidence base to justify use of a narrative approach in clinical practice.

The argument for the validity of empirical research into narrative therapy posed in this thesis, along with the current study, has led the way for empirical investigation of narrative therapy for psychological disorders other than depression. For example, with little adjustment, the manualised narrative approach has potential application to bipolar disorder. Theory of a disordered dialogical self in schizophrenia has already been formulated by Lysaker and Lysaker (2006) and has the potential to inform future narrative practice and empirical investigation of narrative therapy for schizophrenia and other psychological distress involving psychoses. Results on the effectiveness of

narrative therapy for clients with pre-therapy severe symptom severity are interesting when taken in the context of Parker's (1996) proposal that antidepressants treat melancholia, marked by more severe depression and psychomotor disturbance, more effectively than psychotherapy. In the current study, utilising a population of people who largely scored 20 points below the highest score possible on the BDI-II avoided problems related to regression to the mean, but excluded an answer as to whether narrative therapy is effective for clients with very high disturbance. Future research could examine narrative therapy for the population of individuals with extreme depressive symptoms and poor functioning. For external validity, such research could examine narrative therapy alone compared to narrative therapy subsequent to pharmacotherapy.

11.10 Conclusion

This thesis investigated the process and outcome of narrative therapy in the treatment of adults with major depressive disorder, theoretically and empirically. The notion of language and self as overarching constructs that subsume the minutiae of therapy techniques inspired this thesis. From these broad constructs, narrative reflexivity emerged as a dialogic and inter-subjective process relevant to psychotherapeutic change and common to dialogical narrative theory (Hermans & Kempen, 1993), narrative research (Levitt & Angus, 1999), and narrative therapy (White, 2002). To substantiate the theoretical synthesis of narrative theory, research and practice and provide quantitative evidence for the utility of narrative therapy, a process-outcome trial examined the processes of narrative therapy and working alliance and their relation to depressive symptom and inter-personal relatedness outcomes.

Increased narrative reflexivity was found to be associated with improvement in depressive symptoms. Gains in the quality of working alliance were associated with gains in depressive symptoms and inter-personal relatedness at post-therapy. Findings support the hypothesed proposal that narrative reflexivity and the working alliance are two processes associated with successful therapeutic outcome in narrative therapy for adults with depression.

Consistent with research indicating equivalence of bone fide therapies, the benchmarking strategy used in this study found no clear outcome differences between narrative therapy and standard evidence-based psychotherapies, despite major differences in approach. Depressive symptom gains from narrative therapy, along with proportions of clients achieving clinical significance and reliable change, were comparable to results from evidence-based therapies reported in benchmark research investigating CBT, PE and IPT. Post-therapy improvements in depressive symptoms, but not inter-personal relatedness, were maintained at three-month follow-up. Empirical results add to the evidence base for narrative therapy practice in the treatment of major depressive disorder in adults.

This thesis considered elements of a fundamental question of psychotherapy research: How do people with psychological distress achieve change? Considering the complexity of individuals, it is not surprising that we continue to seek the answer to this question. Despite multiple and complex interactions, broad overarching constructs, such as self and language may order such complex systems. Dialogical theorists focus on the importance of dialogue and the notion of other, pivotal to the creativity of change, and embrace the perspective that this change arises from inter-subjective processes, involving intra-personal and inter-personal dimensions.

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Appendix A

School of Psychology and Counselling

Queensland University of Technology

A Narrative Approach to Therapy:

Guiding Principles

and

Practice

Lynette P. Vromans

18th July 2004

A

Appendix B

School of Psychology and Counselling

Queensland University of Technology

Assessment of Adherence Utilizing the

Narrative Therapy Integrity Schedule

(N-TIS)

Lynette P. Vromans

January 2006

Contents

A

The Purpose of the Narrative Therapy Integrity Schedule

A

The Narrative Therapy Adherence Schedule (N-TIS) was developed as part of a PhD project researching the process and outcome of psychotherapy for depression, in which the outcome of narrative therapy could be assessed.

This schedule has been developed to be used in conjunction with the manual "A Narrative Approach to Therapy: Guiding Principles and Practice", which was developed for the PhD project into the outcome of Narrative Therapy.

The N-TIS is intended as a metric indicating the degree to which therapists adhere to the manual "A Narrative Approach to Therapy: Guiding Principles and Practice", as well as therapists' competence in implementing the approach.

The N-TIS may be used by independent raters or by therapists to assist their own adherence to a narrative framework, and to assess their own therapy integrity.

Guidelines for Rating Therapy Sessions

❖ Raters must attend the training sessions for the manualised "A Narrative Approach: Guiding Principles and Practice" prior to rating therapy sessions.

A

❖ Raters must become conversant with both the manual and with the items of the N-TIS and should refer to the manual if necessary to clarify responses to N-TIS items.

❖ To ensure rater consistency, raters must participate in training sessions for the coding the N-TIS.

❖ Although each session is rated separately, at least one session each from beginning, middle and last sessions should be viewed to determine therapy integrity. Raters must view the entire therapy session rated.

❖ Raters should take notes (relevant to integrity) while viewing therapy sessions.

❖ Items should be rated on the scale by circling the number which corresponds with the degree to which the rater evaluates the therapist's adherence to each of the 18 items over the course of the therapy session. Questions are rated on a scale where 0 = Not present; 1 = Present; 2 = Appropriately Applied, excepting Questions 16, 17, 18 (reverse scored).

❖ If an item is not applicable to a therapy session raters should mark the item as "Not Applicable" (N/A). For example, where therapy is in the initial phases, the questions referring to "Living Enriched Stories" may not be applicable, in which case N/A should be circled.

❖ Please do not leave the response to any item blank.

Phase 1 Adherence Items
In developing a therapeutic relationship, did the therapist:

A

Q1.   use verbal and non-verbal communication which exemplified an equal and collaborative relationship between the therapist and the person (for example, the use of non-formal language, room setting, body language)?

N/A

0   *1*   *2*
_____

Not Present   *Present*   *Appropriately Applied*

Q2.   take a non-expert stance, privileging the person's personal knowledge over the therapist's professional knowledge (e.g., by assuming a "not knowing" curious stance of respectful, tentative reflection/questioning)?.

N/A

0   *1*   *2*
_____

Not Present   *Present*   *Appropriately Applied*

Q3.   take a transparent stance (e.g., explain the process of therapy, offer the person the opportunity to read, hear or view his/ her own records, open about why asking questions)?

N/A

0   *1*   *2*
_____

Not Present   *Present*   *Appropriately Applied*

Phase 1 Score ☐ **out of**

☐

Phase 2 Adherence Items
In eliciting problem stories, did the therapist:

A

Q4. use the words and terms expressed by the person when discussing the person's problem?

	0	1	2
N/A	_____		
	Not Present	*Present*	*Appropriately Applied*

Q5. engage the person in externalizing and/or non-pathologizing conversations about the problem?

	0	1	2
N/A	_____		
	Not Present	*Present*	*Appropriately Applied*

Q6. assist the person to take a position and/or justify their position in relation to their experience?

	0	1	2
N/A	_____		
	Not Present	*Present*	*Appropriately Applied*

Phase 2 Score ☐ **out of**

☐

Phase 3 Adherence Items

In deconstructing dominant stories, did the therapist:

A

Q7. assist the person to recognise unique outcomes (elements of the story that were inconsistent with the problem stories e.g., omitted, unacknowledged or disregarded elements) or inquire into the person's influence over the problem?

N/A

0	1	2
Not Present	Present	Appropriately Applied

Q8. shift inquiry outcomes across both the details of who, what, where, when and how **(landscape of action),** and emotion and meaning **(landscape of consciousness)**?

N/A

0	1	2
Not Present	Present	Appropriately Applied

Q 9. challenge social norms and/or explore beliefs supporting the problem story?

N/A

0	1	2
Not Present	Present	Appropriately Applied

Phase 3 Score ☐ **out of**

☐

Phase 4 Adherence Items

In assisting the person to embrace their preferred stories, did the therapist:

A

Q10.   link unique outcomes across contexts and time (past present and future)?

0   1   2

N/A   _____

Not Present   *Present*   *Appropriately Applied*

Q11.   employ the written word to (relevant to or emphasising unique outcomes or the preferred story) either during the session or in session preparation?

0   1   2

N/A   _____

Not Present   *Present*   *Appropriately Applied*

Q12.   assist the person to recognize the perspective of significant other person/s in his/ her life or assist the witnessing of the alternative story from others?

0   1   2

N/A   _____

Not Present   *Present*   *Appropriately Applied*

Phase 4 Score ☐ **out of**

☐

Phase 5 Adherence Items

In assisting the person to live enriched stories, did the therapist:

A

Q13. assist the person to recognise new possibilities in relation to his or her life?

	0	1	2
N/A	_____		
	Not Present	*Present*	*Appropriately Applied*

Q14. negotiate with the person ways in which he/she may experiment or practice preferred ways of being or acting (or discuss with the person how he/she has been being or acting in accordance with the preferred story).

	0	1	2
N/A	_____		
	Not Present	*Present*	*Appropriately Applied*

Q15. mark the end of the session/s by some type of occasion such as: session summary or enquiry into session process (e.g., usefulness of the session) **or** did the therapist present the person with a letter/document outlining the progress or achievements of therapy **or** discuss changes/differences that acting in preferred ways have brought about?

	0	1	2
N/A	_____		
	Not Present	*Present*	*Appropriately Applied*

Phase 5 Score ☐ **out of**

☐

Proscribed practice adherence items- Did the therapist:

A

Q16.   label or diagnose the person or focus on the person's deficits?

* *Please note this does not include listening to the person's problem story.*

	2	*0*
N/A	_____	
	Not Present	*Present*

Q17.   focus exclusively on intra-personal phenomena?

*Please note, this does not refer to comments/ enquiry related to the person's
         emotions,

beliefs.

	2	*0*
N/A	_____	
	Not Present	*Present*

Q18.   direct or provide the person with advice concerning problems?

*Please note, this does not refer to negotiating with the person preferred ways of
         being

or acting eg., making tentative suggestions.

	2	*0*
N/A	_____	
	Not Present	*Present*

Proscribed Practice Score ☐ **out of** ☐

A

Information for Research

Therapist
Code……………………………………………………………………...

Client
Code……………………………………………………………………………

Session
Number……………………………………………………………………….

Date of Therapy
Session…………………………………………………………………

Name of
Rater……………………………………………………………………..

Date of
Rating…………………………………………………………………

Type of Tape……………………………………….. Video □…..................Audio □……

Scoring

	Score Achieved	**Possible Score**
Phase 1	□	□
Phase 2	□	□
Phase 3	□	□
Phase 4	□	□
Phase 5	□	□
Proscribed Practices	□	□

452

A

Reference

Vromans, L. *A narrative approach to therapy: Guiding principles and practice.*

Lyn Vromans

School of Psychology and Counselling

Queensland University of Technology

Beams Road, Carseldine, 4034

Queensland, Australia

Email: l.vromans@qut.edu.au

Appendix C

NARRATIVE THERAPY WORKSHOP

Day 1: Saturday

8.30 am	Overview of Day 1 and Day 2
8.35am	Exercise 1: Introductions
8.50am	The Manual
9.00am	Key assumptions of a narrative approach
9.30am	Exercise 2: What makes therapy work? Common Therapeutic metaphors
9.45am	A narrative approach to therapeutic problems and change
10.00am	Exercise 3: Critical differences
10.30am	**Morning Tea (Provided)**
10.45am	Developing a therapeutic relationship
11.00am	Exercise 4: What do you bring to therapy?
11.15am	Exercise 5: Practice and demonstrate curious, respectful questioning
12.00	**Lunch**
12.30pm	Eliciting problem stories
1.00pm	Exercise 6: Practice and demonstrate externalising conversations
2.00pm	**Afternoon Tea (Provided)**
2.15pm	Deconstructing dominant stories
2.45pm	Exercise 7: Moving the conversation across dual landscapes

NARRATIVE THERAPY WORKSHOP

Day 2

8.30am	Review Day 1 and overview of Day 2	
	Deconstructing dominant stories	
	Exercise 7:	Practice and demonstrate deconstructing dominant stories
8.45am	Exercise 8:	Exploring beliefs
9.15am	Embracing preferred stories	
9.30am	Exercise 9:	Preferred Descriptions: Practice and demonstrate developing alternative stories
10.30am	**Morning Tea (Provided)**	
10.45am	Exercise 10:	Video-Guiding Principles of Narrative Practice
11.35am	Exercise 11:	Video Questions
12.0	**Lunch**	
12.30pm	Living enriched stories	
12.45pm	Exercise 12:	Role-play: Practice and demonstrate the phases of a narrative approach
1.45pm	Depression	
2.00pm		
2.15pm	**Afternoon Tea (Provided)**	
	Framework of sessions	
2.30pm	Research Protocols	
4.30pm	Certification/ End Day 2	

Appendix D

RESEARCH INFORMATION (R)

The Process and Outcome of Narrative Therapy in the Treatment of Depression

Lyn Vromans   *3864 4685*   *l.vromans@qut.edu.au*
Ass. Prof. Robert Schweitzer   *3864 4617*   *r.schweitzer@qut.edu.au*
Dr Roger Lowe   *3864 4550*   *r.lowe@qut.edu.au*
Dr Julie Hansen   *3864 4748*   *ja.hansen@qut.edu.au*
        (QUT, Faculty of Health, School of Psychology and Counselling)
Dr Robert King   *33655142*   *robertk@psychiatry.uq.edu*
        (University of Queensland, Department of Psychiatry, Royal Brisbane Hospital)

You are invited to participate in research which seeks to investigate psychotherapy for depression, with particular focus on how therapeutic conversation may be useful in assisting people suffering from depression. The research is being conducted as part of a PhD project at the Queensland University of Technology, Carseldine, and has important implications for refining strategies that will facilitate recovery from depression, and in assisting the development of future programs.

Screening of clients
Client participants will be individuals aged between 18 and 60 years old, with a diagnosis of depression made by the chief investigator, based on structured interview. The use of anti-depressant medication is accepted.

Exclusion criteria will apply where the initial interview and questionnaire assessment indicates: psychosis; selected personality disorders; non-fluent English; active suicidality; substance abuse, or; concurrent psychotherapy for depression. If research criteria are not met and the client wishes to access low-cost psychotherapy, they will be referred to the Queensland University of Technology Psychology Clinic, Carseldine.

Therapist criteria
At a minimum, therapists are required to have a recognized graduate qualification in the field of mental health with one year experience counselling clients.

Your role
Should you consent to participate in the research, you will be requested to participate in weekend narrative therapy training sessions. You will also be requested to rate audio or visual recordings of therapy sessions using integrity scales specific to narrative therapy.

Results
At research completion, an overview of findings will be sent to you on request.

Questions
If you have any questions about this research please contact Lyn Vromans, the chief
investigator on 3864 4685.

Concerns
If you have any concerns about the conduct of this research please contact the Research
Ethics Officer on 3864 2340 or ethicscontact@qut.edu.au.

CONSENT FORM (S/R)

The Process and Outcome of Two Therapeutic Approaches to the Treatment of Depression

Research Team

Lyn Vromans   *3864 4685*   *l.vromans@qut.edu.au*
Ass. Prof. Robert Schweitzer   *3864 4617*   *r.schweitzer@qut.edu.au*
Dr Roger Lowe   *3864 4550*   *r.lowe@qut.edu.au*
Dr Julie Hansen   *3864 4748*   *ja.hansen@qut.edu.au*
(QUT, Faculty of Health, School of Psychology and Counselling)
Dr Robert King   *33655142*   *robertk@psychiatry.uq.edu*
*(*University of Queensland, Department of Psychiatry, Royal Brisbane Hospital)

Name   ....

Address   ………………………………………………………………………

Telephone   …………………………………………………………………………

By signing below, I am indicating that I:
o   have read and understood information provided in the Research Information Sheet;
o   agree to participate in the research project;
o   have had any questions answered to my satisfaction;
o   understand if I have any questions, I can contact Lyn Vromans on 3864 4685;
o   understand that participation is voluntary and I am free to withdraw from the project at any time without reason, comment or penalty;
o   understand I can contact the Research Ethics Officer on 3864 2340 or ethicscontact@qut.edu.au with any concerns on the ethical conduct of the project.

Signature   ………………………………   Date   ……………………

QUT

Faculty of Health
School of Psychology & Counselling

WANT TO LEARN MORE ABOUT THE PRACTICE OF NARRATIVE THERAPY?

Invitation to Participate in a Narrative Therapy Research Study

TWO-DAY WORKSHOPS: 11th & 18th September

Overview of the Study

We are currently undertaking a study to examine the efficacy of a Narrative Therapy approach in assisting people who meet diagnostic criteria for depression. Furthermore, we are interested in the process of change associated with Narrative Therapy and the ways in which participants' sense-of-self changes during the course of therapy. We believe the study is the first of its kind to examine the efficacy of this form of therapy.

What is Narrative Therapy?

Narrative Therapy, from the Latin term *narrare, to tell*, refers to a form of therapy, based on the notion that people construct personal stories by connecting events and attitudes into sequences over time. Therapy enables the development of preferred alternative stories, which are validated through witness or audience validation. Narrative therapy is characterised by a sense of inquiry and telling of personal stories relating to a listener or audience within a context within which the "taken-for granted" life-story might undergo change. This form of therapy is based upon post-structural principles, which emphasise both an empowerment of the individual and an awareness of a "relational" self.

The use of the story in therapy is not new, but has been part of almost all cultures over generations. The key dimensions of the approach involve developing the therapeutic relationship, deconstructing problems stories and their dominant narratives, and; evoking and audiencing preferred stories.

In training therapists in Narrative Therapy, we will also invite therapists to reflect on the stories that they themselves inhabit with a view to sharing what they discover through their own narratives including professionally constructed stories, which impact upon their work with clients.

Therapist Requirements

We would like to invite therapists, who have, as a minimum: (a) a recognised graduate qualification in the field of mental-health; (b) one year graduate experience providing counselling to clients, and; (c) successful completion of the manualised Narrative Therapy training program developed for the research. You will be requested to provide informed written consent to participate in the study and to complete a demographic questionnaire and will need to attend appropriate supervision.

Why participate?

You will be provided with :

- ❑ The equivalent of two days intensive training in Narrative Therapy involving theory, practice and practical exercises.
- ❑ Opportunity for weekly group supervision in Narrative Therapy over the course of research participation.
- ❑ Social interaction with colleagues, who share an interest in Narrative Therapy.
- ❑ Feedback on the overall research findings.
- ❑ Training and supervision will be provided at no cost.

We are keen to invite therapists to participate in a workshop. The workshop builds upon narrative theory together with the broader literature in psychotherapy to provide training in a social constructionist-narrative approach. Training will be held in Room L420 at QUT Carseldine Campus from 9am to 4.30 pm on two consecutive Saturdays.

What is involved?

In addition to the training component, you will be requested to:

- ❑ Undertake the treatment of two clients, who meet the inclusion criteria for the study. Each treatment involves eight fifty-minute sessions of manualised Narrative Therapy.
- ❑ For each client you will be required to videotape selected sessions (equipment is supplied and treatment undertaken within the Queensland University of Technology Psychology Clinic).
- ❑ You and your clients will be required to complete questionnaires. You will be requested to provide the questionnaires to the client at the end of relevant therapy sessions.

Contact

If you are interested in participating in the study, please contact:

Lyn Vromans

Email: l.vromans@qut.edu.au or phone 3864 4685

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Appendix F

RESEARCH INFORMATION (C)

The Process and Outcome of Narrative Therapy in the Treatment of Depression

Lyn Vromans	*3864 4685*	*l.vromans@qut.edu.au*
Ass. Prof. Robert Schweitzer	*3864 4617*	*r.schweitzer@qut.edu.au*
Dr Roger Lowe	*3864 4550*	*r.lowe@qut.edu.au*
Dr Julie Hansen	*3864 4748*	*ja.hansen@qut.edu.au*

(QUT, Faculty of Health, School of Psychology and Counselling)

Dr Robert King   *33655142*   *robertk@psychiatry.uq.edu*

(University of Queensland, Department of Psychiatry, Royal Brisbane Hospital)

You are invited to participate in research which seeks to investigate psychotherapy for depression, with particular focus on how therapeutic conversation may be useful in assisting people suffering from depression. The research is being conducted as part of a PhD project at the Queensland University of Technology, Carseldine, and has important implications for refining strategies that will facilitate recovery from depression, and in assisting the development of future programs.

Screening
Client participants will be individuals aged between 18 and 60 years old, with a diagnosis of Major Depressive Disorder made by the chief investigator, based on structured interview. Use of anti-depressant medication will be accepted, providing use has commenced prior to the previous 12 week period.

Exclusion criteria will apply where the initial interview and questionnaire assessment indicates: (a) psychosis, substance abuse, bipolar disorder, eating disorder; (b) borderline, antisocial or schizotypal personality disorders; (c) non-fluent English; (e) high risk of suicide; (f) depression secondary to a major physical disorder, or (g) concurrent psychotherapy for depression.

If research criteria are not met, and the client wishes to access low-cost psychotherapy, he or she will be referred to the Queensland University of Technology Psychology Clinic, Carseldine.

Your role
If research criteria are met, you will be requested to provide written informed consent to participate in supportive therapy, which is expected to be beneficial in alleviating depression, with no financial cost. You will be assigned to a therapist who has recognised qualifications in mental health and who has been trained in the treatment of depression. Treatment will comprise 8 fifty-minute sessions over approximately 8 to 16 weeks.

You will be asked to complete questionnaires at therapy sessions and at three-months following the end of treatment. Audio or visual recording of selected therapy sessions is a necessary research requirement. Only the members of the research team

responsible for transcription and the therapy adherence rater will have access to recordings, and recordings will be wiped directly after transcription.

Voluntary participation
The success of this research depends on the assistance of volunteers like yourself, and we would be extremely grateful for your participation. However, your participation is entirely voluntary, and can be withdrawn at any time without comment or reason. Should you agree to participate in the study, you are not obliged to answer questions you find disturbing or intrusive.

Confidentiality
All information will remain confidential. Personal contact information and data will be accessible only to the research team and will be stored securely in locked cabinets. Participants' responses and recordings will remain anonymous. This will be achieved by separating participants' contact information from responses and recordings. A code identifier will allow the research team to match responses and recordings over time. Information will be entered into a computer file anonymously and data analysis will be based on overall responses.

Results
At research completion, an overview of findings will be sent to you on request.

Questions
If you have any questions about this research please contact Lyn Vromans, the chief investigator on 3864 4685.

Concerns
If you have any concerns about the conduct of this research please contact the Research Ethics Officer on 3864 2340 or ethicscontact@qut.edu.au.

A

CONSENT FORM (C)

The Process and Outcome of Narrative Therapy in the Treatment of Depression

<u>Research Team</u>
Lyn Vromans   *3864 4685*   *l.vromans@qut.edu.au*
Ass. Prof. Robert Schweitzer *3864 4617*   *r.schweitzer@qut.edu.au*
Dr Roger Lowe   *3864 4550*   *r.lowe@qut.edu.au*
Dr Julie Hansen   *3864 4748*   *ja.hansen@qut.edu.au*
        (QUT, Faculty of Health, School of Psychology and Counselling)
Dr Robert King   *33655142*   *robertk@psychiatry.uq.edu*
        *(*University of Queensland, Department of Psychiatry, Royal Brisbane
Hospital)

Name ....

Address ……………………………………………………………………………

Telephone.…………………………………………………………………………

Email…………………………………………………………………………………

By signing below, I am indicating that I:
   o   have read and understood information provided in the Research Information
       Sheet;
   o   agree to participate in the research project;
   o   agree to permit audio or visual recording of my therapy sessions;
   o   understand that audio and visual recordings will be destroyed after their
       contents have been transcribed;
   o   understand that my personal information and recordings taken during the
       course of the research will remain anonymous;
   o   understand that my personal information and recordings taken during the
       course of the research will be used for the purpose of research only;
   o   have had any questions answered to my satisfaction;
   o   understand if I have any questions, I can contact Lyn Vromans on 3864 4685;
   o   understand that participation is voluntary and I am free to withdraw from the
       project at any time without reason, comment or penalty;
   o   understand I can contact the Research Ethics Officer on 3864 2340 or
       ethicscontact@qut.edu.au with any concerns on the ethical conduct of the
       project.

Signature………………………………   Date……………………………..

Appendix G

Client Characteristics for the Completer Sample

G. 1 Client Demographic Characteristics

Completer clients were 38 adults, who had: (a) responded to media advertisement for volunteers experiencing depression, (b) provided informed written consent to participate in the study, (c) met research criteria, and (d) completed the eight-session narrative intervention, with valid data. Of these individuals, 28.9% (11) were males and 71.1% (27) females. Client age ranged from 22 to 58 years ($M =$ 40.63; $SD =$ 9.44). Table G.1 shows that all clients had achieved secondary education or beyond and the majority were in paid employment or cared for family at home. All clients described themselves as Caucasian.

Table G.1

Client Education and Work Status (n = 38)

Characteristic	Category	N	%
Education Level	Primary Education	00	00
	Secondary Education	14	37
	Trade Qualification	06	16
	Tertiary Qualification	18	47
Work Status	Paid Employment (Full-time or Part-time)	23	61
		00	00
	Student	08	21
	Cares for Family at Home	00	00
	Voluntary Work	04	11
	Unemployed or Seeking Employment	01	03
	Sick Leave or disability pension	02	05

G2 *Client Clinical Characteristics*

Twenty clients (52.6%) were taking antidepressant medication at initial assessment. Most of the clients had experienced prior depressive episodes. Eleven (28.95%) clients reported that they had experienced one to three previous depression episodes and 16 (42.11%) reported that they had experienced four or more previous depression episodes. Only six (15.85%) of the clients reported that they had no previous episodes of depression. Five people did not respond to the question. Table G.2 shows the frequency and proportion of clients' Axis I co-morbidity, as assessed by the MINI-5.0.0 (Sheehan et al., 2000).

Table G.2

Number and Proportion of Clients with Co-morbidity across Axis I Diagnostic Categories

Major Classification	Axis 1 Category	N	%
Mood Disorders	Dysthymia	14	37
Anxiety Disorders	Panic Disorder	17	44
	Agoraphobia	14	37
	Social Phobia	11	29
	Obsessive-Compulsive Disorder	05	13
	Post-Traumatic Stress Disorder	07	18
	Generalized Anxiety Disorder	24	63
Substance Related Disorders	Alcohol Dependence	07	18
	Non-Alcohol Drug Dependence	02	05

Note. n = 38

Table G.3 shows the frequency and proportion of clients' Axis II co-morbidity, as assessed by the SCID-II-IV (First et al., 1997). According to the SCID-II-IV, 22 clients had no personality disorder, 10 clients had 1 personality disorder, 5 clients had 2 personality disorders and 1 client had 4 personality disorders.

Table G.3

Number and Proportion of Clients with Co-morbidity across Axis II Diagnostic Categories

Cluster	Axis II Category	*N*	%
Cluster A Personality Disorders	Paranoid	03	08
	Schizoid	00	00
Cluster B Personality Disorders	Histrionic	00	00
	Narcissistic	01	03
Cluster C Personality Disorders	Avoidant	10	26
	Dependent	02	05
	Obsessive-Compulsive	02	05
	Passive-Aggressive	02	05
	Depressive	05	13

Note. n = 38

Appendix H

RESEARCH INFORMATION (T)

The Process and Outcome of Narrative Therapy in the Treatment of Depression

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Dr Julie Hansen   *3864 4748*   *ja.hansen@qut.edu.au*
          (QUT, Faculty of Health, School of Psychology and Counselling)
Dr Robert King   *33655142*   *robertk@psychiatry.uq.edu*
          (University of Queensland, Department of Psychiatry, Royal Brisbane
           Hospital)

You are invited to participate in research which seeks to investigate psychotherapy for depression, with particular focus on how therapeutic conversation may be useful in assisting people affected by depression. The research is being conducted as part of a PhD project at the Queensland University of Technology, Carseldine, and has important implications for refining strategies that will facilitate recovery from depression, and in assisting the development of future programs.

Screening
Client participants will be individuals aged between 18 and 60 years old, with a diagnosis of Major Depressive Disorder made by the chief investigator, based on structured interview. Use of anti-depressant medication will be accepted, providing use has commenced prior to the previous 12 week period.

Exclusion criteria will apply where the initial interview and questionnaire assessment indicates: (a) psychosis, substance abuse, current manic episode, eating disorder; (b) borderline, antisocial or schizotypal personality disorders; (c) non-fluent English; (d) high risk of suicide; (e) depression secondary to a major physical disorder, or (f) concurrent psychotherapy for depression.

Therapist criteria
At a minimum, therapists are required to have a recognized graduate qualification in the field of mental health with one year experience counselling clients.

Your role
If research criteria are met, you will be asked to provide informed written consent to participate in the study. Should you consent to participate in the research, you will be asked to attend a two-day training course in a manualised narrative approach to the treatment of depression. You will then be requested to implement the approach with two clients affected by depression for 8 (fifty-minute) therapy sessions over 8 to 16 weeks weeks. Weekly group supervision will be provided.

To assist the monitoring of therapy adherence and the collection of research data, you will be asked to make audio or visual recordings of selected therapy sessions and to

give questionnaires to the clients for completion after each therapy session. Only the member of the research team responsible for transcription and the therapy adherence rater will have access to recordings, and recordings will be wiped directly after transcription.

Voluntary participation
The success of this research depends on the assistance of volunteers like yourself, and we would be extremely grateful for your participation. However, your participation is entirely voluntary, and can be withdrawn at any time without comment or reason.

Confidentiality
All information will remain confidential. Personal contact information and data will be accessible only to the research team and will be stored securely in locked cabinets. Participants' responses and recordings will remain anonymous. This will be achieved by separating participants' contact information from responses and recordings. A code identifier, known only to the participant will allow the research team to match responses and recordings over time. Information will be entered into a computer file anonymously and data analysis will be based on overall responses.

Results
At research completion, an overview of findings will be sent to you on request.

Questions
If you have any questions about this research please contact Lyn Vromans, the chief investigator on 3864 4685.

Concerns
If you have any concerns about the conduct of this research please contact the Research Ethics Officer on 3864 2340 or ethicscontact@qut.edu.au.

CONSENT FORM (T)

The Process and Outcome of Narrative Therapy in the Treatment of Depression

Research Team
Lyn Vromans   3864 4685   l.vromans@qut.edu.au
Ass. Prof. Robert Schweitzer 3864 4617   r.schweitzer@qut.edu.au
Dr Roger Lowe   3864 4550   r.lowe@qut.edu.au
Dr Julie Hansen   3864 4748   ja.hansen@qut.edu.au
        (QUT, Faculty of Health, School of Psychology and Counselling)
Dr Robert King   33655142   robertk@psychiatry.uq.edu
        (University of Queensland, Department of Psychiatry, Royal Brisbane
         Hospital)

Name ....

Address …………………………………………………………………………………

Telephone.………………………………………………………………………………

Email…………………………………………………………………………………………

By signing below, I am indicating that I:
  o   have read and understood information provided in the Research Information
      Sheet;
  o   agree to participate in the research project;
  o   agree to permit audio or visual recording of my therapy sessions;
  o   understand that audio and visual recordings will be destroyed after their
      contents have been transcribed;
  o   understand that my personal information and recordings taken during the
      course of the research will remain anonymous;
  o   understand that my personal information and recordings taken during the
      course of the research will be used for the purpose of research only;
  o   have had any questions answered to my satisfaction;
  o   understand if I have any questions, I can contact Lyn Vromans on 3864 4685;
  o   understand that participation is voluntary and I am free to withdraw from the
      project at any time without reason, comment or penalty;
  o   understand I can contact the Research Ethics Officer on 3864 2340 or
      ethicscontact@qut.edu.au with any concerns on the ethical conduct of the
      project.

Signature…………………………………   Date……………………………..

Appendix I

CLIENT DEMOGRAPHIC QUESTIONNAIRE

For the following questions please tick the box which best applies to you.

1.   Age

Years…………………………   Months…………………………..

2.   Gender

☐   *Male*   ☐   *Female*

3.   Is English your first language?

☐   *Yes (Go to Question 5)*   ☐   *No (Go to Question 4)*

4.   If you answered *No* to Question 3, please answer the following question.

How would you rate your English skills ?

☐   *I speak English fluently*

☐   *I have some difficulty understanding and speaking English*

☐   *I have great difficulty understanding and speaking English*

5. Please indicate the highest level of education you have completed.

☐ *Primary education*

☐ *Secondary education*

☐ *Trade qualification*

☐ *Tertiary qualification*

6. How would you describe your current work status ?

☐ *I am currently in paid employment*
(includes full-time or part-time or self-employed)

☐ *I am a student*
(includes full-time or part-time study)

☐ *I currently work at home caring for family*

☐ *I currently do voluntary work*
(includes full-time or part-time)

☐ *I am currently unemployed and seeking employment*

☐ *I am currently unemployed and am not seeking employment*

☐ *I am taking sick leave from my usual self- paid/ voluntary employment*
or study

☐ *Other: Please state…………………………………………………………..*

7. I have been diagnosed as suffering from a psychiatric disorder apart from depression.

☐ *Yes (Go to Question 8)*   ☐ *No (Go to Question 9)*

8. If you answered *Yes* to Question 7, please briefly indicate the nature of the psychiatric disorder or problem.

……………………………………………………………………………

9. I am currently receiving counselling / psychotherapy for my depression or psychiatric problem.

☐ *Yes*   ☐ *No*

10. In addition to depression, I have major medical problems.

☐ *Yes* (Go to Question 11)   ☐ No (Go to Question 12)

11. If you answered *Yes* to Question 10, please very briefly indicate the nature of the medical problems.

……………………………………………………………………………

12. Is this your first episode of depression?

☐ *Yes (*Go to Q. 14*)*   ☐ *No (*Go to Q. 13*)*

13.   Number of previous episodes of depression.

…………………………………………………………………………

14.   Length of current episode.

Years………………………   Months…......................................

Appendix J

THERAPIST DEMOGRAPHIC QUESTIONAIRE

For the following questions please tick the box which best applies to you or write in the space provided.

1. **Age** Years:……………………..   Months:………………………

2. **Gender**

   ☐   *Male*   ☐   *Female*

3. **Mental Health Discipline**.

   ☐   *Counselling*

   ☐   *Psychology*

   ☐   *Social Work*

   ☐   *Nursing*

   ☐   *General Practice*

   ☐   *Other: Please state……………………………………………………..*

4 **Level of Qualification**

   ☐   *Diploma*

   ☐   *Degree*

   ☐   *Masters*

   ☐   *Doctorate/PhD*

4. **Number of years/ months in counselling practice?**

Years:……………………..   Months:………………………

5. **Please state how long you have been using Narrative Therapy.**

Years: …………   Months:………………….

Please respond to the following statements by circling the number that most closely represents your belief.

6. **The philosophy and assumptions underpinning narrative therapy are consistent with my view of the world.**

1	2	3	4	5
Strongly Disagree	*Disagree*	*Neutral*	*Agree*	*Strongly Agree*

7. **Narrative Therapy is consistent with my beliefs about what induces therapeutic change.**

1	2	3	4	5
Strongly Disagree	*Disagree*	*Neutral*	*Agree*	*Strongly Agree*

8. **Narrative Therapy is efficacious in the treatment of depression.**

1	2	3	4	5
Strongly Disagree	*Disagree*	*Neutral*	*Agree*	*Strongly Agree*

9. **I feel confident to implement Narrative Therapy.**

1	2	3	4	5
Strongly Disagree	*Disagree*	*Neutral*	*Agree*	*Strongly Agree*

Appendix K

HEALTH-CARE CONTACT MONITOR

INITIAL ASSESSMENT

For the following questions please tick the box which best applies to you.

1. Have you been prescribed antidepressant medication for your current episode of depression ?

   ☐   *Yes (Go to Question 2)*   ☐   *No (Go to Question5)*

2. Are you currently taking the anti-depressant medication prescribed for your current episode of depression ?

   ☐   *No, I decided to discontinue with the medication (go to Question5)*

   ☐   *No, my doctor recommended that I cease taking the medication for depression previously prescribed (go to Question 5)*

   ☐   *Yes, intermittently (go to Question 3)*

   ☐   *Yes, I follow my doctor's instructions for taking my medication for depression (go to Question 3)*

3. If you answered *Yes* to Q. 2: What is the name of anti-depressant medication/s, prescribed for you, that you are currently taking?

   …………………………………………………………………………

4. How long have you been taking the anti-depressant medication prescribed for your current episode of depression?

    ………………………………………………………………………………………………………

5. Have you received care from other health professionals **in the last year**?

    ☐   *Yes (Go to Question 6)*   ☐   *No (Go to Question 7)*

6. If you answered *yes* to Question 5, please indicate the nature of the health-care contact.

    ☐   *Psychotherapist or counsellor*

    ☐   *Psychiatrist*

    ☐   *General Practitioner*

    ☐   *Hospitalization*

    ☐   *Emergency Hospital Contact*

    ☐   *Other (Please state the nature of the contact……………………..….).*

7. Are you currently receiving counselling or psychotherapy?

    ☐   *Yes*

    ☐   *No*

HEALTH-CARE CONTACT MONITOR

SESSION 8

For the following questions please tick the box which best applies to you.

1. Have you been prescribed antidepressant medication for your current episode of depression?

   ☐ *Yes (Go to Question 2)*   ☐ *No (Go to Question 5)*

2. What is the name of your medication/s?………………………………………

   ……………………………………………………………………………………

3. If you answered *yes* to Question 1, has the antidepressant medication prescribed been **commenced while participating in the research program**?

   ☐ *Yes*   ☐ *No*

4. Are you currently taking the antidepressant medication prescribed for you?

   ☐ *No, I decided to discontinue with the medication*

   ☐ *No, my doctor recommended that I cease taking the medication for depression previously prescribed*

   ☐ *Yes, intermittently*

   ☐ *Yes, I follow my doctor's instructions for taking my medication for depression*

5. Have you received care from other health professionals **while you have been**

    participating in the research program?

    ☐   *Yes (Go to Question 6)*   ☐   *No*

6. If you answered *yes* to Question 5, please indicate the nature of the

    health-care contact.

    ☐   *Psychotherapy in addition to that received as part of the research*

           program

    ☐   *Psychiatrist*

    ☐   *General Practitioner*

    ☐   *Hospitalization*

    ☐   *Emergency Hospital Contact*

    ☐   *Other (Please state the nature of the contact……………………).*

HEALTH-CARE CONTACT MONITOR

FOLLOW-UP

For the following questions please tick the box which best applies to you.

1. Have you been prescribed antidepressant medication for your current episode of depression?

    ☐ *Yes (Go to Question 2)*   ☐ *No (Go to Question 5)*

2. What is the name of your medication/s?…………………………………

    ……………………………………………………………………………

3. If you answered *yes* to Question 1, has the antidepressant medication prescribed been **commenced after completing the research therapy sessions**?

    ☐ *Yes*   ☐ *No*

4. Are you currently taking the antidepressant medication prescribed for you?

    ☐ *No, I decided to discontinue with the medication*

    ☐ *No, my doctor recommended that I cease taking the medication for*

    depression previously prescribed

    ☐ *Yes, intermittently*

    ☐ *Yes, I follow my doctor's instructions for taking my medication for*

    depression

5. Have you received care from other health professionals **since completing the research therapy sessions?**

    ☐   *Yes (Go to Question 6)*   ☐   *No*

6. If you answered *yes* to Question 5, please indicate the nature of the health-care contact.

    ☐   *Psychotherapy in addition to that received as part of the research*

          program

    ☐   *Psychiatrist*

    ☐   *General Practitioner*

    ☐   *Hospitalization*

    ☐   *Emergency Hospital Contact*

    ☐   *Other (Please state the nature of the contact……………………).*

Appendix M

QUT THERAPY PROCESS- OUTCOME STUDY

CODE IDENTIFIER

a. What is the first letter of your mother's first name? ……………………………

b. What is the first letter of your father's first name? ……………………………

c. What is the year of your birth? ……………………………………………

THANK YOU FOR YOUR PARTICIPATION

Appendix N

THERAPIST PACK

1. You will be provided with 8 envelopes for yourself for each client.
2. Each envelope is labelled "LV".
3. Each envelope is marked according to the Session Number (S1-S8).
4. The Session 1 envelope contains a questionnaire for you to complete **directly after** the session.
5. Each envelope contains questionnaires for you to provide to the client to complete **directly after** the session.
6. The questionnaires are generally quite short. However, there is considerable variation in how people rate the difficulty of questionnaires and in how long different people take to complete questionnaires. Please book the room for a little longer so that you can both sit in the room to complete your questionnaires in privacy, in case the person needs to ask any questions about their responses.
7. Since codes are used for both therapists and clients, names should not be used on questionnaires.
8. For Session 1, when you have completed your questionnaire, place it back into the Session 1 envelope. For each session, request that the client places his/her questionnaire into the relevant envelope.
9. Blank video or audiotapes will be provided for taping selected session. The quality of the audio is **very important**; please ensure speech is picked up as clearly as possible.
10. It is important that you tape **Session 1** and **Session 8**. In addition, please tape **one other session** at random. Therefore, in all, there will be **three sessions recorded.**
11. Make sure you label the tape/s with:
    a. your code identifier
    b. request that the client places his/her code identifier on the tape
    c. date
    d. session number/s recorded (e.g., Session 1; Session 4; Session 8)
12. After the last session has been recorded, tapes should be placed in the Session 8 envelope with the therapist and client questionnaires.
13. Please put **sealed** envelopes in the box allocated for research in the Psychology Clinic, Carseldine, directly after each session.
    Otherwise, please return the envelopes to:
    >Lyn Vromans
    >Room L402
    >School of Psychology and Counselling
    >QUT
    >Beams Road
    >Carseldine 4034
14. If there are any queries or concerns, please contact Lyn Vromans on 3864 4685 or 3864 4925 or email l.vromans@qut.edu.au

THERAPIST PACK

Session 1
      Therapist code identifier
      WAI (Therapist version)
      N-TAS
      Tape
SESSION 2
      Therapist code identifier
      WAI (Therapist version)
SESSION 3
      Therapist code identifier
      WAI (Therapist version)
      N-TAS
      Tape
SESSION 4
      Therapist code identifier
      WAI (Therapist version)
SESSION 5
      Therapist code identifier
      WAI (Therapist version)
SESSION 6
      Therapist code identifier
      WAI (Therapist version)
SESSION 7
      Therapist code identifier
      WAI (Therapist version)
SESSION 8
      Therapist code identifier
      WAI (Therapist version)
      N-TAS
      Tape
FOLLOW-UP
      Therapist code identifier
      WAI (Therapist version)

CLIENT PACK

SESSION 1
      Client code identifier
      WAI: Client version
      DASS: Depression subscale
      STS
      Inventory of Interpersonal Problems-32
      Dysfunctional Attitude Scale
SESSION 2
      Client code identifier
      WAI: Client version
      DASS: Depression subscale
      STS
      Inventory of Interpersonal Problems-32
      Dysfunctional Attitude Scale
SESSION 3
      Client code identifier
      WAI: Client version
      DASS: Depression subscale
      STS
      Inventory of Interpersonal Problems-32
      Dysfunctional Attitude Scale
SESSION 4
      Client code identifier
      WAI: Client version
      DASS: Depression subscale
      STS
      Inventory of Interpersonal Problems-32
      Dysfunctional Attitude Scale
SESSION 5
      Client code identifier
      WAI: Client version
      DASS: Depression subscale
      STS
      Inventory of Interpersonal Problems-32
      Dysfunctional Attitude Scale
SESSION 6
      Client code identifier
      WAI: Client version
      DASS: Depression subscale
      STS
      Inventory of Interpersonal Problems-32
      Dysfunctional Attitude Scale
SESSION 7
      Client code identifier
      WAI: Client version
      DASS: Depression subscale
      STS

       Inventory of Interpersonal Problems-32
       Dysfunctional Attitude Scale

SESSION 8
       Client code identifier
       WAI: Client version
       DASS: Depression subscale
       STS
       Session 8 Health-Care Questionnaire
       Beck Depression Inventory
       Inventory of Interpersonal Problems-32
       Dysfunctional Attitude Scale

*THREE-MONTH FOLLOW-UP
       Client code identifier
       WAI: client version
       DASS-Depression subscale
       STS
       Follow-up Health care contact questionnaire
       BDI
       IIP
       DAS

*Please note: The follow-up questionnaire will be sent by the chief investigator three months after the end of therapy

Table 2.
Assessment Points: Application of Research Instruments

Instrument	TA	CA	S1	S2	S3	S4	S5	S6	S7	S8	FU
Therapist											
Code Identifier	■	■	■	■	■	■	■	■	■	■	■
TDQ	■										
WAI (T)			■	■	■	■	■	■	■	■	
N-TAS			■		■					■	
Client											
Code Identifier		■	■	■	■	■	■	■	■	■	■
CDQ		■									
MINI		■									
PDQ-4		■									
SCID-II		■									
Health-Care Q		■								■	■
BDI		■								■	■
IIP-S		■	■	■	■	■	■	■	■	■	■
DASS-D		■	■	■	■	■	■	■	■	■	■
WAI-S (C)			■	■	■	■	■	■	■	■	■
STS			■	■	■	■	■	■	■	■	■
DAS		■	■	■	■	■	■	■	■	■	■
Rater											
N-TAS			■		■					■	
CTS			■		■					■	
NPCS			■		■					■	

Note. TA=Therapist Initial Assessment; CA=Client Initial Assessment; S1=Session 1; S2=Session2; S3=Session 3; S4=Session 4; S5=Session 5; S6=Session 6; S7=Session 7; S8=Session 8; FU=Follow-up.