A Narrative Approach to Adolescent Depression

By
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A practicum presented to the
Faculty of Graduate Studies
in partial fulfillment of the requirements
for the degree of

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Abstract

The narrative approach to therapy derives from a postmodern theory which emphasizes the unique experiences of individuals. Taken together, postmodernism and narration are powerful metaphors that create a worldview in which the therapist is enabled to focus on the unique personal experiences of individuals, and their abilities to create their own realties. The goal of this practicum was to acquire knowledge and skills in the practice of narrative therapy with individual adolescents who were experiencing issues related to depression.

The practicum was based out of a southern Manitoba counselling center for children, adolescents and families. Sessions were conducted with 5 clients over an 18-week period. This report includes literature reviews on narrative therapy, adolescent cognitive development, and adolescent depression. In addition the report also includes the structures of drama as they relate to narrative examination. The forementioned precedes a description of methodology, findings and conclusions. Included in this discussion are the methods of evaluation used, including The Beck Depression Inventory (1979), some transcribed segments, and the results of a questionnaire. The qualitative methods of evaluation provided the framework for the presentation of client themes, the evaluation of both student practice and learning, and client progress.

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Table of Contents

Chapter 1

Introduction

Educational Objectives

It must be noted that regarding narrative therapy and adolescent depression, a literature review yielded no articles or studies that dealt specifically with the fore mentioned issue. It is this lack of research regarding the efficacy of narrative therapy and adolescent depression that had led to the student's practicum focus.

The objectives in undertaking this practicum were: (a) to use White and Epston's (1990) narrative approach as the foundation of the practicum's clinical practice, (b) to examine adolescent depression under the narrative lens of observation, (c) to focus upon my clinical skill development and become both proficient and competent in the use of narrative therapeutic methods of practice and (d) to demonstrate the appropriateness of the narrative approach regarding individual therapy that revolves around issues of adolescent depression. Along with White and Epston's (1990) approach, it was also my intent to examine client narratives under the lens of the structures of drama. According to David Mamet (1998) our understanding of our life can be nothing more than understanding our personal drama. Adding to this, Joseph Campbell (1949) sees our personal myths as being the projection of a culture's symbols onto our own lives. Regarding the myth of the hero's journey, Campbell (1949) states that our narratives have a direct relevance to our lives. Such examination into our personal myths is

recognized as the gateway to the acquisition of a fully realized existence. It is my hope that examining narratives under these two lenses of dramatic structure and cultural myths will bring both a greater depth of understanding to both myself and the client and also a greater respect for the client's personal narrative.

It was anticipated that the practicum findings would demonstrate that narrative therapy is an appropriate therapeutic approach for adolescents who are experiencing depression. It was hoped that providing a competent service would result in each participant acquiring the belief that they had the power to change their own experience of themselves. Through this change it was hoped that each individual would be able to re-author a more empowering personal narrative by which they could live their lives. Finally it was hoped that the therapist would gain a greater understanding of the effects of language, conversation and story on our individual lives.

Evaluation was based on a qualitative analysis of session notes, the Beck Depression Inventory and a qualitative questionnaire. The components of evaluation examined the progression of participant themes, metaphors and symbols as they pertained to each individual's own unique story.

Adolescent Depression

The clinical literature, over the past number of years, has shown an increased attention to adolescent depression. This attention concerning the mounting evidence of depression among high school adolescents has been generated primarily by the education and mental health communities (Byrne and Baron 1993). According to Ehrenberg and Cox (1990) the importance of

such an investigation of adolescent depression is emphasized by the known association between depression and suicide. Additionally, Ehrenberg and Cox (1990) point out studies done by Klagsbrun (1981) that revealed statistics indicating that suicide rates are increasing at a faster rate for adolescents than for any other age group.

Byrne and Baron (1993) cite a study done by Reynolds (1990) that estimated the number of adolescents in a school setting exhibiting a clinical level of depressive symptoms could range from 6% to 12%. Adding to this, Standard (2000) cites a study by Shaffer, Gould, Fisher, Trautment, Moreau, Kleinman, and Flory (1996) that estimated the incidence of depression regarding youth from ages 9-17 as being in the range of 5%. Standard (2000) points out that this research demonstrated that of the 5% of adolescents who experience depression, very few are actually treated. Here in Canada a study by Ehrenberg, and Koopman (1990) examined the prevalence of depression in a sample of 366 Canadian high school students, using the Beck Depression Inventory. The results of the study found that of the 366 students, one third or 31.7% of the sample were mildly to clinically depressed.

Regarding American statistics of adolescent depression, Standard (2000) cites an American Center for Disease Control report that showed that from 1980-1997 the rate of depression related suicides among 15-19 year old adolescents increased by 11%. Regarding those aged 10-14, depression related suicides increased by 109%. Additionally the CDC's statistics showed that suicide was responsible for more deaths in youth aged 15-19 than any

disease. When we consider these fore mentioned statistics it becomes clear that depression plays a major role in adolescent life. Left untreated, adolescent depression has severe negative consequences.

Studies by Rao et al. (1995) and Weissman et al. (1999) and Standard (2000) point out that the presence of adolescent depression predicts continued risks into adulthood. According to Standard (2000) adolescents will be more likely to experience stressful life events as they progress into young adulthood. Furthermore depressed adolescents are also at higher risk for developing an increased vulnerability to illness, the development of interpersonal and psychosocial difficulties and the development of substance abuse problems (Standard 2000). Ehrenberg and Cox (1990) cite a study by Winokur (1976) which suggested that many depressed adults reported developing depressive symptoms during their adolescence. Keeping the above in mind it becomes essential that adolescents who endure a state of depression are provided the appropriate resources to address their current experiences. Treatment then becomes essential in that, if left unchecked, the depression may result in far reaching effects on the functioning and adjustment of the adolescent. Standard (2000) suggests that the accurate and early diagnosis and treatment of depression in adolescents is essential for prevention of impaired academic, social, emotional, and behavioral functioning, as well as suicide, and depression and suicide as an adult.

Regarding the themes associated with adolescent depression, a review of the literature by Samaan (2000) yielded issues such as a lack of parental nurturance, inconsistent parental discipline, maternal psychological distress,

and negative coping strategies. A study of adolescents by Bennett and Bates (1995) found that poor social support correlated with concurrent and prospective depressive symptoms among the adolescents who were studied. Brage and Meredith (1994) found that themes of loneliness and self-esteem had a direct relationship to adolescent depression.

Although there has been evidence that specific treatments for adolescents such as cognitive behavioral therapies have been successful (Harrington and Whittaker, 1998) they have, for the most part, followed in the traditional vein of therapeutic approaches. Traditional therapeutic approaches have been historically based upon the notion that the location of the problem (pathology) originates within the individual. Likewise, traditional family therapeutic models have generally located problems within the family system as a whole. According to Guterman (1998) the focus of traditional disciplines of family therapy are analyzed under an objective measure of reality. To Guterman (1998) the assumption that the social system is the locus of the problem results in the individual system being pathologized. Traditional forms of therapy which pathologize individuals are incongruent with the professional ethics of social work. This is because social workers have a tendency to view health as a result of the intricate interaction between the person and his/her environment (Germain 1991).

In response to the traditional modernist approach, the postmodernist and social constructionist viewpoints conceptualize the locus of the problem in terms of socially constructed language determined systems, rather than objectively defined social systems (Guterman 1994). To Guterman (1994),

under a postmodern and social constructionist lens, there are no problems in the world that are independent of language. According to Gergen (1991), modernist views of an objective truth have given way to the development of therapies based on alternative points of view. One of the postmodern and social constructionist therapies that have been gaining much attention in the last number of years is narrative therapy. Although there are many different approaches to narrative therapy, the most prominent form is White and Epston's (1990) approach. The philosophical roots of White and Epston's (1990) narrative therapy lay within both postmodern and social constructionist concepts. The cornerstone of narrative therapy suggests that human problems are manufactured in social contexts rather than embodied inside human beings themselves. This viewpoint enables clients to experience liberation on a very individual level (O'Hanlon 1994). It is because of this stance that narrative therapy has provided therapists with a fundamentally new direction that is distinct from traditional approaches (Semmler, and Williams 2000). According to O'Hanlon (1994) narrative therapy addresses the power of cultural systems in shaping both people's lives and the power engendered when clients free themselves from cultural constraints on self-definition.

Semmler and Williams (2000) suggest that social forces such as racism and sexism, when internalized, present potential barriers to the individual's reality. They point out that this is true not only for people of color but also for white clients, where by the identities of white clients are also profoundly influenced by the cultural prescriptions of racial superiority and

inferiority. Furthermore, to Semmler and Williams (2000) it is important to understand the client's greater social and cultural context that has impacted on their development.

Narrative Therapy and Social Work

Although traditional psychotherapy has become a prominent feature in the treatment of depression it has nonetheless garnered much criticism. Some of the main criticisms have come from post modernists, social constructionists, and narrative theorists. In their alternate views, a significant common denominator among the traditional psychotherapies is that the locus of psychological problems lie within the individual. According to Lydon (1995) traditional psychotherapy places the causative factors of depression onto the individual. To Lydon (1995) it is the individual's own cognitive processes that result in the development, maintenance and re-mediation of psychological difficulties. According to D'Andera (2000) due to overemphasis on the client's internal pathology, therapists end up directing little or no energy towards altering those environmental conditions that adversely impact the client's psychological health. Lydon (1995), D'Andrea (2000), and Russell (1999) state that the potential drawback of such an approach is the risk of the therapist losing sight of the role that the social and contextual variables play in various forms of psychological disturbances. According to Russell (1999), individual deficit focused counseling propagates specific and individualist notions of selfhood. Giving full attention to internal processes results in decreased attention being given to the external context (Russell 1999). Another strong criticism comes from multi-culturalist based

therapy. According to D'Andrea (2000) while many counseling practices may be appropriate for individuals who come from white Euro – American backgrounds, they often conflict with the way that non-Western clients frequently think about their mental health. Individuals of Asian, Hispanic, African, and Aboriginal backgrounds construct very different ideas about mental health. To D'Andrea (2000) these culturally constructed ideas typically place greater value on: (1) promoting the collective well-being of the primary group with which one identifies rather than focusing on one's own self-actualization, (2) developing and maintaining long term, intimate and interdependent relationships with members of their group, and (3) intentionally making an effort to avoid interpersonal conflicts.

Narrative therapy, and its emphasis on the greater social and cultural context under which an individual develops, can be an important element in understanding adolescent depression. The research literature regarding adolescent depression has shown that socioeconomic and ethnic factors play important roles in mental health. According to a study by Goodman (1999) socioeconomic factors have a meaningful association with the health of adolescents. Furthermore, a review of the literature by Samaan (2000) had demonstrated that poverty and economic hardship are associated with higher rates of depression. Samaan (2000) reports that the literature demonstrates that children and adolescents from poorer families are more likely to have psychological problems as compared to more prosperous children and adolescents. Regarding ethnicity and socioeconomic status, a study by Cuellar and Robert (1997) demonstrated that socioeconomic status and

ethnicity were found to have a direct affect on mental health status. According to Goodman (2000) it is crucial to consider the social context and patterning of the lives of adolescents in order to clearly understand health and disease etiology. Regarding adolescent depression, this entails the examination of the individual's social and family environments, and socio-structural environments (Goodman 2000).

Regarding gender, narrative therapy and its focus on social and cultural contexts, provides a unique way of understanding issues revolving around sex. Feminist and multicultural theorists argue that the contextual influences of discrimination, oppression and poverty must be included in any understanding of the experience of women, minorities and other marginalized groups (Semmler and Williams 2000, Lyddon 1995, Sands 1998, Neimeyer 1998, and D'Andrea 2000). This is because women and minorities occupy a disproportionately low economic, social and political position in the dominant culture. As Lyddon (1995) points out, most traditional therapies make no distinction between male and female experience and tend to minimize the influence of race, ethnicity and culture on the development of personal forms of belief. Regarding gender differences and depression among adolescents, studies by Brage and Meredith (1994) and Cuellar and Roberts (1997) demonstrated that gender was significantly related to depression. According to Brage and Meredith's (1994) study, gender was significantly related to adolescent depression through self-esteem. It was surmised that adolescent girls manifest depressive symptoms and low self-esteem more frequently than boys because of the stressors inherent in the female sex role.

Furthermore, Standard (2000) states that gender differences must be taken into consideration in both diagnosis and treatment of adolescent depression. Narrative therapy, in regards to mental health issues, addresses all of the above contextual issues regarding power, status and its subsequent affect on gender.

Narrative therapy, as a practice, is a good fit with the profession of social work. Narrative therapy's emphasis on the social and cultural contexts of our lives creates the conditions whereby the therapist is able to depersonalize and separate the problem focused pathology from the individual. Taken together the narrative approach and its counterparts of postmodernism and social constructionism encourages individuals to empower themselves by finding strength and meaning in their unique personal narratives. These mentioned values blend well with the values that are held throughout our social work community. It is the emphasis on these values that has lead me to choose narrative therapy as the focus of my practicum.

Chapter 2

Literature Review

Narrative therapy is a counseling approach that has gained a significant degree of attention in the last 10 years. Although there are several different approaches to narrative therapy, Michael White's (1990) approach is by far the most prominent. This narrative approach is closely related to the theories of social constructionism and postmodern worldviews. As a therapeutic approach, narrative therapy moves beyond the conventional and traditional psychotherapeutic approaches that are common in today's world. Narrative therapy can be thought of as an alternate therapeutic attitude that adopts a non-expert therapeutic stance (Walsh 1998). In its nature, narrative therapy has much in common with anthropological and journalistic approaches (Walsh 1998). Narrative therapy begins with the assumption that therapists are no longer seen as the experts but are seen as collaborators. Under narrative therapy, it is the job of the therapist to ask questions that facilitate the knowledge and experience that are carried in the personal stories. Behavior, under this approach, moves beyond the medical model of problem location. To the narrative approach, problems are seen as elements of an individual's dominant story. According to Neimeyer (1998) of all postmodern trends in counseling theory, narrative may be the most self-conscious in adopting a discursive framework for intervention.

The Postmodern Worldview

Postmodernism started as a criticism of the modernist movement and its ideals. According to Neimeyer (1998) modernism when applied to the human sciences, embodies the enlightenment faith in technological and human progress through the accumulation of legitimate knowledge. Taking this perspective, traditional psychology has historically concerned itself with the development of logical and empirical methods for discovering objective verifiable truths about human behavior. Neimeyer (1998) states that such a research approach has presumed to be increasingly unified and progressive, leading to the discovery of generalizable laws of human behavior, whose validity was established by their correspondence with observable realities.

According to Schneider (1998) postmodernism is the break down of our pre-modern (e.g. religious) and modern (e.g. scientific methodology) institutions, our relinquishment of absolute truths, and our recognition of socially constructed realities. To D'Andrea (2000) postmodernism reflects the potential to transform and liberate individuals from both the way they have historically constructed meaning about their lives and the world in which they live. To him, the transformational potential of postmodernism is rooted in the way it challenges individuals to critically assess the underlying assumptions that comprise many of the taken for granted "truths" which they have accepted about the world in which they live. According to Freedman and Combs (1996) postmodernists are concerned with specific contextualized details, that correspond to differences of meaning rather than the grand narrative, similarity, and facts or rules. Adding to this D'Andrea (2000)

states that postmodernism teaches us to accept the legitimacy of multiple perspectives and to reject the notion of universal organizing categories, traditional concepts of progress, and abstractions such as "universal truths". To D'Andrea (2000) adopting this approach follows the same path modernism was fashioned under as it had shown us how we ought not to blindly have faith in religious or supernatural imperatives that characterized the pre-modern era. Postmodern approaches are grounded in what is called "relativistic thinking". This classification arises because of postmodernism's attention to the multiple interpretations of reality. According to D'Andrea (2000) this is the sort of thinking that liberates individuals from the narrow epistemologies that are characteristic of the pre-modern and modern eras. Furthermore Smith (1994) states that a postmodern stance is one of "radical relativism" that rejects both the claims of science as a privileged ideal and the conception that truth is an approachable ideal.

Postmodernism and its emphasis on the relative nature of knowledge can then be thought of as a system that encourages us to examine how we have to come to understand the essential truths of ourselves and the world we live in. D'Andrea (2000) states that postmodernism's understanding of knowledge and truth as relative constructs are heavily impacted by the historical period and cultural context of which one is a part, aid individuals to liberate themselves from the egocentric and ethnocentric tendencies that have historically characterized human history.

Postmodernism and Social Work

Pennel and Ristock (1999) point out that the postmodern approach to social work is crucial in an era when schools of social work in the United States and Canada have been criticized for failing to incorporate multiple perspectives, particularly those from marginalized groups.

Citing postmodern thought in several disciplines, Gorman (1993) suggests that the embrace of narrative as a method of inquiry and as a transformational tool has the potential to bring social work's practice, research, and social action aspects into harmony. In addition Gorman (1993) states that by devaluing narrative as a method of understanding and change, the scientific ethos in social work has repressed a powerful mechanism of societal consciousness-raising and change. Regarding the traditional scientific/medical view of knowledge Pozatec (1994) states that the problem of certainty in social work is linked to a theoretical worldview that is firmly grounded in a modernist perspective, which favors an objective view of reality based on truths that are knowable, measurable, and predictable. This worldview has heavily impacted our Western intellectual traditions. It believed that the result of these processes of objectification and abstraction that are required to turn social work into a science have violated social work's philosophical belief in the uniqueness of individuals and have devalued what social work practitioners do (Gorman 1993, Prozatek 1994). In contrast the postmodern worldview has the ability to bring other ideas that may hold significance for social work. To Prozatec (1994) although these

ideas have not yet been expounded to a great extent in the social work literature, the influence of postmodernism is being felt in the clinical arena.

Gorman (1993), Prozatek (1994), and Murphy and Parkeck (1994) suggest that social work should consider models of helping that are based on postmodern approaches to clinical work. Adding to this belief, Hartman (1991) suggests that the philosophy of postmodernism has important implications for the profession of social work. One way to accomplish such an approach is for clinicians to take narrative therapy's suggested position of "uncertainty" in clinical settings. The acknowledgment of uncertainty is an essential element of the postmodern practice of social work. Prozatek (1994) and Murphy and Parkeck (1994) believe that the social worker needs to hold open a space in his or her mind for uncertainty and therefore can question how his or her subjective cultural experience may be privileging some aspects of the client's story and marginalizing or disqualifying others (Murphy and Parkeck (1994), Prozatek 1994). Keeping this in mind it then becomes important for the social worker to question how the client's array of cultural experiences influence our interaction with him or her and also how we can access culture and experience in a way that enhances the clinical relationship (Murphy and Parkeck 1994)

Postmodern thinking benefits the practice of social work in other ways. One of the additional benefits that postmodernism holds for the practice of social work is its questioning of the traditional ways of understanding how we know what we know, and how we know who we are. According to Prozatek (1994) postmodernism forces social workers to take into account the context

of relationships, especially those with our clients. To her, they (social workers) can no longer assume that their sense of the context will be the same as the client's experience of context. Social workers cannot assume that what they say will be taken in by the client as a "mirror-like reflection of reality" (Gergen, 1991, p. 119). Words are taken in by clients and processed according to how they have constructed the reality embodied in the interaction. It is essential for practitioners to be aware of this phenomenon, and to socially construct, through the development of a narrative dialogue with the client, a shared reality that they agree is a representation of their interaction.

An essential aspect of postmodern clinical social work is to recognize and explore a client's expressions of experience. This is because the meaning that those experiences embody can become more available to the clients. It is believed that some experiences are inchoate, in that we simply do not understand what we are experiencing, either because the experiences are not storyable, because we lack the performative and narrative resources, or because the vocabulary is lacking" (Bruner, 1986, p. 7). Clinical social workers can be truly helpful to their clients by facilitating their naming of an experience. Giving voice to something previously unacknowledged can be incredibly empowering for clients. Providing an opportunity for this new awareness to happen can be a transformative moment for both client and worker.

Culture and Meaning Making

Regarding the clinical arena Murphy and Parkeck (1994) demonstrate that postmodernism is important to social work practice in that it forces us to examine culture and its central place in making meaning from a new perspective. Although attention to issues of culture and meaning has always been a part of social work, holding a position of uncertainty represents a more respectful approach to cultural difference.

The post-modern worldview's emphasis on culture allows for an awareness of the many layers of culture--global, hemispheric, national, racial, ethnic, religious, political, gender, economic, local, and subjective arenas is essential to the profession of social work (Prozatek 1994). Through the postmodern lens culture is an awareness of our own subjective experience of the world. It is because of this awareness that our own subjective and cultural experience and that of our clients must be accorded privileged status as we interact with our clients (Prozatek 1994).

Another important aspect of postmodern social work is an appreciation of power and the many, often subtle, ways its force can be both exerted and experienced in the clinical domain. Examples of forms of power that can oppress and marginalize clients include the ability of social workers to disseminate information throughout a system and to initiate and maintain a pathologizing discourse, as well as the ways that clients make choices to concede their power to others (Guterman 1996). These forms of power frequently go unacknowledged in the clinical setting, as do many other forms

of institutionalized power. Understanding this opens up the social worker to a greater appreciation of the complexity of each client's life.

Another essential benefit of a postmodern approach to social work is that it enables the worker to recognize and explore a client's expression of experience. This is because the meaning that those experiences embody can often become more available to them (Prozatek 1994). Prozatek (1994) believes that social workers can only be helpful to their clients when they both facilitate the naming of an experience and also give voice to something previously unacknowledged.

In summary, it is essential that social workers explore the uses of narrative as a method of inquiry to document their efforts to promote individual and societal transformation. A narrative-interpretive approach to inquiry addresses the split between practitioner and researcher by embracing the humanistic philosophical assumptions that guide social work practice.

Postmodernism and the Therapeutic Relationship

Postmodernism's approach to knowledge greatly influences the therapeutic relationship. It is a common understanding in our world that, in the therapeutic relationship, the therapist is taken as the expert. Postmodernists see therapists who follow conventional or traditional counseling methods as using their skills to "fix" inherently damaged individuals. Taking this view, traditional counseling methods identify the individual who is in need of repair as not having the necessary skills to bring about the desired changes. Postmodernists (Walsh 1998) see this form of therapeutic relationship to be disempowering for the client. The occurrence of

this mismatch of power in the therapeutic relationship results in the client being forced to embrace the therapist's values and belief system. Regarding the power imbalance that exists in traditional therapeutic relationships, Walsh (1998) uses the example of how clients are labeled as resistive or uncooperative when not meeting the therapist's agenda. Postmodernists refer to this as "Therapeutic Violence" (Walsh 1998).

In summary then, the ideology of postmodernism suggests that: (a) there are no absolute truths, (b) the knowledge and beliefs that individuals have come to think of as truths about life are in actuality intellectual and cultural constructions of the world, (c) realities are constituted through language, (d) realities are organized by culture and (e) there are no essential truths (Gergen 1985, Freedman and Combs 1996).

Social Constructionism

There are several different approaches of postmodernism that have been applied to counseling. While these approaches have in common the belief that human beings actively participate in the construction of reality (Franklin 1998), social constructionism is the specific approach of postmodernism to which narrative therapy is most closely related. In the professional literature, constructionism and social constructionism are terms that are used to describe the human need to actively create, construct meaning and give intellectual significance to one's individual life experiences (D'Andrea 1998). According to Neimeyer (1998) social constructionism is a sharp contrast to the modern worldview. To him, social constructionism endorses a form of postmodernism that transcends the faith in an objectively

knowable universe. According to Laird (1995) social constructionism stresses the inter-subjectivity of knowledge. Therefore, according to Guterman (1994) social constructionists locate knowledge in the context of social groups that include cultural, political, religious, and intellectual communities. According to Atkinson (1991) the legitimization of knowledge requires the judgment of an entire community of observers. He goes on to state that this "legitimization" is a democratic process in which all stakeholders have an equal input.

Kenneth Gergen (1999) proposes four basic assumptions of social contructionism. The first assumption is based on the notion that there are multiple ways to interpret reality. To Gergen (1999) using a social constructionist approach we are then in the position to move past our mainstream realities and thus position ourselves to examine all possible categories of understanding. To Gergen (1999), this process of the acceptance of multiple realities enriches our perspectives. Gergen's second assumption of social constructionism is based on the notion that reality as we know it has been socially constructed. Along with Laird (1995) Gergen (1999) proposes that the social agents of community construct meaning and knowledge. Individuals do not generate meaning by themselves. Freedman and Combs (1996) state that the "psychological fabric of reality" which includes laws, social customs and proper ways of dress and diet arise through social interaction that a person experiences over their lifetime. Gergen's third notion of social constructionism is based upon the idea that our futures are generated by the way we interpret and describe them. To

Gergen (1999) language is a major ingredient of our world of action. To him, language (the way we describe phenomena) constitutes the whole of social life. Additionally Gergen (1999) also offers constructionism as being an invitation to transform social life and create new futures. To him, the development of new forms of language, ways of interpreting the world and patterns of representation will result in challenging the existing traditions of understanding and in turn offer new possibilities for action. Gergen's fourth assumption is based on the notion that refection on our forms of understanding is vital to our traditions. Gergen (1999) states that the dual tasks of maintaining traditions and developing alternate meanings is not an easy balance to maintain. To him, in a world with multiple possibilities there are no universal answers and, therefore, critical reflection is necessary to maintain this balance (Gergen 1999). Gergen's four assumptions lay the essential groundwork for understanding the implications of dialogue and narration in narrative therapy.

Language and the Self

According to Neimeyer (1998) language can be understood as the shifting symbolic order that structures our relationship to reality, as well as to ourselves. Additionally Neimeyer (1999) sees the self as losing its familiar personalism, stability and integrity in a constructionalist account, in part because it is itself shaped by the very linguistic operation that bring into being the social world. According to social constructionism, it is through language that people are able to negotiate new meaning and truth. To Freedmen and Combs (1996) this process of negotiating new meanings

opens up the self to experience itself under a new set of truths. Neimeyer (1998), discusses the two traditional views of formal and informal theories of language as being: (a) the idea that language represents an abstract structure of linguistic signs and grammatical rules that members of a culture learn to refer to, and (b) the notion that public language expresses personal feelings and thoughts resident within the individual. Social constructionalists reject both these theories and instead view language as a network of signifiers whose relationships to the things they signify are essentially arbitrary, rather than fixed and obvious. Neimeyer (1998) believes that from this perspective different language communities can carve up the world in markedly different ways. Furthermore Neimeyer (1998) cites an example by Lutz (1982) which points out that although to Indo-European languages emotions are something real that correspond to specifiable internal states, there are some languages that have no word that can be translated as emotion. Language can then be seen as a paintbrush that has the capacity to create different discriminations that can configure the world of experience differently. To Freedman and Combs (1996) and Gergen (1999) social constructionism presents ideas on how to challenge knowledge, power and negotiate truth. Furthermore Freedman and Combs point out that knowledge is communal and that language is the interactive process through which it is shared. Through a social constructionist lens, the meanings of things remain open, contested, and sites of significant conflict between participants in the same linguistic community (Neimeyer 1999).

Self and Identity

Kenneth Gergen (1999) sees the individual self as being negotiated and defined within the process of relationships. To him the moment in which a person is given a name and is assigned a gender the individual's existence begins to figure in a communal source of knowledge. In other words, once a person talks about "himself", his "thoughts", "feelings" or "beliefs", so does the individual create the reality of "himself" (Gergen 1999). Furthermore once we call this individual by his name, or treat him in various ways, so too is his reality solidified (Gergen 1999).

According to Neimeyer (1998) if we take seriously the social constructionalist assumption that we have no direct access to extralinguistic reality, it then follows that we also have no unmediated recourse to a "real" self beyond the language operations that appear to give it substance. According to social construction theorists, the modern era gave rise to the notion of an independent, individualistic, stable and knowable self as a product of the modern era (Gergen 1999; Freedman and Combs 1996; Neimeyer 1998). The result of this was the generation of the perspective that people are distinct and autonomous agents capable of self-determination. To Neimeyer (1998) this modern view of the self is both overly idealized and insufficiently contextual. To him, the modern view of the self fails in its assumption that people innately possess a consistent set of traits, motives, needs, attitudes and competencies. In contrast to this view of self, social constructionists take the perspective of the self as being deeply penetrated

by the language of one's environment (Freedman and Combs 1996; Gergen 1999; Neimeyer 1998).

According to Curtis (1991) the conception of personality as being socially constructed opens up the possibility of gaining a more relational view of selfhood. Taking this view leads to the notion of identity as being constituted by the living web of connections we create and sustain with the people, and the environment in which we live. Knowledge is then communal and language is the interactive process through which we share this knowledge (Freedman and Combs 1996, Gergen 1985).

Language and Power

To social constructionists power is related to knowledge. Michael White and David Epston (1990) take the position that knowledge is political. Social constructionists by nature of their position frequently analyze the way in which language is structured into different discourses, or systems of narratives that as a result produce a unique version of truth. By way of illustration Neimeyer (1998) points out the discourse of gender. Women have historically been portrayed as more nurturing and emotional, while men have been historically defined as being more achievement oriented and rational. Neimeyer (1998) states that it is these discourses about gender that has legitimated the allocation of low paying care taking and service oriented positions to women, while men are given more direct access to higher status jobs in business and government. To Freedman and Combs (1996), Gergen (1999), and Neimeyer (1998), these prevailing discourses cannot be ignored or redefined without first challenging the existing

institutions and social organizations. Power viewed in this frame is not so much the property of persons, groups or institutions, as it is the process of constructing a discourse that legitimates some form of social control over others or even oneself (Neimeyer 1998). According to French social theorist Michel Foucault, people willingly subjugate themselves to subtle forms of power (Foucault 1980). By this he meant power to be not forms controlled by laws or arms, but of the insinuation of power in the ordinary. To Foucault (1980), it is in the very exercise of these taken for granted practices where we demonstrate our subjugation to power. Power is then perceived as an open and coordinated cluster of relations (Foucault 1980). Regarding Foucault, Neimeyer (1998) points out that when viewed under this lens, power does not reside within people, groups or institutions, as it is the process of constructing a discourse that legitimates some form of social control over others, or even oneself. To Foucault (1980) such attempts are successful only to the extent that they succeed in hiding the methods by which they are produced. The result of such covert mechanisms is that the outcomes that are generated go unquestioned as a natural expression of "the way things are" (Gergen 1999, Neimeyer 1998). To Freedman and Combs (1996) Focault's presumptions demonstrate that language is a device of power. To them power in society is gained in proportion to our ability to participate in the various discourses that shape our society and communities.

To White and Epston (1990) power marginalizes individuals when they internalize the dominant narratives of mainstream culture, most notably when the internalized narratives do not represent their own unique individual

experiences (Freedman and Combs 1996; White and Epston, 1990). Kenneth Gergen (1999) holds that the therapeutic relationship is closely tied to the political. To Gergen (1999) mental health counseling is a process whereby the therapist (with his access to knowledge/power) has the ability to define and create the client's reality. According to Neimeyer (1998) and Gergen (1999), social constructionism poses the ability to help the client win freedom from dominant problem narratives and as a result can help the individual achieve genuine authorship of his life. Gergen (1999) uses the example of the medical model and the focus that is placed onto the process of cause and effect. Under this model, the individual is construed as having problems and the therapist in his or her superiority, is constructed as having the ability to diagnose and label the problems, as well having all the answers to remedy the problem. Guterman (1994) sees the medical model as a billion dollar industry that is both organized around and invested in the practice of positing theories that profess to represent an objective representation of "normal and abnormal" (i.e. DSM-IV). Regarding the labeling power of the medical community, Ginter (1989) states that labeling individuals always represents some function of a socially embedded process and is often less scientific and objective than we have come to assume. In other words it is in the best interest of the medical professions (psychiatry, psychology, social work) to develop labels that legitimate power positions. Furthermore Ginter (1989) points out that because a significant number of professionals are involved in the development and modification of a labeling system doesn't guarantee that it is an objective process. To Guterman

(1994) the concept of reality through the psychiatric discourse does not necessarily mean it is a universal truth. Reality under this lens can then be taken to mean that anything taken to be "real" is only real to the extent that it conforms to our socially agreed upon definition of "reality" or what the repositories of power (medical profession) define reality to be. Using Guterman's (1989) example, reality is what a sufficiently large number of people have agreed to call real. The fact of the matter is that this process is usually forgotten. The result being that the agreed upon definition of "reality" is reified and is as a consequence eventually experienced as a universal truth.

The negotiation of truth is the social constructionist alternative to the one-up, one-down hierarchy of knowledge and power that dominates theory in the scientific arena. The scientific method sees truth as objective and a-historical. The result being that truth is understood as the result of methodologically followed rules that the scientific community peddles throughout the larger culture (Gergen, 1985). However, social constructionism does not equate truth with the rules of culture the way that positivism does. Through language people are able to negotiate meaning and truth. According to Freedman and Combs (1996) language informs how we see the world. To them it is through the negotiation of new meaning that new truths based on individual and relative experience are created. To Freedman and Combs (1996) the fact that there is both no objective reality in the scientific/modernist sense and an infinite way we can interpret reality, it then follows that there is no one interpretation that constitutes "true"

reality. Rather than distilling down several experiences to maintain one universal tradition, social constructionists value the diversity that all the voices bring to the interpretation of experiential reality.

In summary then, a social constructionist view of reality actively promotes a shift in our current understanding of language. Language under this approach is viewed not merely a medium for reflecting or labeling an independent universal reality, but viewed as the very medium by which social reality is constructed. As Neimeyer (1998) points out, because language, as it is currently utilized in our society, covertly sustains existing power arrangements, constructionists tend to adopt a critical, analytic stance toward written and spoken texts, all the while searching for their sociopolitical implications. To social constructionists the most important implications are those that various discourses carry for personal identity.

Narrative Therapy

The narrative approach to therapy is based on a postmodern theory and deconstruct the problem saturated stories of our lives (Merscham 2000). As was previously stated, socially constructed realities are the by-products of language. By employing the narrative attitude, a self exists within the ongoing interchange with others. According to Freedman and Combs (1996) the self continually creates itself through narrative, including other people who are also involved in these narratives. To Walsh (1998) and Gergen (1999) societies construct the lenses through which their members interpret their world. It is these socially constructed realities that provide the beliefs, practices, values and experiences that make up our lives. These socially

constructed realities are taken for granted. Taken together then, postmodernism and narration are powerful tools that can create a worldveiw in which the therapist can provide the basis of the helping principals of narrative therapy. For Gergen (1999) social constructionists understand how the narrative plays a pivotal role by which we make ourselves intelligible to each other. To him we live and die through the narrative that we employ (Gergen 1999). The model of narrative therapy rests on the assumption that our experiences are mapped or categorized into stories or narratives that, as a result, constitutes our reality. According to Freedman and Combs (1996), Gergen (1999), and Merscham (2000) our unique stories are constructed through language and are influenced by such things as, culture, religion and gender. To Gergen (1999) narratives have a centrality to our lives. To him narratives provide us with a sense of order and direction, and thus hold our relations in place.

According to a narrative therapy perspective, the presenting problems that client's bring into therapy reveal what has come to be known as the problem saturated dominant story. According to Gregory Bateson in Freedman and Combs (1996), we make sense out of reality with various maps. Walsh (1998) defines these maps as devices whereby we organize external reality but do not contain all of the terrain. It is under narrative therapy where these "dominant stories" are challenged by the examination of alternate stories. To White and Epston (1990) an individual's story is a map that extends through time. When our stories are told in therapy, numerous details that run contrary to the problem-saturated narratives are often times

omitted (Walsh 1998). Using a "deconstructive ear", it is the therapist's job to then pick up on these omissions and in the process help the individual fill in the blanks to their old story. These times in which the client is not overshadowed by his or her problem are considered what White and Epston (1990) call "unique outcomes". It is through the therapeutic process that these "unique outcomes" are woven together to form new stories. The result of this process is that the dominant story is structured into one that is less problem saturated. Gergen (1999) describes this process as the ability of therapy to enable the client the opportunity to re-story their lives and as a result be able to conceptualize their life trajectories in a new and more livable way.

Practice of narrative therapy, according to Freedman and Combs (1996), rests on the therapist's ability to obtain a firm understanding of the principals of narrative therapy. Understanding these principals is crucial to working with people. One of the first set of principals of White and Epston's narrative therapy is to understand the therapeutic relationship as being a collaboration. According to Gergen (1999) and White and Epston (1990) this collaboration is a process whereby both the therapist and client co-construct the problem definition and the resultant narrative. This method of narrative therapy uses a non-expert based therapeutic stance and focuses on the collaborative re-storying of the client's life. According to Freedman and Combs (1996) connecting with people's experience from their perspective orients the therapist to the specific realities that shape, and are shaped by, their unique personal narratives. Furthermore, the ability to connect with

people in this manner requires that we listen with focused attention, patience and curiosity while at the same time building a relationship of mutual respect and trust. As Freedman and Combs state: "In spite of our education telling us that we do know, we try to listen for what we don't know." (pg. 44).

Harlen Anderson and Harry Goolishian (1992) have done extensive writing on the importance of the "not knowing" stance of the therapist. Regarding Anderson and Goolishian, Freedman and Combs (1996) state that therapy is a process in which we are constantly moving towards what is not yet known. To them, not knowing implies that questions asked do not originate from a place of pre-understanding. Such questions, according to Anderson and Goolishian (1992) are a product of the therapist's desire for the production of particular answers. As Freedman and Combs (1996) point out Anderson and Goolishian make it clear that they do not believe that the "unsaid" is something that is already in existence. To them, the "unsaid" is not something that is hidden in the unconscious mind waiting to be released, but something that emerges through our verbal interactions with each other. To Freedman and Combs (1996) the act of listening is not a passive activity. To them narrative therapy directs therapists to take careful consideration of what they attend to when hearing a client's stories.

Freedman and Combs (1996) characterize listening under a narrative perspective as being deconstructive. As was touched upon previously, narrative therapy sees the dominant story that a person tells as being a connected pattern of events that make meaning for them (Andrews and Clark 1997). Freedman and Combs (1996) see this listening technique as an

avenue to opening space for aspects of an individual's life narratives that haven't yet been storied. Using deconstructive listening allows the therapist to ask questions that fill in the blanks in the client's old story, the result being that the individual demonstrates that he is able to experience himself in new and unique ways. To Andrews and Clark (1996), and Freedman and Combs (1996), as this process of deconstructive listening continues, new meanings and constructions will emerge.

Because post modernists and social constructionists hold the position that there are no problems in the world that are independent of language, it follows then that problems arise as a result of our social interactions (Guterman 1994). Taking such a view results in the therapist moving away from focusing on the individual, or family as being the origin of the problem. Following Anderson and Goolishian's lead, Guterman (1996) points out that if problems are viewed in this fashion, the problem creates the system rather than the system creates the problem. Viewing the individual or family in this way allows the therapist a greater freedom to examine the innate strengths of the family or individual in that he/she is not blinded by "pathology". Taking this stance one can see that the narrative approach is fundamentally strength based. This focus on strengths in narrative therapy takes the form of therapy techniques that are devised to move the problem outside of the person. To Freedman and Combs (1996) these techniques of externalization are based on the belief that the problem is something that is separate and different from the individual. Walsh (1998) believes that externalization is an attitude that invites a person or family to explore their relationship to the problem

and how the individual or family has historically stood up to the problem's influence. Additionally, Merscham (2000) sees this process of externalization, and the subsequent separation from the problem, as an opportunity to encourage the individual to take charge over the oppressive nature of the problem. When the therapist, through the therapeutic conversations, sees a "unique outcome" (times when the problem has not dominated the individual), he uses it as a gateway to the next part of interview process which involves the re-authoring or re-storying of their lives (Andrews and Clark 1996). According to O'Hanlon (1994) focusing on the externalization of the problem is not a process of laying blame but rather one of placing focus on personal accountability. By focusing on the effects of the problem rather than its causes, externalization is used to ignite discussion on how the problem has hindered the individual from changing. This process then places the onus on the individual to take the steps necessary to re-author a more empowering self narrative.

Narratives of the Self and Dramatic Structure

Andrews and Clark (1996) see the narrative framework as being based upon literary metaphors. Through the narrative perspective the dominant story that makes up our lives is seen as the connected patterns of events that give our lives meaning. Gergen (1999) states that the way we view our lives (as a series of "ups" and "downs", progress and setbacks, fulfillment and frustration) sets up our participation in a storied world. Likewise, Neimeyer (1998) sees language as a form of social action that structures itself into different discourses or systems of statements that constitute

stories, images, metaphors, myths, and representations. To him it is through these discourses that our particular view of self is produced. Gergen (1999) goes on to state that because we are treated by others as storied characters, we are often called upon to "tell our stories", to recount our past and to identify our futures. To him, the result of our narrative structures is the formation of certain limitations regarding who we are and what we can become (Gergen 1999).

According to the famous American playwright David Mamet (1998) it is our fundamental nature to dramatize everything. To him, we dramatize an incident by taking events, reordering them, elongating them, and compressing them. To Mamet (1998) we do this so that we understand their personal meanings to us, as we are the protagonist of the individual drama that we have come to understand our life as being (David Mamet 1998). Gergen (1999) describes narratives as fitting into a few common themes. These narratives take on two main forms. The first narrative is the progressive narrative. In this narrative the end point is positive (a success or victory, etc.) and continues to present all of the events that have lead to achieving the success. The second narrative is the regressive narrative. In this narrative the end point is negative (a loss or failure etc.) and continues in its presentation of all the events that lead to the decline. Among the other narratives that Gergen (1999) points out are the hero's saga, the happily ever after, and the tragedy. Such narratives can be classified as being what Joseph Campbell and Carl Jung labeled as being cultural myths or archetypes (Singer 1996). David Mamet (1998) states that we all live by our own

personal myth. To him part of the hero's journey (our lives) is that the protagonist has to change her understanding completely, whether through the force of circumstance or through the force of will. The result of the journey results in the hero revamping her thinking about the world. In the case of narrative therapy this process is called re-storying or re-authoring their lives.

Regarding the narrative, Loewenthal (1996) sees individuals as being their own movie directors. To him our lives are constantly being created under the direction of their personal and cultural narratives. As directors, individuals frequently utilize their own vision (idea or conception of what the story is or should be) to create their own narratives or dominant stories. Cowley and Sprigin (1995) describe this process as filtering out experiences from our memories and perceptions that run counter to our dominant themes. Regarding drama, David Mamet (1991) points out that it is in the nature of the human mind to follow the basic principle of cause and effect. To him, it is the nature of human perception to connect unrelated images into a story, because we need to make sense of the world. It follows then that being the director of our own movie enlists us to determine what images we will need to juxtapose in order to tell our personal stories (David Mamet 1991).

Regarding dramatic structure, Gergen (1991) states that there are definite patterns under which each narrative follows. David Mamet (1998) believes that our understanding or our personal dramas lie in our understanding of the three acts of the play. This understanding resolves

itself into the three parts of: Once upon a time, years past, and then one day. Once upon a time is the narrative that enables us to understand the difficulty, desire, and goal of the protagonist. Years past represents the middle time of struggles where the protagonist's character is tested. And then one day is the part of the narrative where the inevitable yet unforeseen complication engendered by the quest of the protagonist in the middle term, precipitates into the end struggle. This part of the narrative can be viewed as the resolution of the conflict brought about by the middle act. The result of this resolution leads to the generation of answers to the questions that had surfaced at the beginning of the narrative (David Mamet 1998).

In relation to narrative therapy, examining personal narratives under the structures of drama is a way of ordering an individual's personal story. Through such an analysis, personal narratives can be collapsed into structures (3 acts of the play) that allow both therapist and client the opportunity to generate meaning and direction regarding the past, present, and future developments of story. In short, taking such an approach to narrative therapy provided a way to interpret, understand and view an individual's personal narrative from a new perspective (Freedman and Combs 1996).

Narrative Therapy and Dramatic Structure

In striving to make sense out of our lives White and Epston (1990) believe that we arrange our experiences of events in sequences across time. Doing so allows each of us to arrive at a coherent account of our lives and the situations that we face. White and Epston (1990) refer to this process of

ordering our lives as "story" or "self narrative". The success of this storying of experience provides each individual with a sense of continuity and meaning in their lives (White and Epston 1990). Using the structures of drama to order an individual's life is a unique way to bring meaning as well as to open up interpretation for further experiences.

Through the therapeutic process both participant and therapist can develop stories or narratives. When examining each individual's story it can be determined that a person will explain their lives in three distinct components. These three parts are divided into the beginning, middle and end. When placing these three components (beginning, middle and end) under the structures of drama, the past, present and future are transformed into Act 1, Act 2, and Act 3. As the therapeutic dialogue is further developed it becomes evident that each individual's story is held together by patterns involved by the plot (Freedman and Combs 1994). According to de Shazer 1991, through the therapeutic conversation these structures of plot are revealed to be human predicaments, problems, troubles, failures and attempted resolutions. These narrative plot structures follow the basic rules of story in that all drama is created out of conflict (Mamet 1996, Travis 1997).

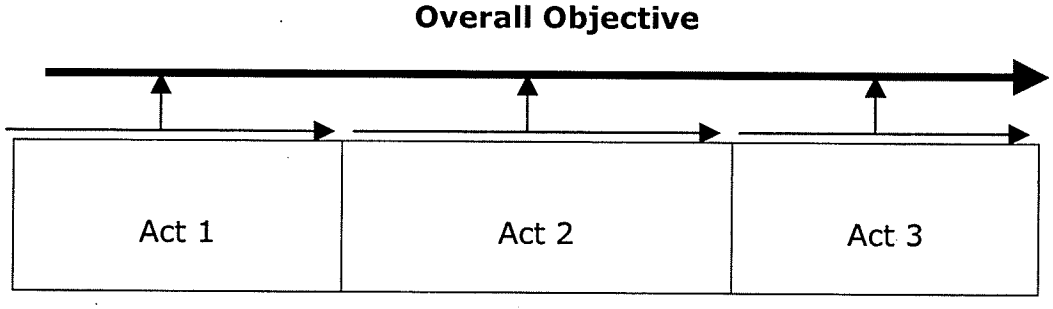
Story Analysis & Dramatic Structure

According to David Mamet (1996) the human mind cannot create random progressions. Mamet (1996) believes that when viewing our lives we will order unrelated events into a dramatic whole that is comprehensible under the rules of drama. To Mamet (1996) it is our nature to elaborate our

perceptions about our lives into hypotheses and then reduce those hypotheses into information upon which we can act. It can be surmised then that dramatic structure is not an arbitrary or a conscious invention but rather an organic codification of the human mechanism for ordering information (Mamet 1996, Travis 1997). Mamet (1996) sees this organic codification as including event, elaboration, denouement; thesis, antithesis, synthesis; boy meets girl, boy loses girl, boy gets girl (or visa versa); act one, two, and three. Using such an examination of story can be a useful way for both therapist and participant towards understanding their own personal narratives.

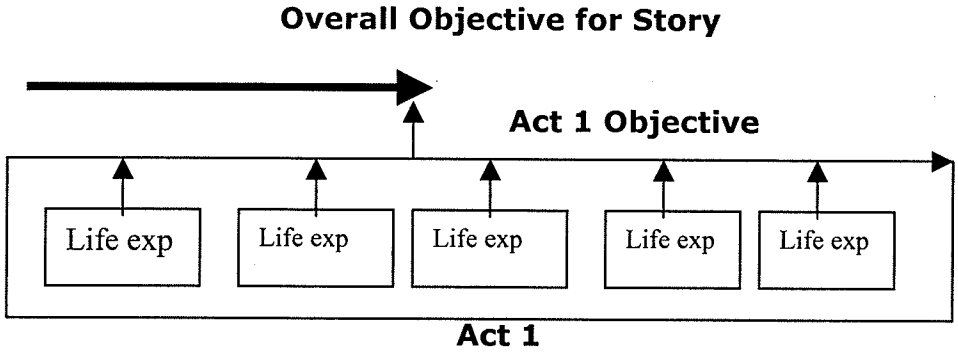
Overall Objectives

When we view an individual's dominant narrative under the structures of drama we must keep in mind that the protagonist (individual) has an overall theme that she/he is attempting to complete or achieve during the course of their life's narrative (Travis 1997). These themes span the entire life of the individual.



As we examine an individual's narrative by breaking his/her story down into acts we can see that the protagonist has a theme for each act. To Travis

(1997) the important element in regarding the themes for each act is that they must support the overall "grand theme". Additionally, Travis (1997) points out that as we continue to break down the individual narrative into smaller sections (our various life experiences) we will see that within each section each character has a specific theme. For the narrative to achieve its goal, each of these objectives must be a valid attempt to achieve or fulfill the overall theme for the act.



It can be surmised then, that using the structures of drama can both enhance each participant's experience of their own "story" and also be a useful means of externalization. In addition, using the structures of drama can be useful in aiding each participant's understanding of their own power in story creation. Opening up such an awareness can lead to a more empowering experience of their own change process.

Character Arcs and Character Analysis

In relation to our narratives, a character arc is the journey of the protagonist through his/her own narrative. Character and story arcs can be compared to what narrative therapy holds as the landscape of action. According to Travis (1997) a character has an arc when there is a discernible

and significant change in character over time. When examining a person's narrative it becomes important for the therapist to plot the character arc. This is so the therapist will be in the position to begin to feel the ebb and flow of the individual's unique experiences and how they have shaped the development of the client's personality. In addition to character arcs it is also important to understand the elements of the character's personality. The character analysis is different from the character arc in that through the character analysis the subjective nature of the individual is considered.

Understanding each participant's individual character can be an essential component in the determination of story development as well as understanding behaviors and actions. Understanding the subjective understanding of character can open the door for both a greater awareness of personal change and a greater understanding of story development.

Story Objectives

Internal & External

Obstacles that we face either internal or external are the keys to our personal conflicts. According to Travis (1997) and Mamet (1996) narrative objectives fall into the two categories of external and internal objectives. External objectives can be defined as all objectives that we are aware of by simply observing the behavior of our main character or protagonist. They are the objectives that are pursued through the character's actions. Regarding the individual's personal narrative, internal obstacles are dominant discourses that define the problem as an "internal struggle". This struggle could include a person's relationship with their depression. This would

include the individual's interaction with the depression's self critical, self-defeatist elements. In contrast, external obstacles would be story elements that are external to the character. This could include the influences of culture and society on the main character's story. A person's depression may be inflamed or aided by the barriers afforded to age, gender or race.

As was previously mentioned drama is created out of conflict. It is through this conflict that we engage in our struggle for knowledge (Mamet 1996, Travis 1997). The obstacles that we face either internal or external are the keys to our personal conflicts. According to Mamet (1996) and Travis (1997) without obstacle there is no conflict and thereby no story. Keeping this in mind, it then becomes important that we define the overall themes that we, as the main character of our narratives, face. This includes an examination of all obstacles, as they appear in each act, sequence, and scene/experience in our lives. The obstacles that each of us face in our own lives are the obstructions that our characters face in attempting to achieve their objectives.

Obstacles come in three distinct categories:

1. Other characters
2. The environment
3. The self

Other Characters

Other characters in our narratives can include family, friends, co-workers, spouses, romantic interest etc. It is through our daily interactions with the other characters of our personal narratives that often times create the various obstacles that obstruct us from fulfilling our objectives. As Travis (1997) points out, a character's conflict is often the result of other characters in our narratives. Understanding all significant characters of the individual's personal narrative is believed to help place the participant's challenges into the right context.

The Environment

When we view our narratives the environment under which we develop can sometimes be an obstacle in itself. The environment in which we live be it physical, political or social strongly impacts on how our character develops, and what our character views himself/herself to be. The environment or setting of our personal narrative directly impacts the means our character will use in order to achieve her/his objectives. By understanding the environment of the narrative one is in the position to understand the actions and motivations of the character.

The Self

Internal obstacles can be thought of as the aspects of the individual that inhibit the character's progress toward the objective. This is the internal conflict which Mamet (1996) sees as our internal struggle for knowledge which, if overcome, leads to our own character being both enriched and cleansed. Adding to this, Travis (1997) states that it is our internal obstacles

that give our stories their deepest resonance. Regarding the personal narrative, inner struggles can be thought of as the personal relationship an individual has with his problem. How is the individual's relationship with his problem limiting his ability for development of a more preferred experience? Internal struggles with the self can be seen as the internalizing discourses an individual engages in. These internalized conversations within the self can restrain the individual to a narrow and limited definition of who they believe themselves to be.

The Transformative Power of Narrative

Following the narrative approach we can see that deconstructive questioning invites individuals to view their stories from different perspectives. Through this form of questioning a person is given the opportunity to see how their stories are constructed, to note their limits, and to discover other possible narratives (Freedman and Combs 1996). According to White and Epston (1990) deconstruction helps us unmask the personal truths that hide our biases and prejudices behind the disembodied ways of speaking that legitimate our subjugating dominant stories. So under the narrative perspective we can see that our experiences are collapsed into narrative structures, or stories that make our lives intelligible. As we forge our identities through our stories, we as a result of our dominant narrative, give some patterns of experience more weight than others (Cowley and Springen 1995). It is through this process along with the cultural pressures of our environment that we develop our personal myths and dominant stories.

According to Merscham (2000) it is through the externalization and deconstruction of influence that leads to re-storying or re-authoring. The end result of the re-authoring process renders the client the power to recreate his own reality through the construction of new dominant stories. The drama then can be seen to possess the capacity to both integrate great tragedy and also integrate great transformations into our lives. Regarding the transformative power of drama, David Mamet (1998) sees the true drama as calling for the hero to exercise his will, to create his own character and to generate the inner strength to continue on. To Mamet (1998) it is the hero's striving to understand, to correctly assess, and to face his own character (or face his own narrative) that inspires us and gives the drama power to cleanse and enrich our own characters. Adding to this, Mamet (1998) states that the narrative that we perceive can, at one end of the spectrum, make us a better person by exciting within us the capacity for synthesis. Thus, the ability to re-author our lives (synthesizing unique outcomes into our dominant story) is to integrate within us a more complete understanding of our stories. As in the completion of a drama, achieving this integration signals the truth. This truth according to Mamet (1998) is a "truth" that comprises all that had been overlooked, disregarded, scorned and denied. It is at the end of the drama where truth prevails and we are once again made whole. For Mamet (1998) it is this rediscovery of self (narrative truth) that restores us to rest until our next journey begins.

In summary then, narrative therapy is based upon the notion that change comes from the client instead of the therapist. To White and Epston

(1990) culturally prominent internalizing discourses attribute blame for problems to the individual. To them, not only do these culturally prominent discourses confer on the person narrow and pathological identities, but their also separates the individual from important persons in their lives who might otherwise be sources of support and assistance (White and Epston 1990). The role of therapy can then be seen as one where the individual is helped to muster resistance to the dominant narratives, and in the process help them re-author a more positive individual identity (Neimeyer 1998). While narrative therapists take an active part in creating the context for change, the client is always in control of the re-authoring process. The progressive process of building personal competence through unearthing unique outcomes and discussing client strengths help aide in the formation of new stories. Nichols and Schwartz (1998) see the overall goal of narrative therapy as being the ability to help the individual in rewriting his/her dominant story into something more positive and comprehensive. A full understanding of our narratives includes all experience, not just the problematic components. To Nichols and Schwartz (1998), re-authoring entails not just the problematic aspects of the story, but its overall structure. This means that the individual can include positive aspects of their story along with his/her problem-saturated components that they bring into therapy (Nichols and Schwartz 1998).

Narrative Therapy and Adolescence

Regarding therapy with children and younger adolescents there has been many concerns. With younger adolescents, a therapy such as the

narrative approach may be inhibited by the limited ability to deal with abstract issues. Narrative therapy and its emphasis on metaphor and symbolism requires the ability of the individual to employ his ability to view his life in an abstract way. For narrative therapy to be successful the individual must be able to conceive of his problems or challenges as an externalized entity that can be examined as something apart from the self. In addition the individual must also have the ability to view his life in terms of "story" or "narrative". Such an understanding rests on the ability to see one's self as the "protagonist" or main character of the drama that comprises his/her life.

Adolescence is an exiting time in regards to the individual's ability to view the world and his/her place in it. This new found cognitive ability opens up an increased accessibility to the therapeutic approaches to therapy. According to Hacker (1994) adolescence is a time where individuals gain a new found way to experience the conditions of his or her existence. It is through adolescence that the child's way of interpreting the world is forever altered by the unique aspects of his/her own cognitive development. In this adolescent period the individual will first begin to experience his/her life conditions on an abstract level. Adolescence is a time where young people become able to build upon their concrete mental operations and incorporate them into a higher level of formal operations (Sandtrock 1993, Hacker 1994). According to Cotton (1994) a major aspect of these cognitive changes involves the development of abstract thinking. Cotton (1994) points out that one of the critically important features of adolescent's cognitive development

is the newfound ability to conceptualize oneself and engage in introspection and self-reflection. Prior to adolescence, children exist in a world of concrete reality. To Newton (1995) the preadolescent has a tendency to both view and describe his/her self in terms of concrete physical facts and competencies.The preadolescent's cognitive development makes it neurologically possible for an increase in abstraction as the adolescent is now in the position to begin to describe his/her self in more theoretical and abstract terms (Newton 1995). It is through adolescence that individuals develop the cognitive capacities to think seriously about the past and the future, possibilities and impossibilities of life, their own thoughts, and other people's perceptions of them (Santrock 1993, Hacker 1994, Cotton 1994). Adding to this Hacker (1994) states that whereas children tend to dwell on what is, adolescents are able to conceive of future possibilities for themselves for which they can decide to strive. Regarding narrative therapy, adolescence is a time where the individual is in the position to begin generating hypotheses, ideals and pictures of their present, past and future. This cognitive development leads to the ability of the adolescent to attack problems from a new point of view. Hacker (1994) points out that adolescents, when describing themselves, are able to draw from a greater variety and number of abstract schemes, that reflect greater use of psychological interpersonal, and future oriented constructs. This new ability to conceptualize oneself, and engage in a new found introspection and self-reflection bodes well for the participation in narrative based therapy.

In summary, adolescence is a time in life where the individual acquires an awareness of his life on an abstract level. This new found awareness is a representation of the individual's cognitive development. Through this developmental stage the individual is moved from childhood's concrete reality to a more profound abstract reality. It is through this newfound abstract thought that the individual is capable of viewing her existence as possibilities of underlying psychological characteristic, traits, dynamics, and motives within herself as well as within others (Hacker 1994). Adolescent cognitive development allows one to choose and accept responsibility for the choices made, create meaning in one's life, and cope with the arbitrariness of meaning and behaviors. These actions are not exclusive to the adult, rather they are behaviors encountered in adolescence as well (Hackler 1994).

Gender & Culture

In recent years, the emergence of feminist perspectives in the realm of psychology has drawn attention to the value laden nature of mainstream psychotherapies and has raised questions about the relevance of these therapies (Lyddon 1995). Postmodern scholars have been particularly critical of traditional therapeutic approaches that focus on the individual as the source of psychological problems and define psychological adjustment in terms of dominant cultural values (Sands 1998, Lyddon 1995). Postmodern and feminist counselors believe that traditional treatment approaches fall short in that they pathologize and blame the individual for having negative thoughts without first acknowledging the societal context under which they develop. According to Sands (1998) unlike most traditionally based empiricist

treatment strategies, feminist and post modern counselling views the psychological distress that women experience as being a logical response to an often oppressive patriarchal society. From a feminist perspective, gender is both a cause and a consequence of women's experience in a male centered society (Sands 1998, Lyddon 1995). As a result of this, feminist counselors consider the client in the political context of her environment. Through this approach the individual is encouraged to consider both the role of gender socialization plays along with societal message, and pressures that are contributing to the problem at hand (Sands 1998). According to Lyddon (1995) and Sands (1998) rather than attempting to bring an individual's beliefs into line with those of the dominant culture, feminist counselors encourage clients to examine and re-negotiate various gender-based beliefs and meanings.

According to postmodern theories such as the narrative perspective, contextual influences of discrimination, oppression, and poverty must be included in any understanding of the experience of women, minorities and other marganalized groups (Semmler and Williams 2000, Lyddon 1995, Sands 1998, Neimeyer 1998, and D'Andrea 2000). This is because women and minorities occupy a disproportionately low economic, social, and political position in the dominant culture. As Lyddon (1995) points out, most traditional therapies make no distinction between male and female experience and tend to minimize the influence of race, ethnicity and culture on the development of personal forms of belief.

The Efficacy of Narrative Therapy

Despite the fact that the narrative approach has been used for some time, there is little research indicating its efficacy. Although it has gained a measure of popularity in recent years, narrative therapeutic practictioners have yielded few empirical studies examining its efficacy. Furthermore a review of the literature did not yield any outcome studies regarding adolescent depression.

According to Etchison and Kleist (2000), the lack of outcome studies, is due to the social construction perspective upon which narrative therapy is based upon. To Etchison and Kleist (2000) the incompatibility between the objectivity of quantitative research and the belief in individual experience in the construction perspective is cited as being one of the reasons there is a lack of outcome studies on narrative therapy. Etchison and Kleist (2000) believe that a social construction orientation such as narrative therapy is inconsistent with traditional quantitative research methods. Qualitative research methods are usually more conversational and interactional in their approach and thus run counter to quantitative methodology's reliance on objective observation. Etchison and Kleist (2000) believe that the lack of respect the scientific community has of qualitative research has lead to the small amount of research produced to support narrative therapy.

In addition, Etchison and Kleist (2000) point out that the lack of research on narrative therapy may also be due to a small number of researchers who have been trained in qualitative analysis. Furthermore Etchison and Kleist (2000) point out that most counselling agencies employ

more quantitative methods of analysis when evaluating clinical practice. This is because quantitative analysis is both more respected throughout the scientific community and is less time consuming/cost efficient in its application.

Although limited in scope, there have been a few notable research based outcome studies regarding the use of narrative therapy.

David Besa's 1994 study is one of the few who have researched the efficacy of narrative therapy. In his study Besa (1994) used a single system design to evaluate White and Epston's version of narrative therapy in reducing parent/child conflicts. Therapy with six families was evaluated and according to Besa, all families documented significant improvement in functioning. It was Besa's conclusion that narrative therapy is an effective approach to family therapy.

A second article by Etchison and Kleist (2000) reviewed the literature of outcome studies regarding narrative therapy. Studies by Besa (1994), St. James-O'Conner, Meakes, Pickering and Schuman (1997), Weston, Boxer and Heatherignton (1998), and Coulehan, Friedlander and Heatherington (1998) were all reviewed. Etchison and Kleist's review of the literature demonstrated that all four studies had positive outcomes.

The study by Coulehan et al. (1998) utilized Carlos Sluzki's narrative approach. This study involved eight therapists (who were trained in different therapeutic disciplines) and eight families. Through video taped sessions and post session questionnaires, a coding system was used to indicate,

demonstrate and record the different ways each family perceived their problems.

The results identified change in the way the family described the problem. This included multiple changes in views and descriptions of the problem. The second change that was identified involved the change in each family member's affective tone. Through this change each individual was able to explore the positive aspects of both the individual experience and of the family as a whole. The resultant change was found be the result of a successful transformation of story (Etchison & Kleist, 2000).

In addition, St. James O'Connor, Meakes, Pickering, and Schuman (1997) have examined client experiences with narrative therapy. Their study was used to determine what families found helpful and not helpful in the application of the narrative approach. Through a four question qualitative interview it was determined that family members generally found narrative therapy to be helpful. The results of the interview also indicated that there was a greater reduction in problems for those families who had been involved in narrative therapy for a longer period of time.

In summary narrative therapy is a therapeutic approach that reminds the therapist that objectivity and neutrality do not exist. Neiymeyer (1998) by taking this perspective the therapist becomes sensitized to the ways that power is both constructed and concealed in our recursive professional practices. Through narrative therapy our taken for granted belief in a stable, singular, sustainable identity is challenged (Neimeyer 1998). Through narrative therapy we understand that identity is, instead, a function of our

conversational context. Viewed this way, we come to understand that the narratives which we choose to employ may alter these images that we have of ourselves. Narrative therapy offers a fresh understanding to the therapeutic relationship. Under this system of understanding, people are no longer tied to a generalized definition of self. As Neiymeyer (1998) points out, narrative therapy both challenges and frees people to negotiate with others to create more fluid identities. The result is that individuals are encouraged to strive to use the narrative resources of their own unique cultures to script more satisfying lives.

Empowerment

Consonant with social construction thinking, the narrative concept of empowerment challenges traditional therapists to move beyond a predominant focus on an individual's interpersonal mental phenomena and become more knowledgeable of social, political, and economic barriers that impede personal development (Lyddon 1995, White and Epston 1989). It is these barriers that adversely affect the members of marginalized groups. Sands (1998), D'Andrea (1998) and Lyddon (1995) point out that when these barriers are brought into the therapeutic dialogue, the enhancement of the individual's sociopolitical awareness may become a potential therapeutic outcome in itself. Being able to see the influences of culture has on our lives allows the therapist and client to view the problem in the proper context. Taking such a view removes self-blame and individual pathology. According to Lyddon (1995) such an enhancement may not only represent an important

shift in context but also may function as a significant precursor to client social involvement and action.

Narrative therapy and its focus on the socially constructed realities closely mirror the professional values and ethics of social work. Not only does narrative therapy remove the locus of the psychological problem away from the individual but it also provides a greater consideration of the influences of gender, culture, and class variables on personal experiences and beliefs. Finally, it employs empowerment and social change as therapeutic strategies. The result of the narrative approach is that it employs an understanding of an individual's social, economic and political contexts. Through this understanding an individual is given the agency to move past culturally defined realities and thus empower herself through her own unique experience of reality. As a social worker I find that the narrative approach encompasses much of the values that I deem important to the profession. Narrative therapy is an approach that has the ability to transcend our taken for granted worldviews and as a result generates both new opportunities and new possibilities for change.

Chapter 3

Methodology

Intervention Setting

The setting for this practicum was a community treatment center that serves adolescents. This adolescent treatment center is an accredited mental health service provider within the province of Manitoba. By utilizing a client centered program management model the community program provides a continuum of fully integrated community and hospital based mental health programs and services to Winnipeg children, adolescents, and their families. Services are particularly targeted to under serviced groups such as the Aboriginal and deaf or hard of hearing populations. Clinical services range from brief interventions in acute situations to intensive longer-term treatment service. The adolescent treatment community program is an agency that provides a range of mental health services to children and adolescents who experience psychiatric and or emotional disorders. It is the agency's goal to be sensitive, responsive and innovative in meeting the changing needs of children, adolescents, families and communities. In its essence the adolescent community program assumes a leadership role in the delivery of a prompt, accessible range of integrated mental health services. Therapy is provided by clinicians from various backgrounds including social work, psychiatry, psychology, occupational therapy, and nursing.

Client Criteria

The practicum was based on working with 5 clients over a 4 month period. Adolescents and or young adults aged 16-18 were selected from intakes that had been completed at the practicum setting. Age range was important to the practicum's overall goal in that individuals needed to possess the cognitive development required for abstract thought. This was important in that the practice of narrative therapy works in the realm of symbol and metaphor. It was believed that the practicum age range provided the therapist with a level of cognitive development that would be more suitable for what was being attempted. Referrals to agency were made from family practioners, psychiatrists, and community health clinics. The focus of the praticum was on adolescent depression. The 4 individuals who were selected for participation in the practicum were selected based on their scores on Beck's 21 item Depression Inventory (BDI). Each individual had been diagnosed as experiencing emotions and behaviors that were consistent with depression. Of the four cases two participants were male and two participants were female. The physician's diagnosis of each participant's depression was based on criteria of the DSM IV (1994). The formal DSM IV diagnosis of major depressive episodes required the presence of five of the following symptoms being experienced for at least two weeks. The symptoms are:

1. Sad, depressed mood,
2. Loss of interest and pleasure in usual activities,
3. Difficulties in sleep,

4. Shift in activity level, becoming either lethargic or agitated,
5. Poor appetite and weight loss, or increased appetite and weight gain,
6. Loss of energy, great fatigue,
7. Negative self concept; self reproach and self blame; feelings of worthlessness and guilt,
8. Difficult in concentration,
9. Recurrent thoughts of death or suicide,

The participants entered the practicum yielding a wide range of presenting problems. In conjunction with depression, these issues ranged from suicide ideation/attempts, illness, sexual abuse, anxiety, relationships, communication and family conflict/family dynamics.

Client Consultation

An initial screening was used to provide face to face information and to discuss both issues of agency protocol regarding confidentiality and the requirements of the practicum itself. The screening was also used to determine the compatibility of the individual's goals for therapy with the students goal's for the practicum. In this initial screening areas of supervision, student credentials, practicum time lines and issues of participant confidentiality (see appendices) were also discussed.

Supervision

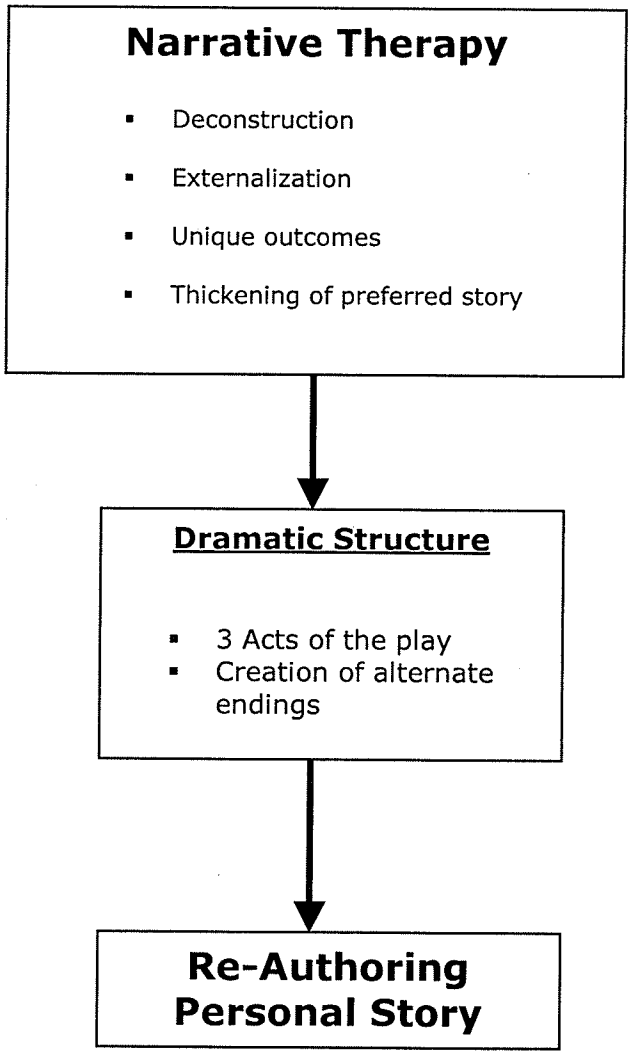
Clinical supervision was provided by the onsite supervisor Linda Croll. Supervision was comprised of weekly consultations. These consultations

included, the evaluation of participant functioning, the change process, learning goals, and the development or alteration of therapeutic strategies. Supervision also included the practicum supervisor observing the therapeutic sessions via one-way mirrors. Client information and record keeping were done according to the agency's mandate and policy.

Session Content

Session content was based on White and Epston's (1990) narrative therapeutic principals of deconstruction, externalization, unique outcomes, and the thickening of preferred stories/re-authoring process. Each participant's narrative was also viewed under the structures of drama. Individual stories were collapsed into a three act structure. Using dramatic structure was a means of:

- Identifying changes
- Generating themes
- Externalization of problems
- Understanding direction of story
- Developing preferred story



Session Content

Therapeutic Relationship

As was previously stated, the practice of narrative therapy rests on the ability of the therapist to form a strong collaborative relationship with the client (Freedman and Combs 1996). White and Epston (1990) and Gergen (1999) refer to this collaboration as a process whereby both the therapist and client co-construct the problem definition and the resultant narrative. Co-construction of the problem involves the utilization of the individual's

words and phrases that best describe the problem's intentions, beliefs, and practices. This process of collaboration is what Freedman and Combs (1996) call "naming the plot". Naming the plot or problem enables the client and therapist to determine the tactics and means of operation that the problem employs (Freedman and Combs 1996).

Deconstruction of Problem

According to Freedman and Combs (1996) deconstruction invites people to see their own personal narratives from different perspectives. This enables the individuals to see how their narratives have been constructed, the limitations of their stories, and most importantly that there are other possible narratives to be lived. The purpose of deconstruction is to "unpack" the individual's taken for granted assumptions or "personal truths" that keep the person from exploring other avenues of personal meaning. Freedman and Combs (1996) point out how deconstruction can help unmask the individual's "so called truths" that hide their personal biases and prejudices that give legitimacy to the restrictive and subjugating dominant stories. Zimmerman and Dickerson (1996) state that the deconstruction of the problem is a way to directly challenge the personal and cultural stories that have contributed to the creation and maintenance of the problem at hand.

Externalization

Externalization is a narrative therapeutic technique that separates the individual from his or her problem. According to Madigan (1996) and Semmler and Williams (2000) externalizing the problem is established

through the therapist and client creating a name for the problem which emphasizes an external existence from the individual's life. Externalization is important as it promotes the idea of dialogue about problems as opposed to monologues about problems (White and Epston 1990). Externalization is a process that allows the client to increase his/her control over the presented problem. This view of problem is important in that the individual or family is not blamed for creating or maintaining problems. Presenting problems can be externalized into problem lifestyles, career, pattern, or an objectified oppressive tyrant (White and Eptson 1990, Selekman 1993). When creating an externalization of the presenting problem Selekman (1993) points out that, " it is most important to carefully utilize family members' language and belief material about the problem, otherwise family members will interpret your new construction of their problem situation as being too unusual and will disregard it." (Selekman 1993, p. 73).

Thickening of Preferred Stories: Integrating Unique Outcomes

Unique outcomes are problem free situations that are identified in the past, present or future. These moments represent experiences that would not be predicted by the plot of the problem-saturated narrative (Freedman and Combs 1996). In short, unique outcomes are experiences that are exceptions to the problem (times where the problem was not dominant). Unique outcomes can be found in either the landscape of action (sequential events that happened in the individual's life) or the landscape of consciousness (personal meanings, preferences, values, and intentions) (Zimmerman and Dickerson, 1996; Parry and, Doan 1994).

David Mamet (1996) states that the personal narratives that we perceive can make us better people by exciting within us the capacity to synthesize our lives. This process entails the ability to integrate within us a more complete understanding of our stories. In narrative therapy, this integration is known as synthesizing our unique outcomes into our dominant stories. By doing so, the individual is provided the opportunity to challenge or move past his or her dominant problem saturated story. The integration of unique outcomes gives clients the ability to experience a more complete understanding of his or her self.

Practice Evaluation

Operational Definition of Depression

The practicum evaluation utilized the Beck Depression Inventory, the development of both a narrative and character arc and a qualitative exit interview. Depression was examined under a global definition of what constitutes depression. Under this category depression was operationalized using Beck's 21-item inventory. Although Aaron T. Beck is associated with the development of the cognitive theory of depression, the Beck Depression Inventory and its 21 inventory of symptoms was not selected to reflect any particular theory of depression (Carlson 1998, and Stehouwer 1985). It was felt that using the 21-item inventory would be useful in that it would provide a starting-point with which the individual could both identify and articulate their depressive symptoms. The 21-item inventory could be used by both the therapist and client to find individual themes within their experience of depression.

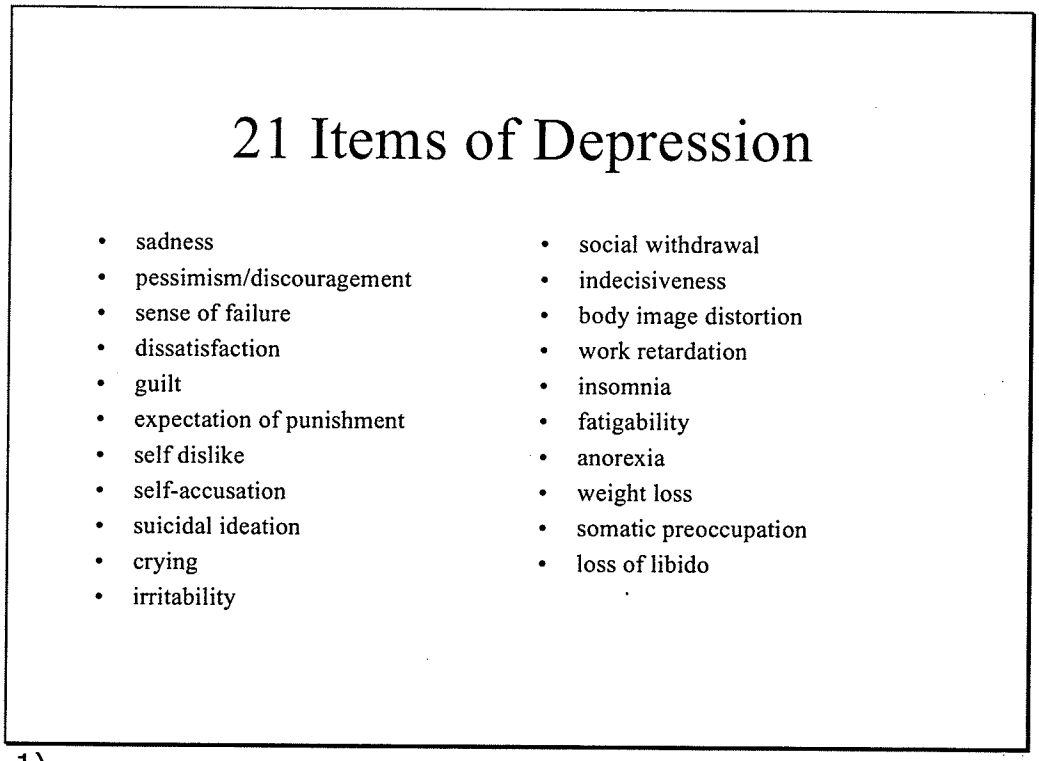
Measures

The measures which were used represented the means to calibrate the specific area of depression that was under study. Depression was measured using the Beck Depressive Inventory (1978). The age range suggested as appropriate for the tests are from age 16 and up. Keeping this in mind, the age range of the participants ranged from 16-19 years. The BDI was administered at three points of the intervention. These points took place during the first, middle and last sessions. It was hoped that by choosing three points of testing, client progress would be more readily distinguishable.

Beck Depressive Inventory (BDI)

The Beck Depression Inventory (1978) is a well known and widely used self-report inventory that measures an overall level of depression in adults and adolescence. According to a literature review regarding the Beck Depression Inventory, Byrne and Baron (1993) found that the BDI was the favored measure of adolescent depression. It is important to note that the Beck Depression Inventory was designed to assess depression independent of any particular theoretical bias. The BDI is very versatile in its application as it can be administered via paper and pencil, computer or orally. The Beck Depression Inventory is a 21-item test that is presented in a multiple-choice format. Each of the 21 items of the BDI attempts to measure a specific symptom or attitude that appears to be both consistent and specific to the experiences of depressed individuals. Each inventory items coincide to a specific category of depressive symptom or attitude. Each category is used

to describe a specific behavioral manifestation of depression and consists of a graded series of four self-evaluative statements. These statements are rank ordered and weighted to reflect the range of severity of the symptoms from neutral to maximum severity. Each statement is preceded by a scoring weight. The weights range from 0 to3. The score is obtained by taking the highest score circled for each item and adding the total number of points for all items. Interpretation is based on the total score, which may range from 0 to 63. Among depressed clients, scores in the 0-9 range denote minimal depression, 10-18 suggest mild depression, 19-29 are considered moderate depression, and scores in the 30-63 range indicate severe levels of depression. The 21 items measure the following symptoms and attitudes:



(Fig. 1)

According to Stehouwer, (1985) the BDI is a simple, quick and helpful tool in gathering information about a patient's depressive state. Because of its simplicity the BDI can be administered in any setting to a variety of individuals. The time required for the test varies from 5 minutes to 15 minutes. Another one of the strengths of this test is that the BDI is appropriate for subjects who display a wide range of abilities. Because the test can be administered orally, all that is necessary is that the subject be able to understand the words of the test. The BDI is ideal in that subjects do not have to write a response, but merely can endorse a particular answer. This makes is it particularly useful for individuals who have a short attention span, difficulty reading, and for individuals who may be less accommodating with a longer test. It must be noted that the BDI is not a diagnostic test, but rather a test that measures overall extent or depth of depression. Keeping this in mind, it is an appropriate test for my clinical practice in that the participants with whom I worked with would not suffer the consequences of being diagnosed or labeled as being depressed.

The Beck Depression Inventory is a measure that can be used as both a quantitative and qualitative tool. It is because of its qualitative capabilities that it demonstrates its compatibility with my clinical practice evaluation. The BDI can be used to assess the components of a patient's depression. According to Freeman and Reinecke (1993) by doing an item analysis of the scale, the therapist can quickly identify the areas of foci of the depression. Freedman and Reinecke (1993) point out that two individuals with the same score may be very different in terms of the profile of their scores. As an

example they point out that two clients with the score of 33 may differ markedly. Client A may endorse items 1 to 11 at the highest level yielding a score of 33, on the other hand client B may endorse items 11 to 21 at the highest level and also yield a score of 33. Although the level of depression is equivalent, the content of their concerns is very different. Freeman and Reinecke (1993) point out that clinically; it is often found that items 3,5,6,7 and 8 cluster together, suggesting a self-critical stance. Additionally, Freeman and Reinecke (1993) state that items 4,12,15,17 and 21 often co-occur, indicating that the individual primary concerns center around the experience of energy loss, decreased motivation, and feelings of anhedonia. Regarding other qualitative features of the BDI, Stehouwer (1985) cites studies by Connelly and Johnston (1993), Hammen and Padesky (1977) and Stehouwer, Bultsam, and Termorshuizen (1985), that demonstrated that the qualitative features of the BDI (1978) delineate differences in depressive symptomology between both adults, adolescents, and men and women.

Using the BDI would ensure that the therapist and client could mutually examine the test results regarding both changes in themes and presence or influences of the depression in his or her personal experiences. Keeping with the narrative and social constructionist perspective, it is important to note that the BDI is not a diagnostic test, but rather a test that measures overall extent or depth of depression. The BDI according to Byrne and Baron (1993) is consistent with the view that depression is a continuum or dimension rather than a label that denotes a distinct condition or entity.

The BDI measures experience but does so without classifying or labeling the individual.

Psychometric Properties

According to reviews done by Stehouwer (1985), Carlson (1993), & Waller (1996), the results of the reliability and validity studies strongly support the BDI as being an accurate measure of depression. Test re-test reliability was shown to be strong as it demonstrated consistent relationships between the BDI and clinical states of depression. Using a Spearman-Brown correlation, reliability figures ranged from .90 to .93. These correlations were all significant at the .01 level. As was demonstrated in Stehouwer's (1985) review, concurrent validity coefficients ranged from .65 to .75 in regards to a comparison made between the BDI and psychiatric patients. In addition, regarding content validity the 21-item inventory adequately covers a wide variety of symptoms and attitudes associated with depression. Overall, the results of the reliability and validity studies strongly support the BDI as being a very useful and accurate measure for assessing levels of depression. Regarding the BDI and adolescents, a literature review by Byrne and Baron (1993) found internal consistency reliability for non-clinical adolescents to have ranged from .80 to .90. Additionally, their review of the literature found a test retest reliability coefficient of .74. The research done on the psychometric properties of the BDI has demonstrated that it is a stable measure that is consistent in its measures over time.

Qualitative Analysis

The qualitative approach to information gathering is an exploratory and descriptive process. Qualitative analysis provides an examination of the individual's own language and emotions. Qualitative methods are complementary to narrative therapy in that their goals are to be descriptive in that the analysis of data is comprised of both people's own written or spoken words and their observable behaviors. Additionally, qualitative analysis is a process that aims to be interpretive in exploring the personal and unique meanings individual's make of their own circumstances and experiences (Maxwell, 1996).

Note Taking

Note taking was used as a qualitative means of information gathering. Note taking can be an important element of the practice of narrative therapy. Freedman and Combs (1997) point out that the collaborative process of note taking can make a story more real to the individual involved. With regard to the practicum, the note taking and narrative transcription was a collaborative process between both therapist and participant. The note taking was comprised of mapping out with the participant the various structures of the personal narrative. The development and transcription of story arcs, character arcs, and themes were used to illustrate the progression of story development. Through the transcriptions both the participant and therapist were able to track changes in both character and story. The note taking process was used as a catalyst for the re-authoring or re-storying process of narrative therapy. Throughout the therapeutic process the transcription of

session notes afforded both the therapist and the participant the opportunity to review previously obtained statements and beliefs (story arcs, character arcs, themes etc.) that demonstrated evidence of the individual's participation in his/her new preferred story. Such a review was used to examine the change process that each participant was engaged in.

Developing a narrative map through note taking followed the basics of qualitative analysis. Specific details regarding symbol, metaphor, character, story, and context were placed within an overall structure of drama. Experiences and events were placed into a story structure that included the three-act composition. Through this informational organization the therapist and participant were able to slowly develop the individual's story.

Identifying meaning units as they pertained to the structures of narrative included:

- The development of the individual's personal story arc by acts (Act 1, 2, 3)
- The creation of a character analysis as it developed through each act of the story.
- Developing narrative themes as they emerged through the distillation of story.
- Developing themes and symbols as they related to story and character.

In addition to note taking, the therapist and participant also included the creation of diagrams. Use of diagrams is important to therapy in that it is a way to organize our ideas and thoughts. To Selekman (1997), the use of diagrams is a way to integrate our logic and imagination. Diagrams capture

a tremendous amount of information that helps us to see the relationships, connections, and patterns of our ideas (Selekman 1997).

A qualitative questionnaire was also used in this practicum. The questionnaire was issued during the last session to determine insights into the participant's feelings of the therapeutic content and process. It also allowed the participants the opportunity to evaluate for themselves how effective the therapeutic process had been for them. In addition the questionnaire was also used to obtain a general sense of their overall satisfaction with the service that was received. Feedback from individuals during the termination phase of therapy can be a crucial element to the therapist understanding the client's perceptions of how they experienced the therapeutic process. The use of an exit interview is also important in that it provides insight into the client's feelings about helpfulness towards enacting change in his or her life. The exit interview was based upon open-ended questions such as: "Your feelings of the counselling sessions were?" What, if anything, did you find helpful or not helpful in the counselling sessions?" "What do you feel you have accomplished through the counselling sessions?" "Has there been a change in the way you view your life?" and "Do you feel that your experience of depression has changed?".

Chapter 4

Case Analysis

Overview

In this section a case by case analysis is provided for each participant who was seen throughout the practicum. Each participant was engaged using the narrative therapeutic approach. All cases are discussed using a comprehensive analysis of each participant's personal narrative.

Although differing in presenting problems, each participant was approached using the same narrative focus. Each participant's narrative was both dissected and examined using the structures of drama. Using a "not knowing stance" allowed each participant the freedom for both self-expression and self-direction. Although this approach was taken, it must be noted that most participants were interested in an "expert driven" approach. To address this issue the therapist created an environment that fostered the development of a collaborative relationship. This collaboration was achieved by including each participant in the note taking process. This involved engaging each individual's full participation in developing the language, metaphor, symbolism and diagrams used in each session. Creating such an environment of collaboration fostered the development of both enthusiasm and comfort for both participant and therapist. This partnership between therapist and participant was essential in the establishment of both trust and security. It was under this atmosphere that each participant was afforded the opportunity to fully experience and explore the full meaning and depth of their own unique stories.

Data Collection

Each participant contracted to engage in 12 to 14 counselling sessions. Although each participant was committed to the completion of the therapeutic process 2 participants did not require the fulfillment of all 14 sessions. This is because they had achieved sufficient progress to terminate at an earlier point in time. In total there were 5 individuals who agreed to participate in the practicum. One participant was seen for 1 session and determined that she did not need or want services at that time. The remaining 4 participants attended the following number of sessions: Participant A was seen for 8 sessions, participant B was seen for 13 sessions, participant C was seen for 14 sessions and participant D was seen for 9 sessions.

Extensive note taking was used to record and transcribe themes, story construction, metaphors and symbols. This form of data collection is consistent with narrative therapy's belief in the importance of note taking to capture each individual's vocabulary and phrases when describing their own personal experiences. Such a process allows the therapist to both validate and reflect back the power of their own language and metaphor. Diagram construction between both therapist and participant was also used in conjunction with the note taking process. Data was also collected from intake forms and phone conversations with both participants and parents. Written assessments from psychologists, psychiatrists and therapists were also utilized.

Participant A

Participant A was a 17-year-old Caucasian male who came to therapy with issues of depression. Participant A had suffered from medical problems for the past number of years. It took participant A four years to develop a diagnoses of Crohn's disease. Participant A's illness had caused a delay in physical maturation. The Crohn's disease had postponed the process of puberty. It was noted that participant A was dealing with, common issues for a 13 year old at the age of 17.

Participant A was referred to the agency by a pediatric adolescent clinic. He was assessed as having a 2-month history of depressive symptoms including increased irritability, decreased concentration and increased distractibility. He also was reported as experiencing both anhedonia and showing little interest in socially engaging with his peers.

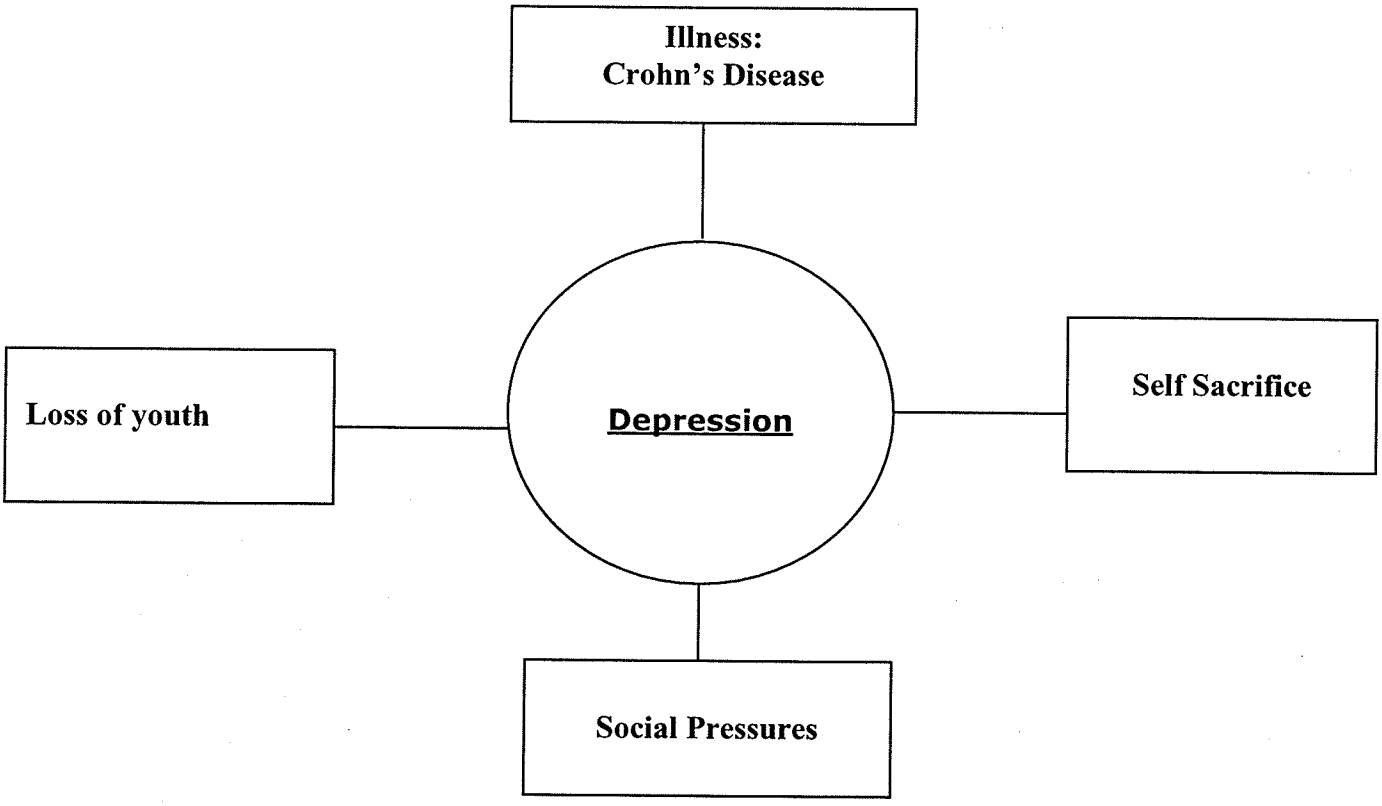
Participant A has been diagnosed with Crohn's disease. Coping with the illness had generated much stress, anxiety and depression in his life. Illness had resulted in extended hospital stay and resulted in lengthy absences from school. Because of the illness' impact, Participant A was often bed ridden which resulted in social isolation. Because of condition and resultant social isolation, participant A experienced periods of "mourning" as he felt that his youth had past him by. The illness had kept him from an important developmental period. His depression was also related to stress regarding choice of peers. Participant A had a group of friends who were much younger.

Teachers and other adults have criticized and chastised him for his involvement with younger friends.

Narrative Map of Depression

Participant A's Depression involved 4 major narrative components:

1. Illness: Crohn's Disease
2. Self sacrifice
3. Perceived loss of youth
4. Social pressures regarding friends



Symbolism and Metaphors

Much of the clinical focus centered on the externalization of participant A's depression. This externalization was achieved through the creation of

symbols and metaphors. Participant A viewed his depression as an "enemy" or "intruder" whose sole purpose was to take control of his emotions and life. Participant A described his experience of depression as being a constant battle that was being waged on a daily basis. When asked for details concerning the battle he was engaged in, participant A stated that his depression was an enemy who used "stealth tactics". Participant A felt quite vulnerable to the attacks of his depression as he never knew when they would strike. The most alarming element of his depression was that once he understood that the depression had made an advancement on him, it was already too late. Once his depression had successfully infiltrated participant A felt powerless. This sense of powerlessness lead participant A to just "give up" and "surrender" to the process of his depression. This subordinate position meant that his depression was left to its own devices. Participant A's depression was left to come and go as it pleased.

When asked for specific characteristics of his depression, participant A stated that his depression was a "trickster" who used its guile and stealth to devise "sneak attacks" on his defenses. Participant A stated that his depression was successful in that it understood all of his vulnerabilities. The depression according to him would actually use his insecurities against him. Being depressed prompted participant A to "sell himself out" to the depression. When depressed participant A found that he would actively turn against himself by over exaggerating his insecurities. This process further enflamed the depression and added to its intensity and duration. Participant A also stated that his depression would always be looking for times where his

defenses were low. He found that his most vulnerable moments were times when he was stressed, or exhausted. When in these vulnerable moments participant A's depression would "drill inside his head" until it had penetrated into a depth that it allowed it to take over his thoughts and emotions.

When the depression had taken control over participant A's emotions and thoughts, it was felt that a filter was placed over his eyes and sensory organs. This "filter" was used to screen out all information that ran counter to his depression. The result was participant A being precluded from seeing any "good things" that were present in his life.

Participant A also employed symbolism to describe his Crohn's disease. Participant A described his Crohn's disease to be "sniper" or "mercenary" who was always looking to catch him off guard. Having knowledge that this "sniper" was always lurking in the darkness ready to "get him" caused participant A much stress, as he was always weary of his condition's ability to "flare up". In the past, this sense of unease resulted in participant A becoming a social recluse. It was felt that this "sniper's" sole purpose was to ensure that participant A would never be able to enjoy himself socially. It was felt that whenever he was out and having a good time the sniper would attack. Participant A also stated that "just knowing it's out there" was enough to ruin any social outing.

Participant A also discovered a relationship pattern between his Crohn's disease and his depression. He believed that his illness and his depression had entered into a "partnership". Participant A felt that his illness created stress in his life which in turn made him vulnerable to the

depression. Likewise, when he put his mind to battling his depression, his illness would "flare up" and bring his spirits down even farther. Participant A described each element of the depression and Crohn's disease as possessing the capacity to open the door for each other. It was felt that he was constantly waging war against two enemies. Amassing his armies against one always left him vulnerable from attack from the other. Participant A felt that, in the past, it was a no win situation.

Story Arc

Act 1

Act 1 of Participant A's narrative involved the "good times" of the protagonist's life. This was a time of calm and ease. Participant A described his early life as being filled with happiness of both his self and his circumstances. He was a good student, a good person, and had many positive social relationships.

Act 2

Act 2 of participant A's narrative was seen to be a "turning point" in both the story and in his life. Act 2 was the part of the story where "things changed forever". It was felt by participant A that this was the "time of struggles" and where the "test of character" occurred. The major developments of this act were the discovery of his Crohn's disease, his depression and resultant feelings of "loss". The onset of participant A's Crohn's disease had left him hospitalized on many occasions. The last hospital stay took place in grade eleven and lasted for a significant period of time. The result of the hospital stays kept participant A away from his social

life such as social outings and social interactions. It was felt that the onset of the Crohn's disease and the resultant absences from school had somewhat delayed his maturation period. Participant A described the theme of this particular moment as being "a loss of youth" in that he never had the opportunity to experience all the "fun things" that people his age are privileged to go through.

Around the same period of time participant A stated that his depression emerged. The emergence of the depression caused a further set back to an already trying time. This depression signaled a new time of confusion. Participant A felt as though he was not the type of person that could be depressed.

Additional themes that emerged throughout this act included, "a test of character", "a test of will", and "a battle or war against himself". This time of struggles entailed what participant A envisioned as a battle to resist the changes that both the depression and Crohn's disease were inflicting on his character. This act was seen as a pivotal time in the story where his future would be determined.

Act 3

The participant was asked to develop two endings to his story. This included "a good ending" and "a bad ending". Participant A's good ending consisted of a return to his "real self". Participant A envisioned his good ending as a time where he could fully regain what was lost. The "good ending" would be a time where participant A regains his former disposition. This meant a return to his "happy" and "outgoing" self. In this ending,

participant A has weathered the storm and as a result becomes a stronger person. The successful transition from act 2 to act 3 entailed the defeat of his depression and a new found strength and resolve regarding his Crohn's disease. The culmination of the 3rd act demonstrated the purpose of the struggles of act 2. This purpose was a great test of both character and will. Each struggle was put into his life for the sole purpose of spiritual growth. Making the successful transition to act 3 was a signal that his "tests" were successfully completed. This culminated in the development of a greater depth of character that would successfully lead him into the next phase of his life. Participant A stated the "good ending" would demonstrate to him that he would be able to face anything that life would bring to him in the future.

In contrast, the "bad ending" consisted of a "failure to overcome". This failure would signal the further demise of his "real self". In this ending the battle with his depression is lost. This loss signified a life that would be defined as a constant "struggle to survive". It was believed that the depression and its negative perspective would result in a further weakening of his body. It was perceived that this weakness would give birth to a stronger form of his Crohn's disease. The 3rd act would culminate in both his depression and Crohn's disease teaming up to destroy his "character" and "will".

Character Analysis

Through the therapeutic process both therapist and participant identified two distinct characters within the narrative. It was believed that

over the course of time the nature of participant A's narrative had transformed him into a different character.

Act 1 of the narrative presented a character that was defined as "the self" or "preferred self". It was determined that this character inhabited the "good times" of the story. This was a time of calm and ease. Act 1 presented a conflict free environment that allowed his character the freedom to be "himself". The character that this "real self" included were based on the following traits:

- someone that was happy go lucky
- someone who was high energy/full of life
- helpful
- funny
- optimistic/possessed a positive outlook

It was believed that this character (the real self) constituted the essence of who the character really was. The real self was the person that participant A was supposed to be. A return to this "real self" encompassed many of the therapeutic goals.

In contrast, it was determined that the "struggles" of Act 2 had brought about a drastic change in character. It was theorized that the various challenges that comprised the second act forced the character to undergo a "metamorphosis". The character, through the onset of his Crohn's disease and depression, was subjected to a transformation. This new Act 2 character was titled "the false/negative self". The character that this "false/negative self" included was based on the following traits:

- depressed
- pessimistic/negative outlook on life
- low energy
- someone who lacked motivation
- more introverted
- more cautious/less spontaneous
- different

It was determined that this "false/negative self" was something that was not a natural part of participant A's character. This was demonstrated by participant A stating that the struggles of Act 2 left him feeling "different" and "unnatural". Although participant A desired a return to the "the real self" he understood that he would be forever changed by the trials he had faced. Although participant A understood that it was still possible to return to his "real self", he also understood that he would never be able to completely return to his old self. Participant A believed that the completion of Act 2 would leave him forever "different".

Unique Outcomes

Participant A began experiencing unique outcomes early into the therapeutic process. The more participant A understood about his depression, the more proactive he became. Participant A's understanding of his depression enabled him to challenge his thoughts and feelings. Having an understanding of how his depression worked gave participant A a more objective view of his experience. As therapy progressed Participant A found that he was demonstrating the ability to pause his depression long enough to

"see things how they really were". Participant A described this process as being able to remove the "filters" from his eyes long enough to gain a proper assessment of his situation. Being able to put a "pause" on his depression meant that participant A could properly judge his emotional reactions. Positive aspects of his life could now be validated and acknowledged.

Being able to see his life from a more objective position allowed participant A to properly assess the appropriateness of his emotional reactions. Participant A came to the conclusion that the assumptions that his depression would lead him to were not necessarily based on accurate information. The more participant A could challenge his depression the more he was able to see the "good things in his life". Through this ability participant A found himself gathering more and more control over his emotional reactions.

Through note taking both therapist and participant were able to document the frequency of the experiences of the unique outcomes. Having a created such a map allowed for an assessment of the change process. Being able to track the frequency of the unique outcomes allowed both the therapist and participant to compare where the story's protagonist was in his story. It was found that the frequency of unique outcomes closely mirrored the development of participant A's emerging strength. Participant A's improved mood seemed to rise with the frequency of the occurrence of the unique outcomes. Participant A stated that the unique outcomes that he became aware of or integrated into his story had a direct impact on his perceived strength.

This process of mapping out unique outcomes through note taking was also applied to his Crohn's disease. Participant and therapist documented all the times when his Crohn's did not hold him back from preferred activities. Each instance where participant A "took charge" over his Crohn's disease was integrated into his emerging "character strengths". Using such an approach to note taking was useful to participant A in that it could be used as further proof of the change process.

Change Process

Themes

At the beginning of therapy, participant A presented the following themes:

- a time of struggle
- a fight against "self"
- powerlessness
- loss
- negativity
- overall pessimism

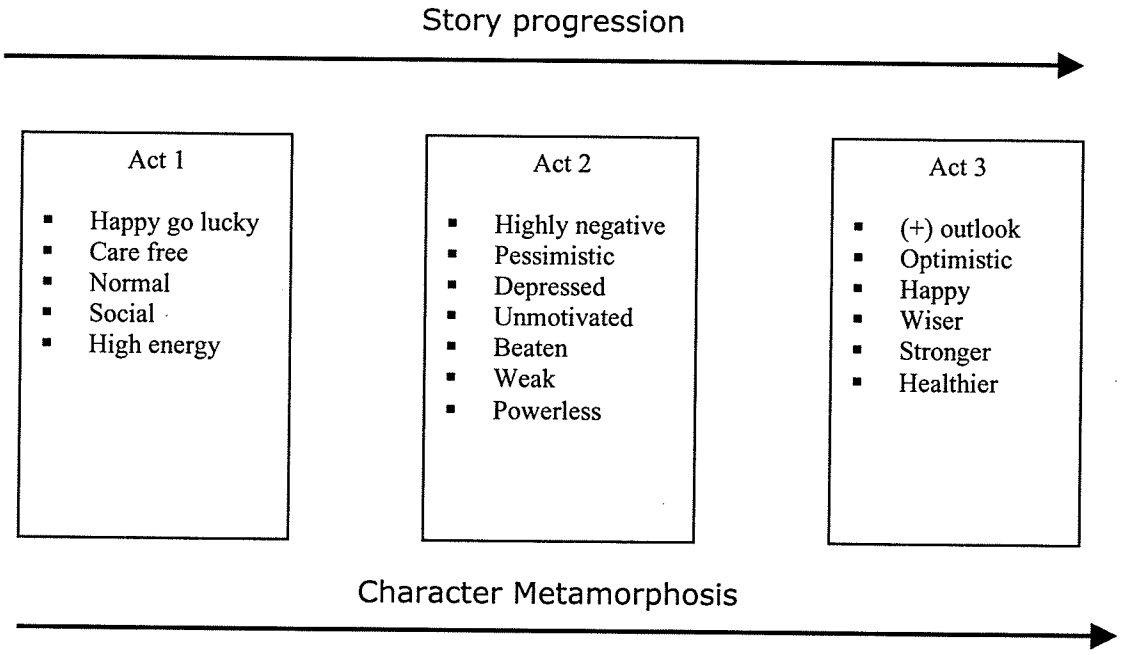
These themes were consistent with where participant A found his life to be in the present. The experience of his depression and Crohn's disease had overwhelmed his sense of resolve. Participant A's depression and physical condition had left him feeling defeated and powerless.

As the frequency of participant A's unique outcomes were both experienced and integrated new themes began to emerge. The following themes were documented to be representative of:

- a return to his "true self"
- triumph/victory
- strengthening of his character
- control over life
- commitment to health
- optimism regarding future
- wisdom
- satisfaction with life

These themes were consistent with the character/story metamorphosis participant A was experiencing. The more he understood his depression, the more control he was able to exert over it. The integration or re-storying of participant A's unique outcomes signaled the emergence of the "good ending" participant A had formulated for himself.

Change Process: Character Arc



Formulating a character and story arc aided both participant A and the therapist in determining the direction of the change process. Character and story arcs provided a map to determine if participant A was moving towards the realization of his preferred story.

Participant A BDI Scores

When considering participant A's BDI scores, it must be noted that he had been administered anti-depressant medication previous to this therapeutic intervention. The medication may have possibly skewed the results of the BDI scores. Participant A's BDI pre-test score was 13. This score fell into the mild depression range. Scores on the pretest that clustered around items 4,15, & 17, were consistent with participant A's concerns over his physical symptoms regarding energy loss, his decreased motivation and his feelings of anhedonia.

Participant A's posttest score was tabulated as being 3 and fell within the minimal range of depression. Although this suggests a significant decrease in scores, it must be noted that by the time of termination participant A was feeling the full effect of the medication he was taking. Thus, any conclusion regarding the success of the therapeutic intervention must be held with caution. The scores on the posttest displayed improvement in the overall self-critical dimensions. The scores from 1-13 fell from 9 (pretest) to 1 (posttest). Questions 14-21 showed a modest decrease from 4 (pretest) to 2 (posttest). The changes from pretest to posttest were congruent with the change in story themes that were recorded from beginning to end. At termination Participant A felt less negative about his life,

but still had concerns over his health issues and physical condition as his scores on questions 15 and 20 demonstrated his lack of motivation and physical strength.

Participant A Questionnaire

The qualitative questionnaire responses from participant A closely mirrored both the BDI self report as well as the overall story and character arcs that were developed. Regarding the 1st question, participant A found therapy to be very helpful. When asked about his overall feeling of the narrative approach participant A stated that he really liked the "life as a story" approach. When asked what participant A felt he had accomplished he replied, "I've realized some things about myself I had suspected but never knew for sure". When asked if there had been a change in the way participant A viewed his life he replied, "yes, I am happier again... things seem to be more positive now". These statements are congruent with the 3rd act themes and character arc that were established throughout the therapeutic process. Regarding the therapist, participant A found him to be friendly and enthusiastic. It was suggested that these two factors made the process of therapy "a lot easier". Overall participant A found the narrative approach to be a favorable way of understanding his life stating that it was a "very good method of therapy".

Participant A Summary

Overall participant A was a good candidate for the utilization of the narrative approach. Participant A took to the "life as a story" concept immediately. His ability for abstract thought regarding symbolism and

metaphor worked well with the therapist's approach to externalization. Participant A's progress was swift, and resulted in him needing only 8 sessions. It must again be noted that participant A was showing a positive reaction to the anti-depressant medication. It was observed that by the first session participant A was already feeling an emotional improvement. Therefore it is difficult to assess how significantly the narrative intervention contributed to this participant's overall change process or the improved BDI scores.

Participant B

Participant B was a 16-year-old Caucasian male who came to therapy with issues of depression and social anxiety. Participant B was diagnosed as having both a clinical depression and an anxiety disorder. Participant B was referred to the agency by his family doctor for assistance with his depression and school phobia. It was documented that participant B had a history of difficulty at school. This was marked by poor academic achievement and mild signs of attention deficit hyperactive disorder.

Participant B had been absent from school for 2 years due to onset of depression and anxiety. His social isolation and depression was linked to family dynamics. Regarding family dynamics, participant B came from a single parent household. He also demonstrated a strong mother- son bond.

Story Arc

Act 1

Act 1 of participant B's narrative was a time of normalcy. Through this act the "real" participant B developed. This was a time where participant B was most comfortable with himself and his life. Participant B found this time in his life as "a time where I was just a normal kid, doing normal kid stuff". Participant B found himself to be a reasonably well-adjusted and happy person in this stage of his story.

Act 2

In contrast to act 1, act 2 was a time of struggle and change. In this act participant B was subjected to many negative life experiences which resulted in the loss of his "real self". In this act participant B experienced the

fallout from the break up of his mother's long term relationship, the death of his mother's godchild, and the development of his mother's alcohol addiction. Through these negative life experiences participant B's symptoms of depression and social anxiety surfaced. The onset of the depression and social anxiety resulted in participant B's exit from school and subsequent isolation from friends. This act was described as a time of personal turmoil and darkness.

Act 2 was seen to be a perilous time where the path of his character was uncertain. Participant B was unsure if his character had enough desire or will to overcome the struggles of act 2.

Participant B's "good ending" would be measured by the exit of both his depression and anxiety. Having these two elements removed from his life would signal a return to his preferred "real self". Through his trials of the second act his character is able to develop the ability to "take charge" of his life. Through this new-found strength participant B's character is able to "get things done" in spite of his depression and anxiety. At its core participant B's good ending concludes with participant B once again becoming the person that he knows himself to be.

Participant B's bad ending would be signaled by a further spiral into his depression and anxiety. In this ending participant B is overtaken by his depression and anxiety, and is left cut off from the world. The bad ending of participant B's story concludes with his departure from achieving his life goals. He is unable to attend school and loses touch with all positive social

contacts. In essence, the bad ending culminates in participant B's failure to accomplish the goals that he wished to realize.

Metaphors

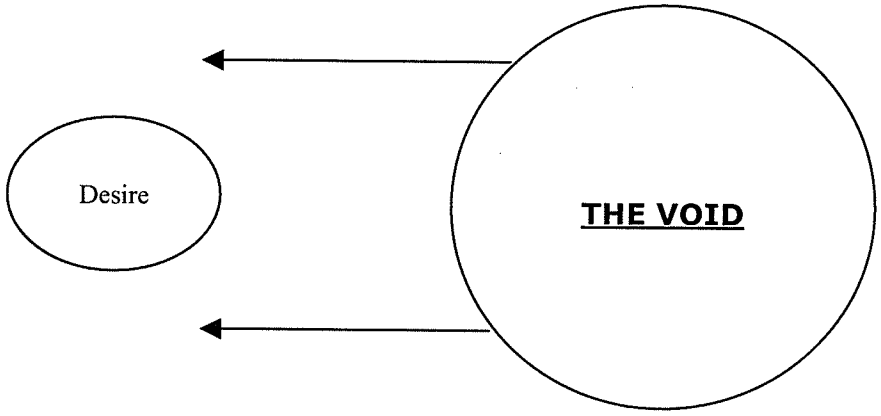
Much of the clinical focus centered on the externalization of participant B's depression. This externalization was achieved through the creation of symbols and metaphors. Participant B was very skilled in using abstract thought to formulate metaphors and symbols. This ability was undoubtedly the result of his artistic tendencies.

Participant B understood his depression as having 2 distinct parts. The first part consisted of the experience of overwhelming sadness and despair. This component was the "feeling" aspect of the depression. This aspect of depression was understood to be an "amplifier". This amplifier identified and intensified all negative experiences and emotions. The result of this amplifier was to intensify and prolong the duration of the depression.

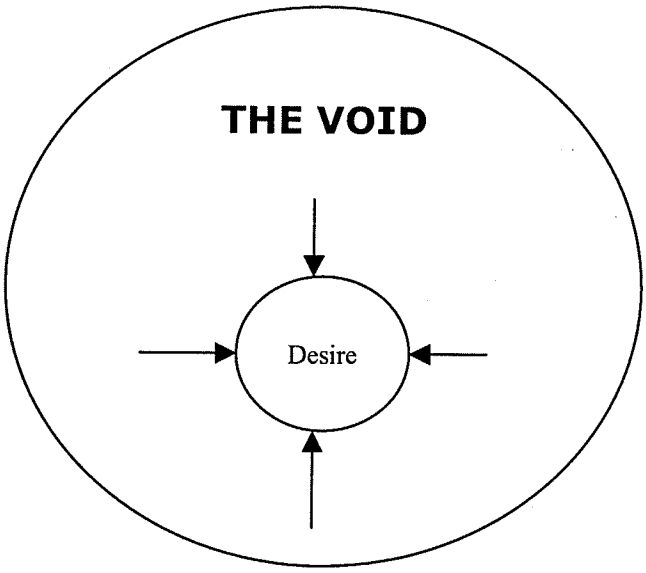
The second and more prominent element of the depression was labeled the "Void". This "void" was the dominant form of depression that was experienced throughout the therapeutic process. Participant B felt that the void was an emotionless state that cut him off from all emotions. The void was a bottomless pit of blackness that destroyed all of his positive emotions. One of the results of the "void" was social isolation. The void had a tendency of cutting off participant B from the world around him. Participant B explained the void as having the ability to nullify all the purpose and reason to life. Being inside the void removed all reason and meaning.

At the beginning of therapy Participant B felt that once the "void" encapsulated his life, it was too strong to resist. Any "desire" or "will" to overcome or resist its presence was digested and disintegrated. Both therapist and participant created the following diagram to demonstrate the process of the void.

The Void



The void encroaches on desire.



Desire is engulfed by the void and is digested and destroyed.

Participant B described his relation with his depression (the void) as one of "surrender". Because of its immense power, participant B felt as though he was defenseless. It was participant B's "lack of resistance" that resulted in his surrendering to his depression. It was thought that because of his subordinated position that his depression/void was able to occupy residence in his life for as long as it pleased. Participant B stated that the void would control when it would strike and how long its duration would last. The best participant B could do was to be passive and try to make it through the experience.

The Wall

The onset of participant B's depression and social anxiety resulted in the formation of a "wall" that separated him from the outside world. The erection of this wall established a barrier from engaging in social interaction. This barrier had kept participant B from showing the world who he really was. The "wall" was the armour that his depression used to cut him off from both the feeling of emotions and the world around him.

The Fortress of Solitude

Through the experiences of his social anxiety and depression, participant B became more and more isolated from the outside world (the erection of the "wall"). Participant B's anxiety had blocked him from social interactions. The depression/void further inhibited his motivation to engage in any form of social activity. The only safe place for participant B was his

home. Participant B's home was described to be a refuge from the outside world. This refuge was entitled participant B's "fortress of solitude". Throughout the therapeutic process it was found that although the "fortress of solitude" was a place of refuge it also aided in his social isolation and depression. Becoming overly dependent on the security of his place of refuge kept participant B from social interaction with the outside world. The security that the "fortress of solitude" afforded thwarted any motivation for participant B changing his circumstances. This was most evident in his decision to stop attending school. It was much easier to retreat into his fortress of solitude than to challenge his depression and anxiety.

As the therapeutic process continued it was determined that although the fortress of solitude was primarily a positive thing, it also possessed negative components. Participant B came to realize that becoming overly dependent on the safety of his home life actively prolonged his depression. Participant B came to realize that positive social interaction with his friends proved to be a deterrence to his depression. The more socially isolated participant B was, the longer the duration of the depression. Near the end of therapy it was concluded that the fortress of solitude was important to participant B in that it was a safe place where he could let his guard down and be himself. In contrast, it was also determined that becoming too dependent on the safety that the fortress offered was also a detriment to his overcoming his depression. Understanding the pros and cons of the fortress enabled participant B the ability to negotiate his way to a more balanced approach. It was determined that it was okay to use the fortress of solitude

as a safe place for his "real self", but it was not okay to become overly dependent on it.

Miracle Grow

Through the process of therapy it was found that there were certain components in participant B's life that provided him with strength when facing his depression and anxiety. These components when activated would initiate the growth of participant B's desire to overcome his depression. These components were comprised of the following three elements:

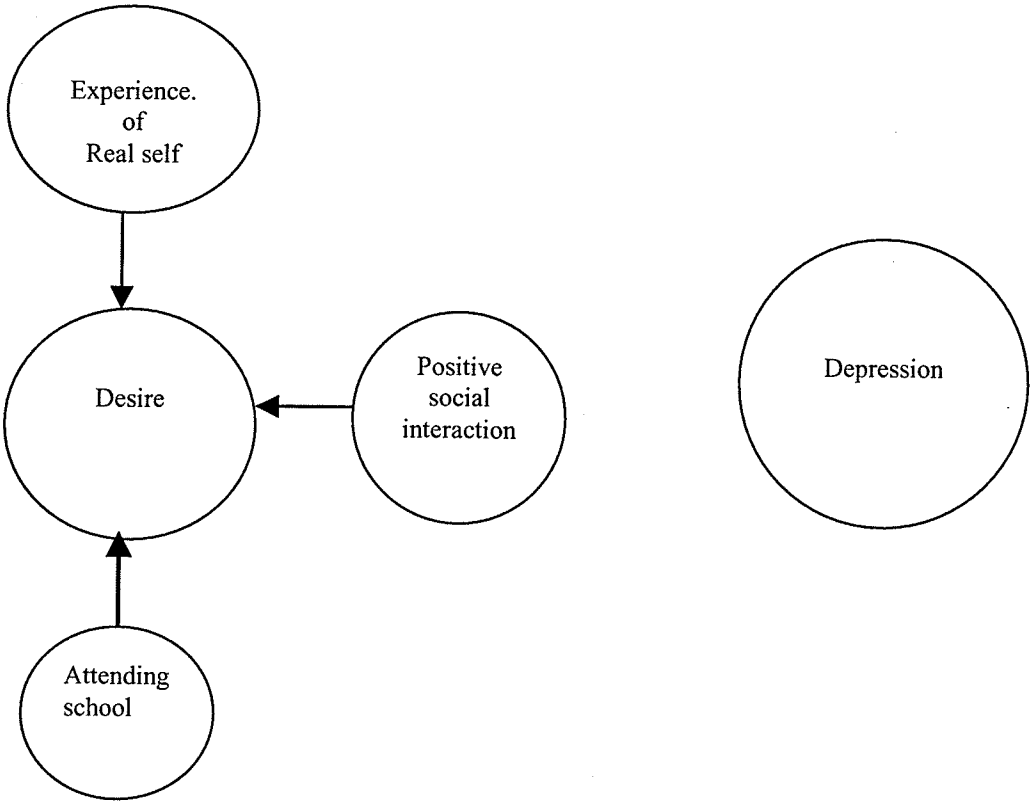
1. Returning to school
2. Engaging in positive social interaction
3. Allowing himself the opportunity to be "his real self"

It was determined by participant B that the fore mentioned elements acted as a "fertilizer" that aided in the growth of his desire. He labeled this fertilizer "miracle grow". The more committed he become to staying with school, engaging in social interaction and allowing himself the opportunity to be his "real self" the more participant B was able to stymie his depression.

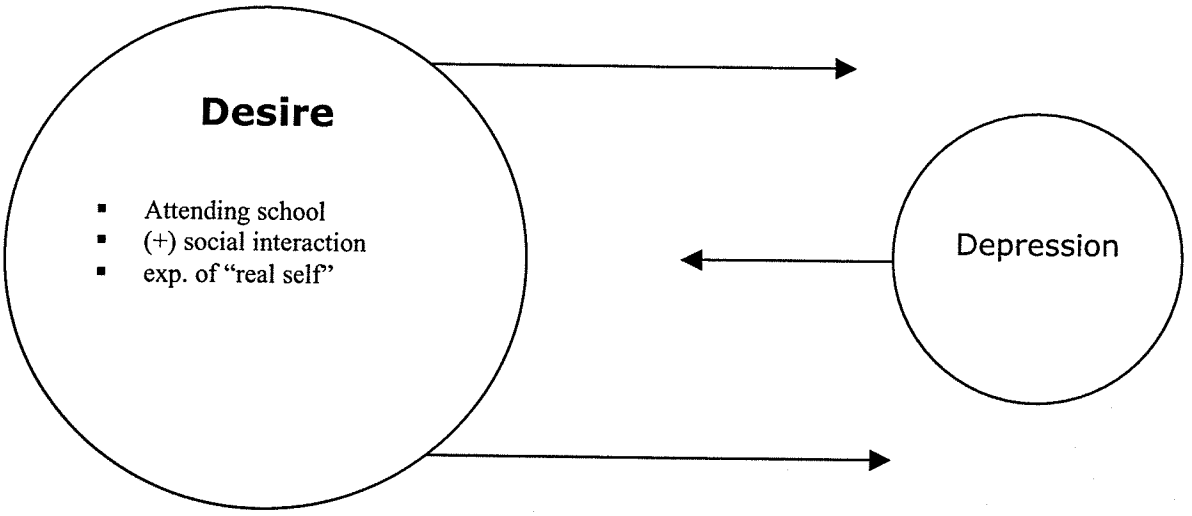
It was found that staying in school and socially interacting with peers lessened the duration and intensity of the experience of depression. Being able to do this enabled participant B to change his relationship with his depression. When he was able to socially interact and attend school in spite of his being depressed participant B changed his "passive" relationship to an "active" relationship. Both therapist and participant created the following

diagram to demonstrate the process of how the fertilizer or "miracle grow" worked.

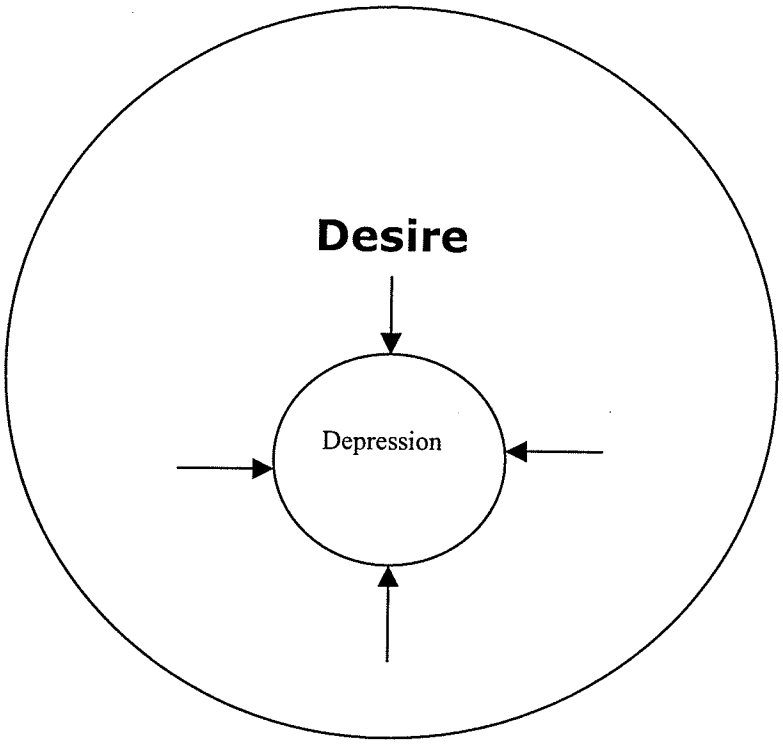
3 components converge on desire



3 components are digested and cause desire to grow.



Depression is engulfed by desire and digested and destroyed



Character Analysis

Throughout the therapeutic process three distinct characters were identified within participant B's narrative. It was determined that participant B's narrative transformed his character into 3 unique parts.

The first character was entitled "the original or real self". This was the preferred character that encapsulated much of what participant B felt that he really was. The "original or real self" was comprised of the following traits:

- A very social person
- Good humored

- Good natured
- Relaxed

This character was the pre-anxiety and pre-depressed person. Of all the character types this character was the foundation or starting point of all the others. It was felt that the other two characters were variations of "the real or original self".

The second character was entitled "the depressed character". It was determined that this "depressed character" surfaced early on in Act 2 of participant B's narrative. The advent of many negative experiences in both the family and school setting signaled the emergence of a depressed and anxiety-ridden state of experience. These life-altering experiences resulted in participant B's character undergoing a transformation. Participant B believed that his depression and social anxiety had negatively transformed him into someone who was "alien" or "foreign" to what his character had been up to that point. The character that this "depressed self" included was based on the following traits of someone who was:

- fearful
- socially anxious
- withdrawn and isolated
- morbid/ held a negative disposition
- passive
- weak
- carrying an emotional load.

In the latter stages of the therapeutic process a new character also emerged. This character developed in sharp contrast to the "depressed self" and was a positive marker in the actual change process. The emergence of this new character signaled the beginning of Act 3 of participant B's narrative. This character was called "the Quarterback". This character displayed the following traits:

- Strong sense of focus
- Efficient - has ability to get things done
- Resilient
- Motivated
- Emotionally Strong
- The play maker – cool under pressure

This "Quarterback" character was utilized in times of stress. Participant B called on this character when in need of initiating or engaging himself into the process of "getting things done". The "Quarterback" had the ability to lead participant B out of times when his depression/anxiety was threatening to over take his sense of control. The Quarterback was able to guide him through his situation in spite of the circumstances that he faced. Participant B stated that the Quarterback was the "go to guy" when the game was on the line. He pointed out that the Quarterback did not have the ability to eradicate the depression, but rather was able to negotiate him through it.

Unique Outcomes

The frequency of Participant B's unique outcomes steadily increased over the therapeutic process. The most significant unique outcome occurred

midway through the therapy. During the middle of therapy Participant B experienced a set back regarding his depression. It was at this time that participant B was overwhelmed by the "void". This experience had prompted him to withdraw from participating in the therapeutic process. A decision to quit therapy was made based on participant B's feelings that therapy was uncovering too many "negative experiences". Through phone contact it was identified that even though he was in the midst of a major depressive episode, participant B was still able to reach out to friends. This behavior was identified as being something that was out of the ordinary. Participant B realized that this was the first time that he was able to, despite his depression, exert some form of control on his actions. His willingness to reach out socially was understood to be a new dimension in the relationship with his depression. No longer was participant B willing to take a "passive stance". Instead, it was believed that his willingness to reach out was a demonstration of his desire to both "get better" or to "change" his circumstances. This particular unique outcome signaled a significant change in both character and story. This moment would later be identified as being the "turning point" in his personal narrative. It was after participant B realized the significance of his actions that he agreed to re-enter therapy.

Building upon his newly found "will" and "desire" to overcome his depression, participant B set into motion many more positive experiences for himself. It was determined that his unique outcomes occurred every time participant B attended school in spite of both his social anxiety and his depression. This was because it demonstrated his commitment to his

preferred story. Another important unique outcome that occurred was that for the first time participant B was starting to become more socially integrated at school. Participant B stated that people were beginning to approach him on a more frequent basis. For the first time in his life people were initiating contact with him. This was used as a marker for a major character change. Through this change in character, participant B found himself further integrating through participation in school activities. Participant B was now defined as someone who was "approachable". Participant B also stated that it was the first time that he felt as though he was "known to exist". He stated that it was the first time he really felt like he "belonged" or that he was "one of the people". This new approachable character was understood to be someone who was interesting, funny and intellectually stimulating.

Through the process, participant B stated that doing things in spite of his depression and anxiety lessened the duration and intensity of the experience. As his confidence and familiarity with his new character rose, so did the frequency of his "unique outcomes".

Change Process: Themes

Documenting and comparing the changing themes was useful to both therapist and participant in that actual change in story and character could be tracked. By creating a list of themes participant and therapist were able to monitor story direction regarding preferred experience such as the realization of the "good ending" or "bad ending". Understanding such direction enabled the participant to make needed adjustments regarding

which experience they wanted to live. At the beginning of therapy participant B presented the following themes:

- Life as a struggle
- Losing the battle
- Overall sense of pessimism
- Isolation
- Leading an unproductive life

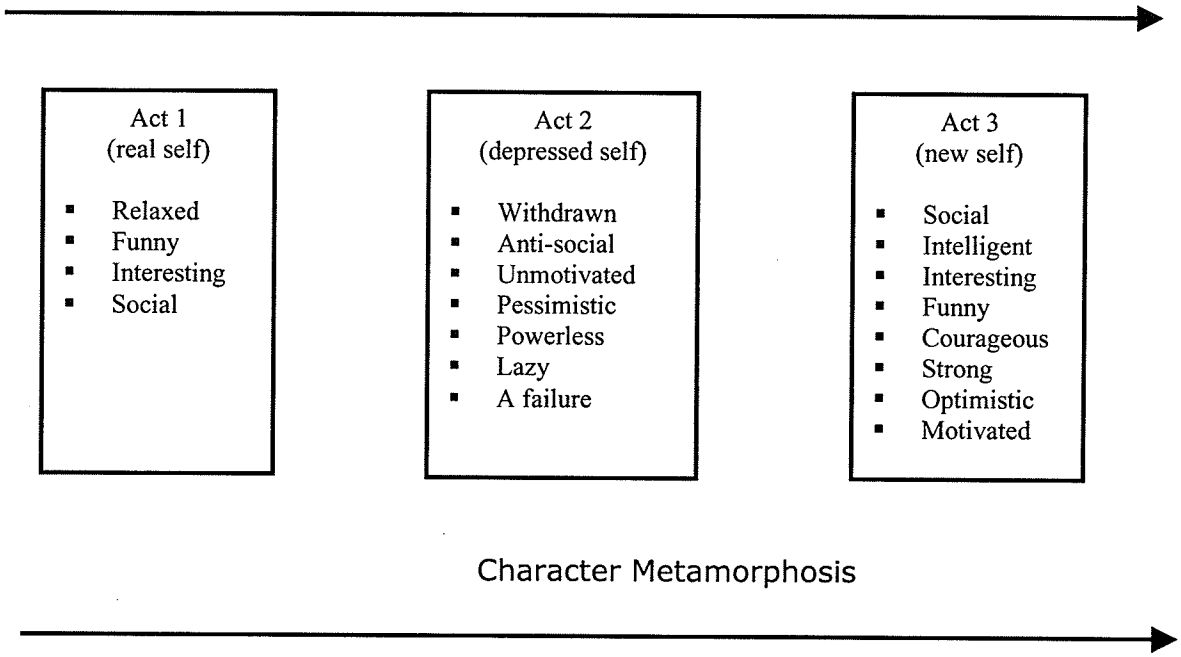
These themes were consistent with where participant B found his life to be. The experience of his depression and anxiety had in effect cut him off from social interaction, school, and his own motivation to "get things done".

As the frequency of participant B's unique outcomes were both experienced and integrated new themes began to emerge. These following themes were documented to be representative of:

- Power to change his life
- Power to control emotions
- Test of character/overcoming obstacles
- Courage/strength
- Optimism in the future
- Winning the battle

These themes were consistent with the character/story metamorphosis participant B was experiencing. The change in themes signified the emergence of the "good ending" participant B had formulated for himself.

Change Process: Character Arc



Formulating a character arc demonstrated to both participant B and the therapist that he was on his way to realizing the "good ending" or preferred story.

BDI Scores

Participant B's BDI pre test score was 9. This score fell in the minimal range of depression. It must be noted that participant B was on anti depressant medication at the time and this may have skewed the results of the self-report. Participant B did experience a set back midway through the therapy process and did demonstrate more moderate to severe behaviors that were consistent with a deeper form of depression. Scores on the pre-test were clustered around the self-critical questions of the BDI. The cluster of scores mirrored the narrative themes that participant B presented in the therapeutic sessions. Scores on questions 2,3 and 7 mirrored participant B's

sense of failure and self-reproach. Likewise, question 12 matched well with participant B's feelings of social isolation and basic disinterest in people.

Participant B's post-test score was tabulated as being 3 and again fell within the minimal range of depression. The post-test results showed modest improvements in the overall self-reports of depression. The improvement in scores from pretest to posttest were consistent with emerging themes that participant B formulated. Narrative themes of failure seemed to mirror the lower scores on questions 3 and 7. The experience of failure had been replaced with productivity and success as participant B was able to accomplish long held goals including attending and succeeding at school and socially integrating himself within the school community.

Participant B Questionnaire

The qualitative questionnaire responses from participant B closely mirrored both the BDI self report as well as the overall story and character arcs that were developed. Participant B found the therapy to be satisfactory. Participant B reported finding the therapeutic approach to be helpful in that it enabled him to "get out the things he needed to say". Participant B also reported that the narrative approach worked for him in that his overall feelings of depression and anxiety had significantly lessened. Regarding the therapist, participant B found that he never felt pressured to share things he wasn't comfortable sharing. Participant B also felt the therapist provided him with the freedom to explore whatever was of interest or concern to him at the time. In answering the 5th question, which asks if there has been a change in the way he viewed his life, participant B stated that he is "more

hopeful". Overall participant B stated that narrative therapy was important to him in that it allowed both the opportunity to be heard and provided the environment in which he could share his story.

Participant B Summary

Overall participant B was an exceptional candidate for narrative therapy. Participant B quickly accepted the concepts of narrative therapy and demonstrated a strong capacity for abstracting his life using symbolism and metaphor. Having this ability for abstraction enabled participant B to assume more direction and creative control over the development and examination of his story. Participant B also demonstrated a strong commitment to the therapeutic process with the return to therapy after an emotional set back incurred mid way through the practicum. Externalization and re-storying was quickly adopted by participant B. This predilection for narrative techniques hastened participant B's progress. It must be noted that this strong congruence with the narrative approach may have been benefited by participant B's innate artistic abilities. A strong sense of visualization no doubt contributed to participant B's story formulation.

Participant C

Participant C was a 16-year-old Caucasian female who came to therapy with issues of depression. Participant C was documented as experiencing a challenging nervous and developmental system since her birth. A psychiatric consultation also yielded the identification of symptoms of both Attention Deficit Hyperactive Disorder and Pervasive Developmental Delay. It was noted that participant C's social communication skill difficulties, anxieties, hypo-responsive tactile system, and idiosyncratic behaviors could also lie along the Asperger's Syndrome continuum. It was believed that although participant C's behaviors were along the Asperger's spectrum, reports of history and current level of functioning did not support a full diagnosis of this syndrome.

Participant C came to therapy with a history of anxiety and depression. When young she was diagnosed as having a tactile defense behavior. This tactile system left participant C being hypo-responsive to touch. It was because of this that she was highly uncomfortable with physical cuddling at birth, resulting in early bonding difficulties between participant and parents. Participant C also had been observed to have high difficulty with any form of change in the environment and in relationships. Participant C also has been diagnosed with symptoms consistent with ADHD. Additionally, the participant has communication difficulties with verbal communication regarding emotions and experiences.

A psychiatric diagnosis also outlined social communication difficulties; anxieties, hypo-responsive tactile system and idiosyncratic behaviors may be

along the Asperger's syndrome continuum. However, it was noted by her doctor, that her behavior and level of functioning do not support diagnosis of the full syndrome.

Participant C was reported as historically having had difficulty with emotional boundaries regarding friends. She becomes emotionally over involved with friends' problems. This intensifies her current experience of depression and generates further stress. With regards to family dynamics, participant C's family had a history of depression.

Participant C Story Arc

Act 1

Act 1 in participant C's life involved a "time of contentment". Participant C's life was described as "stable" and "grounded". This was a time when participant C found was the safest period of her life. She was surrounded with good friends and a community which she considered to be a "true home". This first act was described to be a "stress free" time in her life as well as being the only time she truly felt integrated.

Act 2

Act 2 in participant C's life involved "the turning point" in her life. This "turning point" entailed her family's relocation from a small urban centre, to Winnipeg. It was from this relocation that a downward spiral in mood and general functioning was initiated. According to participant C, Act 2 was the origin of her depression. Participant C described the second act of her story as being filled with loneliness and isolation. In this act participant C faced many obstacles which included increased family tension, a decreased level of school performance, and conflict in her interpersonal relationships.

Throughout this act there continued to be a "longing" for the better times that had gone past.

Act 3

Participant C's "good ending" would entail "love winning out in the end". Participant C found this to mean that she would find her true happiness. The therapist found that her "good ending" was much less realistic and more "fantasy" than the other participants' "good ending". Participant C believed that in her good ending her "Internet love" would come and "rescue" her from her miserable existence at home. Once removed from her home life, it was believed that her life would begin to "get better" and as a result return her to her previous state of emotional functioning. When asked for a more "realistic" version of her good ending, participant C stated that she would "somehow get over her depression and become more stable". To this she added that she would prefer to obtain a more "middle ground" regarding her emotions. This was defined by participant C as being "not too high, and not too low... but just in between". Although she desired to "overcome her depression" participant C believed that she would never be able to "wipe her depression out". Instead, participant C envisioned her "good ending" as being one where she would be able to use her depression in a positive way. This was described as being a state where she, because of her depression, would aide her in developing a greater compassion and awareness for the suffering of others.

In contrast to the "good ending" participant C envisioned her "bad ending" as one where things "never change". In this ending participant C

envisioned her life as continuing along the same path. Participant C did not envision her "bad ending" as one where her depression intensifies but rather an ending where her depression continues unchanged. This was defined as the continuance of her "blah life". This ending also included her experience of being a "prisoner" in her own house.

Character Analysis

Through the therapeutic process both therapist and participant identified one distinct character within the narrative. It was believed that over the course of time the nature of participant C's narrative would be consistent.

Act 1 of the narrative presented a character that was defined as "the happy self" or "preferred self". It was determined that this character inhabited the "time of stability" in the story. This was a time of calm and ease. Act 1 presented a conflict free environment that allowed her character the comfort of safety and contentment. The character that this "contented person" embodied the following traits:

- Friendly
- Stable
- Contented
- Happy
- Outgoing
- Loyal

Although the character in the 1st Act of participant C's narrative was the "preferred" character, she nonetheless believed that she would never be able

to return to this state. Participant C believed that she was not "destined" to be a happy person and therefore would never be able to return to that previous state of being.

In contrast, it was determined that the "Test" of Act 2 had brought about the formation of participant C's real character. It was theorized that the various challenges that comprised the second act brought about her character's "metamorphosis". The relocation to Winnipeg subjected her into a transformation. This new Act 2 character was based on the following traits:

- Depressed/sad
- Pessimistic/negative outlook on life
- Low energy
- Someone who lacked motivation
- Withdrawn
- Loyal
- Blah personality

It was determined that this act 2 character was something that would be consistent for the rest of her life. Depression was thought to be a natural part of participant C's character. The character of this act would not attempt to remove the depression from her life but rather learn to live with it as best she could.

Metaphors

An attempt was made throughout therapy to externalize participant C's depression using symbolism and metaphor. Participant C did not easily

take to the concept of externalization. This may have been a result of both her disinterest in the therapeutic process and her ability being incongruent with the narrative method. The one main externalization that was established was centered around her concept of her depression. Participant C viewed her depression to be a "big black blob". This "black blob" when activated, had a tendency to "blanket" every aspect of participant C's life. Participant C stated that this "blob" was most likely to get her when she was either "stressed out", "feeling overwhelmed" or "in a down mood". When vulnerable participant C described becoming "lost" in the void of blackness. Because the "black blob of darkness" engulfed her so completely, participant C felt as though she could not "fight it". Rather, she found herself becoming submissive or passive in her relationship with the depression. Participant C felt that her passive stand against her depression allowed it to occupy an unlimited space in her life. Without the capacity for resistance, participant C felt as though her depression could have its way with her life.

Participant C also found that her depression controlled her choices in life. Being depressed was not something participant C felt was necessarily apart from herself, rather she felt as though her depression was an essential part of her character. Participant C did not feel as though she could ever "remove" the depression from her life. Being depressed was essential to participant C in that it had, for the most part, altered the course of her "life's story". In this story, it was felt that depression would alter her life in the way that was "meant to be". Therefore participant C felt as though her depression was both essential and unavoidable. It was with this theme that

the therapy took on less externalization of the depression and more integration with the depression. This was achieved through the use of symbolization.

Because it was deemed that depression was an "essential" and "important" part of her life, it was determined that participant C alter her relationship with it. Both participant and therapist explored how she could have a more positive relationship with her depression. It was concluded that if depression was an essential component in her life's story, it must have a deeper meaning or purpose to the character's journey. Through this examination participant and therapist symbolized the relationship with her depression to be one of a "friendship" or "alley". It was believed that her depression had given her a deeper appreciation for "human suffering" and "human struggles". Utilizing her relationship with depression as being one of "friendship" afforded participant C the opportunity to use her emotions in a more positive way. The challenge for participant C was to transform her depression from an antagonist to one that was more an "alley". It was determined throughout the therapeutic process that in order for depression to be a positive force in her life, she had to first learn how to "master it". This supported participant C's ability to develop coping skills that allowed her to control her depression to an extent where she did not "lose" herself in the void or "black blob" as she had previously experienced her depression to be.

Internalized Discourse: Depression's Inner Voice

When in a negative cycle, participant C stated that the voice of her depression became very prominent inside her head. Participant C stated that the "voice of depression" was based on a script that outlined the following statements:

- Nobody liked her
- She had no friends
- She was stupid
- She would never amount to anything of significance
- She was all alone in the world
- She was a prisoner in her house

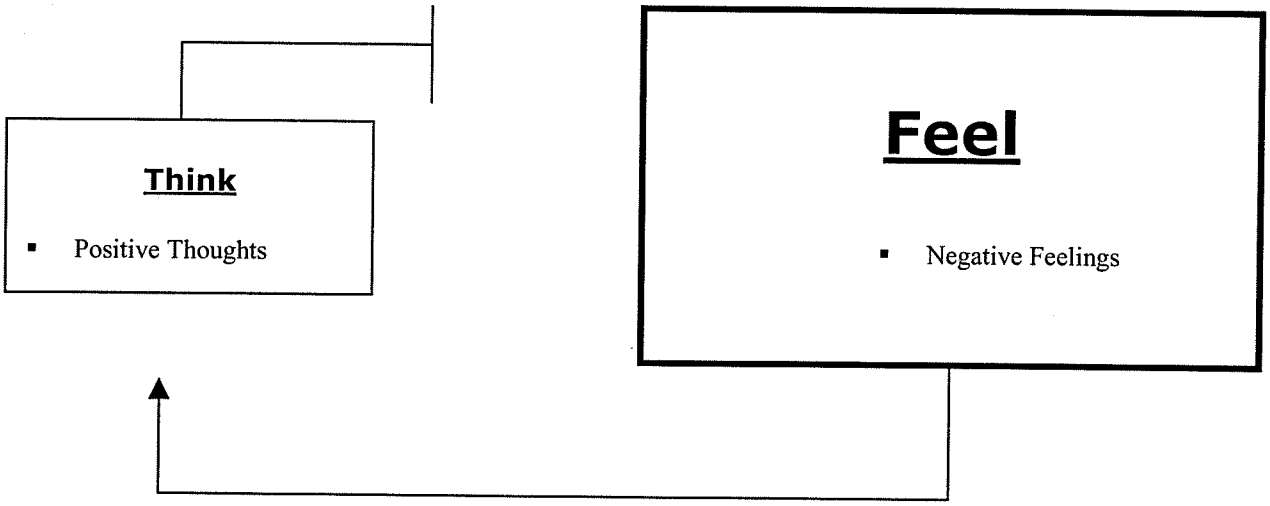
Participant C understood that the voice of depression would usually come through in moments of high stress and times of isolation. It was determined that participant C was "immune" from the voices of depression when she was engaging in positive social interactions. Understanding this connection enabled both the participant and therapist to develop strategies that resulted in her reaching out to people when she was feeling most vulnerable to the "voices of depression".

Externalizing the Process

In an attempt to understand her depression, both participant and therapist created a diagram to map out the process of her depression. By externalizing the process participant C was able to physically see her relationship with her experience of depression.

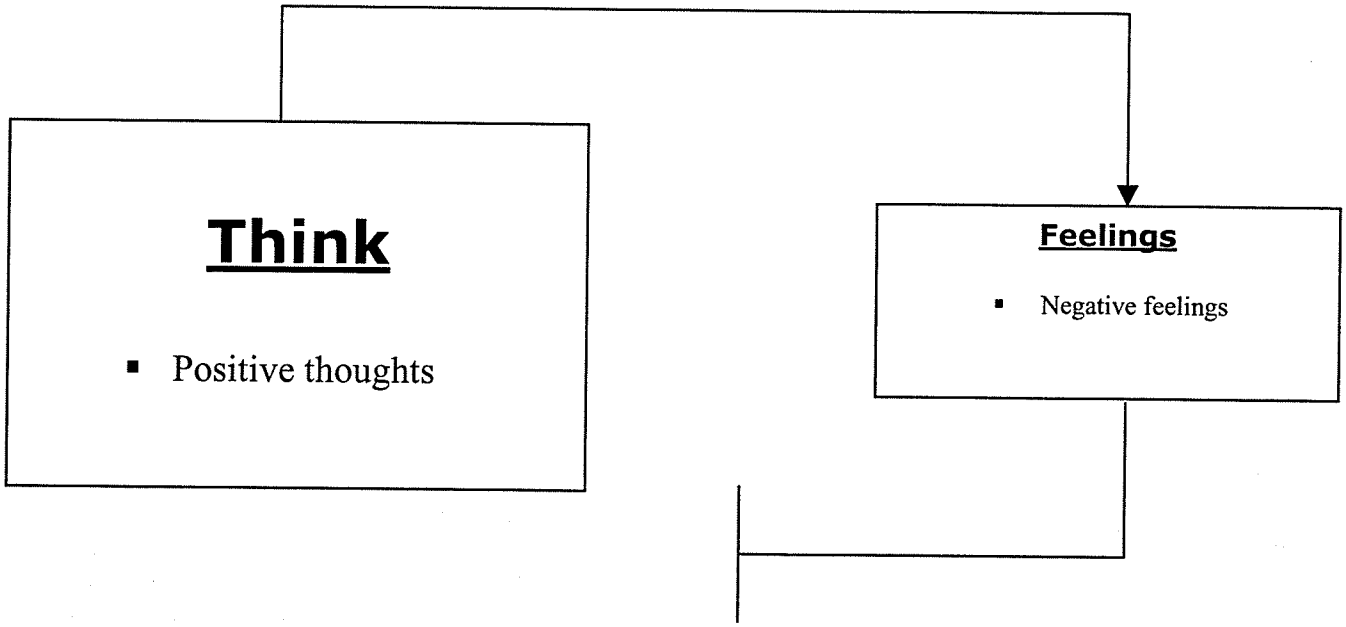
Negative Cycle

Feelings control thoughts.



Positive Cycle: Depression as Ally

Thoughts control feelings.



It was determined that when depressed participant C fared far better when she was able to "hear herself" think about positive thoughts. The more positive things participant C could identify about her life, the less intense her depressed feelings were. Likewise, the more participant C surrendered to her depression, the less apt she was to see any positive aspects in her own life. Participant C stated that being able to think before she felt gave her a more "objective" view of her story.

Unique Outcomes

Throughout therapy participant C was only able to identify three main unique outcomes. The first unique outcome identified was participant C's ability to control her emotions. Up to this point participant C had felt "powerless" and "passive" regarding her relationship with her depression. Midway through therapy participant C established a moment where she found the power and will to "stand up to her depression" and thwart its advance on her life. Participant C stated that when she had felt her depression encroaching upon her life, she was able to be objective enough to understand that "things in her life weren't as bad as her depression wanted her to believe". Understanding this, participant C was able to rationalize away her negative thoughts. When asked why in this moment she took this particular stance she replied "because I didn't feel like being depressed at that moment". This particular instance was identified as being significant in that it was the first such time she was able to control her emotions. It was agreed upon by both participant and therapist that this moment signaled a new character trait that enabled her to make "choices" regarding how she wanted

to react to her negative thoughts and emotions. It was agreed that this unique outcome demonstrated to her that it was possible for her to not be depressed.

The second identified unique outcome regarded her decision to enter into a romantic relationship with a "real person". This choice constituted a unique outcome in that she was enabling herself to "open up" to other people in a significant way. Participant C had always held people at arms distance. Participant C stated that she had always been a very private person and did not open up or share her inner "secrets" with anyone. The decision to enter into a relationship was seen to provide participant C with an opportunity to begin "opening up" to other people. Another positive aspect of this relationship is that it opened up participant C to a more realistic understanding of relationships. Prior to entering this relationship, participant C was engaging in Internet relationships with the opposite sex. These relationships were largely superficial and provided participant C with the escapism of fantasy. The choice to enter a "real" relationship was found to offer participant C with a more realistic way of relating. Although participant C was able to understand the different dimensions of each type of relating, she was unable to make a clear distinction or preference between the two. Participant and therapist were able to agree that the choice to enter into a "face to face" relationship did provide her with a more complete understanding of human interaction.

The third unique outcome identified was the expansion and development of her social networks. Participant C had always had a limited

social network. It was because of this that she found herself becoming overly dependent on her "best friend". Participant C stated that without her "best friend" she was left, for the most part, without any positive social interaction with her peers. It was determined that the beginning of the 2001 school year granted participant C the opportunity for the further development of her social networks. Participant C stated that her school year was "off to a great start" as she had been able to connect with many more people than she had ever had before in her life. When asked what was different this time around, participant C felt that she had given herself more of an opportunity to let herself connect with her peers. Participant C felt that she was more open, outgoing and positive when interacting with people. It was believed that this new way of presentation was a major catalyst in making her more personally accessible to her classmates. The result of her new way of presentation lead to her integrating herself into a substantial circle of friends. Being less dependent on her best friend left participant C feeling more secure and less isolated than she had previously experienced. Being with her new friends was significant for participant C in that it enabled her to experience herself as "not being depressed". Participant C found over time that she was apt to be depressed when surrounded by people that she liked. It then became important for participant C to utilize her network of friends in times she was feeling overwhelmed by depression and negativity.

Change Process: Narrative Themes

Documenting and comparing the changing themes was used to determine the course of participant C's narrative. It was hoped that creating

a list of themes that participant C had identified would enable the therapist to monitor story direction. It was hoped that participant C would be able to understand which direction her narrative was moving in the realization of the "good ending" or "bad ending". It was also hoped that understanding such direction would enable participant C to make the needed adjustments regarding what experience she wanted to live. At the beginning of therapy participant C presented the following themes:

- Life sucks
- Life is "blah"

These themes were very pervasive throughout much of the therapy. Altering these two themes was difficult in that they had been strongly adopted to be the foundation of participant C's life story.

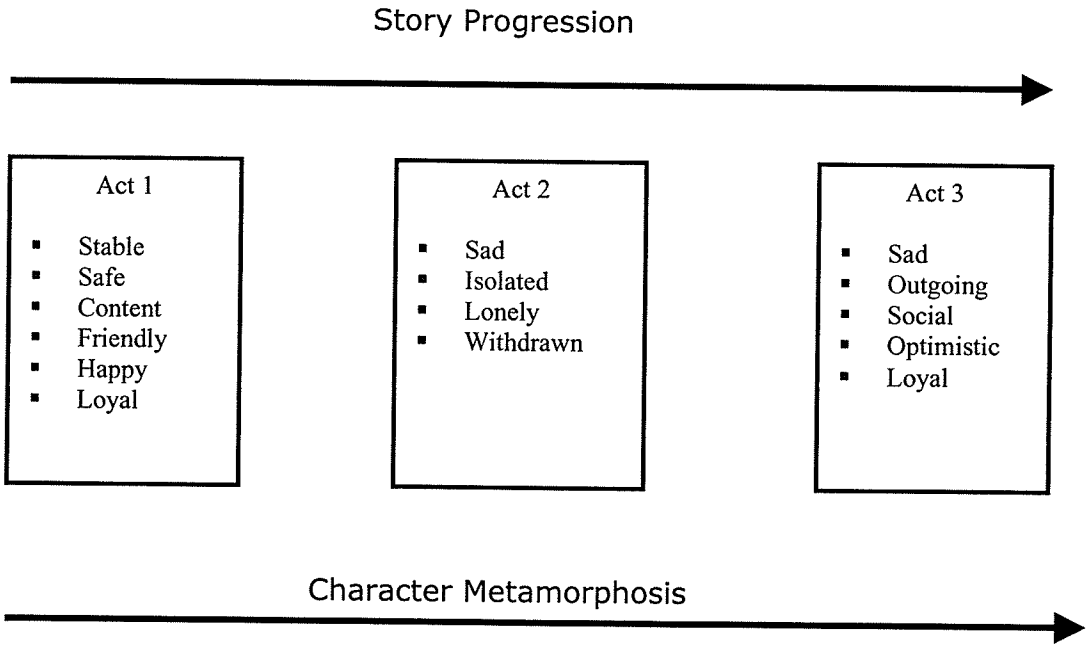
As participant C attempted to gain a different relationship with her depression (depression as a "friend or ally") she was able to begin formulating more life affirming themes. These newly developed narrative themes coincided with the emergence of participant C's newly formed social networks.

- Life is sweet with the occasional sting
- Life is an attempt to do the impossible as nothing is easy
- Life is not crying because it's over but smiling because it happened.
- Life as a test to see what you can take
- Everything happens for a reason

Although participant C was able to generate a more positive understanding of her life, she nevertheless was unwilling to give up her more negative themes of "life sucks" and "my life is blah". It was determined that participant C found a certain romantic quality in her depression and did not fully want to change or explore alternate realities.

Change Process

Character Arc



Participant C's character arc demonstrated some positive changes in character but it was found that sadness or depression was a prominent feature in each of the three parts of the story.

BDI Scores

Participant C's BDI pre test score was 11. This score fell in the mild depression range. Scores on the pre-test were clustered around the self-

critical questions of the BDI. The cluster of scores mirrored the narrative themes that participant C presented in the therapeutic sessions. Scores on questions 1, 2 and 4 mirrored participant C's description of her life being void of any meaning or interest such as the narrative theme of her life being "Blah". Likewise scores on questions 3, 7, and 8 matched well with participant C's themes of self criticism and self reproach including feelings of being worthless, stupid and not being liked.

Participant C's posttest score was tabulated as being 10 and again fell within the mild range of depression. The post test results showed a slight change in the overall dimensions of her self-reported depression. Participant C's scores for questions 1-13 were somewhat lower than on the pretest. In contrast participant C's scores on questions 14-21 were marginally higher. Although participant C was feeling less self critical of her life near the end of the therapy she was feeling more physical symptoms related to the stress of both school and family conflicts.

The overall change from pre test to post test was 1. This change in score was consistent with participant C's overall progress. As was previously stated, participant C did not feel as though she had overcome or lessened her depressive experience. Rather participant C stated that depression would always be an essential part of her life. In her words depression was something that she "could not change in her life". Furthermore the BDI scores are also consistent with participant C's self reports on the qualitative questionnaire.

Participant C Questionnaire

The qualitative questionnaire responses from participant C mirrored both the BDI self report as well as the overall story and character arcs that were developed. Regarding the 1st question, participant C found therapy to be satisfactory. Participant C regarded therapy as neither negative nor positive. This response was consistent with participant C's overall indifference to the therapeutic process. When asked her overall feeling of the narrative approach participant C again stated her indifference. She reported the approach was "ok" and "fine enough". Participant C stated that she found the narrative approach/therapist to be helpful in that "it was good to know someone was really listening to me". When asked what participant C felt she had accomplished during the therapy process, she replied, "I know I can explain my feelings if I want to". When asked if there had been a change in the way participant C viewed her life she replied, "No". This answer was found to be congruent with the overall themes that participant C established throughout the therapeutic process. Regarding the therapist, participant C stated that she would have preferred the use of more "vague questions". Overall participant C did not find the narrative approach to be a favorable way of understanding her life. Rather, participant C found the "life as a story" to be very "annoying and frustrating".

Participant C Summary

Participant C was the only individual to show minimal improvement. This may have been due to participant C's lack of interest and desire for treatment. Although participant C attended all 14 sessions, she made it clear

on many occasions that the only reason she was in attendance was because she felt forced by her mother. Participant C was very guarded throughout the therapy and tended to control the flow and direction of each individual session. Participant C was the gatekeeper of knowledge and would only let the therapist know what he needed to know at that moment.

Participant C presented in a way that was reminiscent of someone much younger than her years. It was noticed from the start of therapy that participant C was socially behaving at a level that is consistent with a 12-13 year old level. This immaturity was at times, in direct contrast to participant C's cognitive abilities. This lack of both maturity and social skills created a barrier to the development of the participant therapist relationship. The delayed maturation and lack of social skills was consistent with a doctor's assessment that was acquired midway through the therapeutic process. This assessment outlined participant C's social communication difficulties as being along the continuum of Asperger's syndrome. Although there were signs of behavior that were consistent of such a diagnosis, it was reported that her high level of functioning did not support a full diagnosis of the syndrome. This assessment was further supported through observations that were made throughout the practicum. Participant C's themes of extreme aloneness, poor communication skills and a resistance to change were reminiscent of the behaviors that are consistent with Asperger's Syndrome (Davison and Neale 1994, Szatmari 2000). Furthermore Harris and Glassberg (1996) state that although individuals with Asperger's syndrome are sometimes able to function independently in work or living situations, they may continue to

have difficulties with social interaction that can lead to the experience of considerable depression and anxiety in adolescence or early adulthood.

Although minimal, participant C did find some benefit from the therapeutic process. Participant C did report therapy useful in that she was able to open up to another person for the first time. Using the therapeutic sessions as an opportunity to develop her communication skills demonstrated to her that "she could explain my feelings if she wanted to".

Regarding the therapeutic approach, participant C did not find the narrative approach to be a useful way to address her depression. Participant C was very resistant to the idea of lessening or removing depression from her life. It was observed that participant C found much romance in her depression in that it opened the door to her "being saved". It was believed that one of her Internet relationships was going to "save her" from her miserable life at home. This fantasy was a strong theme that fueled participant C's resistance to change. In addition, participant C strongly identified her depression as being an essential component of her personality. It was because of this understanding that the thought of "removing depression from her life" was deemed to be impossible. It was through this identification that participant C was able to understand the "gifts" her depression had given her. Through an exploration of her depression it was understood that her depression had given her a greater depth of character. Such a depth resulted in her becoming more "human" and "compassionate".

Overall participant C accomplished the ability to understand that she had the ability to control her depression if she chose to and that she had the ability to open herself up to other people if she chose to do so.

Because of participant C's conflicts within her family system further services would be offered to this participant and her family through the agency.

Participant D

Participant D was a 16 year old Caucasian female. Participant D was documented as having a long-standing history of suicidal ideation and self harm. Prior to her contact with the agency participant D had spent a period of time at a urban hospital for concerns over an escalation of her suicide ideation. Participant D had also experienced sexual abuse form her former stepfather in the past. Participant D was prescribed medication in the early spring but had since chosen to discontinue due to unfavorable side effects. Participant D came to therapy with a past history of suicide ideation and a history of self-harm behavior. She had tried committing suicide in the past. Participant D also had a past history of sexual abuse by her stepfather that had occurred at two different points in time. In addition, participant D was also experiencing a mild form of anxiety. This anxiety was working in conjunction with her experience of recurring flashbacks, both conscious and unconscious, (nightmares) regarding the abuser and resultant episodes of abuse.

Because of the prior sexual abuse participant D was left with negative experiences and conceptions regarding men. One of participant D's themes of her life included being "used" by all significant male figures in her life.

Family dynamics

Participant D's home life presented as being very chaotic and disorganized. Although the mother-daughter bond was initially strong, the current relationship was under strain as past issues surfaced involving participant D's sexual abuse. Most notably, the mother had allowed the

former abuser, D's step father, to re-enter the home. This decision lead to the stepfather once again perpetrating sexual abuse against participant D. This sense of betrayal had been building for the past few years and was now beginning to surface. Participant D was also experiencing conflicts involving her stepbrother. It was noted that participant D's stepbrother's maturation had resulted in a strong resemblance in both physical appearance and mannerisms to the stepfather. Such a resemblance had begun to generate many emotions and memories of the past sexual abuse.

Participant D resided in a single parent household that included herself and her two brothers. The mother daughter relationship, at the time of therapy was strained. This was due to issues of betrayal and resentment due to her mother allowing the abuser back into the household. Participant D's family also had a history of depression and addictions. In addition to the mother-daughter conflict, there was also an intense conflict between participant D and her stepbrother. Participant D's stepbrother, through physical maturation/development, began to strongly resemble her step-father/abuser. This strong physical/behavioral resemblance was triggering memories and emotions in participant D that had since been forgotten. Participant D's stepbrother's presence, provided the source of pointed conflict in her relationship with her mother. These family dynamics created a negative and chaotic environment for participant D.

It was agreed upon by both participant and therapist that therapy sessions would be used to address her depression without the use of

medications. It was participant D's overall goal to become "emotionally healthy". Participant D came to therapy with the following goals:

1. Become emotionally healthy without the use of medications
2. To once again attend school
3. To find employment

Story Arc

Act 1

Act 1 in participant D's life was a short period in her life. This was a time where participant D found herself to be "most normal", and was the period of time that occurred before the sexual abuse. This time was described as being the happiest time of participant D's life. This happiness was marked by participant D being able to be the person she felt she really was.

Act 2

The second act of participant D's narrative was marked by events that would change her character forever. This transformation in character was brought about by her experience of sexual abuse. It was at this point where participant D's life took a gradual spiral into depression. These events also changed the make up of participant D's family environment, as relationships between family members were irreparably damaged. This chaos had transformed participant D into someone she "did not recognize". The result of this metamorphosis lead to participant D being hospitalized for both suicidal ideation and self-harm behavior.

Act 3

The bad ending of participant D's narrative entailed the continuance of her depression. In this ending participant D continues to lose herself in her depression. This is a time where participant D's life is further marked by failure and rejection. Through the escalation of depression participant D is unable to continue with school, and as a result never makes it back. Not being able to "get past her issues" leaves participant D isolated and lonely. She never acquires the opportunity to engage in any positive relationships and as a result lives the duration of her life in solitude. This ending is culminated by participant D's failure to ever regain a sense of "normalcy or happiness" in her life.

The good ending was marked by the overall theme of participant D becoming "healthy". The good ending entails participant D finally moving beyond her depression/issues. Through this process she is able to find a sense of what was lost. Being able to demonstrate "healthy choices" in her life enables participant D to become structured and productive. In this ending participant D returns to school and finds a "good job". Finding her "self" opens the door for participant D to find a partner who wants to be with her for who she is rather than what she can give. For the first time in her life participant D understands her worth as a person. This understanding allows participant D to involve herself with people who both respect her and treat her well. The overall theme of this act is "a return to happiness".

Character Analysis Participant D

Through the therapeutic process both therapist and participant identified two distinct characters within the narrative. It was believed that the occurrence of one significant event would mark a change in participant D's character.

The first character was called "good and happy person". This person was the preferred person or character, and was in existence before her crucial character "change" took place. This "good and happy self" was comprised of the following traits:

- "Good" person
- Outgoing
- Relaxed
- Happy
- Intelligent
- Athletic

This character comprised much of participant D's early life. Although a preferred character, participant D felt that she could never fully return to her previous existence. It was felt that her sexual abuse had changed her for life.

The second distinct character that participant D inhabited was the one that emerged after the sexual abuse had occurred. This character was believed to run counter to the Act 1 character. This character was labeled as being the "depressed character". This character was identified as having the following traits:

- Screwed up
- Different than most people
- Depressed
- Pessimistic
- Unproductive
- Unmotivated
- A failure
- Stupid
- Lost
- Quiet

The second act character was the character that participant D brought to therapy. She felt that her life events had left her feeling "so different" that she didn't know if she would ever become "normal" again. The sexual abuse and her negative romantic relationships had left participant D with feelings of being "worthless" and "used". These two elements, combined with participant D's absence from both school and employment fed the experience of and identification with her depression.

In the latter stages of the therapeutic process a new character also emerged within participant D. This character slowly developed into someone who was quite different than the "depressed person" she had believed herself to be. This newly forming character was a positive marker in the actual change process. The emergence of this new character signaled the beginning of Act 3 of participant D's narrative. This newly emerging character displayed the following traits:

- Capacity to be positive
- Motivated
- Productive
- Self loving
- Healthy
- Resilient
- Strong

Although participant D began to see the emergence of these new qualities, she nevertheless was still struggling to fully realize this new character. As participant D stated "I know I have the capacity to be a good person. I just wish I could experience it more often". It was agreed that the emergence of this new character was an indicator of participant D's emerging health. The ability to experience herself in a more positive and constructive way was a marker that participant D's "good ending" had the possibility of being "realized".

Metaphors & Symbols

Externalization of participant D's depression was achieved through the development of three major symbols or metaphors. The first symbol participant D identified was externalizing the depression as being a "Bottomless pit or black void". The danger that this "bottomless pit" presented was that when "free falling" through this void all meaning and reason for existence was lost. In her past, falling in such a "bottomless pit" resulted in a stay at a mental health facility. Throughout this therapeutic

process participant D was able to resist falling into the "bottomless pit". Regarding participant D's depression, the "Bottomless pit" was the deepest experience on the spectrum. Battling her void was a constant war for participant D. It was believed that in many ways this war was a battle of "life and death". At the beginning of therapy "keeping her mind off of it", the depression was her best defense against her "blackness".

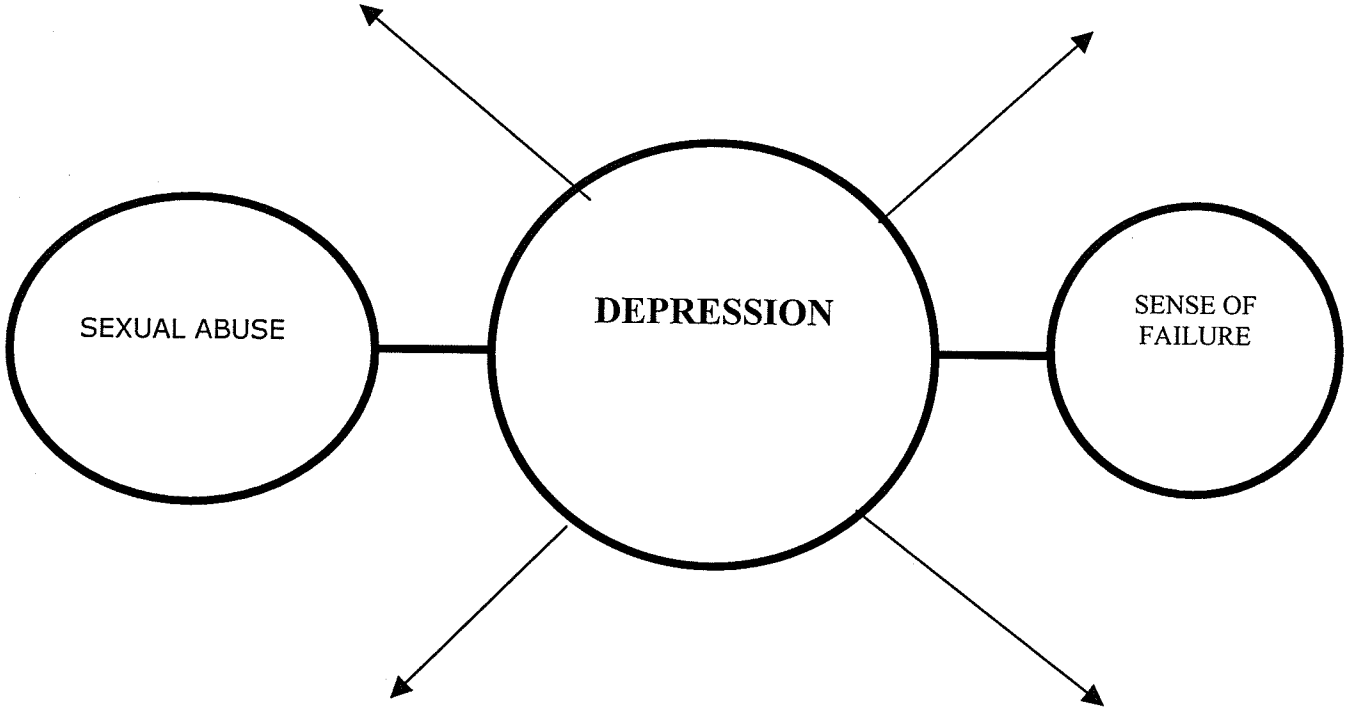
As therapy progressed, and unique outcomes integrated into her life, the "bottomless pit" shrank in size. This reduction in size resulted in a substantial loss of her depression's power. Participant D felt that as she became more "healthy" it was more unlikely that she could ever fully lose herself in the "black void". Depression could still be a factor in her life but was not the overall threat that it once was.

Participant D's depression was also externalized using a "thief" metaphor. When examining her story participant D spoke largely in terms of "loss". The second Act of participant D's life dealt specifically with things that were "taken from her". It was determined that her stepfather's choice to abuse her had taken away participant D's childhood. Experiencing the sexual abuse also robbed participant D of her feelings of "normalcy". Participant D felt that the abuse had "made her different" and "screwed her up". Participant D stated that her stepfather had "taken her soul from her". She had felt that her previous life had been "stolen" from her. In addition participant D felt as though her depression had "stolen her personality". The onset of participant D's depression resulted in the formation of a "new person". This new person was devoid of any discernible characteristics that

comprised participant D's earlier life. Participant D also stated that her depression had stolen her motivation and productivity. Not being able to attend school or work left participant D's days empty. This lack of motivation and productivity reinforced participant D's feelings of failure and self-reproach.

The third metaphor identified involved viewing depression as a bomb. When examining her life participant D was aware of her potential to "blow". This condition usually resulted in participant D engaging in self-harm behavior. Although not common, these moments of self-harm were always of great concern. Participant D identified 3 major components to her "bomb"; they included a) depression b) sexual abuse c) sense of personal failure. It was determined that the two components of sexual abuse and her sense of personal failure fueled her depression. If left unchecked during times of great stress, the emotional intensity of the depression had the potential to "blow up". The challenge that participant D faced was being able to both monitor her emotional escalation and being able to "defuse her bomb".

The Bomb



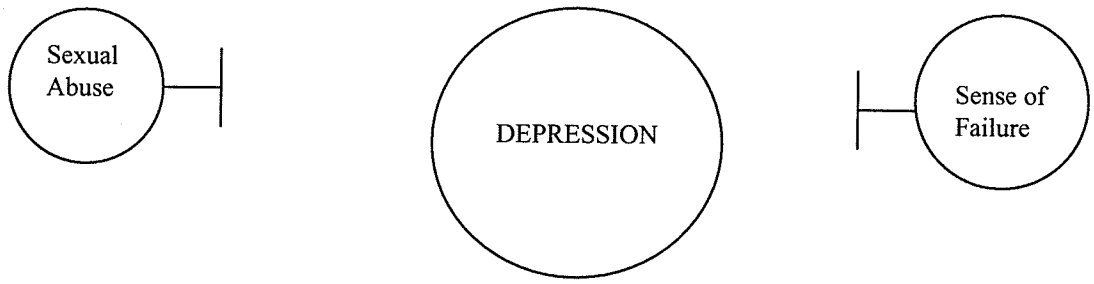
Sexual abuse and sense of failure fuel depression. Depression expands.

The Dismantled Bomb

Participant D came to understand that most people, through their own life experience, each have the components to build a depression. The difference for those who weren't depressed was that they were able to dismantle the components of the depression. Through the progression of therapy, participant D came to realize that she would always have the components to create a "bomb" or depression. She understood that our life stories are defined by many tragic experiences. Coming to terms with these experiences meant that she didn't necessarily have to use them to feed or create her depression. Through the identification and integration of her unique outcomes, participant D found that she possessed within her other

stories that she could live. Choosing to identify with her emerging preferred story, participant D found a way to begin dismantling her depression.

Components are disconnected. The bomb is dismantled or unarmed.



Throughout the therapeutic process participant D was also encouraged to externalize all of her "negativity" onto paper. Participant D stated that she never had the opportunity to confront her stepfather about all the things he had "taken" or "stolen" from her. It was because of this that participant D was encouraged to begin formulating a list of all the "unhealthy" things she had accumulated from her stepfather. To symbolize a separation from the negative aspects of her life, participant D agreed to physically burn the list at a later date. This act of burning the list was to symbolize "a cleansing" of participant D's life.

Participant D's Unique Outcomes

The frequency of participant D's unique outcomes steadily increased over the therapeutic process. The first identified unique outcome was participant D's commitment to therapy. It was stated from the first session that participant D's decision to come to therapy was solely hers. Participant D stated that she was committed to her "personal health" and that she had a

desire to work out her personal issues. It was determined that taking such a stand towards her "emotional health" was a demonstration of her feelings of personal worth. Participant D was able to see that her commitment to her emotional health was a demonstration of someone who "loved or cared about themselves".

The second significant unique outcome identified was participant D's decision not to use medication. This decision not to use medication was based on two factors. The first was that she did not like the side effects or the overall "drugged up" feelings it left her with. The second factor was that she did not want to become "overly dependent" on the medications. Taking medications for an extended period of time was not something participant D viewed as an improvement or success regarding her depression. Both participant and therapist understood this choice as representing the emergence of personal strength and resolve.

The third significant unique outcome identified was participant D's ability to return to school. Participant D initially entered therapy with the feelings of personal failure and a sense of personal apathy. This was due in part to Participant D's extended absence from school. Experiencing unproductive days contributed to both the creation and continuance of her depression. By enrolling herself back into school, participant D found that she had begun to "take control" over her life. Fulfilling this objective participant D found herself moving one step closer to her "life objectives". Every day she attended school was believed to strengthen her resolve to "become healthy" and to "overcome her depression".

The fourth significant unique outcome identified was participant D's employment. Finding part time work was an important occurrence in that it further allowed participant D the experience of being productive and self-sufficient. Becoming productive was important in that it kept her mind off her depression and gave her the feeling of accomplishment. By taking charge of her life in this manner, participant D felt that she was taking back some control over her life and depression.

The fifth significant unique outcome was identified as being the most important. As the therapy progressed, participant D found herself being able to "trust" men once again. One of the dominant themes in participant D's life was that of men "stealing things from her", having lost her childhood to her stepfather's abuse and her self-esteem from her previous boyfriends. Participant D found herself distrustful of all men. Being able to open herself up to another man signaled a change in participant D's vision of men. Being able to choose a man who respected her was believed to be significant in that it demonstrated the way she had felt about herself. Making good choices regarding men was a marker of how participant D felt about what she deserved. It was determined that if a person truly "loves themselves" they will pick people who will validate their own experience of personal importance. Having chosen to date a man who treated her well was a strong indicator for both participant and therapist that further demonstrated she was moving towards her goal of "becoming healthy". The choice she had made in this instance was a strong marker for change and signaled the possibilities that lay ahead of her in the future. It was deemed that "finding

a good man who will love her for who she is and not for what she can give them" was indeed becoming a real possibility for participant D.

Change Process

Dominant Discourses Participant D

Documenting and comparing the changing themes was a method used to chart the course of participant D's narrative. Creating a list of themes that participant D identified enabled the therapist to monitor story direction. Reviewing story and character development was a crucial element of therapy. Finding evidence of change was important for participant D. It allowed her factual evidence that indicated the positive movement of her narrative, the realization of the "good ending" versus the "bad ending". At the beginning of therapy participant D presented the following themes:

- Depression/sadness/loss
- Feeling "screwed up"
- Frustration
- Being a failure in life
- Feeling "different" or "abnormal"
- Feelings of being lost
- Being unproductive
- Feelings of being used
- Never meeting anyone who would love her for who she was versus what she could give them

These dominant discourses/themes were very strong at the beginning of therapy and were very difficult to change. Altering these themes was heavily dependent on the continual validation of unique outcomes.

New counter themes began to emerge as participant D began to both identify unique outcomes and then integrate them into her own life. This new experience of herself lead to the development of the following themes:

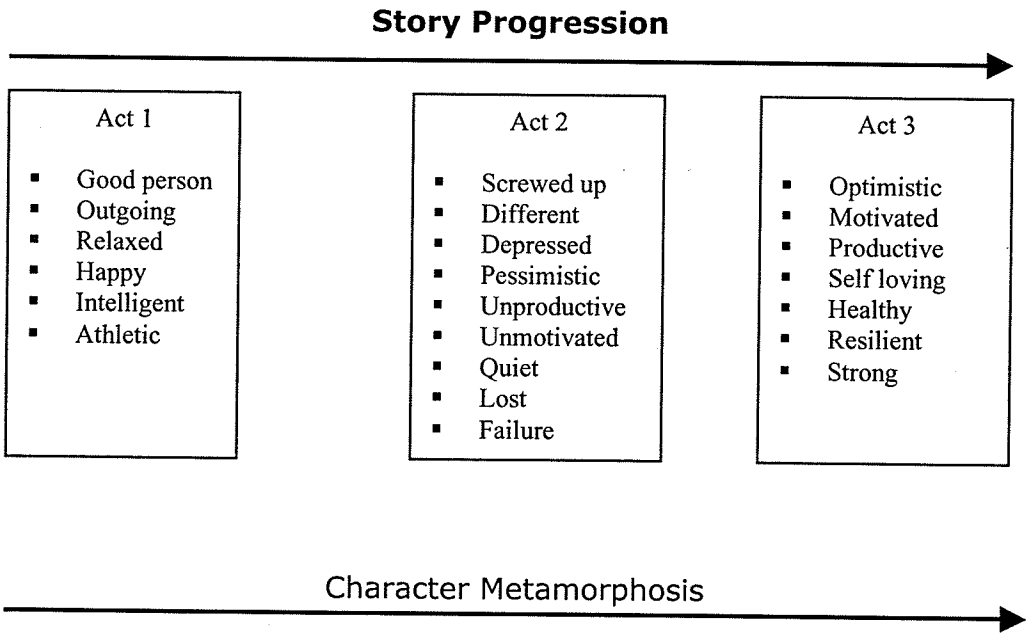
- A growing optimism
- Becoming more structured in her life
- Deserving of good things in her life
- It's possible to meet "good men"
-

A major factor in the changing themes was participant D's choice to bring structure and productivity back into her life. Attending school and securing employment reestablished a sense of "self esteem" that had been dormant an extended period of time.

Although participant D could not fully verbalize her "self love" she nevertheless was able to understand how her actions could be perceived to be a demonstration of someone who generally "loved themselves". The idea of self-love was a new concept for participant D and would be something that participant D stated " would have to happen on its own".

Change Process

Character Arc



BDI Scores

Participant D's BDI pretest score was 28. This score fell into the moderate depression range. Scores on the pretest were clustered around the self-critical questions of the BDI. The cluster of scores mirrored the narrative themes that participant D presented in the therapeutic sessions. Scores on questions 3, 6, 7, 8 and 14 mirrored participant D's feelings of self -reproach regarding her being "screwed up", "not normal" and her feelings of "being a failure". Likewise scores on questions 13, 15, 17 and 18 matched with participant D's themes of being unmotivated, unproductive and feeling depleted of physical energy.

Participant D Summary

Participant D was the only individual who was not taking medication at the time of my practicum. This decision was based on two factors. The first

factor was that she did not want to be dependent on medication for her happiness. Participant D stated that she wanted to "do it herself". Becoming healthy on her own was believed to be a more permanent solution. The second factor was based on participant D's aversion to the medication's side effects.

Participant D demonstrated a good understanding of the process of narrative therapy. She was able to comprehend both the externalization and the re-authoring process. In spite of all the positive changes participant D was making in her life she was still unwilling to acknowledge her "self love". Participant D was nonetheless able to understand how her current choices were evidence of an emerging self-love. She understood how her actions could be interpreted as actions that were consistent with someone who cared about herself. At the end of therapy participant D was gaining an awareness of the power she had over the direction her narrative could take. Through this understanding participant D realized that it was indeed possible to actualize the "good ending" to her story. Obtaining a fuller understanding of her life opened participant D to the realization that an individual's personal narrative is not static but fluid in its nature. It was hoped that participant D would be able to continue with the belief that "change is possible".

Although committed to the therapeutic process participant D would attend, on the average, once every three weeks. It was observed that even at this interval participant D demonstrated a noticeable improvement in her mood and behavior. With participant D's progress, only 9 sessions were needed. Although a noticeable change was observed, participant D was not

able to attend her last therapy session. This resulted in the absence of both her BDI posttest as well as completion of the participant satisfaction questionnaire.

Chapter 5

Conclusion

The practice of narrative therapy was found to be an exceptionally rewarding experience for the student. Narrative therapy's focus on exploring client strengths and building towards positive change was found to be congruent with the professional values of social work in that its focus is on the de-pathologizing clients. A narrative-interpretive approach to inquiry addresses the split between practitioner and client by embracing the humanistic philosophical assumptions that guide social work practice. The therapist is no longer the "expert" in the definition and diagnosis of the individual, rather the client himself holds the power to the meaning making process.

The use of dramatic structure also complimented the narrative approach in that it added a greater dimension to the "meaning making" process between the therapist and participant. The following is a review of some of the thoughts and ideas that emerged throughout this practicum experience.

Summary

Gender & Culture

Regarding the practicum, a narrative approach to understanding the participants' experience within a political and cultural context was met with limited success. Most of the practicum participants were more interested in the effects of their immediate environments versus the effects of the culture or social context. Gender issues were addressed as opportunities to discuss how our culture and society have influenced their experiences of depression.

Each participant was asked to place his/her story into its cultural, social, or political context. Participant D explored how living in a patriarchal society had made it easy for men to oppress women. Participant D reported that because of the power imbalances and inequalities, men were able to treat women as objects that they could use for their own pleasure. She associated this theme of oppression with her own experiences of being used by men, whether through the sexual abuse she experienced from her step father or through her own personal romantic relationships with men. To participant D the men in her life were direct examples of how society legitimates a "power over" attitude towards women. In addition participant B stated that depression was, to an extent, more expected from women than from men. This was because society socializes women to be more emotional, and to sacrifice their own happiness in favor of their husband's or children's happiness. Although these issues were discussed, both female participants did not feel as though these social and political factors played an important role in the overall origins or maintenance of their depression.

The male participants viewed depression as a phenomena of weakness. This societal belief was thought to be a cultural myth that our society routinely upholds. Participant A felt that men are socialized to be emotionally strong and resilient. In contrast to women, men are not allowed to show any emotions. Both male participants felt that it was easier for women to be depressed than men. It is under this context that men are not supposed to talk about feelings or emotions. Rather it is up to them to figure out solutions by themselves. Additionally, participant A felt that the North

American culture socializes us to be pessimistic about the way we view life. Participant A believed that our society is based on insecurities that force us to look upon life in negatives and not positives. When questioned participant A stated that the media bombards us with disparaging images and stories on a daily basis. It is this representation of the world that effects the way we view our lives.

In addition, both male and female participants viewed our culture as marketing "happiness". This was believed by all to be a cultural myth that has shaped our lives since the day we were born. To them happiness was an expectation that everyone in our society is pressured to achieve. This pressure was viewed as an extra burden in that being "screwed up" was a demonstration of failure. Participant C stated that depression doesn't always have to be a negative experience. To her, depression is, to some degree, a healthy experience. Participant C explained that this view of depression as being normal or healthy is undermined by our society's happiness ideal. She felt that society doesn't let people experience sadness in a healthy way.

Empowerment

Narrative therapy and its strength based emphasis proved to be beneficial in that it allowed each participant to understand that they possessed the strength to change. Taking a "non expert" stance allowed each participant to find answers through their own personal experiences. Being aware that they were their own "script writers and authors" enabled each participant the opportunity to see the power in their own sense of creation. Consistent with social constructionist thinking, the narrative concept of

empowerment challenges rationalist and empiricist/cognitive therapists to move beyond a predominant focus on an individual's interpersonal mental phenomena and become more knowledgeable of social, political, and economic barriers that impede personal development (Lyddon 1995). It is these barriers that adversely affect the members of marginalized groups. D'Andrea (1998) and Lyddon (1995) point out that when these barriers are brought into the therapeutic dialogue, the enhancement of the individual's sociopolitical awareness may become a potential therapeutic outcome in itself. According to Lyddon (1995) such an enhancement may not only represent an important shift in context but also may function as a significant precursor to client social involvement and action.

Critical Analysis

Deconstructive Questioning

Enlarging the landscape

Throughout the therapeutic process the therapist utilized White and Epston's approach to deconstruction. Many narrative based questions were used to deconstruct each participant's story. It was concluded that the use of such questioning resulted in the participant becoming conscious of the many gaps and ambiguities that were evident in each individual's dominant narrative. The result of this consciousness lead each participant to examine and approach their own narratives in a new and original way. Having this newfound ability resulted in each participant creating new/ alternate stories that ran counter to the original dominant themes. The deconstructive questions that were used throughout the therapeutic process were:

- What conclusions about the main character can we come to when examining your story?
- Why does the protagonist utilize such behaviors in this instance?
- What Act/scene of the story did such behaviors originate from?
- What are the barriers or obstacles that the protagonist is currently facing that is keeping him from the 3rd Act resolution?

History of Relationship Questions

Questions regarding the history of the relationship with the problem were used throughout the therapeutic process as a means to determine how the character of the story sustained, enflamed, or aided the problem's existence. Using history of relationship questions in conjunction with dramatic structure (viewing the participant's story as a novel or movie) was found to be an important way for each participant to develop an awareness of information of which the protagonist of the story was not wholly aware. Having the story become externalized allowed both the therapist and participant to engage in a character analysis. Through a character analysis the participant was able to identify behaviors and beliefs that supported the problem/obstacle 's existence. The history or relationship questions that were used throughout the therapeutic process included:

- Examining Act 1 character developments, what story events lead the current behaviors?
- Does the character have any choice in the way he is reacting?

- What specific scenes can we pull from the story that demonstrates why the character chooses to react in this particular way?
- What does the character get out of being depressed?
- If we were to do a story arc, where do we see the origin of these beliefs ?
- What kind of partnership does the character have with the depression? How does one feed off of the other?
- How does the depression actually control or influence the protagonist?

The Influence of Context

As in all stories the context under which it develops exerts powerful influences on character and story development. Using context questions throughout the therapeutic process was an important tool in exposing the effect of the greater surroundings each participant found himself in. Context questions dealt with environment/culture, gender in society, and the influence of additional characters. Through the use of context questions each participant was able to view how the character's problem was supported by other mitigating factors. Context questions that were used throughout the therapeutic process included:

- Did the context of setting of the story influence the protagonist's ideas and beliefs?

- As we review the story can you think of any specific situations that made the protagonist more susceptible to the depression?
- How do you feel society's view of women/men had influenced the protagonist depression and self -concept?
- What if any effect did the other characters in the story have on the protagonist's depression?
- Did any of the other character's benefit from the protagonist's emotional condition?

Plot Device Questions

Viewing the participant as both the writer and director of their own lives was an important tool for them to understand their own creative power. When examining each participant's story the therapist found it useful to inquire into the unique "plot devices" that were being used throughout the story. Understanding plot devices was a way for the participant to both take responsibility for and engage in the "meaning making process". Understanding themselves to be the scriptwriter and director of their story enabled each participant to understand their own "creative control". The devices of plot questions included the following:

- Of what purpose does the depression have to the overall story?
- What was the purpose of having the character react this way to the situation?
- Why was it important for the character to experience depression in these instances and not the others?
- What kind of statement is the author/director of this story trying to make?
- Is the depression used as a metaphor?

- Why do you think the story is set up in this manner? Is there a reason to this set up?

Narrative Therapy and Dramatic Structure

Michael White and David Epson (1990) view the narrative metaphor as a story that extends through time. Mapping out such a story through its appropriate frame of time is essential for the perception of difference and for the detection of change (White and Epston 1990). Utilizing dramatic structure was a valuable tool in this "mapping out process" in that it both organized the narrative into a cohesive frame of time and also provided a cogent demonstration of change.

If, as White and Epston (1990) state, our lives are stories that extend through time, it can then be surmised that our lives will consist of three distinct parts. These parts include the beginning, middle and future. Applying dramatic structure to the participant's narrative enabled the therapist to organize the individual's story into the appropriate units of time. The use of the Acts of story composition provided the structure in which the participant's story would be mapped. Act 1 encompassed the past, Act 2 encompassed the present (middle struggles) and Act 3 encompassed the future (resolution). The use of 3 acts of story composition allowed both the therapist and participant the ability to begin the comprehensive "meaning making process" that entails narrative therapy. Using the dramatic structure allowed the therapist insights into the participant's subjective interpretation of his/her own unique story. Through this story organization the therapist and participant were able to create both story and character arcs.

Life Analysis

In therapy a person will explain their lives in three distinct components.

PAST	PRESENT	FUTURE

Story Analysis

Act 1 **Once upon a time**	Act 2 **Years past**	Act 3 **And then one day**
▪ Introduction to protagonist's goals	▪ Middle struggles	▪ Resolution of conflict

Using dramatic structure the participant's life was broken into the 3 components Of Act 1 (the past) Act 2 the present (time of struggles) a time when they come for therapy, Act 3 the resolution of conflict.

Landscape of Action and the Story Arc

The use of story arcs within the therapeutic process fit well with the narrative concept regarding the landscape of action. The utilization of story arcs corresponded to the development of the "story grammar" that constitutes the landscape of action. The "who, what, where and when" of the participant's narrative was exposed by arcing the individual's story into the elements of setting/environment, other characters, and self. Through the creation of story arcs both the participant and therapist were able to develop the overall relationship between the person and problem, along with how the setting/environment, and other characters also influenced the themes and

direction of the story. Once a story arc had been sufficiently developed, each participant's problem was examined by the use of specific scenes or experiences. Examining specific scenes allowed the therapist and participant to understand a) what happened, b) the sequence of events, and c) the other characters that were involved. The landscape of action was developed through what Freedman and Combs (1996) call "how" questions. Throughout the therapeutic process the therapist utilized such questions as: "How did the setting or environment affect the character's reaction to the situation?", "What effect did the other significant characters have on the protagonist's life?", "What were the defining scenes of the story?"

Landscape of Consciousness and the Character Arc

The use of character arcs within the therapeutic process also fit well with the narrative concept regarding the landscape of consciousness. The utilization of character arcs was an essential component in the participants' ability to reflect on the implications of experiences stored in the landscape of action. The development of character arcs was a way in which each participant could generate meaning in their personal stories. According to Freedman and Combs (1995), we only become really involved in the narrative once we are able to reflect on the meanings of the individual's actions. Placing the character arc within the confines of the story arc was a way to move between the landscape of action and the landscape of consciousness. Drawing on key story developments opened the door to an analysis of the protagonist's wishes, motivations, beliefs, and actions as they pertained to the each significant scene or development. Regarding the

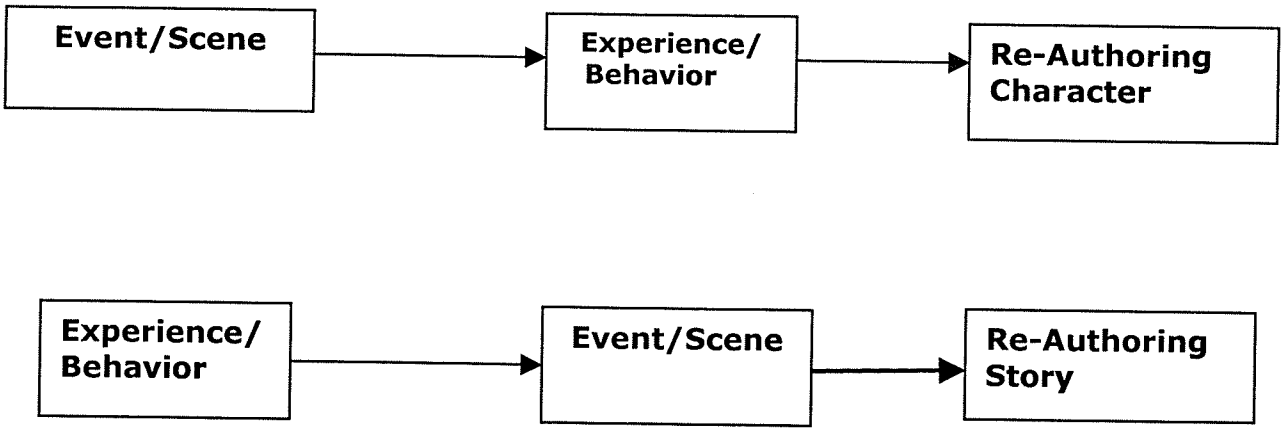
character arc, meaning questions that were used included: "What do you attribute the change in character to?" "What do you appreciate most about what this character is demonstrating?", "What does these particular reactions to the problems say about the protagonist's character?".

Utilizing character arcs was also a way to demonstrate change in a more vivid and real way. Being able to identify key moments in story and the subsequent change of behaviors allowed each participant the opportunity to become fully present and aware of the change process in which they had found themselves. As each story developed, character arcs allowed each participant to re-experience and validate the change process. Questions used to generate this awareness were:

- Why could these new/different behaviors be significant?
- Why is this character acting the way she is acting?
- How are these new beliefs altering the character's journey?
- Looking back at the character arc, what can we conclude.... Is this a good sign.... What are some examples of the significant indicators of the change process?"

Just as in narrative therapy, the therapeutic process of co-authoring of the participant's narrative was a result of the back and forth movement between story arcs and character arcs. The identification of a unique or different character trait or behavior by the participant signaled the therapist to move into the story arc to determine what specific "scene" was a demonstration of the new behavior and vise versa. Through this back and forth exchange between participant and therapist and story arc and character arc, new stories were created and expanded. An example of this would be

when a participant would come to therapy in a "Good mood". Identifying the "good mood" as being a unique outcome/new experience allowed the therapist to place the character trait into the story. By asking the participant what had set up this "good mood" allowed the therapist and participant to build a "scene" of the story that could be integrated into the overall story. Thus a new and different story arc would emerge. In contrast, when a significant "event/scene" unfolded, the therapist would ask how the character responded. If the participant was able to see the character's reaction as "different" or "significant", the new behavior was added to the overall character arc. Additions to the character arc were then used as concrete evidence for character change or character/story metamorphosis.



Story Arc and the Dominant Discourse

Throughout the therapeutic process it was important to expose the dominant discourse that each participant was living his/her life under. Having utilized questions such as: "What sustains the depression?" "What

role does the depression play in the overall story?" " What resistance does the protagonist have against the depression?" "What meaning does the depression have to the character?" Having utilized such questions exposed the subjugating dominant stories that encompassed each participant's life. Being able to expose the participant's dominant discourse paved the way for the development of story arcs.

Exposing dominant discourses helped both therapist and participant to display dominant story themes as they related to each individual act as well as the overall theme of the narrative. Through the process of therapy each participant was asked to expose the dominant theme of his/her personal story. In conjunction with the exposure of the dominant theme, each participant was also asked to expose dominant themes that encapsulated each individual act. The dominant discourse that was identified for each act was then built into the overall theme of the story. Throughout this process the story was arced into a structure in which each participant was able to both view the change process as well as begin taking a more active role in story creation.

The Participant as Screen Writer

Internalizing Discourses

Throughout the practicum, the therapist approached each participant as being the author/screenwriter of his/her story. Approaching each participant in this manner allowed the participant the opportunity to see his/her own involvement in the creative process that entailed story development. Internalizing dialogues were exposed by the therapist through

transcribing passages of inner dialogues each participant had in relation to their feelings of depression. Many participants scripted their inner dialogues as an exercise in self reproach. Many of the participants stated that their inner scripts with their depression resulted in dialogue passages that included their depression telling them that they were "no good", "ugly", "stupid", "damaged" and "useless". Exposing these inner dialogues into a transcribed script format allowed the participant to be viewed as holding the creative control. Taking such an approach resulted in the therapist asking the following questions:

- Why are these particular words being used?
- What is the significance of that passage of dialogue?
- What is the reason you are writing these words for the protagonist?
- How does the use of these words tie into the specific scene?

Using this approach was also useful in pointing out more positive aspects of inner dialogue.

- I've noticed a significant change in dialogue here. Why the change? What direction is the author now taking in regards to character development?
- What does this new choice of words signify about the development of the character?

- This passage of dialogue certainly is different then what took place in earlier scenes. What does this new choice of words signify?

Helping each participant become cognizant of their own creative control helped them consider their own power in character development. Externalizing the problem in this way allowed the objectification and separation of the internalized problem (Freedman and Combs 1995).

Participant Therapist Relationship

The successful application of narrative therapy rests on the ability of the therapist to create with the participant a solid foundation for relating. According to White and Epston (1990) the foundation of the relationship entails collaboration between participant and therapist. Gergen (1999) suggests that it is through this collaboration that the participant's problem is co-constructed. For the purposes of this practicum, it was important that the therapist approached each participant with what Anderson and Goolishian (1992) define as "the not knowing" stance. Each participant was informed at the beginning of treatment that the therapist was not the "expert" and that it would be up to the participants themselves to define what his/her life circumstances meant. This "not knowing" stance proved to be an essential component in the development of the therapeutic relationship in that each participant felt as though they were more equitable in regards to the problem definition and solution. Client B actually stated that it was the first time that he was the "expert" in therapy. Keeping this in mind, many of the

participants struggled with the "expert" role. It was found throughout this practicum that the participants were more apt to let the therapist take control of the session's direction and content. When asked to take more control over the direction of the therapeutic session, most of the participants stated that they were more accustomed to the "traditional" way of therapeutic dialogue.

One of the biggest challenges of the therapeutic dialogue was actively engaging each participant into the development of his/her own narrative map. With the participants' preference for letting the therapist direct treatment, it was difficult to engage each individual into a more empowered state of self-definition. This factor played a key role in the therapist taking more of an active role regarding session focus and direction.

Although the "not knowing" stance of the therapist is useful in promoting the exposure of additional information, it was found that this stance alone was not sufficient to bring about the desired level of disclosure. The therapist found that the therapeutic stance of "not knowing" needed to be modified to one of a "wanting to know" stance. It was found through this practicum that "enthusiasm" was a key in developing a dialogue regarding story development. When questioned about what kind of story each participant envisioned himself or herself as having, the majority answered "boring" or "not very interesting". Through the therapist's "wanting to know" stance, an enthusiasm was developed for both participant and therapist regarding story and their own personal lives. It was found that the amount of enthusiasm that was displayed by the therapist affected the level of

interest in each participant's own story/narrative. Selekman (1993) points out that with adolescents it is important to create a therapeutic climate that is playful and full of surprises. He states "Each new adolescent case is approached with passion, spontaneity, and playful use of humorous elements..." (Selekman 1993). High energy displayed by the therapist resulted in each participant's further involvement in the therapeutic process. This heightened "enthusiasm" regarding each participant's narrative was a useful tool in that it demonstrated the therapist's genuine interest in the unique world of each individual. The therapist demonstrated this "enthusiasm" by continually pointing out key elements in each participant's story that made for an intriguing "plot", "theme" or "premise". This strategy of validation was used in the initial sessions as both participant and therapist sought to develop a mutual interest in his/her personal story. This process of story building is consistent with narrative therapy's acknowledgment that the therapeutic dialogue is an intersubjective co-creation of meaning between the therapist and client (Cheung, 1998).

While relationship building, the therapist felt, at times, that the practicum focus limited the process of developing rapport with the participants. It was found that in order for rapport to be built between participant and therapist, the adolescent needed to be given the opportunity to have the freedom to talk about things that did not pertain to his/her problem. This freedom was important in that depression had become the focal point of all of their adult relationships with parents, teachers, therapists, and doctors. It was found that each participant needed to be

accepted as individuals who were separate from their problems. This concept is important to narrative therapy's assumption that people are not their problems. In order to demonstrate this belief, the therapist allowed the session's contents to include other "non-problem" topics of discussion. It was found that relating to each participant in this manner allowed for the development of greater rapport in the therapeutic relationship as the participants did not always want the session to revolve around their problems. Allowing the participant the freedom to discuss other non problem topics provided the individual a "break" from the overwhelming aspects of their day to day lives. It was important to provide the participants with the opportunity to relate to an adult in a way that was not fully dominated by problems.

In addition, it was found that this practicum and its time frame constraints and specific focus limited the therapist's ability to provide the necessary conversational freedoms. In regard to the practicum's intended focus, the therapist found himself taking more direction than was felt comfortable for the moment. Talking about personal interests and day to day activities seemed to both improve each participant's mood and temporarily remove the burdens of their depression. Continually pulling the focus back to the depression or problems forced the participant to return to "the realities of life", thus disrupting moments of respite from their depression or problems. Had the practicum been extended over a greater period of time, the rapport between participant and therapist would have developed at a more natural rate. Providing the freedom to discuss other

non-problem topics gave the participants the opportunity to reveal to both the therapist and themelves that their problems were not the entirety of their lives. Relating in this way demonstrated that the participants had other things that did not pertain to depression in their lives.

Culture and the Therapist

In hindsight the culture of the therapist did not seem to have any real effect on the therapeutic process. Although the therapist was of Asian decent, culture did not play a significant role in any of the therapeutic outcomes. Perhaps this is because the therapist is fourth generation Canadian. Being grounded in the western culture allowed the therapist the ability to relate to each participant on the same cultural wavelength. Upon reflection, it was felt that it may have been useful to include questions that pertained to the therapist's culture on the exit questionnaire.

Upon reflection, it was felt that the culture of the therapist holds the possibility of playing a significant role in the therapeutic outcomes. The practice of narrative therapy and its collaborative approach to the "meaning making process" is heavily grounded in the culture that defines our lives. As Alan Watts (1999) points out, cultures such as the east and west have completely opposite ways of synthesizing meaning. To him, depending on what philosophy we are employing, the world will be cut up into different units of meaning. Allan Watts states "On the other hand such major Oriental philosophies as the Vedanta, Buddhism, and Taoism arise in cultures far less concerned with controlling the world.... Thus for Oriental philosophy, knowledge is not control" (p. xiv). This existence of different cultural

philosophies may pose important influences in the interpretation of our clients' lives.

Narrative therapy and its reliance on interpretation of symbol, language and story can open the door for cultural influences on the meaning making process. The meaning of an individual's story can change depending on what perspective the therapist chooses to take. It is because of this that culture can be both a positive influence and a negative influence on the therapeutic process. It becomes important if the therapist and the participant come from different cultures, that the therapist be aware of his/her own "taken for granted" reality. This is so any interpretation or re-authoring of story is done from the participant's own preferred way of meaning making. If the therapist is not conscious of his/her own cultural bias, he/she is then in the position of ordering information in a way that will alienate the participant from his own preferred reality. In contrast, being from a different culture opens the door to the generation of many novel and alternate ways of interpretation. Such differing approaches to the meaning making process, holds the possibility of opening the participant into a new way of interpreting his/her narrative or life situation.

Problem Externalization

It was found throughout the practicum that each participant was able to demonstrate an adequate understanding of and ability for problem externalization. Problem externalization was found to be effective in that it enabled each participant the opportunity to view his/her depression as something that was apart from him or her. This ability was important in that

many of the participants initially viewed their depression as being a part of who their characters were. Depression in many instances was seen as being inseparable from their personalities and thus unchangeable. Through externalization each participant was able to examine their unique relationship with their depression. This examination revealed a) the control the depression had over them, b) what the participant did to help or enable the depression's duration or intensity, and c) what control the participant had over the depression's occurrence, intensity or duration.

This exploration of the problem/participant relationship was essential in providing the participants the opportunity to explore how their depression had altered or changed their personality. Externalization allowed each participant the opportunity to see that depression wasn't necessarily an unchangeable dimension of his or her personality, rather it could be viewed as a separate entity whose existence depended on the unique relationship that each individual chose to have with it. By taking such a view each participant was afforded the opportunity to develop a "new relationship" with the depression and thus alter his or her experience of it.

Although some of the participants did not feel that they could remove depression entirely from their lives, they understood that they did possess a certain control over the experience of it. Understanding their relationship with depression opened up the possibility that they could actually change this relationship.

Metaphor and Symbolism

It was assumed at the beginning of the practicum that the adolescent's cognitive level of development would aide in the development and understanding of metaphor and symbolism when exploring personal narratives. Although this assumption proved to be true, it is still uncertain if the practicum experience can produce a general conclusion that holds true for all adolescents. The practicum was the beneficiary of including participants who had a stronger aptitude for both metaphor and symbolism. Of the four participants two had shown artistic abilities in both language (poetry) and drawing. Having artistic aptitudes aided in the creation and acceptance of both personal metaphors and symbolism as a means of story analysis.

It was found throughout the practicum that the participant's ability for abstracting their narratives through metaphor and symbolism was not enough. In addition, the practicum demanded that the therapist also possess a strong aptitude for understanding metaphor and symbolic thought. It was found that even though each participant had the ability for such abstraction, they would typically need an initiation into the process. This behavior was consistent with the expectation typically held of the client therapist relationship whereby the therapist will guide and direct the therapy process. This expectation forced the therapist to bring forth his own creativity and imagination. Throughout this process the therapist would actively generate his own metaphors and symbols and offer them to the participant. This process seemed to be a "hit and miss" exercise in that the participant could

agree or disagree with each symbolic offering. This cycle of "hit and miss" proved to be an important spark for engaging each participant into the excitement of personal exploration. This process of interaction again demonstrates narrative therapy's adherence to dialogue as an art form. It was found that narrative therapy with adolescents rests on the ability of the therapist to verbally engage each individual with creativity, imagination and intuition regarding questions, comments and insights. The challenge that the therapist encountered was trying to avoid using narrative therapeutic techniques as linguistic tricks that came off as being shallow and forced (Freedman and Combs 1997). It was found at times that the therapist was trying too hard rather than incorporating the narrative techniques in a natural unforced manner. The therapist found that it was, at times, difficult to find a balance between genuine enthusiasm and forced creativity.

Some of the most common metaphors that were used throughout the practicum were of the "battle" and "war" variety. Depression was often symbolized to be the "enemy/intruder/thief" who was invading their lives. This externalization and resultant personification of depression as being the enemy was important in that it enabled each participant the opportunity to "take action" against a perceived enemy. The use of metaphor and symbol allowed each participant the chance to view their depression/problems as being something outside of their personality.

Weekly sessions would commence with "battle assessments" which outlined the progress of the war. Strategies regarding "defenses" and "offensive strikes" were discussed in relationship to developing or modifying

coping schemes. At the beginning of therapy most participants employed more of a defensive scheme or stance against depression. As time progressed, the participant and therapist began developing "offensive strikes" against depression. The shift in relationship evolved with the participant's own feelings of control and personal strength. The more in control they felt the more able they were to "take action" against their depression.

Although the battle and war metaphors were a prominent feature of the practicum other metaphors also emerged. Along with the "war" and "battle" metaphors, some participants also saw their depression as constituting a "test or lesson" or a "gift". These metaphors evolved out of an appreciation of what experiencing depression had given them. One participant found that his illness and depression had provided a "test of character" that resulted in a newfound strength and courage he wouldn't have achieved without his depression and disease. Another participant saw her depression as a gift in that it allowed her to become "more human". Through her depression this participant found that her experience had given her increased empathy towards other people's "struggles" and "challenges". These alternatives to the battle and war metaphors are important in that once the "lessons" and "gifts" of the story are identified the therapy can then center on what the re-visioned story will look like (Parry and Doan 1994).

Dramatic Structure

The 3 Acts of the Play

Using dramatic structure as a means to collapse personal narratives into distinct units of meaning proved to be a useful tool for most of the participants in the practicum. Providing a structure in which the individuals could map out their own personal narrative/story was useful in that it provided a way in which the individual could both examine and share their unique lives with the therapist. The three act structure was laid out for each client as consisting of Act 1 which comprises the desires and goals of the character, Act 2 which comprises the middle struggles where the protagonist is tested, and Act 3 a resolution of the conflict brought about by the middle act.

All of the participants viewed the first act as comprising an "ideal" or the preferred self that they felt they should or wanted to be. Participant's A and B saw the first act as being defined as a time where the protagonist was "happy", "content" and "well adjusted". Participants A and B felt as though Act 1 was a demonstration of how they really were and that their current struggles of Act 2 were a presentation of a character that was not a true representation of what they really were. Of all the participants, only C saw her first act as a turning point in the story.

All the participants identified their current lives to be in the middle act or Act 2 of their personal dramas. Keeping with the themes, each person saw themselves in a time of "struggles" or "test of character and will". All participants also saw this act as the act that was most important to their

stories. It was felt that the developments in this act were crucial in determining the fate of the protagonist. Act 2 was seen as the crucial component in determining how the story would end. Participants A and B felt that in overcoming Act 2 the protagonist would be able to return to the character of Act 1. Thus the resolution of Act 2 would be a return to the equilibrium that was established in Act 1. Participants A, B and D viewed Act 2 as a crucial moment of change. It was during this act that they felt their character had been irreversibly changed. They believed that there would be no possibility of returning to the way they were in Act 1, rather they would be transformed into a somewhat different character. Each participant saw the middle act as an act full of "obstacles". It is in this act where their depression was either formed or activated.

Regarding Act 3, each participant was asked to form two different understandings of what this part of their life could encompass. The therapist's goal for this Act was to generate possibilities. Participants were asked to formulate the "happy" ending, and the "sad" ending. All the participants described their preferred ending (happy ending) as one where their depression and other life obstacles were overcome. The female participants saw the culmination of this act as one where they would find a "good" job, a loving partner and the establishment of a family. The male participants saw this act as one comprising professional and personal successes. Client D saw this act as one where his new found emotional strength would help him deal with his physical condition more positively. The "bad" ending was comprised of much of the emotional state that they were

currently experiencing. This ending included a life filled with depression,sadness, and failure. Using alternate endings was a way to engage each participant in a discussion regarding the process of re-authoring one's life. Through a discussion of each alternate ending the therapist provided the participant an opportunity to generate an understanding of the change process. Together the participants and the therapist were able to explore how each ending had the potential to materialize by the choices each protagonist made. By focusing on the preferred or "happy" ending the participant could generate possible solutions that would lead to this preferred ending. Likewise, the "Bad" ending was used as a signpost to indicate what could potentially materialize if the depression were to overtake the protagonist's life. By focusing on the "Bad" ending the participant and therapist were able to generate an action plan or intervention that would safeguard this ending from materializing. The development of these alternate endings was crucial to the therapeutic process in that the participant and therapist were able to gauge the process of "choices" and the effect they would have on the development of the narrative. It was found that each "unique outcome" that was uncovered could be compiled as evidence that the preferred story/ending was materializing. Unique outcomes were used to thicken or strengthen the participants perceived ability to author a preferred life experience.

Having each participant formulate an alternate ending to their narratives is in line with future oriented questioning. According to Selekman (1997) future oriented questions are important in that they help create

possibilities for the individual. He states: "Having families or individuals envision a future place in time in which they have realized their desired outcomes can be a liberating experience for them, particularly when they are feeling so paralyzed by their presenting problems" (Selekman 1997, p.82).

Externalization of the participant's narrative was important in that it gave each individual the opportunity to both view their problems and their lives from a different perspective. Viewing the participant's life as a story in this manner provided the participant a different opportunity to understand their choice of actions, reactions, desires and goals. This approach was most helpful when client's would answer "I don't know" to questions that were asked regarding actions or reactions to their life circumstances. Collapsing the participant's narrative into the structures of drama allowed both the therapist and individual to view his/her life in an externalized way. When approached this way the participants' "I don't know" answer could be turned into an opportunity to develop an "hypothesis". Encouraging the participant to view his or her life as if he/she was viewing a "movie" or reading a "story" allowed for the development of possible explanations for actions or reactions. The questions that were employed were as follows: "If we viewed your life as a movie how could we explain the character's motivation to engage in such actions?" "What evidence has the story demonstrated that leads us to such an assumption?" "Knowing what we know of the character's development in the 1st act, what kind of assumptions could we make regarding the choices the character is currently making?" "What were the most important scenes of the movie that spoke to the development of these feelings and beliefs that

the character has about him/herself?" "Viewing the character's current struggles, what possible strengths were demonstrated in earlier scenes/acts that are currently being overlooked?" It was important in these instances that the participant was given the option of generating possibilities and not exact truths. In many instances the participants actually did not know with certainty the answers to the questions posed by the therapist. Asking each participant to view himself/herself as the protagonist in their unique stories freed up the generating of possibilities. It was found that the more possibilities that could be generated, the greater understanding of each character's "tendencies".

Collapsing the participants' narratives into the structures of drama, and three acts of a play, enabled both the individual and the therapist to track the development of change. As the narrative was examined, the protagonist's changes and progressions could be mapped according to Act or scene. Through this identification the participant and therapist were able to compare and evaluate changes in character as a marker of progress.

This approach to narrative also proved beneficial to those participants who desired an understanding of why the problem behaviors or depression symptoms occurred. Narrative therapy is an approach that is traditionally non-linear or causal. Under a narrative approach cause is seen more as a result of societal influences, or grand narratives that have shaped us from the levels of culture, family, community etc. Cause in this regard, can be seen as a continual process of transaction between the dominant and grand narratives in which the individual finds him/herself engaged. This process

gave the participant the structure that enabled him/her to map out his/her character's development through the placing of life experiences into the appropriate acts and thus begin an understanding of how such behaviors originated. Additional meaning was achieved by examining the participants' stories under the elements of setting, context, and time.

Understanding the major themes of each act also played an important role in the therapeutic dialogue. Being knowledgeable in the dramatic dimensions of each act allowed the therapist to engage each participant in an active development in narrative/story themes. If a client was unsure about where he/she was in her story the therapist was able to assist in placing the participant's life into the appropriate act. Through this placement, the therapist then offered the participant some common themes of the each specific act in which they found their lives. This knowledge of drama provided a starting point that enabled the participant to begin engaging in an examination of his/her dominant story.

Unique Outcomes

One of the challenges that this practicum presented was the acknowledgment and integration of unique outcomes into each participant's personal narrative. It was found that, at times, many participants resisted the acceptance of the unique outcomes that were identified. Many of the participants opted to identify with the more negative experiences that they had encountered rather than the more positive aspects of their lives. Freedman and Combs (1996) point out that this process occurs when a person is living in a problem saturated story. The result of such a process

leads to the individual becoming blind to his/her unique outcomes. The challenge in these instances was to enable the participant to both acknowledge that a unique outcome existed, and then assist the participant in integrating it into his/her narrative.

Using the narrative technique of story externalization and perspective taking was a positive counter for problem saturated circumstances. When a participant was resistant to their unique outcomes the therapist's externalization of the individual story proved to be an effective way to change perspective. Externalization was a way to depersonalize the story (view the self as a character in a story) and thus bring the participant to a more objective view of experience. Approaching each individual's life as a story or movie also allowed the participant to understand how a particular event (unique outcome) could be interpreted to be significant to the character's development and motivation. When viewed as a character in a story, individuals were more apt to see a) that a unique outcome did indeed exist and b) to understand the significance the event held to the character's ability to live a preferred existence. Using "points of view" questions were also very effective in unique outcome identification. Using such questions as "Can you understand from my point of view how this event could be viewed as being significant?" "What do you think I've noticed that would lead me this conclusion?" and " Looking over the story, what evidence is there to lead us to such an assumption?" Taking such a perspective change allowed the participants to remove their own biases regarding unique outcomes and develop a more objective or removed understanding. Through this line of

questioning, participants were able to generate a hypothesis as to why a life event could be understood as being "unique", "significant" or "positive".

With reference to the identification and integration of "unique outcomes", participants who were more committed to the change process fared better than those who were not as committed. This may have occurred due to the participants being more apt to take responsibility for eliciting change in their lives. It was surmised that the failure to acknowledge unique outcomes could have been a result of a resistance to change. Identifying unique outcomes signifies to the individual that there are moments when the problem such as depression did not have a hold over them. Identifying these moments as being "unique" or "significant" opened the possibility that they possessed the capacity to control their life circumstances. Getting to this understanding signified a willingness to take charge or to develop behaviors that would elicit change. Considering those who were not as committed to change, seeing unique outcomes may have a correlation to difficulty in accepting positive aspects in their lives.

Family Involvement

In reviewing the practicum it is evident that a number of cases pointed toward the need for family work. Family work would have been beneficial in gathering information regarding relationship dynamics and the subsequent effects on behavior and affect. Participants A, C and D were all living in environments that either sustained, initiated, or compounded their emotional state. Looking back, the practicum could have been better served by

including the family members at the beginning, middle and end of the therapeutic process.

Although the individual work with the participants was important, one cannot escape the fact that the adolescent is closely affected by the dynamics of his/her own family environment. It is through this environment where personality, behavior, and identity are formed. It is because of these intricate associations that the individual cannot be fully understood apart from his family. In developing this practicum, the therapist and the participants would have been better served by considering this point.

Involving family would have provided a greater overall awareness for both the therapist and the family. Such awareness would be beneficial in that each family member's perspectives regarding the problem at hand could be openly examined and shared. The result of such sharing would provide the therapist with a deeper awareness of the participant's behavior. Furthermore, involving family within the therapeutic context would also provide the participant with an audience or witnesses to the emerging preferred story. Such an audience is important in that it is a valuable process to circulate the news of the formation of an alternate story. Through this circulation the desired direction for changes that are emerging are emphasized (Freedman and Combs 1994, Andrews 1997).

Evaluation Measures

The practicum utilized three methods of evaluation. The first method of evaluation was the use of the Beck Depression Inventory (1978). The BDI is a self-report inventory that is used to measure overall levels of depression

in both adolescents and adults. The second method of evaluation was the use of note taking and transcription of the narrative structures of each participant's unique story. This included the development and examination of story arcs, character arcs, themes, metaphors and symbols. The third method of evaluation was the use of an exit questionnaire regarding feedback on the therapeutic process. Taken together each method of evaluation was used to develop an awareness of the overall change process.

The Beck Depression Inventory

The use of the BDI as a qualitative measure was demonstrated to be useful to the evaluation of the overall experience of each participant's depression. The BDI proved to be a successful measure for assessing the components of each individual's depression. An item analysis of the BDI scale quickly identified the areas of foci for each participant's depression. This proved to offer an invaluable insight into the participants' feelings regarding their experiences of depression. Taken together, the BDI scores matched the overall self-reports of each participant regarding the experienced elements of their conditions. The participants who symbolized their depression as an inner voice that demoralized them through criticism and belittlement matched with their BDI scores that clustered around items 3, 5, 6, 7, and 8. This cluster of scores is consistent with the individual holding a self-critical stance. For the participants who explained their experience of depression to be a "blob" or a "weight" that depleted their motivation and energy also matched well with their scores on the BDI that clustered around items 4, 12,15, 17, 21. These clusters of scores are held to the experience of

depression that centers around energy loss, decreased motivation and feelings of anhedonia.

As a self-report instrument the BDI also proved to be useful as it presented a glimpse into the elements of depression that comprised each participant's experience. The insights that the BDI generated aided the therapist in the overall approach and direction taken towards the participant's depression. Such preliminary knowledge was useful to both the therapist and participant regarding the generation of metaphors and symbols. The BDI was an excellent means to begin the externalization process. Once an initial understanding was obtained the therapist was then in the position to open up a dialogue that was of greater relevance to each participant. Through the preliminary knowledge obtained by the BDI the therapist was able to capture a greater sense of the participant's unique experience of depression. The BDI offered the therapist a starting point for both examining changes in themes and influences of the depression on the participant's individual experiences. Furthermore it provided a mirror in which to gauge the congruence of the participant's verbal disclosures, metaphor and symbolism against the written self-report (BDI). In summary, the use of the BDI was a useful means to measure and examine both the dimensions of depression and the change process.

Note Taking

Note taking was an effective way of identifying the change process. Transcribing the arc or the story and the emergence of themes and symbols was an excellent way of both informing and involving the participant in the

change process. The therapist found that note taking was a collaborative process that facilitated the development of both rapport and partnership. Note taking allowed for a common goal of story construction and re-construction. Mapping the narrative through session transcriptions proved to be beneficial in that both the participant and therapist were able to witness the evolution of each individual's personal narrative.

The ability to review previous session notes and diagrams allowed the therapist and participant to gauge or identify the change process and also determine where the story was headed (story development regarding preferred ending, or bad ending). Through the reviewing of session notes (story map) one participant witnessed her story theme transform from "A totally blah story" to " a good story with lots of interesting twists and turns". This process of story examination was beneficial in that it was a concrete way to initiate adjustments in the re-storying process. In addition, the reviewing of previous session notes provided validation regarding participant progress. By restating key moments in the story such as unique outcomes or evidence of the emerging preferred story, the therapist was able to make the individual's experience of the emerging story seem more real.

Note taking also allowed the therapist to repeat back to the participant important passages of dialogue that they had said. This element of note taking aided each participant in the uncovering of other previously ignored character traits. One participant stated that she "saw life as being sweet with the occasional sting" and also that "life is an attempt to do the impossible". Asking the participant to repeat the fore mentioned statements

aided in the awareness of optimism about life that was previously disregarded. The repetitive process of the individual restating the belief to the therapist for note taking and the therapist's subsequent reflection of the words back to the participant reinforced within the participant the changes that were occurring.

The creation of diagrams also proved to be helpful. Developing diagrams of the presenting problem was a creative way to both understand and examine the problematic issues. Being able to visually see the problem offered the participant a tangible representation of his or her own experience. Selekman (1997) sees the use of diagrams and pictures as representing "memory anchors" for key work associations that in turn helps us become more imaginative in our thinking. This imagination is vital to the construction of metaphor and symbolism throughout the therapeutic process.

Change Process

Looking back at the practicum experience, it becomes difficult to determine if the intervention was successful in its objective to reduce the symptoms of depression within each participant. Although each participant did show signs of positive change in both their BDI scores and narrative themes, it must be noted that 3 of the four participants were on anti-depressant medications. Each participant did acknowledge experiencing beneficial effects from the medications they were currently taking. It is because of this factor that any changes that did occur cannot be solely attributed to the practicum intervention. Any evident change could possibly

lie within previous studies done regarding the positive effects that therapy adds to medication (Paykel, Scott and Teasdale 1999).

Learning Goals

When looking back over the practicum it can be concluded that the student's learning goals had been achieved. The practicum had afforded the student a rich learning experience. Through the therapeutic process the student was able to fully immerse himself into the narrative approach. The result was a greater understanding of the structural nuances that comprise the practice of narrative therapy. Through this learning experience the student was able to become more adept and skilled at the transition from theory to practice.

The utilization of the narrative approach was found to be very compatible with adolescents. The collaborative process between therapist and participant proved to be an excellent way to engage each individual into an active interest into his/her own life. The "not knowing stance" afforded each participant the opportunity to become the "expert" in regards to each therapeutic session. Being able to experience themselves as "the expert" allowed each participant to become aware of their own responsibility regarding the "meaning making process". Being the "expert" also allowed each participant the power to both define the direction of therapy as well as the direction of his/her own life. Being the "expert" in their own lives aided each participant's understanding of the creative control that they each possessed. Understanding this opened the door for increased responsibility

regarding actions, reactions, and interpretations of the challenges that they had faced.

It was also found that the structures of drama proved to be an important addition to the practice of narrative therapy. Approaching each participant's narrative with an understanding of drama was useful in that it gave the individual story a structure under which meaning could be developed. Using dramatic structure was a means of :

- Identifying change through the use of story and character arcs.
- Externalization of problems
- Understanding the direction of the story
- Developing a preferred story (good ending/bad ending)

The use of dramatic structure in regards to the personal narrative proved to be an excellent way of ordering information. Ordering information through the structures of drama opened up both the therapist and participant to new possibilities for interpretation and examination. It was through this process that the therapist and participant were afforded an opportunity to engage in an innovative way to engage in the meaning making process.

Regarding the service provided, it is concluded that the student was able to provide a competent service to each participant. The practicum afforded each participant the opportunity to elicit a measure of positive change in his/her life. It was determined that the application of the narrative approach allowed each participant the opportunity to instill positive change upon his/her life. This change process was elicited through the development

of an alternate story that ran counter to the problem-saturated story that was brought into therapy.

In reflection, the student's experience at MATC had generated much satisfaction in the learning experience that he was afforded. The positive feedback from each participant further solidified the belief in narrative therapy's ability to initiate positive change in the lives of clients. The practice of narrative therapy was also found to be highly congruent to the values of social work. Being able to practice narrative therapy further developed and expanded the therapist's understanding of the profession of social work.

Conclusion

In summary, narrative therapy demonstrates that contemporary forms of psychotherapy tend to explain psychological ills in terms of intrapsychic cognitive processes that are viewed as being distinct from their social, economic, and political contexts (Guterman 1994, Sands 1998, Lyddon 1995, Semmler and Williams 1998). Lyddon (1995) suggested that by emphasizing the social nature of our personal and shared constructions of reality, social constructionism holds the potential to be a corrective agent to traditional psychotherapy's shortcomings. The practice of narrative therapy contributes to the development of contextually sensitive theories of the self, psychological adjustment, and the process of change.

Narrative therapy and its focus on socially constructed realities closely mirrors the professional values and ethics of social work. Not only does narrative therapy remove the locus of the psychological problem away from

the individual but it also provides a greater consideration of the influences of gender, culture, and class variables on personal experiences and beliefs. Finally, it employs empowerment and social change as therapeutic strategies.

In conclusion, narrative therapy is an approach that is both compatible and congruent with the values and ethics of the social work profession. This is because its central focus is to appreciate the cultural, gender, and socioeconomic positions that encompass our clients' lives. Starting with this viewpoint leads the practitioner to honor the resources of strength and resilience contained in the rich individual reservoirs and social networks. Utilizing the narrative approach results in an understanding of an individual's social, economic and political contexts. Through this understanding an individual is given both the agency to move past culturally defined realities and the personal power to create their own preferred experience of reality. As a social worker I find that the narrative approach embodies values that I deem important to the profession. Narrative therapy is an approach that has the ability to transcend our taken for granted worldviews and as a result generate both new opportunities and new possibilities for change. It is hoped that the theory and practice of narrative therapy develops a greater audience in the social work community.

References

Anderson, H. & Goolishian, H. (1992). The client is the expert: A not-knowing approach to therapy. In McNamee, S. & Gergen, K (Eds.), Therapy as Social Construction. Inquiries in Social Construction. (pp.25-39). London, UK: Sage Publications Inc.

Atkinson, B., Heath, A., And Chenail, R. (1991). Qualitative research and the legitimization of knowledge . Journal of marital and family therapy, 17, 175-180.

Andrews, J. & Clark, D. (1996). In the case of a depressed woman: Solution-focused or narrative therapy approaches? Family Journal, 4 (3), 239-241.

Bennett, D. S. & Bates, J. E. (1995). Prospective models of depressive symptoms in early adolescence attributional style, stress, and support. Journal of early adolescence, 15(3), pg. 299 + Retrieved April 19, 2001 from EBSCO database (Academic Search Elite) on the World Wide Web: http://www.ebsco.com

Besa, D. (1994). Evaluating narrative family therapy using single-system research designs. Research on Social Work Practice, 4 (3), and pp.309+. Retrieved January 19, 2001 from EBSCO database (Academic Search Elite) on the World Wide Web: http://www.ebsco.com

Brage, D. & Meredith, W. (1994). A causal model of adolescent depression. Journal of psychology interdisciplinary and applied, 128(4), pp. 455+, Retrieved March 19, 2001 from EBSCO database (Academic Search Elite) on the World Wide Web: http://www.ebsco.com

Byrne, B. M., & Baron, P. L. (1993). The Beck Depression Inventory: Testing and cross-validating a hierarchical factor structure for non clinical adolescents. Measurements and evaluation in counselling and dvelopment, 26(3), pg. 164+. Retrieved March 15, 2001 from EBSCO database (Academic Search Elite) on the World Wide Web: http://www.ebsco.com

Campbell, J. (1949). The hero with a thousand faces. New York: MJF books.

Carlson, J. F. (1998). Review of the Beck Depression Inventory. In James C. Impara and Barbara S. Plake (ed.) (1998) The 13th Mental Measurement Yearbook. (pp. 125-126). The Buros Institute of Mental Health Measurements of the University of Nebraska.

Cheung, M. (1998). What is narrative? Its implications to clinical social work practice. Manitoba Social Worker, 30(1), 5-8.

Connelly, B., & Johnston, D. (1993). The prevalence of depression in high school populations. Adolescence, 28(109), pg. 149+. Retrieved March 19, 2001 from EBSCO database (Academic Search Elite) on the World Wide Web: http://www.ebsco.com

Cotton, N. S. (1994). Discounting adolescent angst as natural dangerous teens. Brown University Child & Adolescent Behavior Letter, 10(6) pg. 1+. Retrieved May 30, 2001 from EBSCO database (Academic Search Elite) on the World Wide Web: http://www.ebsco.com

Coulehan, R., Friedlander, M. L., Heatherington, L. (1998). Transforming narrative: A change event in constructivist family therapy. Family Process, 37, 17-35

Cowley, G. and Springin, K. (1995). Rewriting life stories. Newsweek, 125(16) pp. 70+. Retrieved January 5, 2001 from EBSCO database (Academic Search Elite) on the World Wide Web: http://www.ebsco.com

Cuellar, I. & Roberts, R. E. (1997). Relations of depression, accultruation, and socioeconomic status in a Latino sample. Journal of behavioral sciences, 19(2), pp. 230 +, Retrieved April 19, 2001 from EBSCO database (Academic Search Elite) on the World Wide Web: http://www.ebsco.com

Curtis, R. (1991). The relational self. New York: Guildford.

D'Andrea, M. (2000). Post modernism, constructivism, and multiculturalism: Three forces reshaping and expanding our thoughts about counseling. Journal of mental health counseling, 22(1), 1-16.

Ehrenberg, M. F., & Cox, D. N. (1990). The prevalence of depression in high school students. Adolescence, 25(100), pg. 905+. Retrieved March 15, 2001 from EBSCO database (Academic Search Elite) on the World Wide Web: http://www.ebsco.com

Etchison, M. & Kleist, D. (2000). Review of narrative therapy: Research and utility. Family Journal, 8 (1), pp. 61+. Retrieved October 19, 2001 from EBSCO database (Academic Search Elite) on the World Wide Web: http://www.ebsco.com

Foucault, M. (1980). Power/Knowledge: Selected interviews and other writings, 1972-1977. New York: Pantheon Books.

Franklin, Cynthia (1998). Distinctions between social constructionism and cognitive constructionism: Practice applications. In Cynthia Franklin & Paula S. Nurius (Eds.), Constructionism in Practice (pp.57-96). Milwaukee, Wisconsin: Families International Inc.

Freedman, J. & Combs, G. (1996). Narrative Therapy: The Social Construction of Preferred Realities. New York, NY: W.W. Norton & Company.

Freeman, A., and Reinecke, M. A. (1993). Cognitive therapy of suicidal behavior: A manual for treatment. New York: Springer publishing company.

Gergen, Kenneth J. (1985). The social constructionist movement in modern psychology. American Psychologist, 40 (3), 266-275.

Gergen, Kenneth J. (1991). The saturated self: Dilemmas of identity in contemporary life. New York, NY: Harper Collins.

Gergen, Kenneth J. (1999). An Invitation to Social Construction. Thousand Oaks, CA: Sage Publications.

Germain, Carol. B. (1991). Human behavior in the social environment. New York, NY: Columbia University Press

Ginter,, E. J. (1989). If you meet Moses, Jesus, Mohammed, Buddha on the road kill them! Journal of Mental health counseling, 11, 335-344.

Goodman, E. (1999). The role of socioeconomic status gradients in explaining difference in US adolescences' health. American journal of public health, 10, pp. 1522 +, Retrieved April 19, 2001 from EBSCO database (Academic Search Elite) on the World Wide Web: http://www.ebsco.com

Gorman,J.(1993). Post modernism and the conduct of inquiry in social work. Journal of Women and Social Work, 8(3). Pg. 247+, Retrieved Jan 5, 2002 from EBSCO database (Academic Search Elite) on the World Wide Web: http://www.ebsco.com

Guterman, J.T. (1994). A social constructionist position for mental health counseling. Journal of mental health counseling, 16(2), 226-245.

Guterman, J.T. (1996) Doing mental health counseling: A social constructionist re-vision. Journal of mental health counseling, 18(3), 228-253.

Hacker, D. J. (1994). An existential view of adolescence. Journal of Early Adolelscence, 14(3), 300-328.

Harrington, R., and Whittaker, J. (1998). Systematic review of efficacy of cognitive behavior therapies in childhood and adolescent depressive disorder. British medical journal, 316 (7144), pp. 1559+ retrieved January 27, 2001 from EBSCO database (academic search elite) on the World Wide Web: http:/www.ebsco.com.

Harris, S, L., & Glasberg, B. (1996) Pervasive developmental disorders: Distinguishing among subtypes. School Psychology Review, 25(3) pg. 308+. Retrieved Oct 15, 2001 from EBSCO database (Academic Search Elite) on the World Wide Web: http://www.ebsco.com

Laird, J. (1995). Family-Centred Practice in the postmodern era. Families in Society, March, 150-162.

Loewenthal, D. (1996). The postmodern counselor: Some implications for practice, theory, research and professionalism. Counseling psychology quarterly, 9(4), 373-382.

Lydon, W. J. (1995) Cognitive therapy and theories of knowing: A social constructionist view. Journal of counseling and development, 73 (6) 579-586.

Madigan, S. (1996). The politics of identity: Considering community discourse in the externalizing of internalized problem conversations. Journal of Systemic Therapies, 15(1), 47-62

Mamet, D. (1991). On directing film. New York, NY: Penguin Books.

Mamet, D. (1998) Three uses of the knife: On the nature and purpose of drama, New York, NY: Columbia University Press.

Maxwell, J. A. (1996). Qualitative research design: An interactive approach. Thousand Oaks, CA: Sage Publications.

Merscham, C. (2000). Restorying trauma with narrative therapy: Using the phantom family. Family Journal, 8(3), 282-287.

Neimeyer, R. A. (1998). Social constructionism in the counseling context. Counseling psychology quarterly, 11(2),135-150.

Newton, M. (1995). Adolescence: Guiding youth through the perilous ordeal. New York: W. W. Norton & Company.

Nichols, Michael P. & Schwartz, Richard C. (1998). Family Therapy: Concepts and methods (fourth ed.). Boston: Allyn & Bacon.

O'Hanlon, Bill (1994). The promise of narrative: The third wave. The Family Therapy Networker, Nov/Dec, 19-29.

Pozateck, E. (1994). The problem of certainty: Clinical social work in the postmodern era. Social Work, 39(4) pp. 396 + Retrieved Jan 5, 2002 from EBSCO database (Academic Search Elite) on the World Wide Web: http://www.ebsco.com

Parry, A., & Doan, R. E. (1994). Story revisions: Narrative therapy in the postmodern world. New York: Guildford Press

Pardeck, J. T., & Murphy, J. W. (1994). Social implications of post modernism for social work practice. Social Work, 39(4), pp. 396+ Retrieved Jan 5, 2002 from EBSCO database (Academic Search Elite) on the World Wide Web: http://www.ebsco.com

Samaan, R. A. (2000). The influence of race, ethnicity, and poverty on the mental health of children. Journal of health care for the poor and underserved, 11(1), pg. 100 +. Retrieved April 19, 2001 from EBSCO database (Academic Search Elite) on the World Wide Web: http://www.ebsco.com

Sandtrock, J. W., & Yussen, S. R. (1993). Adolescence: An introduction (5th ed). Madison, Wisconsin: WCB Brown and Benchmark.

Schneider, K. J. (1998). Toward a science of the heart: Romanticism and the revival of psychology. American Psychologist, 53, 277-289.

Selekman, M. D. (1993). Pathways to Change: Brief therapy solutions with difficult adolescents. New York: Guidford Press

Selekman, M. D. (1997). Solution Focused Therapy with Chidren: Harnessing family strengths for systemic change. New York Guilford Press.

Semmler, P. L., & Williams, C. B., (2000). Narrative therapy: A storied context for multicultural counseling. Journal of multicultural counseling and development, 28(1), pg. 51+. Retrieved March 15, 2001 from EBSCO database (Academic Search Elite) on the World Wide Web: http://www.ebsco.com

Singer, J. K. (1994) Boundaries of the soul: The practice of Jung's psychology. New York, NY: Double day.

Standard,R., P. (2000). Assessment and treatment of adolescent depression and suicidality. Journal of Mental health counselling, 22(3), pg. 204+. Retrieved March 19, 2001 from EBSCO database (Academic Search Elite) on the World Wide Web: http://www.ebsco.com

Stehouwer, R. S. (1985). Beck Depression Inventory. In Daniel J. Keyser & Richard C. Sweetland (ed.) (1985) Test Critiques Volume II. (pp. 24-28). Test Corporation of America. Kansas City, Missouri.

St. James-O'Connor, T., Meakes, E., Pickering, M. & Schuman, M. (1997). On the right track: Client experience of narrative therapy. Contemporary Family Therapy: An International Journal, 19, 479-495.

Szatmari, P. (2000). The Classification of Autism, Asperger's Syndrome, and Pervasive Development Disorder. Canadian Journal of Psychiatry, 45(8), pg. 731+. Retrieved Aug 19, 2001 from EBSCO database (Academic Search Elite) on the World Wide Web: http://www.ebsco.com

Waller, N. G. (1998). Review of the Beck Depression Inventory. In James C. Impara and Barbara S. Plake (ed.) (1998) The 13th Mental Measurement Yearbook. (pp. 125-126). The Buros Institute of Mental Health Measurements of the University of Nebraska.

Walsh, W. M. (1998). Narrative family therapy. Family Journal, 6(3), 332-337.

Watts, A. (1995) The Tao of Philosophy. Boston: Turtle Publishing.

White, M., & Epston, D. (1990). Narrative Means to Therapeutic Ends. New York: W.W. Norton & Company.

Zimmerman, J. L., & Dickerson, V. C. (1996). Situating this special issue on narrative. Journal of Systemic Therapies, 15(1), 1-4.