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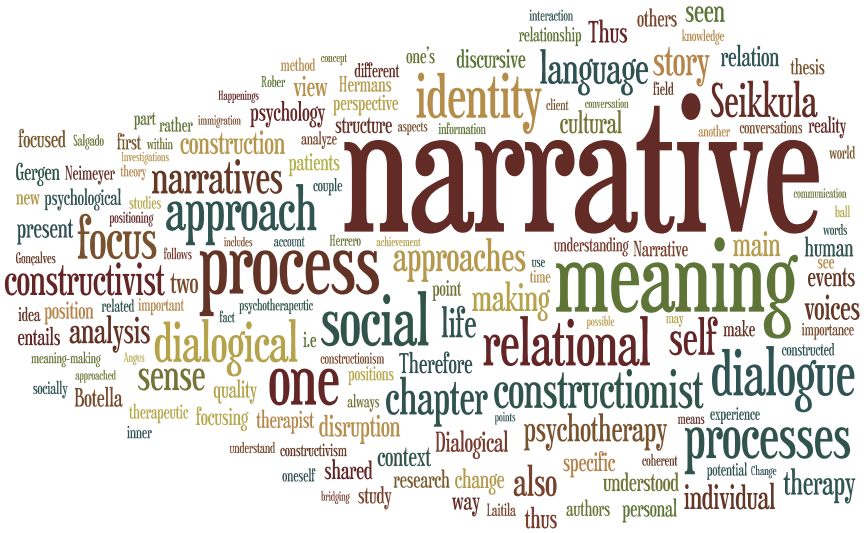
Bridging Constructivism and Social Constructionism:

A Dialogical And Relational Approach To Narrative And Meaning Making



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Since words are the basis of this thesis, we thought that this title page would be the most appropriate. Taking a look at the picture it is possible to figure out a first taste of our own narrative regarding research.

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TESI DOCTORAL

Tittle: Bridging Constructivism And Social Constructionism: A Dialogical And Relational Approach To Narrative And Meaning Making

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Doctoral Dissertation

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Chapter 1

INTRODUCTION

> *(…) We are beings in transit, and airports are an adequate metaphor of the post-modern times we are living. They are transient points of arrival and a privileged space for departing in various directions. Psychotherapy can be understood as the boarding gate. In an airport there are no correct or wrong flights, there is just a multiplicity of proposals. The quality of an airport, as the quality of psychotherapy, depends on the multiplicity of routes that it enables.* Gonçalves (1995a).

The goal of this thesis is to contribute to the understanding of human meaning making processes and their relation to psychological

well-being. This contribution is drawn from constructivist, and social constructionist approaches, heavily relying on narrative theory.

Although constructivist and social constructionist approaches share the basic assumption that meaning making processes are embedded and constructed in interaction in specific sociocultural contexts, both paradigms differ regarding the emphasis they place to the individual *vs* the social word. However, latest research has come to recognize some meeting points for bridging both approaches when the focus is on narrative and language (McNamee, 2004).

This thesis aims at exploring some of these meeting points, since it is situated at the crossroad of the integration of constructivist and constructionist approaches, when analyzing meaning-making through a narrative focus. Therefore, it presents four studies focused on two integrative narrative approaches in which constructivist and social constructionist perspectives are intertwined.

Many of the studies published on this topic have failed to fully utilize the potential of attending the interactional, social, and cultural embeddedness of narrative production and tend to circumscribe to the study of narrative mostly understood as an individual construction. Being

aware of this need, this thesis represents an effort in the direction of taking into account cultural and relational aspects of narrative, including the therapist-client interaction (instead of the client's discourse exclusively) as one of the main focus of research.

In what follows we will first review the starting point and main conceptual assumptions of social constructionism, in order to emphasize its contribution to the shift from understanding mind as an information processing tool to understanding it as a relational meaning-making process. In a Second stage, we will focus on narrative as a psychological tool emphasizing its relation to language and identity. In the third stage,, the review will move to psychotherapy, in order to highlight how narratives can be reconstructed and used as a therapeutic tool. As noted, our intention has to do with emphasizing constructivist and constructionist contributions to these issues, thus focusing on their meeting points more than on their disagreements, since both paradigms are not seen as opposite in this thesis. Finally, we will discuss our attempt of bridging both social constructionist and constructivist approaches through a narrative focus.

1.1. From Information Processing to Relational Meaning Making

The social constructionist movement in psychology has its origins in the seminal work of Gergen (1973) in which he argued, among other things, that (a) psychological knowledge (and the theories it is based on) are more related to the attribution of causes and meaning to actions than to actions themselves, (b) that such frameworks for the attribution of meaning are a product of historical and cultural circumstances, (c) that when the historical and cultural circumstances change, many of the principles underlying a theory may also change; and thus that, (d) the field should be considered "a historical inquiry". Gergen's (1985) further work set out the main tenets of constructionism: (a) questioning the generally accepted truths, (b) taking into account the historical and cultural specificity of knowledge, (c) assuming that knowledge and social action are inseparables, and (d) assuming that social processes underlie knowledge construction.

The main implications of a social constructionist position sparked a fruitful debate in the realm of psychology especially because they diverged critically from some of the main tenets of the then dominating

view deriving from information processing cognitive psychology. Three of these debates are briefly discussed in what follows.

Cognitive science had undeniably contributed to understanding how individuals process, store, and retrieve information (for example the narrative grammar of a story) but were unable to advance a more nuanced comprehension of how meaning is constructed (i.e., how do we make sense of a narrative)—a question that originally inspired the so called "cognitive revolution". This epistemological roadblock was likely to be due to the inherently relational nature of meaning making; to the fact that to make sense, for example, of a story, we naturally rely on cultural, social, and interpersonal patters of interpretation.

Shifting the focus from information to meaning, and assuming that meaning is socially constructed entails highlighting the essentially relational (vs. individual) nature of meaning making. Therefore, a psychology focused on culture, on the set of shared symbolic systems, was needed. As Bruner (1990) discussed, the fact that people participate in their culture and channelize their psychological processes through it, makes it illusory to design a study based solely on the individual—because the "individual" is already populated by his/her cultural matrix. Thus, approaching "narrative meaning making", for instance, as a

essentially individual cognitive faculty entails ignoring that the way one makes sense of a narrative is patterned by his or her language, culture of origin, family processes, and relational positions (a fairy tale such as Sleeping Beauty is likely to be interpreted differently by a child, a feminist leader, or a psychoanalyst).

Assuming a social constructionist position also entails a contextualist (vs. realist) approach to knowledge construction. The notion that meaning is the product of a relational process (i.e., culturally situated, relative, and changing) leads to assume that there is no direct link between knowledge and the perception of reality. "Reality" needs to be construed to make sense, and this construction is inevitably relational and discursive. This is closely related to the notion that every situation is interpretable and made meaningful by a process of interpersonal "supplementation": a supposedly "flattering" comment to a workmate can be an episode in a sequence of harassment, intimacy, flirting, friendship, or sarcasm depending on the other's supplementation (i.e., his/her reaction to it). Thus, the "real" and "objective" nature of the original comment is indecipherable unless it is socially situated. As discussed by Gergen (1992), reality seems to be a matter of perspectives

and these are products of exchanges and social consensus, that is, built into the systems of social communication.

In summary, two of the main tenets of constructionist critique are derived from the premises that knowledge is communal and socially constructed and that the instruments with which it is constructed are discursive.

1.2. Meaning, Language, Narrative and Selfhood

Both constructionist and constructivist approaches share the basic epistemological assumption that "reality" is not revealed to us but reached through a process of construction. This entails that the meaning of what happens is not a passive, neutral, objective, detached, and external fact but the result of an active, passionate, subjective, engaged, and (inter)personal process of ongoing inquiry.

This process is assumed to be an essentially linguistic one. All major constructivist and constructionist authors incorporate the notion that language is not (or not only) a tool for *representing* reality, but a means to make sense of it in a social context—although admittedly each one of them emphasizes a particular version of this assumption, from the

more individual constructivist to the more socially oriented constructionist ones.

This non-representational view of language (along the lines of the philosophical work of Ludwig Wittgenstein) entails that we do not necessarily view things “as they are” but in fact contribute to their being “as they are” by a generative, constitutive, and social/interpersonal process of linguistic construction. Therefore, the attribution of meaning to one’s experience depends on interpretative acts. These interpretative acts are embedded in one’s participation on conversational discursive practices by means of which people produce shared social “realities” that operate as frameworks of intelligibility.

For instance, approaching the end of a relationship as a “breakup” entails adhering to a socially constructed discourse that equates any relationship ending to a dramatic, painful, and potentially traumatic life event. Such a discourse is sustained by hundreds of cultural productions such as popular movies, songs, novels, and self-help books. What’s more, one actively contributes to this discourse by participating in the many conversations that help to make sense of what is happening and, at the same time, consolidate such a way of making sense of it.

Language, thus, is not conceived as a mere tool for representing reality but rather as a tool for constructing reality and constituting the "individual". A move is made from the notion of language as representational toward language understood as constitutive.

Regarding the narrative structure of meaning making processes, it was first explicitly highlighted by Sarbin (1986), and in these more than 25 years, the body of scholarly literature supporting this assumptions has grown so much that it has even fostered the publication of books addressed to a general audience such as Jonathan Gottschall's "The Storytelling Animal" (Gottschall, 2012). The main point in Gottschall's volume nicely illustrates that stories aren't merely essential to how we understand the world--they are how we understand the world. We weave and seek stories everywhere, from data visualization to children's illustration to cultural hegemony.

When we encounter an experience, we tend to attribute a narrative structure to it. In this respect, Sarbin (1986) quoted Michotte's (1946/1963) experiments on the perception of causality as supporting the narrative structure of proactive meaning-making processes. Even when the subjects in Michotte's experiments did only see geometrical figures moving randomly around a screen, they tended to report what they had

seen by constructing a story with its associated features (i.e., characters, motives, plot, and dramatic effects). These descriptions included words attributing motivations, emotions, age, gender and relationships between the two objects, for example, "The little ball is trying to play with the big ball, but the big ball doesn't want to play so he chases the little ball away. But the little ball is stubborn and keeps bothering the big ball. Finally, the big ball gets mad and leaves."

The notion of identity as a story has permeated constructivist and constructionist approaches since their historical beginnings:

> Our present identity is not a sudden and mysterious event but a sensible result of a life story. (…) Such creations of narrative order may be essential in giving life a sense of meaning and direction. (…) The term ‘self-narrative’ will refer to an individual’s account of the relationship among self-relevant events across time. In developing a self-narrative we establish coherent connections among life events. Rather than see our life as simply ‘one damned thing after another’, we formulate a story in which life events are systematically related, rendered intelligible by their place in a sequence or unfolding process. (Gergen, 1994, p. 187).

From this point of view identity does not emerge from inside out nor is an exclusively individual byproduct of one's personal growth. Rather, the development of a sense of personal identity is comparable to attaining a sense of communicational or cultural competence (Hymes, 1972).

Given that existence entails the passage of time, the narrative dimension of identity overlaps with the discursive and relational one. Consequently, the construction of one's identity entails positioning oneself through a time dimension. Since the essence of narrative is time, the construction of identity is also a narrative achievement. Narratives of identity help one to establish a time sequence between personally relevant events. Thus, the narrated events become intelligible thanks to their position relative to a sequence or unfolding process.

Since narrative is an essentially linguistic achievement, the structure of language affects the structure of identity. Kelly (1969) anticipated this idea when he proposed, drawing from Korzybski's (1933) general semantics, that the terms that we use to refer to things express the structure of our thought and, particularly, that those referred to ourselves express the structure of our personality. The self is not an entity, closed off from the world and having an existence in itself, but, rather, extended

toward specific aspects of the environment, both interpersonal and physical (Rosenberg, 1979).

We are all motivated by having our version of events taken seriously. Since every narrative is part of a polyphony of potential competing ones, all of them incorporate to a greater or lesser extent rhetorical devices to undermine alternative versions and to avoid being undermined by them (Potter, 1996). In this sense the relationship between a given narrative and its alternatives is a dialogical one, i.e., in general a narrative is an answer to its competitors.

Self-narrations satisfy our need of stability; they give us a sense of self-identity, and stability of the relational patterns (Burr, 1995). Telling others about oneself is no simple matter; we come to express what we think others expect us to be like (Bruner, 2004). To manage social life successfully the individual has to be able to make his/herself intelligible as a perdurable, integral, or coherent identity (Gergen, 1994). Personal features, moral character, and personal identity are the results of the relation itself. Some theories consider identity an achievement of the mind, a "vital story" narratively coherent and consistent (Gergen, 2006) even though, from the constructionist point of view, identity is considered an achievement of the relation. Thus, people change from one

relation to another and it's not possible to achieve stability in all of them (Anderson, 1997). What we acquire is more a potential to communicate and to represent a self rather than a deep and durable "truly self" (Gergen, 1994).

Guidano (1995) emphasizes the "agentic self"; the person is an agent that evolves and keeps all his/her characteristics of the self as an active and unitary process. According to that, the definition of the self or identity that refers to a stable reality doesn't make any sense any more within this approach. We are authors and we define ourselves by extension of our projects. We are a multiplicity of characters that gives us a concept of authorship (Hermans, 2006). This authorship concept lays the foundations for the construction of the identity concept (Gonçalves, 2000). It is this concept of authorship, in contraposition to the concept of identity, that ensures the complexity, flexibility and diversity conditions.

Moreover, the signifier character of language and discourse doesn't come from isolated words (Polkinghorne, 2004). On the contrary, it comes from the way in which these words are combined and are able to establish a narrative matrix. This narrative matrix represents the process through which the authorship feeling is co-built (Gonçalves, 2000, p.31). As Bruner (2004) points out, we seem unable to live without both

commitment and autonomy. As he mentions, a self-narrative must create a convincing autonomy (i.e., the feeling that one has a certain freedom of choice). Nevertheless, it must also relate the self to the world of others (and this commitment to others--family, friends, and institutions--limits our autonomy). Sewell & Williams (2002) point out the shared building of meaning thatlanguage allows. However, Gonçalves (2000) specifies that this shared signification only makes sense because it's embedded in an embodied nature of the experience.

Focusing on the family, Kelly already suggested that conversation in the family, like in any other group with a shared history, is organized in contrasting polarities of meaning (Kelly, 1955). The organization of meaning in antagonist polarities makes the identities of family members interdependent (Ugazio, 2001). By "composing" oneself with the other participants of the conversation, the set of processes that have been traditionally called identity develop. At the same time, one embeds one's own identity into the other participants' one (Cecchin, 1996).

As Neimeyer (2006c) reflected, narrative psychology and dialogical self theory served to move from a modernist view of the self as single, stable, and well-integrated towards a postmodern conception of identity as multiple, shifting and interpenetrated by the social world.

Thus, meaning is best understood, expressed and constructed in narratives. Therefore, we rely on the assumption that only narratives do full justice to the rich lived experience of the individuals in their social and cultural contexts (Wong, 2010). Furthermore, constructionist metatheory places emphasis on the sociocultural origins of the narrative construction (Polkinghorne, 2004), even though it doesn't entail cultural determinism, which means that we acquire the narrative abilities in our interaction with the other, not just "being interacted". From this metatheory, it follows the relational theory which purpose, according to Gergen (1992), is to understand the human action in terms of a relational process. That means moving the focus from the individual towards the relation (Shotter, 1997). Thus, self-concept is not understood anymore as a private cognitive structure but as a discourse about the self. Therefore, the traditional concern over the conceptual categories (self-concept, schemes, or self-esteem) is substituted by an understanding of the self as a story that becomes intelligible within the current relations (McLeod, 2004). The relational theory explains that we use stories to identify ourselves and ourselves with the others (Wortham, 1999). Consequently, narrations are part of the social actions as they make the events become socially visible and they establish expectations for future events (Shotter,

1997). Following this idea, this theory proposes that to be a self with a past and a potential future doesn't mean to be an independent agent, unique and autonomous. On the contrary, it means to be immersed in interdependence (Hoffman, 1992).

1.3. Reconstruing Disrupted Narratives: the Challenge of Psychotherapy

Regarding the therapeutic context, the constructionist approach proposes transcending narration (Gergen, 1994) and, in this sense, the focus moves from the individual mind towards the joined management of reality (McLeod, 2004).

Taking into account what we have been discussing until now, the aim of therapy should not be to change an impracticable narration for another one more useful. It should rather be to allow the client to participate in the continuous process of creation and transformation of meaning (McLeod, 1996). A story is not just a story, is an emplaced action. It acts to create, sustain or modify worlds of social relation (Gergen, 1994). Thus, it is insufficient that the client and the therapist develop a new way of self-comprehension that seems realistic, aesthetic,

and inspirited in the heart of the dyad. It is important to take into account whether the new form of signification is useful in the social realm.

The therapeutic process is understood as an experiential context for co-constructing multiple vocalities of the narratives that were lived in the past, experienced in the present, and projected to the future (Fireman, 2002). Guidano (1995) elaborates on this idea discussing that in the centralized vision of the self the therapeutic dialogue redirects itself to the feelings of the client.

Human problems that constitute the main focus of psychotherapy cannot be understood disconnected from the discursive practices in which they acquire meaning (Botella, 2001). Gonçalves (1995) points out that when patients come to therapy they already have narratives of their life, and that they are both authors of them and actors in them. Therefore, he recommends taking into consideration that self-narratives are open ended and that future events and actions need to be included in the present plot for them to make sense.

Language plays a crucial role in this narrative reconstruction process, because, as mentioned, identities are build, maintained and questioned in language: "if the interpretation of what we are and do only

acquires structure and meaning through language, if this meaning is not stable but varies continuously then our experience is susceptible to various interpretations or constructions" Burr (1995, p.50). If meaning and positioning are interpersonally negotiated in language, then identity emerges as temporary and its changes and maintenance are embedded in language. The question is, in the words of novelist Lawrence Durrell: "Are people continuously themselves, or simply over and over again so fast that they give the illusion of continuous features?"

Psychological problems can be conceived of as the result of a block in the relational and discursive process of meaning making and positioning, as a failure to "be oneself over and over again"(Botella, 2001). The relevance of narrative processes in the therapeutic context can be inferred from the fact that it is both the material with which therapists work and the mean to foster changes (Gonçalves, 2000).

To promote the aforementioned approach to psychotherapeutic change, the therapist needs to position him or herself accordingly. Anderson and Goolishian (1992) summarize this idea when they state that: *"therapy and, therefore, the therapeutic conversation, involves a process of "being there together". The therapist and consultant speak with one another, and not to the other. And in doing so, between the two*

of them, explore the complexities of new meanings, new stories, new realities".

There are some crucial elements to create both a dialogical conversation and a collaborative relationship in the context of therapy that should be taken into account. Anderson (1997) has formulated them as follows: (a) adopting ignorance as a focus; (b) accepting that the client controls the therapeutic process and, thus, it is uncertain; (c) cultivating humility; (d) generating trust and credibility; (e) asking conversational questions; (f) being consistent; (g) keeping synchrony; and (h) honoring the client's story.

1.4. Towards bridging the gap between Relational Constructivism and Dialogical Theory

An intense debate, which is still alive, has been established regarding the differences and specificities of both paradigms - constructivist *vs* constructionist. Regarding narrative and its role in each perspective, this debate has been characterized by several issues, which may be summarized as follows. On the one hand, from a constructivist approach, narrative characteristics are understood as reflecting the clients' inner mental state, which, in some cases, may involve a lack of

situatedness of the socio cultural aspects that could explain individual narratives. On the other hand, from a social constructionism paradigm a strong focus is placed on interaction and cultural context focusing on macro-narratives, sometimes diminishing the individual sense of authorship. Another related opposition has to do with the consideration of the self as internal, coherent, and reflective which characterizes a constructivist approach, while from a social constructionist approach identity is understood as a discursive accomplishment constructed through interactions. Finally, when focusing on psychotherapeutic narrative studies, constructivism has been blamed for focusing on clients' narratives instead of focusing on the development of dialogue, and for being mostly focused on the client's micro-narratives. In a similar way, most of the studies developed from a social constructivism paradigm have been criticized for relying exclusively on macro-narratives, considering them as a whole, in a case-study format. Thus, enabling an open-ended, exploratory, and discovery-oriented analysis (Avdi & Georgaca, 2007; 2009).

Despite those differences widely discussed and evidenced in narrative research, there have been also some initiatives focused on highlighting the common grounds of constructivist and constructionist

approaches. This is the case, for example, of McNamee (2004) who defended that the shared desire to engage in transformative dialogue that both approaches defend could represent a first bridge. Extending this idea into Bakhtin's notion of dialogue, a relational engagement can help to consider private thoughts as internal dialogues and, thus, the private, inner construct can be seen as the sum of relations that are imprinted in oneself. Assuming that through narrative people coordinate dialogue, voices, and relationships, McNamee proposes that precisely narrative could be the focus of the relational commonalities between constructivism and constructionism.

In line with this integrative approach, in this thesis we will focus on the two main attempts of bridging social constructionist and constructivist approaches in psychology that have been developed focusing on narrative and dialogue. The first one is the Relational Constructivist approach, proposed by Luis Botella and collaborators (see Botella, 2001; Botella & Herrero, 2000). The second one is the Dialogical Theory and, more specifically, the Dialogical Investigations of Happenings of Change methodology, developed by Jaakko Seikkula and collaborators (see Seikkula, Laitila,, & Rober, 2012).

Relational Constructivism

Relational constructivism, as mentioned by their authors, constitutes "*an attempt to press the dialogue between constructivism and social constructionist further and to enrich it with the voice of narrative and postmodern approaches*" (Botella, Herrero, Pacheco, & Corbella, 2004). Therefore, from this approach narrative is considered as a root metaphor for understanding meaning making, as shared by constructivist and constructionist approaches (Botella & Herrero, 2000). From this perspective, self-narratives are supposed to provide the scaffolding for interpersonal accounts of our experience (Neimeyer, Herrero, & Botella, 2006). Furthermore, people come to see themselves, in part, as they are seen by others. Thus, the self-narrative, even if personal, is always extensively coauthored by relevant others (Neimeyer, Herrero, & Botella, 2006). From this specific perspective, the importance of culture is also taken into account, as far as the themes, roles, and discourses available in a culture also shape the self-narratives (Botella, 2001). As their authors underline, this approach is heavily influenced by the ideas of Wittgenstein and Bakhtin, authors that are usually related to the constructionist approach.

In brief, relational constructivism involves ten main assumptions (for further details see Botella, Herrero, Pacheco, & Corbella, 2004; Botella & Herrero, 2000), which we will relate with the bridging points commented above:

(a) being human entails construing meaning; human beings are proactively oriented towards a meaningful understanding of the world.

(b) meaning is an interpretative and linguistic achievement; experiences in themselves don't carry meaning. One needs to pattern events, to interpret them so as to be able to predict them. This interpretation is a linguistic achievement, which is always open to re-interpretations.

(c) language and interpretations are relational achievements; they are patterned and located in the context of shared forms of intelligibility. This idea emphasizes the importance of the relational focus discussed above and pointed out by McNamee (2004).

(d) relationships are conversational; one's words or actions need to be supplemented by the others' to mean something, this meaning can always be re-construed. This idea reminds the importance of the relational engagement commented above (McNamee, 2004).

(e) conversations are constitutive of subject positions; conversations create subject positions that are contingent to them, the set of subject positions conforms one's self-concept – conceived not as a totally private process, but as the results of internalizing significant conversations. This idea resounds with the one of McNamee (2004) that proposes seeing the private inner narratives as a form of relational coordination, conforming a polyphonic chorus of voices.

(f) subject positions are expressed as voices; voices are discursive expressions of different subject positions, constituted in internalized conversations. Both inner dialogue and externalized conversations conform a dialectical interchange.

(g) voices expressed along a time dimension constitute narratives; there is always more than one voice to be heard, and thus to tell the story, it is in this reconstructive potential where it lies the essence of human change. This point focuses on the importance of narrative and the transformative dialogue that, as argued above, both constructivist and constructionist share.

(h) identity is both the product and the process of self-narrative construction; the content of one's life story, in which one choses to

include or exclude some events, configures the sense of identity, which can be equated to a sense of authorship.

(i) psychological problems are embedded in the process of constructing narratives of identity; psychological problems are a loosely and ill-defined human ways to belong and relate to the world. What seems to be common to most of them are the experience of unintelligibility and loss of personal agency. Again, a strong emphasis is placed to relation; psychological problems as the way people relate themselves to the world and to the others.

(j) psychotherapy can be equated to a collaborative dialogue addressed to transform the client's narratives of identity, the importance of dialogue in therapy, and the view of the therapist as a language expert.

Therefore, a discursive and relational approach to constructionism assumes that individual identity emerges in the processes of relational interaction, not as a final product, but constituted and reconstituted in the different discursive practices in which one participates (Davies & Harré, 1990). We maintain our identity by means of a process of constant positioning that always entails a component of indetermination, since the meaning of any specific interaction is always open to alternative

interpretations--or, in Gergen's terms (1994) to new forms of supplementation.

Finally, it is also important to highlight that the emphasis that constructivist psychotherapy places on reflexivity and self-awareness applies equally to client and therapist (Neimeyer, 2008). This is an important factor that Gergen (1994) criticized about constructivism: the fact that the narrative of the therapist is never threatened and it is assumed as justified. As Neimeyer (2008) stresses, "therapy begins with who we are, and extends to what we do", it is a way to emphasize the importance of the quality of the therapeutic presence.

Dialogical Theory

Dialogism has been presented as the possible solution of seeing the self as multiple but still letting space for a sense of self-identity (Salgado & Hermans, 2005). Therefore, it can be understood as a possible bridge between constructivist position with an individual focus and constructionism position with a social focus.

In the Dialogical theory of the self, which is directly influenced by Mikhail Bakhtin, selfhood processes have a dialogical nature, thus the

self is in continuous dialogue an interplay between *I* positions, each one with a different voice (Salgado & Hermans, 2005).

Emphasizing the relational aspect, dialogism understands human existence and human meanings as created within and by relations. Dialogicality refers to some essences of the human condition, notably that our being in the world is thoroughly interdependent with the existence of others (Linell, 1998). By not focusing on the stories, but on the storytelling as dialogue and on narratives in action, it emerges the relationship between a narrator and the audience (Rober, Seikkula & Laitila, 2010). Furthermore, the personal realm is bounded with the socio-cultural realm, not as independent identities but as mutual defining poles (Salgado & Hermans, 2005). Voices are seen as the tools by which the *I* establishes a specific relation with another; all utterances are multivoiced because two voices are present in every act of speaking: the voice of the speaking person and the voice of a social language (e.g., one's generation, one's genre) (Hermans & Dimaggio, 2007).

From dialogical perspective, the creation of meaning is also a main aspect, thus language and human existence share a common goal: to create meaning through addressivity and communication. Addressivity is seen as double, since each utterance is always addressed toward an object

but also to an interlocutor. Sequenciality is an important characteristic of dialogical actions, which are part of a sequence; therefore situated interpretations of utterances (or acts) are partially dependent on their positions in sequences of actions; they are a response to the voices that came before (Rober, Seikkula & Laitila, 2010). This means that in every process of meaning making an *I* addresses, anticipates, and responds to an interlocutor (psychically present or not) voicing a specific position toward that audience. This positioning is dynamic, it changes depending on the audience, and it creates the multiple *I* positions (Salgado & Hermans, 2005).

Each position has a story to tell, adding to this narrative perspective, the self is seen as a complex narrative process. Furthermore, the dialogical perspective adds to this narrative view a spatial dimension, including the addressee since there is always a teller and a listener (Hermans, 2009). Stories only exist through the presence of others; listeners are thus co-authors of the story, which is an interactional accomplishment (Rober, Seikkula & Laitila, 2010). In this way, subjectivity and personal identity are understood as communicational processes, with the others and with oneself, in such a way that it becomes a discursive construction. It is, therefore, a relational or dialogical

production, in which the addressed audiences are a constitutional part of the self, represented as different subjectivities, with specific world-views, intentions and motivations, that can agree or disagree with each other (Hermans & Dimaggio, 2007).

Dialogical theory conceives language as a concrete, lived, and socially shared reality where speakers and listeners work together to negotiate meaning (Shotter, 2003). Thus, speaking and listening are understood as parts of collective activities between speakers and listeners, whom are mutually influenced (Linell, 1998; Potter & Wetherell, 1987).

From the dialogical point of view the common understanding of conversation as the mere transmission of information, which still characterizes many research approaches, is replaced by the view of one speaker collaborating with others in constructing a joint situated meaning (Bakthin, 1986; Buber, 1970, Linell, 1998). Furthermore, although dialogue is basically a form of communication, from this approach it also constitutes the way of engaging with others and this implies that *dialogue is communication, but it is also the relation and process of forming oneself* (Seikkula, 2008)

From a dialogic perspective it is important to attend to the multiple different voices stemming in and between persons, and focus on how external (outer) and internal (inner) dialogues impact each other (Linell, 1998). Therefore, the central focus of psychotherapy moves towards the relational events, in which insights emerge through the external and internal dialogues (Hermans & Salgado, 2010). Important aspects of the polyphony are the voices of each therapist. Therapists participate in the dialogue trough the voices of their professional expertise but also trough their personal and intimate voices (Seikkula, 2008). Listening acquires a relevant position from this approach, especially careful listening as expressed in the therapists' simple questions, which have been labeled "speaking as a listener", constitutes responses that encourage genuine dialogue (Seikkula & Olson, 2003).

When applying the dialogical approach to the psychotherapeutic setting, this perspective emphasizes studying not only what is told, but rather how things are told and how they are responded, in the dialogical process of conversation. In addition, dialogical perspective includes examination of various inner and outer voices and positions embedded in a specific social and cultural context, and which come up in the external, outer dialogue (Salgado & Hermans, 2005). Furthermore, what is not

(yet) said, is also of great importance, since is the result of a process of selection which can only be understood by taking into account the dialogical context in which the stories are told (Hermans, 2009; Rober, Seikkula & Laitila, 2010).

This approach has been adopted in the studies developed by Seikkula (2002), and colleagues (e.g., Seikkula, Laitila & Rober, 2012) in the Dialogical Investigations of Happenings of Change (DIHC), with the aim of improving mental health care meetings. The interest of these studies, both theoretically and methodologically, rely on the "outer dialogue" that includes family members and professionals rather than the client's "inner dialogue" (Seikkula, 2008).

1.5. Objectives and Thesis Outline

As mentioned before, this thesis aims at contributing to the understanding of human meaning making processes and their relation to psychological well-being relying on narrative theory. In order to

accomplish this aim, four different studies have been developed addressing the following three objectives:

1. To analyze the characteristics and the existence of prototypic narratives that differentiate depressed from anxious patients;
2. To analyze narrative disruption and the perceived quality of life in immigration processes;
3. To analyze meaning making processes from a dialogical approach in a psychotherapeutic setting of a couple therapy for Intimate Partner Violence.

As can be inferred, in the first two objectives, the study of narratives is addressed from a relational constructivist approach, which seemed the most appropriate when working with individuals. The third one is focused on the Dialogical Methods of Investigations of Happenings of Change, which seemed the most appropriate when working with family and couple therapy. The first two objectives will be addressed with two studies, one for each objective one. The last one will be addressed with two studies. Taking into account these objectives, this document has been structured in six chapters, each of them having a specific focus.

After having detailed the rationale and objectives of the thesis in the present chapter, the **second chapter** presents the first study focused on meaning making processes of depressed and anxious patients, in which the prototypical narratives of these two types of patients are analyzed. More precisely, the study focuses on the analysis of self-characterizations using the Narrative Assessment Grid (Botella & Gámiz, 2011), a methodology specifically created for this study, which is founded on the work of various authors in the field. The **third chapter** summarizes the second study that we have developed, focusing on the meaning making processes of immigration. In this study we discuss the narrative disruption and quality of life exhibited by a group of immigrated adolescents compared to a control group. In this case, the methodology approach is based on the use of the Biographical Grid (Neimeyer & Stewart, 1996), and the analyses are performed following the rationale of the Grounded Theory. The **fourth** and **fifth chapters** have to do with the meaning making processes in a couple's therapy for Intimate Partner Violence. The two studies developed are presented in each of these two chapters. In both cases, the methodology approach is based on the proposal developed by the Dialogical Investigations of Happenings of Change (Seikkula, Laitila & Rober, 2012), which allows

for an analysis of the dialogue taking into account both the client and the therapist. Finally, this thesis also includes a concluding chapter (**chapter 6**), a closing remarks chapter (**chapter 7**) and a reference list.

In the conclusion we highlight the main findings of each study and the way in which they provide new information on human meaning making process focusing on a narrative approach. We also point out the potential clinical implications derived from this research program, the limitations, and the issues that are left for future work.

In the next part of this introductory chapter we will present a summary of each study presented in this thesis as well as a review of the methodology followed in the thesis.

1.5.1. Narrative Assessment: Differences Between Anxious and Depressed Patients

The relevance of narrative processes to psychotherapy has been increasingly acknowledged in recent decades. Both in terms of new proposals for specific forms of narrative therapies (see, e.g., Angus & McLeod, 2004) and study of the characteristics of client-generated narratives in psychotherapy (Neimeyer, 1995), story-telling and meaning construction have been added to the repertoire of constructs that help enhance understanding and foster improved psychotherapeutic outcomes

and processes. As summarized by Angus (2012, p. 368) “clinicians and psychotherapy researchers alike have increasingly drawn on the concept of narrative to identify the processes entailed in generating explanations of everyday events and organizing these experiences into a coherent view of self, as an unfolding life story”.

Among the host of factors that contributed to the acknowledgment of the relevance of narrative processes in psychotherapy, at least three seem to be crucial:

(1) The growing interest in a narrative approach to psychology (not only to psychotherapy) during the late 1970’s and the 1980’s. This interest included disparate areas of the field such as social, developmental, clinical, and educational psychology, and was part of what Sarbin (1986) in his seminal volume called “a revived psychology,” as opposed to one stifled by the methodological and epistemological rigors of strict positivism. Constructivism had been an intrinsic part of this “revival” since decades earlier. Within this evolving framework, the narrative approach to self-identity (dating back to William James) gained acceptance as an alternative to more mechanistic approaches (see McAdams & Adler, 2010, for a detailed review).

(2) Specifically in the domain of psychotherapy research, there was a realization on the part of psychodynamic psychotherapists interested in conflictual relational narratives of the fact that a very high percentage of their psychotherapeutic sessions had a narrative discursive structure (see Luborsky, Barber, & Diguer, 1993). These authors reported that patients in brief psychodynamic psychotherapy spontaneously disclosed an average of 4 to 6 personal stories per session. This finding has been confirmed by Client Centered Therapy (Angus, Lewin, Bouffard, & Rotondi-Trevisan, 2004) and by Emotion Focused Therapy (EFT; Rotondi-Trevisan, 2002). In EFT, it was established that 74% of all external narrative sequences entailed the disclosure of a personal story, leading Angus and McLeod (2004) to conclude that "psychotherapy can be characterized as a specialized, interpersonal activity entailing emotional transformation, meaning construction and story repair" (Angus, 2012, p. 368).

(3) As psychological development is correlated with the ability to create narratives in an increasingly complex way, the relationship between psychological well-being and narrative seems clear. Thus, as Gonçalves and Machado (1999) claim, there is a need for a move "from

the microscopic study of verbal modes to a macroscopic approach in which these modes are organized into narratives".

The combination of these three independent but related developments helped bring about a framework in which it emerged that (a) human action and meaning-making processes adopt a narrative structure, (b) psychotherapy is a fundamentally narrative activity, and (c) narrative research should focus on the macroscopic approach.

Therefore, in this chapter we test the usefulness of a form of narrative analysis based on the multidimensional approach to narrative processes discussed above. In this case, our goal is to test for commonalities and differences between a group of narratives from patients with depressive symptoms and another group of patients suffering from anxiety.

As Gonçalves and Machado (1999) pointed out, different psychopathological situations present specific meaning-making processes that can be identified in different prototypical narratives. Thus, in light of the differences between depressed and anxious patients evidenced in the

research field[1], in this chapter we analyze those differential patterns in the narratives, and explore the main differences between them.

To this aim, we apply the Narrative Assessment Grid (NA-Grid) (Botella & Gámiz, 2011) to a sample of patients' narrative self-characterizations. The NA-Grid is a combination of the narrative analysis dimensions proposed by the main authors in the field.

1.5.2. Making Sense of Immigration Processes: Overcoming Narrative Disruption

A better and deeper understanding of the narrative disruption process and its relation to quality of life can provide important information for psychotherapeutic process and outcome. As Neimeyer (2006b) discussed, narrative disruption can be destructive in its consequences, but in a more limited degree it can play a valuable role in positive adaptation.

Sewell and Williams (2002) defined narrative disruption as *the process through which the person's ability to story his or her experience in a coherent way is compromised* (p. 209). Thus, this inability to connect

[1] A complete literature review from previous publications is given in chapter 2.

the current self with the past self leads to an inability to construe a coherent future self.

Narrative disruption has not been studied in the field of immigration from the constructivist approach. In the field of general psychology, some studies have found a process of narrative disruption as a consequence of immigration (Fog, 2007; Langellier & Peterson, 2006; Manderson & Rapala, 2005) but none has either studied the narrative disruption process itself, or proposed a way to quantify it. The only study that approached narrative disruption itself, in the field of grief, concluded that such disruption, when successfully overcome, entails a process of *narrative transformation* in which the regressive narrative of the past is transcended (Herrero, Neimeyer, & Botella, 2006). Therefore, in this chapter we use narrative analysis to understand the narrative disruption process of the immigrant adolescent population.

Narrative disruption, as a deviation from life story coherence, has been related to psychological well-being and quality of life (Adler, Wagner, & McAdams, 2007). Most of the studies published until now have focused either on the objective dimension of quality of life (Velarde-Jurado & Avila-Figueroa, 2002) or on the subjective one (Camfield & Skevington, 2008; Fleck & Skevington, 2007;

Schwartzmann, 2003; World Health Organization, 1997). In contrast, our study aims at measuring the meta-subjective and narrative dimensions of quality of life—almost neglected until now.

To do so, we apply the Biographical Grid Method (BGM) (Neimeyer & Stewart, 1996), a specific type of repertory grid technique.

In sum, in this chapter we assess the applicability of the BGM for analyzing (a) narrative disruption processes in the "normal" (i.e. non-clinical) immigration population of adolescent immigrants in Catalonia, (b) the perceived quality of life of adolescent immigrants analyzed meta-subjectively and narratively. Finally, we correlate these results with psychometric measures of friendship quality and acculturation processes, which have also been related to well-being (Castellá, 2003; Landsford, Criss, Pettit, Dodge, & Bates, 2003).

1.5.3. Complexities of Dialogue in Therapy for Intimate Partner Violence: Addressing the Issue of Psychological Violence

As opposed to these two previous chapters, in this chapter, narrative analysis is not approached as an individual and inner dialogue but as a relational and cultural one. For this reason, a couple's therapeutic process for Intimate Partner Violence, is approached from a dialogical

perspective. This is done, under the assumption that focusing not only on *what* is said, but rather on *how* it is said--and what is *responded* to what is said--can elucidate the co-construction of new and shared meanings, and thus advance the process of change. Applying this perspective, dialogue is indeed communication, but it is also *the relation and process of forming oneself* (Seikkula 2008). From a dialogical viewpoint, the more one can include different voices within a polyphonic dialogue, the greater are the possibilities for emergent understanding (Seikkula & Trimble 2005).

In dialogical approaches, the focus is on the "outer dialogue"--which includes the couple and the therapists--rather than on the client's "inner dialogue" (Olson, Laitila, Rober, & Seikkula, 2012). Understanding responses as generators of change, and including the views of the therapists as fully embodied persons providing responses (Seikkula, 2008), seems to have the potential to advance beyond previous research, in which the therapist has tended to be relegated to a secondary position.

In specific terms, the analytical method followed in this chapter is the *Dialogical Investigations of Happenings of Change* (DIHC) (Seikkula *et al*. 2012), which is the first research method to focus on multi-actor

dialogue settings. This method incorporates a vision of dialogue as a producer of insight, and thus it focuses on the dialogical qualities of conversations in psychotherapy sessions. Therefore, it allows for a general categorization of the qualities of responsive dialogues at both the macro- and micro-analytical level (Seikkula, Laitila & Rober, 2012), and it includes all the members present in the psychotherapy setting (i.e. not just the family members but also the therapists).

As mentioned above, in this context, the dialogical responses of the therapist are seen as fundamental (Seikkula, 2008) in developing polyphony, which for its part is viewed as a basis for creating and co-constructing new meanings (Olson *et al*., 2012). Furthermore, this method incorporates certain important aspects of the psychotherapy context, and this may make it possible to understand change as a collaborative manifestation, occurring among all the participants in the psychotherapy session. Hence the focus of the research moves away from the inner experiences of the patients and towards the actual dialogue--*and it is the dialogue itself that constitutes the trigger for change* (Seikkula, Laitila & Rober 2012; Olson *et al*. 2012).

Dialogical research within mental health therapy has indicated that dialogical properties seem to characterize good outcome cases

(Seikkula *et al*., 2012). Moreover, from a dialogical perspective, focusing on the present moment – i.e. focusing in the immediate dialogical context- is of great importance (Seikkula, 2008). Other relevant findings include results obtained using the Narrative Process Coding System (which is the last stage of DIHC): there is evidence that the use of the reflexive mode, which refers to the client and therapist's shared, mutual, and reciprocal analysis of experiences and the generation of meanings (Laitila *et al*., 2001), might be indicative of change and a good outcome (Angus, 2012). In this study, we shall present an analysis of how these three dimensions may be related, and how this relationship may produce change within a process of couple therapy for psychological IPV.

1.5.4. Increasing Responsibility, Safety, and Trust through a Dialogical Approach: a Case Study in Couple Therapy for Psychological Abusive Behavior

In this chapter we analyze the same data with the same method than in the previous chapter, but with a different focus. The previous chapter seemed to corroborate the potential of the Dialogical Investigations of Happenings of Change to analyze talk and dialogue when focused on the co-construction of new-shared meaning. For this reason, in this chapter, we apply the same method to understand how

some important dimensions in a couple's therapy for Intimate Partner Violence are dealt with in the therapeutic context.

Focusing on dialogue may be especially relevant in cases where the tool of violence is language-based, i.e., existing on a symbolic and semantic level rather than as actual physical harm. Hence, by looking at the voices, addressees, and positioning of the couple in the session, it may be possible to understand the dynamics of the relationship, and specifically, the dynamics associated with violence. Such an analysis makes it possible to focus, first of all, not just on the meaning of what is said, but also on the sense of the words in the actual present moment (the voices). Secondly, in this procedure, one will look closely at the persons to whom the words are addressed, considering them to be not just addressees within the present moment, but also addressees in the person's past. Finally, such an analysis will examine how the couple members position themselves in the present moment of the session (positioning) (Seikkula *et al*. 2012).

In looking at the main goals in couple treatment for IPV (see chapter 5 for a review), in this chapter we shall focus on the issues of *responsibility*, *safety*, and *trust*, as aspects that acquire particular importance in this kind of therapy. These aspects are identified

throughout the analysis of the therapy, and an explanation about how they are understood and dealt with from a dialogical point of view is given. Because of the special relevance of the therapist (as mentioned above), the present study emphasizes this aspect, and highlights the use of reflective dialogues.

1.5.5. Method: Integrating Constructivist and Social Constructionist Approaches to Narrative

For the two first chapters of this thesis, a relational constructivist approach to narrative is followed; the narrative analysis method is a macro- micro-level one. On the one hand, chapter two follows a macro-analysis of the narrative with the Narrative Assessment Grid (NA-GRID) (Botella & Gámiz, 2011). On the other hand, chapter 3, uses the Biographical Grid (BG) (Neimeyer & Stewart, 1996), to analyze narrative disruption and quality of life, and it follows a macro- micro-analysis of the narrative, with the Grounded Theory being the method of analysis.

In the third and fourth chapters; both studies are focused on a dialogical approach; the method followed is the Dialogical Investigations of Happenings of Change that analyses the narrative at a macro- micro-level.

Chapter 2

Narrative Assessment: Differences Between Anxious and Depressed Patients

2.1. Introduction

The relevance of narrative processes to psychotherapy has been increasingly acknowledged in recent decades. Both in terms of new proposals for specific forms of narrative therapies (see, e.g., Angus & McLeod, 2004) and study of the characteristics of client-generated narratives in psychotherapy (Neimeyer, 1995), story-telling and meaning construction have been added to the repertoire of constructs that help enhance understanding and foster improved psychotherapeutic outcomes and processes. As summarized by Angus (2012, p. 368) “clinicians and psychotherapy researchers alike have increasingly drawn on the concept of narrative to identify the processes entailed in generating explanations of everyday events and organizing these experiences into a coherent view of self, as an unfolding life story”.

Among the host of factors that contributed to the acknowledgment of the relevance of narrative processes in psychotherapy, at least three seem to be crucial:

(1) The growing interest in a narrative approach to psychology (not only to psychotherapy) during the late 1970’s and the 1980’s. This interest included disparate areas of the field such as social,

developmental, clinical, and educational psychology, and was part of what Sarbin (1986) in his seminal volume called "a revived psychology," as opposed to one stifled by the methodological and epistemological rigors of strict positivism. Constructivism had been an intrinsic part of this "revival" since decades earlier. Within this evolving framework, the narrative approach to self-identity (dating back to William James) gained acceptance as an alternative to more mechanistic approaches (see McAdams & Adler, 2010, for a detailed review).

(2) Specifically in the domain of psychotherapy research, there was a realization on the part of psychodynamic psychotherapists interested in conflictual relational narratives of the fact that a very high percentage of their psychotherapeutic sessions had a narrative discursive structure (see Luborsky, Barber, & Diguer, 1993). These authors reported that patients in brief psychodynamic psychotherapy spontaneously disclosed an average of 4 to 6 personal stories per session. This finding has been confirmed by Client Centered Therapy (Angus, Lewin, Bouffard, & Rotondi-Trevisan, 2004) and by Emotion Focused Therapy (EFT; Rotondi-Trevisan, 2002). In EFT, it was established that 74% of all external narrative sequences entailed the disclosure of a personal story, leading Angus and McLeod (2004) to conclude that

"psychotherapy can be characterized as a specialized, interpersonal activity entailing emotional transformation, meaning construction and story repair" (Angus, 2012, p. 368).

(3) As psychological development is correlated with the ability to create narratives in an increasingly complex way, the relationship between psychological well-being and narrative seems clear. Thus, as Goncalves and Machado (1999) claim, there is a need for a move "from the microscopic study of verbal modes to a macroscopic approach in which these modes are organized into narratives".

The combination of these three independent but related developments helped bring about a framework in which it emerged that (a) human action and meaning-making processes adopt a narrative structure, (b) psychotherapy is a fundamentally narrative activity, and (c) narrative research should focus on the macroscopic approach.

Following this macroscopic approach, the main narrative dimensions that have been proposed to analyze client-generated narratives in psychotherapy are presented below (Gergen, 1994; Gonçalves, 2000; Gonçalves & Henriques, 2000a, 2000b, 2000c, 2000d; McAdams, 2006; and Neimeyer, 2006).

1. *Narrative Structure and Coherence*

1.1. *General Orientation:* (The *Who, When,* and *Where* of the narrative). The general orientation of a narrative informs us as to the characters and the social, spatiotemporal, and personal contexts wherein the events occur. It can include past and future events. As the meaning of the narrative is influenced by its context, the general orientation makes the narrative more comprehensible.

1.2. *Structural Sequence:* (The *What* of the narrative). The structural sequence of a narrative is established through the stringing together of a series of events so that they constitute a retelling of the temporal sequence of lived experience. In its most minimal form it includes: (1) an initial event; (2) an internal response to the event (i.e., goals, plans, thoughts, or feelings); (3) an action and (4) its consequences.

1.3. *Evaluative Commitment:* (The *Why* of the narrative). Evaluative commitment informs us as to the significance

that the narrator ascribes to the event being narrated, i.e., about its importance within his or her world outside the narrative itself. High levels of evaluative engagement are noticeable due to a more emotional tone in the narrative being told.

1.4. *Integration* refers to the clarity of the narrative thread or plot, i.e., the extent to which the author is capable of construing an overarching sense of connection to the variety of events being narrated.

2. *Narrative Content and Multiplicity*

2.1 *Thematic Variety* refers to the degree to which different themes are included in the narrative, as well as to the description and detailed discussion of their specific contents.

2.2. *Variety of Events* refers to the number of events included in the narrative.

2.3. *Variety of Scenarios* refers to the number of scenarios included in the narrative.

2.4. *Variety of Characters* refers to the number of characters included in the narrative.

3. *Narrative Process and Complexity*

3.1. *Objectifying* refers to the level of sensorial complexity of the narrative, i.e., to the extent to which it includes specific sensorial details.

3.2. *Emotional Subjectifying* refers to the narrative's level of emotional complexity. High levels of emotional subjectifying lead to narratives that describe in great detail the emotional states associated with the events.

3.3. *Cognitive Subjectifying* refers to the level of cognitive complexity of the narrative, i.e., exploration of the multiplicity of internal experience in terms of thoughts.

3.4. *Metaphorizing* refers to the narrative's degree of complexity in terms of metacognitive expression and meaning construction.

4. *Narrative Intelligibility*

According to the work of Gergen (1994), the inextricably social nature of a self-narrative entails that it must be intelligible to be useful as a self-identity construction—otherwise it would be literally incomprehensible, and its author would thus be placed in a state of social isolation. To be intelligible, a narrative should:

4.1. Establish valued final goals;

4.2. Make goals non-conflicting;

4.3. Make goals reasonable;

4.4. Select events relevant to the achievement of this goal;

4.5. Place these events within a sequence;

4.6. Characterize its cast of characters and provide them with stable identities; and

4.7. Draw causal links among the events.

5. *Other relevant dimensions (McAdams, 2001; Adler, Wagner, & McAdams, 2007)*

5.1. *Contamination sequences* are episodes with a progressive beginning followed by a regressive ending.

They are related to depression, dissatisfaction, and neuroticism.

5.2. *Redemption sequences* are episodes with a regressive beginning followed by a progressive ending. They are related to high levels of generativity, resilience, and quality of life.

6. *Narrative position of the self*: The client's position relative to his or her self-narrative and its possibility for therapeutic change can be characterized as (i) victim, (ii) partially in control, (iii) moderately agentic, and (iv) highly agentic.

Gonçalves and Machado (1999), focusing on the *content* of their problematic patients' narratives, carried out a Grounded Theory Methodology analysis of interviews about significant life narratives with patients that met DSM-IV criteria for agoraphobia (n = 24), opioid dependency (n = 18), alcoholism (n = 20), anorexia (n = 11), and depression (n = 20). Hierarchically clustering their meanings, they derived a prototypical narrative for each diagnostic group. Their results indicated that "the convergent validity found for the prototypical narratives for these types of dysfunction supports the specific nature of

cognitive organization in these dysfunctions, as well as the possibility of identifying this specificity in prototypical narratives" (p. 1187).

Gonçalves, Henriques, Alves & Soares (2002), conducted a study in which they applied their coding manuals for narrative structure, process, and content to 40 patients diagnosed with agoraphobia. In their study they corroborated that these dimensions showed a high level of inter-rater reliability and a high level of internal consistency. According to their results, the manuals allowed them to distinguish between the participants' narratives, but they were unable to discriminate between successful and unsuccessful narratives, with the single exception of the dimension called "objectifying" (agoraphobic patients tend to objectify significantly more in unsuccessful narratives than in successful ones). Overall, according to their results agoraphobic patients obtained significantly higher structure/coherence scores than they did for either narrative process/complexity or content/multiplicity.

Dimaggio and Semerari (2001) introduced the concept of "psychopathological narrative forms" in order to classify what forms pathological narratives take. In their work they proposed the following categories of narrative dysfunction (p. 4):

1. Impoverished Narrative

a. Deficit in Narrative Production

b. Alexithymical Narratives

2. Deficit in Narrative Integration

a. Basic Integration Deficit

b. Deficit in Integration Between Multiple Self-Other Representations

c. Overproduction of Narratives and Deficit in Hierarchization

d. Deficit in Attribution to the Correct Mental Functions and Deficit in Distinction Between Reality and Fantasy (Between Primary and Disconnected Representation)

According to these authors (Dimaggio & Semerari, 2001, p. 5) an *impoverished narrative* is one that does not leave the patient with a set of stories sufficient to cope with the world of relationships. An *alexithymical narrative* on the other hand "does not refer to emotional states and does not contain comprehensible descriptions of problems that the therapist should be tackling". *Basic integration deficit* entails an inability to "blend together the elements of mental activity into a coherent

narrative" (p. 10). *Deficit in integration between multiple self-other representations* does not allow the subject to realize that multiple representations are various facets of the same phenomenon (p. 10). *Deficit in hierarchization* results in the lack of a "dominant theme that predominates over the others in a discourse" (p. 11). Finally, narratives can be pathological by *not discriminating between reality and fantasy*.

Dimaggio and Semerari's (2001) classification of pathological narrative forms includes categories of narrative *structure* (e.g., lack of integration), *process* (e.g., lack of hierarchical complexity), and *content* (e.g., lack of emotional states in the narrative).

In another series of two studies (Semerari *et al*., 2003; Dimaggio *et al*., 2008) these authors applied their Grid of Problematic States to the intensive analysis of single cases: first in 27 transcribed treatment sessions with a single patient, and then in transcripts of the first 18 psychotherapy sessions with three patients. In both studies they demonstrated that the clients' narratives during sessions "made it possible to identify consistent clusters of constructs signaling the existence of different mental states" (Semerari *et al*., 2003, p. 349) and that these clusters changed as therapy advanced.

Moreira, Beutler, and Gonçalves (2008), also addressed clients' narrative processes in psychotherapy as a combination of narrative *structure*, *process*, and *content*. As discussed by these authors, two patients, one with a good therapeutic outcome and another with a poor therapeutic outcome, were selected from each of three psychotherapeutic models (cognitive, narrative, and prescriptive therapies). Sessions from the initial, middle, and final phases for each patient were evaluated in terms of narrative *structural coherence*, *process complexity*, and *content diversity*. In this case, they did find some differences among the groups of patients in terms of overall narrative production at the end of the therapeutic process: cases with good outcomes presented a higher overall narrative change than poor outcome cases, to a statistically significant degree. However, as they also discuss, besides overall narrative change, no further statistically significant differences were found between groups (probably due to the small size of the sample) although it should be noted that non-statistical analysis suggested trends and possible differences to be analyzed in further studies.

This study's goal was to test the usefulness of a form of narrative analysis based on the multidimensional approach to narrative processes discussed above. In this case, our goal was to test for commonalities and

differences between a group of narratives from patients with depressive symptoms and another group of patients suffering from anxiety.

As discussed by Angus (2012), findings from the field of the cognitive psychology of autobiographical memory indicate that clinical depression is marked by a preference for over-general autobiographical memory and a consequent difficulty in accessing and disclosing specific autobiographical memories (see Williams *et al.*, 2007). In Habermas and colleagues' work (*et al.*, 2008), depressive explanatory style has been found in narratives of depressed patients, in which a negative evaluation of oneself and a non-agent profile can be found. Furthermore, in their study, they had expected that the life narratives of depressed patients would present few internal evaluations, and although depressed narratives didn't present fewer internal evaluations, they were more focused on the past than those of the control group. This pattern has been correlated with reduced self-coherence, increased rumination and worry, impairment of social problem-solving, and a reduced capacity to imagine future events (Conway & Pleydell-Pearce, 2000).

While the body of research on the cognitive psychology of the effects of anxiety on autobiographical memory is not the same as in depression, there are a number of studies (particularly focused on *social*

anxiety) that indicate that anxiety may be characterized by biases in autobiographical memory recall, including (1) recall of social memories with properties relating to self-referential information, and (2) an imagery bias such that anxious individuals recall memories of anxiety-provoking events from an observer perspective and base current images of the self on memories of early adverse experiences (see Morgan, 2010). Regarding narrative coherence, neither in individuals with post-traumatic stress disorder Pos (PTSD) nor in those with Social phobia has evidence been found to validate the premise that memories are less coherent and more fragmented (Rubin, Feldman & Beckham, 2004; Rubin, 2011; Stopa, Denton & Wingfield, 2013)

Research on anxiety has also focused on the locus of control by indicating that individuals who experience less internal control might present higher levels of anxiety, which can lead to perceptions of lack of control, and therefore to avoidance of anxiety-provoking situations (Ntynen, Happonen & Toskala, 2010). Moreover, repetitive thought has been understood as a key element of a number of anxiety disorders, such as generalized anxiety disorder, social anxiety, and PTSD (Segal, Williams, & Teasdale, 2002; Watkins, 2008).

As Goncalves and Machado (1999) pointed out, different psychopathological situations present specific meaning-making processes that can be identified in different prototypical narratives. Thus, in light of the differences between depressed and anxious patients discussed above, we expect to find differential patterns in the narratives, and to explore the main differences between them.

2.2. Method

Participants

The participants in the study were 29 patients (26 women and 3 men), who received psychotherapeutic treatment at the "*Servei d'Assessorament i Atenció Psicoterapèutica Blanquerna*" (SAAP; the University Psychotherapy Center at Ramon Llull University) and were randomly chosen from the database. The mean age of the participants was 23.8 years (maximum = 29; minimum = 20; SD = 2.64). The mean of psychotherapeutic sessions per patient was 17.41 (maximum = 89; minimum = 3; SD = 24.51). The sample was made up of patients' narrative self-characterizations. The sample of narrative self-characterizations was divided into two groups according to a combination of (a) the patients' presenting complaints, (b) their scores on the *Beck*

Depression Inventory (BDI), and (c) their scores on the *Beck Anxiety Inventory* (BAI). Thus, Group A (anxious patients; n = 14) was made up of clients (a) whose presenting complaint was focused on anxiety, (b) whose scores on the BDI (≤ 15) were indicative of minimal or mild depression, and (c) whose scores on the BAI (≥ 19) were indicative of moderate or severe anxiety. Group B (depressed patients; n = 15) was made up of clients (a) whose presenting complaint was focused on depression and mood, (b) whose scores on the BDI (≥17) were indicative of moderate or severe depression, and (c) whose scores on the BAI (≤13) were indicative of minimal or mild anxiety.

Instruments

We applied the Narrative Assessment Grid (NA-Grid; see Table 1) (Botella & Gámiz, 2011) to the sample of patients' narrative self-characterizations. The NA-Grid, as discussed above, is a combination of the narrative analysis dimensions proposed by the main authors in the field, and is summarized in Table 1.

Table 1. *The Narrative Assessment Grid*

0. Narrative Synthesis
Setting: • Where does the action happen? • When does the action happen? Cast: • Who appear as characters? • What actions are attributed to them? • What intentions are attributed to them? • What personality traits are attributed to them? • What motivations are attributed to them? • What emotions are attributed to them? Plot: • What happens? Why does that happen? Narrative goal: • What is the narrative trying to prove? What is the goal to be reached or avoided? What is the implicit or explicit message?
1. Narrative structure and coherence
1.1. General orientation of the narrative ☐ 1. Low ☐ 2. Medium ☐ 3. High 1.2. General structural sequence of the narrative ☐ 1. Low ☐ 2. Medium ☐ 3. High 1.3. General evaluative implication of the narrative ☐ 1. Low ☐ 2. Medium ☐ 3. High 1.4. General integration of the narrative ☐ 1. Low ☐ 2. Medium ☐ 3. High 1.5. General coherence of the narrative (*1.1+1.2+1.3+1.4*)/4
2. Narrative content and multiplicity
2.1. Thematic variety ☐ 1. Low ☐ 2. Medium ☐ 3. High 2.2. Variety of events ☐ 1. Low ☐ 2. Medium ☐ 3. High 2.3. Variety of scenarios ☐ 1. Low ☐ 2. Medium ☐ 3. High 2.4. Variety of characters ☐ 1. Low ☐ 2. Medium ☐ 3. High
3. Narrative process and complexity
3.1. Degree of objectifying ☐ 1. Low ☐ 2. Medium ☐ 3. High 3.2. Degree of emotional subjectifying ☐ 1. Low ☐ 2. Medium ☐ 3. High 3.3. Degree of cognitive subjectifying ☐ 1. Low ☐ 2. Medium ☐ 3. High 3.4. Degree of metaphorizing (reflexivity) ☐ 1. Low ☐ 2. Medium ☐ 3. High

Table 1 (continued). *The Narrative Assessment Grid*

4. Narrative intelligibility
4.1. Degree of clarity of the rated narrative goal ☐ 1. Low ☐ 2. Medium ☐ 3. High 4.2. Degree of conflict among different goals ☐ 1. Low ☐ 2. Medium ☐ 3. High 4.3. Degree of reasonability of the rated ultimate goal ☐ 1. Low ☐ 2. Medium ☐ 3. High 4.4. Relevance of the narrated events (evaluate for all the events) Event #: Relevance ☐ 1. Low ☐ 2. Medium ☐ 3. High 4.5. General structural sequence of the narrative (same as 1.2) ☐ 1. Low ☐ 2. Medium ☐ 3. High 4.6. Stability of the characters Character: Stability ☐ 1. Low ☐ 2. Medium ☐ 3. High 4.7. Intelligibility of the causal links ☐ 1. Low ☐ 2. Medium ☐ 3. High
5. Narrative form (specify the combination of rudimentary forms)
5.1. Contamination narrative ☐ Yes ☐ No 5.2. Redemption narrative ☐ Yes ☐ No
6. Narrative Position of the Self
☐ 0. The protagonist appears completely helpless, subject to his/her circumstances; all of his/her actions are motivated by external forces. ☐ 1. The protagonist is mostly subject to the circumstances, and the control of the plot is chiefly in external forces. ☐ 2. The protagonist shares the control of his/her actions equally with external forces. He/she doesn't completely control them and he/she is not completely subject to them. ☐ 3. The protagonist holds a position of agent, he/she can exercise control over his/her life, initiate changes on his/her own and affect the course of his/her experiences. ☐ 4. The protagonist has fought actively about how to overcome a situation of impotence and has emerged victorious (generally trough the acquisition of self-consciousness, control of the situation, or more power).

Procedure

Patients' self-characterizations were elicited during the first therapy sessions by the usual procedure of inviting them to "*write a character sketch of (client's name), just as if he/she were the principal character in a play. Write it as it might be written by a friend who knew him/her very intimately and very sympathetically, perhaps better than anyone could ever really know him/her. Be sure to write it in the third person. For example, start out by saying '(client's name) is.'*" (Kelly, 1955, p.323).

To make sure that self-characterizations included a narrative dimension and not just a static description, the words "*please include also the story of how he/she became like he/she is now*" were added at the end of the request.

As usual, no restrictions were given to the client regarding the length of the text, but we excluded from the study those that were shorter than one typed or handwritten page or longer than five so as not to let the merely textual characteristics of the narrative contaminate our analysis.

Each patient's narrative was scored in each one of the narrative dimensions included on the NA-Grid. To guarantee reliability and reduce

scorer biases, five independent specially trained raters scored each narrative, and disagreements were discussed until a consensus was reached. The coders were five doctoral level collaborating therapists with a specific training of 20 hours in narrative analysis of self-characterizations using these specific dimensions. Cronbach's alpha coefficient was used to compute inter-judge reliability, and it was high (0.64 before consensus; 0.80 after consensus), considering that it was applied to a textual analysis method with a strong semantic base. Thus we could confirm, as Gonçalves, Henriques, Alves & Soares (2002) found, that the coding systems are still reliable, and even with lesser amounts of observer training (They needed over 60 hours of training.).

2.3. Results

Table 2 presents the distribution of the scores of each narrative dimension assessed by the NA-Grid in each of the two patient groups (A and B).

Table 2. *NA-Grid scorings' distribution on each narrative dimension in both groups (A & B)*

Group	Scoring	Narrative Dimension
A (Anxious)	High	General Structural Sequence General Evaluative Implication General Integration Thematic Variety Variety of events Degree of cognitive Subjectifying* Degree of Metaphorizing Grade of reasonability the rated ultimate goal Relevance of the narrated events General structural sequence of the narrative Intelligibility of the causal links
	Medium	General Orientation Variety of Characters Degree of Objectifying*
	Low	Variety of Scenarios Grade of conflict among different goals
B (Depressed)	High	General Structural Sequence General Evaluative Implication General Integration Thematic Variety Variety of Events Variety of Characters* Degree of Emotional Subjectifying Degree of Cognitive Subjectifying* Grade of clarity of the rated ultimate goal* Grade of reasonability the rated ultimate goal Relevance of the narrated events General structural sequence of the narrative
	Medium	General Orientation General Structural Sequence Variety of Scenarios Metaphorizing* Stability of the characteristics of the characters* Intelligibility of the causal links
	Low	Grade of conflict among different goals

* $p < .05$

As can be seen in Table 2:

(a) Both groups presented more high scores than medium or low ones.

(b) The distribution of narrative dimensions according to score (high, medium, and low) was similar in both groups: the highest percentage of narrative dimensions being scored as “high”, the second one being “medium”, and the third one “low” in both Group A and B.

In order to obtain more specific results, a more detailed analysis was necessary. Thus, so as to reveal possible differential patterns between patients’ narratives in groups A and B, a comparison of the two groups in terms of the percentage of scores for each narrative dimension was carried out (see Table 3).

Table 3. Na-Grid *scorings' percentage comparison of groups A & B in each narrative dimension*

Narrative Dimension	Group	Scoring	Percentage
General Orientation	A	Low	6.7%
		Medium	73.3%
		High	20%
	B	Low	0%
		Medium	71.4%
		High	28.6%
Structural Sequence	A	Low	13.3%
		Medium	26.7%
		High	60%
	B	Low	0%
		Medium	42.9%
		High	57.1%
Evaluative Implication	A	Low	6.7%
		Medium	20%
		High	73.3%
	B	Low	7.1%
		Medium	21.4%
		High	71.4%
Integration	A	Low	6.7%
		Medium	20%
		High	73.3%
	B	Low	0%
		Medium	35.7%
		High	64.3%
Thematic Variety	A	Low	13.3%
		Medium	26.7%
		High	60%
	B	Low	14.3%
		Medium	35.7%
		High	50%
Variety of Events	A	Low	20%
		Medium	20%
		High	60%
	B	Low	14.3%
		Medium	35.7%
		High	50%

Table 3 (continued). Na-Grid *scorings' percentage comparison of groups A & B in each narrative dimension*

Narrative Dimension	Group	Scoring	Percentage
Variety of Scenarios	A	Low	46.7%
		Medium	26.7%
		High	26.7%
	B	Low	21.4%
		Medium	57.1%
		High	21.4%
Variety of Characters*	A	Low	26.7%
		Medium	46.7%
		High	26.7%
	B	Low	28.6%
		Medium	28.6%
		High	42.9%
Objectifying*	A	Low	46.7%
		Medium	53.3%
		High	0%
	B	Low	42.9%
		Medium	42.9%
		High	14.3%
Emotional Subjectifying	A	Low	33.3%
		Medium	33.3%
		High	33.3%
	B	Low	28.6%
		Medium	28.6%
		High	42.9%
Cognitive Subjectifying*	A	Low	6.7%
		Medium	13.3%
		High	80%
	B	Low	7.1%
		Medium	35.7%
		High	57.1%
Metaphorizing*	A	Low	33.3%
		Medium	26.7%
		High	40%
	B	Low	21.4%
		Medium	57.1%
		High	21.4%
Intelligibility/Clarity*	A	Low	33.3%
		Medium	33.3%
		High	33.3%

Table 3 (continued). Na-Grid *scorings' percentage comparison of groups A & B in each narrative dimension*

Narrative Dimension	Group	Scoring	Percentage
Intelligibility/Clarity*	A	Low	33.3%
		Medium	33.3%
		High	33.3%
	B	Low	0%
		Medium	28.6%
		High	71.4%
Intelligibility/Conflict	A	Low	66.7%
		Medium	26.7%
		High	0%
	B	Low	71.4%
		Medium	28.6%
		High	0%
Intelligibility/Reasonability	A	Low	13.3%
		Medium	26.7%
		High	53.3%
	B	Low	0%
		Medium	35.7%
		High	64.3%
Intelligibility/Relevance	A	Low	0%
		Medium	20%
		High	53.3%
	B	Low	7.1%
		Medium	21.4%
		High	57.1%
Intelligibility/Sequence	A	Low	6.7%
		Medium	26.7%
		High	66.7%
	B	Low	0%
		Medium	42.9%
		High	57.1%
Intelligibility/Stability*	A	Low	20%
		Medium	40%
		High	40%
	B	Low	21.4%
		Medium	50%
		High	28.6%
Intelligibility/Causal Links	A	Low	0%
		Medium	40%
		High	46.7%
	B	Low	0%
		Medium	53.8%
		High	46.2%

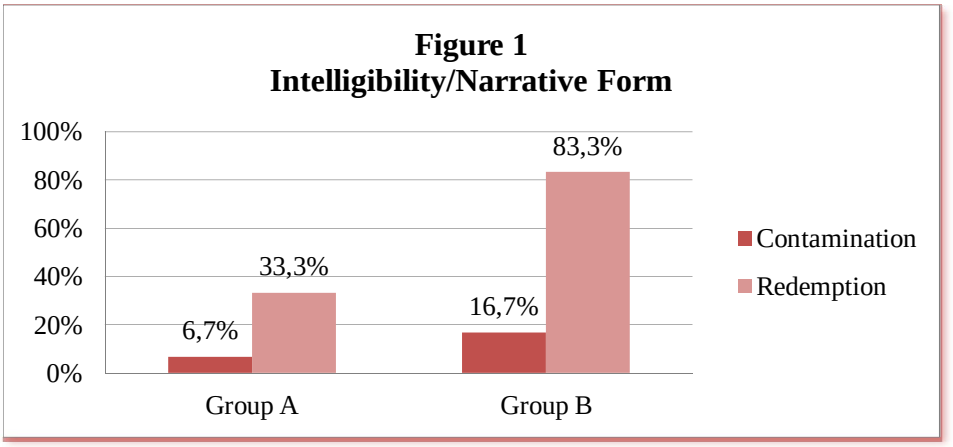
Note: * Most discriminating dimensions on both groups.

As can be seen in Table 3, the dimensions that most distinguish the two groups are: variety of characters, objectifying, cognitive subjectifying, methaporizing, intelligibility/clarity, and intelligibility/stability. These results will be discussed in the discussion section.

Results from the last two dimensions: intelligibility/narrative form, and narrative position of the self are pictured in Figures 1 and 2, respectively.

Intelligibility/Narrative Form: 83.3% of the patients' narratives in group B presented a narrative with a redemptive form, while 33.3% of the patients' narratives in group A presented this form. Results also indicated that 16.7% of the patients' narratives in group B were characterized by a narrative with a contamination form, while in group B the percentage for this narrative form was 6.7%. (see Fig. 1).

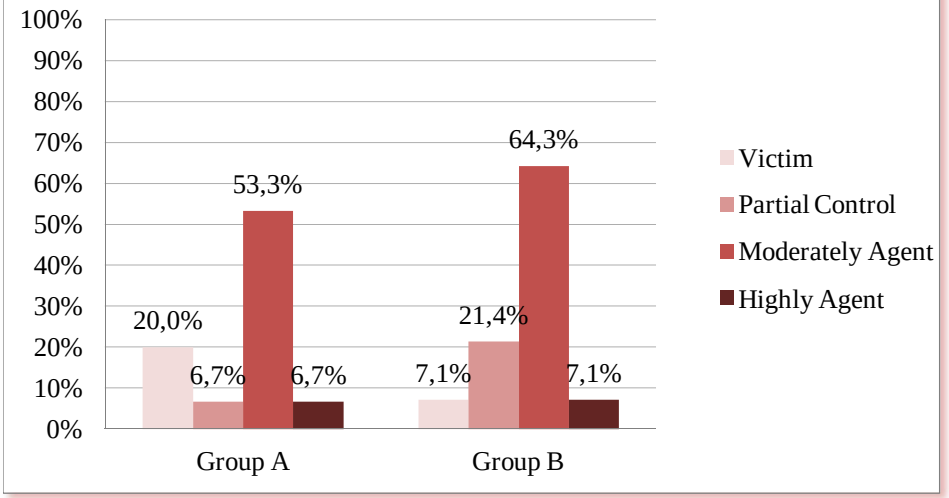
Figure 1. Intelligibility/Narrative form



Narrative Position of the Self: 64.3% of the patients' narratives in group B presented a position of the self with a moderate degree of agency, while 53.3% of the patients' narratives in group A presented this position. 21.4% of the patients' narratives in group B presented a position of the self as having partial control, while 6.7% of the patients' narratives in group B were characterized by this position. Finally, 20% of the patients' narratives in group A were characterized by a position of the self as a victim, while 7.1% of the patients' narratives in group B occupied this position. (see Fig. 2).

Figure 2. Narrative Position of the Self

Figure 2
Narrative Position of the Self



2.4. Discussion

According to our data, when trying to distinguish depressed patients (Group A) from anxious ones (Group B), only in six (out of 22) of the categories assessed is there a clear difference between the high scores for Group A and B.

These six categories deserve a more detailed discussion, precisely because they are so discriminative.

In the case of depressed patients, they seem to be characterized by a higher proportion of high scores for (a) Variety of characters, (b) Objectifying; and (c) Intelligibility/Clarity. This combination gives an

image of a way of experiencing the world that is markedly specific in its degree of detail, but is lacking in both emotional content and deeper meaning (because of the high level of objectifying). At the same time their narrative goals are quite coherent and clear—as indicated by the high level of intelligibility/clarity. Also, there is a remarkable variety of characters. These last two features could give the wrong impression: that of a very rich interpersonal world and a very clear existential project. However, this is not really the case, because the high level of objectifying strips the narrative of any profound sense of emotional meaning. Thus, narratives in this group are quite factual and clear, but also quite detached, rigid, and too coherent to be existentially relevant.

This result is consistent with the body of research on the structure of the Personal Construct System of depressed patients (for a review see Winter, 1994). Such research has repeatedly proven that *constriction* (i.e., a narrowing of one's perceptual field in order to minimize apparent incompatibilities) is associated with high levels of depression in moderately to severely depressed clients. This would explain our result of high levels of objectifying. Also, the pattern of construct system constriction has been proven to lead to tight and logically consistent patterns of construct relationships, which can explain our result of a high

level of intelligibility/clarity. However, our results seem to suggest that depressed clients need not always constrict their "perceptual field" in the sense of excluding people from it; they can include many people, but focus only on their superficial features so as to avoid potentially painful emotional and meaning-making processes—a possibility previously anticipated by Gonçalves (2000). Thus, the narrative pattern in depressive patients in our sample seemed not exactly to be characterized by the sort of preference for over-general autobiographical memory and a consequent difficulty in accessing and disclosing specific autobiographical memories that we mentioned before (see Williams *et al*., 2007), but rather by the constriction of these memories to exclusively objective details deprived of rich emotional content. Therefore, along the lines of what Habermas and his colleagues (*et al*., 2008) expected in their study depressed patients narratives presented less internal evaluation.

As for those patients whose complaint is related to anxiety, they seem to be characterized by a higher proportion of high scores for (a) Cognitive Subjectifying, (b) Metaphorizing; and (c) Intelligibility/Stability. This combination gives an image of a way of experiencing the world that is remarkably detailed in the dimension of

thought and reflection, stable and characterized by an approach that is quite meta-analytical.

This result is consistent with others from the realm of Mindfulness Based Cognitive Therapy (e.g., Segal, Williams, & Teasdale, 2002) that demonstrate that anxious patients tend to think too much and in a ruminative way (Watkins, 2008), to the extent of not paying enough attention to the sensorial and emotional details of the "here and now". Along the same lines, stability turns out to be a problem in this case because, as already discussed by Segal, Williams, and Teasdale (2002), this kind of patient tends to consider his or her thoughts as the absolute truth, and they are unable to attain any distance from them. This is also consistent with the prior studies, mentioned above, that indicate that that anxiety may be characterized by biases in autobiographical memory recall of social memories with properties relating to self-referential information. Furthermore, this methaporizing and cognitivizing tendency can be related with the observer position that anxious patients tend to present (Morgan, 2010). Finally, as predicted in the introduction, no differences in coherence were found in anxious patients (Goncalves, *et al*., 2002; Rubin, Feldman & Beckham, 2004; Rubin, 2011; Stopa, Denton & Wingfield, 2013).

Regarding the narrative dimensions that allow for the two groups to be distinguished thanks to a differential distribution of low scores, depressed patients seem to be characterized by a lower proportion of low scores for (a) Intelligibility/Clarity, and anxious patients seem to be characterized by a higher proportion of low scores for (b) Variety of Scenarios.

The first of these two differential results complements the one mentioned above; i.e., patients whose complaints are related to a depressed mood seem to be characterized by a higher proportion of high scores for intelligibility/clarity *and* by a lower proportion of low scores for the same dimension. This bidirectional discriminative power is likely to indicate that intelligibility/clarity is a core narrative dimension for distinguishing depression from anxiety. Again, this result is probably related to the traditionally demonstrated high logical consistency of depressive patients' construct systems. Depressive constriction increases logical tightness, and the less one pays attention to experience, the more coherent it is.

Regarding the higher proportion of low scores for the dimension *variety of scenarios* among anxious patients, it is quite unsurprising

considering their tendency to avoid anxiety-provoking (i.e., new and unknown) situations (Ntynen, Happonen & Toskala, 2010).

It is also quite relevant to note that none of the rest of the 22 dimensions of narrative analysis allows for the establishment of a marked distinction between the two groups (which does not mean that they cannot be distinguished from a group of non-clinical narratives; keep in mind that our comparison is between depressed and anxious patients exclusively).

This lack of general differentiation, apart from the selected dimensions already discussed, gives the impression that anxiety and depression are likely to share a common ground of psychological processes (*Coherence* and *Narrative Position of the Self*) and to diverge in a number of selected narrative dimensions (*Intelligibility*, *Narrative Process*, and *Narrative Content*).

The divergent dimensions have already been discussed. The convergent ones are theoretically coherent with a narrative theory approach: both anxiety and depression (and a host of other forms of psychological distress) introduce an episode of coherence invalidation in the person's narrative, leading to the need to reconstruct one's own self-

narrative by an active process of meaning-making so as to recover the lost sense of coherence and a newly found narrative position—two of the main goals of any process of psychotherapy, and particularly of a narrative/constructivist one. This notion is a pervasive one in the constructivist and narrative literature; as an example, see Neimeyer & Mahoney (1995) and Angus & McLeod (2004).

The last dimension that deserves some special attention refers to the Narrative Position of the Self, and as set out in the introduction, both depressed and anxious patients tend to present a non-agent position (Habermas, *et al*., 2008; Ntynen, Happonen & Toskala, 2010). According to our results this idea seems to be validated, as the percentage of "highly agent" is quite low in both groups. However, in our results, the percentage of anxious patients that presented themselves as victims was higher than in the depressed patients. Therefore, it seems that anxious patients tend to present themselves as having a lesser degree of agency and with more external locus of control (Ntynen, Happonen & Toskala, 2010)..

With respect to the limitations of this study, the sample size might be the most relevant. Thus, although we were able to test the applicability of the NA-Grid according to different "variables" and its discriminative

power with respect to the patients' complaints, further research with a bigger sample is needed before reaching any conclusions. Furthermore, although the NA-Grid has been very useful for conducting an initial, general narrative screening in that it allows for the study a great number of narratives due to its format, in order to reach a deeper understanding of these narratives other techniques for the analysis of narratives, such as Grounded Theory Methodology, might be more useful (e.g., Hardtke & Angus, 2004).

Regarding the use of self-characterizations among the host of patient-generated narratives, only a few studies have included these to study selfhood constructing processes. We agree with Leite and Kuipper (2008) that self-characterizations may help to get to know the client's "self-concept clarity"—i.e., the internal consistency and temporal stability of the self. Knowing a client's level of self-concept clarity might help predict the extent to which (a) he or she may have difficulties in clearly defining and understanding personal problems or (b) he or she is aware of the need for change. For these reasons we believe that it is important to do further research on self-characterizations because they provide potentially useful information for therapeutic practice.

Chapter 3

Making Sense of Immigration Processes: Overcoming Narrative Disruption

3.1.Introduction

Narrative disruption has been studied in relation to different psychosocial processes such as grief (Neimeyer, 2004; Neimeyer, Herrero, & Botella, 2006; Neimeyer, 2006a; Neimeyer, Burke, Mackay, & Stringer, 2010), acute stress disorder (Currier, 2010), cancer (Roussi & Avdi, 2008), the effect of infertility on women (Kirkman, 2003), psychosis in general and schizophrenia in particular (France & Uhlin, 2006; Lysaker & Lysaker, 2002). Sewell and Williams (2002) defined narrative disruption as *the process through which the person's ability to story his or her experience in a coherent way is compromised* (p. 209). Thus, this inability to connect the current self with the past self leads to an inability to construe a coherent future self. As Neimeyer (2006a) discussed, such disruptions can take multiple forms, as a threatened disorganization of the previously scripted life story, as a narrative dissociation, or as dominance. Palgi and Ben-Ezra (2010) integrated those disruptive forms in exemplifying a narrative treatment for Post-Traumatic, Acute Stress Disorder.

Narrative disruption has not been studied in the field of immigration from the constructivist approach. In the field of general psychology, some studies have found a process of narrative disruption as

a consequence of immigration (Fog, 2007; Langellier & Peterson, 2006; Manderson & Rapala, 2005) but none has either studied the narrative disruption process itself, or proposed a way to quantify it. The only study that approached narrative disruption itself, in the field of grief, concluded that such disruption displays *narrative transformation* in which the regressive narrative of the past is transcended (Herrero, Neimeyer, & Botella, 2006). Therefore, in this study we use narrative analysis to understand the narrative disruption process of the immigrant adolescent population.

Narrative disruption, as a deviation from life story coherence, has been related to psychological well-being and quality of life (Adler, Wagner, & McAdams, 2007). Most of the studies published until now have focused either on the objective dimension of quality of life (Velarde-Jurado & Avila-Figueroa, 2002) or on the subjective one (Camfield & Skevington, 2008; Fleck & Skevington, 2007; Schwartzmann, 2003; World Health Organization, 1997). In contrast, our study aims to measure the meta-subjective and narrative dimensions of quality of life—almost neglected until now.

To do so, we will apply the Biographical Grid Method (BGM) (Neimeyer & Stewart, 1996), a specific type of the repertory grid

technique. This technique allows us to assess narrative disruption by analyzing the level of integration of the traumatic experience in the self-narrative (Neimeyer, 2006a).

The better and deeper understanding of the narrative disruption process and its relation to quality of life can provide us with important information for the psychotherapeutic process and outcome. As Neimeyer (2006b) discussed, narrative disruption can be destructive in its consequences, but in a more limited degree it can play a valuable role in positive adaptation. Following with this non-pathologizing approach, narrative disruption may appear in "normal" immigration processes; we believe that by analyzing them we will be able to detect some important characteristics or phases that narrative disruption may follow to be overcome.

Our aim is to assess the applicability of the BGM on analyzing (a) narrative disruption processes in the "normal" (i.e. non-clinical) immigration population of adolescent immigrants in Catalonia, (b) the perceived quality of life of adolescent immigrants analyzed meta-subjectively and narratively. Finally, we will correlate these results with psychometric measures of friendship quality and acculturation processes,

which have also been related to well-being (Castellá, 2003; Landsford, Criss, Pettit, Dodge, & Bates, 2003).

The BGM was first proposed by Neimeyer (1985) as a way to assess and better understand the entire narrative in which the trauma is present. This method has been used mostly in studies related to trauma elaboration and PTSD (Neimeyer, 2004). Neimeyer and Stewart (1996) applied it to a patient that had suffered an assault; results showed high-polarized ratings and high distance between the ideal and the self. Using the G-Pack program, the authors also found that the patient construed his life into two diametrically opposed clusters: one referring to the past full of positive self-elements and another construing the post-traumatic self and the future self, related with negative self-elements. The BGM has also been used in relation to trauma in grief processes, specifically in the case of bereaved mothers (Gerrish, Steed, & Neimeyer, 2010). In this study, the cases of two women that had lost their child were analyzed. Results showed polarized ratings in both cases (even though one case had just 1% of balanced rates and the other had 32%). Moreover, one case presented low self-esteem in the moment of the trauma and higher in the current moment, while in the other case the traumatic moment was better integrated, even somehow compatible with the ideal. Sewell and

colleagues (1996, Sewell, 1996) applied a variation of the BGM, the Life-Events Repertory Grid (LERG) in the study of survivors among Vietnam combat veterans (Sewell *et al*., 1996) or mass murder (Sewell, 1996). By comparing a clinical group with a control group in both studies, less level of construct elaboration of the "traumatic" event (for the clinical group) than the "negative" one (for the control group) was found. Furthermore (clinical) subjects in both studies showed high polarization because of their inability of construing elaborately (i.e. with "shades of grey"). In contrast to these results, Sermpezis and Winter (2009) also used the LERG and found that in PTSD the traumatic event appears as over-elaborated instead of the under-elaboration found by Sewell and colleagues (1996, Sewell, 1996). Because of this non-agreement of the community on the level of construct elaboration in PTSD, we decided to base our analysis on the Euclidean Distances measure instead of the construct elaboration.

As Gerrish *et al*. (2010) claimed despite a number of studies supporting the methodological rigor of the BGM (as discussed before), there remains limited research documenting its use with traumatized population. In our case, we claim that there is currently no research documenting the utility of the BGM in immigrated population (who are

likely to suffer a trauma). Some research has applied the repertory grid in immigration from a clinical constructivist approach, but a revision of this is far from the scope of this research. For a review, please see Winter (2011), Sermpezis (2007), and Liebkind (1989).

With all that has been stated above, we expect that:

a) The immigrant group will show higher levels of polarization and lower levels of self-esteem.
b) The immigration process, at an early stage of life, brings forth a process of narrative disruption, which may or may not be overcome.
c) This process of narrative disruption will be related to the perceived quality of life of adolescent immigrants, following the idea of Adler, Wagner, and McAdams (2007) that life story coherence and well-being are related.

3.2. Method

Participants

A total of 884 high school students with ages ranging from 14 to 16 (mean age = 15.2) participated in the study: 51.81% of them were

girls and 48.19% were boys; a total of 204 (23.07%) were immigrants, and among these, 43 (21.07%) were second generation immigrants (i.e., Spanish-born children of foreign-born parents). Participants were recruited among informed volunteers from five high schools in Barcelona that collaborated in this research. All the students in those high schools that were enrolled in the lasts two courses of the *ESO* (Compulsory Secondary Education) were invited to participate in the study, and the resulting amount of 884 were the ones that did not refuse to participate.

After the sample was assessed initially, it was divided in two groups according to their scores: a control group of 15 Catalan-born participants, of whom 8 had high scores in the Friendship Quality Scale and 7 had low scores, and another group of 15 immigrants, of whom 8 had high scores in the Friendship Quality Scale and 7 had low scores.

Instruments

Three different questionnaires were used in this study. The first one was a sociometric questionnaire, elaborated ad-hoc, with questions related to personal characteristics of the participants (name, date and place of birth, courses that they have taken at high school, place of birth of their parents, gender, and time they have been living in Barcelona).

The other two questionnaires were the "*Friendship Quality Scale*" (adapted from Bukowski, Hoza, & Oivin, 1994) and the "*Vancouver Index of Acculturation*" (adapted from Ryder, Alden, & Paulhus, 2000). Taken together, these two questionnaires offer information on the quality of friendship and the level of acculturation, the two indicators that this study focuses on to determine the level of adaptation/integration of the immigrated children to the new culture. These two measures also give information about the level of well-being of the adolescents participating in this study, as both friendship quality and acculturation have been consistently related to well-being (Bukowski & Sippola, 2005; Castellá, 2003; Cook, Deng, & Morgano, 2007; Davidson *et al*., 2008; Everett & Cummings, 2000; Wong, Yingli, Xuesong, & Qiaobing, 2010).

The *Vancouver Index of Acculturation* is a Likert-type scale questionnaire; it consists of 16 items related to cultural preferences from both their culture of origin and host culture. Therefore, there are 8 items that refer to the original culture and 8 more that refer to the host culture. The items included in the questionnaire refer to: Traditions (e.g., *I often participate in my heritage cultural traditions*), Social Activities (e.g., *I enjoy social activities with people from the same heritage culture as myself*), School Activities (e.g., *I like to study and do the homework with*

classmates of my heritage culture), Entertainment (e.g., *I enjoy entertainment (e.g. movies, music) from my heritage culture*), Humor (e.g., *I enjoy the jokes and humor of my heritage culture*), Behavior (e.g., *I often behave in ways that are typical of my heritage culture*), Values (e.g., *I believe in the values of my heritage culture*), and Friendship (e.g., *I am interested in having friends from my heritage culture*). As mentioned before, each of those items is also formulated in relation to the Catalan culture. This questionnaire was only applied to the immigrant adolescents.

The Friendship Quality Scale (adapted from Bukowski *et al*., 1994) is also a Likert-type scale questionnaire devised to assess the quality of friendship and interpersonal relations of adolescents. It assesses five dimensions: Companionship, Level of Conflict, Helpfulness, Protection, and Intimacy. This questionnaire was applied to all the adolescents (immigrants and non-immigrants).

Finally, the participants that presented the higher and lower scores in the Friendship Quality Scale of both groups -immigrants and non-immigrants- were interviewed. In the interview, we applied the Biographical Grid method and, finally, immigrant participants were invited to write a sketch about their life story.

Procedure

In the *first phase,* the questionnaires were applied to all the participants. In the *second phase*, results of the questionnaires were used to identify extreme scores both in the control and the immigrant groups and to select participants to be interviewed. Immigrant adolescents that were not from Spanish-speaking countries were excluded from the interview, as language difficulties would have contaminated our procedure (that heavily relies on language nuances and narrative). Furthermore, the second-generation immigrants were also excluded because the major narrative disruption is more likely to happen in those who have experienced the immigration process themselves.

During the interview, the *third phase* of this study, the life-review technique (see, e.g., Mahoney, 2003) was applied and used to construct a grid. The life-review technique starts by presenting the participant with the following prompt: *"Imagine that you want to write a book about your life, which are the chapters that you would include in it? Think about the title of each chapter and explain a little bit about each one."* This technique helps to elicit the participant's narrative focused on the transitional moment when immigration happened without having to be forcefully proposed by the interviewer. It also allows bringing forth the

changes between one life narrative stage and another, giving thus information about the transition. Life narrative chapters thus elicited were considered the elements in the Biographical Grid.

According to the information about the changes in the transitions, both the interviewer and the interviewee built the Biographical Grid (BG) (Neimeyer & Stewart, 1996). As Neimeyer (2006a) highlighted, when applied to traumatic narratives, "biographical grids" have been used to help subjects to articulate fundamental life events (e.g., adaptation vs. being alone) through a systematic process of comparing and contrasting critical life episodes, of which the trauma is only one. Subsequently, the person rates each life episode (e.g., born, primary school) on each theme (integrated vs. alone), producing a matrix of ratings that can be analyzed to suggest the level of differentiation or integration of the traumatic experience with other "chapters" in the person's life narrative. As will be discussed in more detail, this technique allowed us to (a) assess the narrative disruption by analyzing the level of integration of the traumatic experience in the self-narrative; (b) compute a measure of self-esteem by correlating the scores in the "self now" element with the ones in the "ideal self" element; and (c) compute a measure of quality of life

(assessed meta-subjectively and narratively) by correlating the score of each life narrative stage with the ideal self.

In the case of the native group, they were asked to choose the most significant chapter of their life, the one that entailed a higher amount of change for them. This chapter was considered as a Life Event so as to allow for a comparison with the immigration event in the immigrant group.

The triadic method was used (Kelly, 1955) for the elicitation of constructs. Participants were presented with three elements at a time, written on cards, and asked, *"How are two elements similar and thereby different from a third one?"* (Kelly, 1955). Each participant's answer to this question provided first the emergent pole of the construct (when talking about similarities), and afterwards the submerged pole, i.e., the contrast (or implicit) pole of the construct (when talking about the difference). The elements were rated along each individual construct on a seven-point Likert-type scale.

To analyze the results of the BG, we used the G-PACK software (Bell, 1987), which is an integrated suite of programs for the elicitation and analysis of repertory grids. Despite not being the most recent

software package, G-PACK was chosen because it easily allowed us to calculate the Euclidean distances among the different "chapters" of each participant. The procedure followed in the G-PACK software was to hierarchically cluster elements by a clustering algorithm based on similarities, specifically, ordinary distances (Euclidean) with complete linkage (for a review, see Bell, 1988).

The analysis of the participants' "chapters" was carried out according to the following grid-derived indexes:

a) Pre-Immigration Quality of Life (Pre-QoL): Euclidean distance between the scores of the chapter immediately previous to immigration (or the one characterized as main chapter for the native) and the Ideal.

b) Post-Immigration Quality of Life (Post-QoL): Euclidean distance between the scores of the chapter immediately following immigration (or the one characterized as main chapter for the native) and the Ideal.

c) Change in Quality of Life (C-QoL): the result of the difference between the Pre-Immigration Quality of Life index and the Post-Immigration one. This result indicates the amount of change experienced in the perceived quality of life.

d) Post-Immigration/Now Change (C-Post/Now): Euclidean distance between the scores of the chapter immediately following immigration (or the one characterized as main chapter for the native) and the one referring to the present moment.

e) Pre-Immigration/Post-Immigration Change (C-Pre/Post): Euclidean distance between the scores of the chapter immediately previous to immigration (or the one characterized as main chapter for the native) and the one immediately after. This result indicates the amount of Narrative Disruption caused by the immigration or the main chapter chosen by the native.

f) Pre-Immigration/Now Change (C-Pre/Now): Euclidean distance between the chapter immediately previous to immigration (or the one characterized as main chapter for the native) and the present moment. This result indicates to what extent the narrative disruption is maintained.

g) Self-esteem: Euclidean distance between the present moment and the Ideal. This result indicates participants' self-esteem.

Notice that, being based on distances, the scores of indexes Pre-QoL, Post-QoL, and Self-esteem should be interpreted to mean that the higher the score, the higher the distance: thus, a score of 5 in any index

entails a higher amount of the variable that the index refers to than a score of 8. Regarding the indexes that entail measuring change between distances, the same geometric reasoning applies but precisely because they are measuring change, in these cases the higher the score, the higher the amount of change.

Finally, participants belonging to the immigrant group, during the final part of the interview, were asked to write a sketch explaining what happened in each chapter, how they felt, and what transitional process happened that led them to the end of that chapter and the beginning of another one. They were also asked to rate to what extent each chapter transition changed both themselves and their lives. This rating followed a Likert scale ranging from “nothing at all” to “totally” (see Figure 3 for an example). To analyze this rating, we attributed a number to each answer (from 1 to 5, consecutively) so as to allow for inter-subject comparisons and to detect the “transition chapters” that represented more change for each participant. Narratives were analyzed following a Grounded Theory Methodology approach.

Figure 3. Example of the Rating Included in the Sketch at the End of Each Chapter

• How did the transition from this chapter to the next one change yourself and your life?	
To myself:	To my life:
☐It totally changed me	☐ It totally changed my life
☐It changed me a lot	☐It changed my life a lot
☐It changed me quite a lot	☐It changed my life quite a lot
☐It changed me a little bit	☐It changed my life a little bit
☐It didn't change me at all	☐It didn't change my life at all

3.3. Results

As already discussed, we selected participants with the higher and lower scores in the Friendship Quality Scale so as to interview them. Thus, and according to the maximum and minimum scores of our sample, a score up to 68 was considered low and 91 or more was considered high. This selection process identified 30 participants to be interviewed (15 with high scores and 15 with low scores).

Now, we will first present the results of the BG. In the first place, we analyzed the Biographical Grids so as to calculate to what extent both groups used polarized ratings (i.e., extreme ratings of 1 or 7) versus more balanced ones (i.e., ratings of 4). Results showed that the immigrant group used more polarized ratings (44.18% of all scores were polarized) and less balanced ratings (9.64%) than the native group (28.05% and 12.83%, respectively). Therefore, the immigrant group tends to construe their identity in terms of "extreme contrast, with few shades of grey in between" (Neimeyer & Stewart, 1996). The native group's scores in polarization are close to the theoretical probability of having extreme scores in a scale of seven points (28.57%) (Feixas *et al*., 2010), which indicates "normal or average" cognitive polarization. On the other hand, the immigrant group present high scores when comparing to this theoretical probability.

The second analysis consisted in calculating the means of results in each dimension (i.e. transition between chapters), already mentioned in the procedure, for both the immigrant and the native groups, as well as their significance. Results are presented in 4 and Table 5.

Table 4. *Biographical Grid: Means of Both Groups in Each Dimension*

Dimensions	Immigrants	Natives
Post-Immigration Quality of Life	8.11	5.27
Change Post-Immigration and Now	6.25	3
Change in Quality of Life	-2.50	0.57
Change Pre-Immigration and Post-Immigration	8.35	5.90
Self-esteem	4.93	3.31
Change Pre-Immigration and Now	7.17	5.74
Pre-Immigration Quality of Life	5.61	5.84

Table 5. *Biographical Grid: Significance of the Means of Both Groups in each Dimension*

Paired Samples Test									
		Paired Differences					t	df	Sig. (2-tailed)
		Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference				
					Lower	Upper			
Pair 1	Pre-QoL Immigrants - Pre-QoL Control	-.125	3.39	.98	-2.28	2.03	-.13	11	.901
Pair 2	Post-QoL Immigrants - Post-QoL Control	2.53	2.59	.75	.88	4.18	3.38	11	.006*
Pair 3	C-QoL Immigrants - C-QoL Control	-2.65	3.33	.96	-4.77	-.54	-2.76	11	.019*
Pair 4	C-Post/Now Immigrants - C-Post/ Now Control	2.89	3.35	.97	.76	5.02	2.99	11	.012*
Pair 5	C-Pre/Post Immigrants - C-Pre/Post Control	2.45	3.13	.90	.46	4.44	2.71	11	.020*
Pair 6	C-Pre/Now Immigrants - C-Pre/Now Control	1.69	3.23	.93	-.36	3.75	1.81	11	.097
Pair 7	Self-esteem Immigrants - Self-esteem Control	1.80	2.41	.70	.27	3.34	2.60	11	.025*

As can be seen in Table 4, in the dimension Post-Immigration Quality of Life (Post-QoL), immigrants clearly have higher scores: more distance from the ideal. Concerning the change between the Post-Immigration moment and Now (C-Post/Now), the immigrant group has higher scores: they considered that they have changed more than the native group. In the dimension of Change in Quality of Life (C-QoL), the immigrant group presents lower scores, which are negative scores, thus QoL has decreased. In the dimension about the change between the Pre-Immigration moment and the Post-Immigration (C-Pre/Post), the immigrant group presents higher scores: they considered that they have changed more than the native group. In the self-esteem dimension, the immigrant group presents higher scores, further distance from the ideal, than the native group. As shown in Table 5, all these dimensions are significant, have a significant relation between the means of both groups. The last two dimensions that are not significant are Pre-QoL and Change between the Pre-Immigration moment and Now (C-Pre/Now).

To analyze the results of the narratives written by the immigrant group, first we will present the general results of the ratings on the changes in the transitions of each chapter (see Table 6), and we will relate these results to the results obtained in the BG (commented above).

In total, there were 10 narratives analyzed (3 participants from the immigrant group dropped out of school during the process, and 2 dropped out of the study). In the second part of this analysis, we will present the results of the Grounded Theory analysis. Finally, in the third part, we will focus on different groups of specific cases and we will relate this analysis with the results obtained in the questionnaires and in the narratives.

Following with the first part of this analysis, results showed that, in general, for the participants the change in themselves in C-Pre/Post -narrative disruption- has been lower than the change in themselves in C-Post-Now. This result is coherent with the one obtained in the Biographical Grid, which shows that the second dimension in which both groups differ more is C-Post/Now, in which the immigrant group considered that they have changed more than the native group. In contrast, the change experienced in their lives has been higher in C-Pre/Post than in C-Post/Now. This result is coherent with the one obtained in the Biographical Grid which shows that the third dimension in which both groups differ more is C-QoL, therefore a decrease in their quality of live after immigrating. According to these results, it seems that immigrants give more importance to the change in their lives than in themselves, when dealing with the immigration process. Furthermore, the

change in themselves seems to be higher from the moment after immigration to the current moment.

Table 6. *Narratives Analysis: Ratings on Changes in Intersections of each Chapter*

	Change from Pre-Immigration Chapter to Post-Immigration (C-Pre/Post)		Change from Post-Immigration Chapter to Now (C-Post/Now)	
Subjects	Change in ME	Change in my LIFE	Change in ME	Change in my LIFE
1	3	3	3	3
2	4	5	5	5
3	2	4	2	4
4	1	3	5	5
5	3	4	5	4
6	5	5	5	5
7	4	5	4	4
8	2	3	1	1
9	5	5	5	5
10	4	4	3	3
Total	33	41	38	39

In the second part of this analysis, we will present the results obtained with the Grounded Theory. In Table 7 we present a detailed analysis of the adjectives used in the Pre-Immigration moment, the Post-

Immigration moment, and the Present Moment in the narratives of each participant. In Table 8 we present those adjectives according to their meaning for the participants.

Table 7. *Results of the Grounded Theory: Adjectives used in the Narratives*

Subject	Pre-Immigration Chapter	Post-Immigration Chapter	Present moment Chapter
1	Happy, funny, didn't want to grow up	Sad, missing my family in my country, nervous, happy to see mother and grandmother again	Life changes, the physic and feelings change, has family and friends, think about the future and the goals that wants to reach
2	Playful child, funny, happy, unconscious, took the decision of coming to Spain	Happy to see mother again, feeling weird the first day of school, no friends	Has friends, knows the language, more mature and conscious, wants to study and do things right in the future
3	Family, friends, play, run, freedom, happiness	Happy to see father again, afraid, feeling weird, missing the family, it was not easy	New friends, love, happiness, feeling secure, feels oneself and having a place
4	Happy, unconscious	Feeling lonely, mother worked many hours, would have preferred to stay in the home country, grew up fast and became very responsible, sad	Proud of mother, wants to be a lawyer, thinking about the future
5	Easy, young, entrusted, innocent, everything full of light, happy	Everything changes, problems with sister, father inexistent, feeling lonely, unsecure, few self-esteem	New person, more light, innocent but strong, everything changes
6	Happy, everything was nice, lots of friends, missing parents	Feeling weird, sad, different than what expected, happy to see parents again	Feeling positive Looking at the future
7	Lots of friends, feeling relaxed and feeling good	Feeling weird, new friends but missing the old ones	Big high school, new friends, sometimes feeling lonely
8	Good life, being with all the family, happy and joyful	Worried, happy to see mother, nervous for school, language and friends	New friends, more sociable, knows the language, playing football helpful
9	Joyful, complete happiness, no worries	Sad, feeling lonely	Feeling better, all the family together
10	Lot of free time, happy, shy with girls	Different life, feeling like another person, feeling weird	High school, feeling better, wants to know how will it be the future

Table 8. *Results of the Grounded Theory: Adjectives according their Connotation*

	Chapters/moments		
Adjectives	Pre-Immigration Chapter	Post-Immigration Chapter	Present moment Chapter
Positives	happy funny unconscious lots of friends playful being with family	happy to see the parents again	new friends love feeling better knowing the language secure mature conscious
Neutral			high school life changes the physic and feelings change think about the future and the goals that wants to reach
Negatives	missing the parents took the decision of emigrate	sad missing the family in home country nervous feeling weird no friends feeling lonely worried afraid	sometimes feeling lonely big high school

As can be seen in Table 8, the narratives in the Pre-Immigration moment are full of positive adjectives, while in the Post-Immigration moment the predominant adjectives are negatives. In the present moment chapter there seems to be a balance with more adjectives situated in the neutral place. Again much more positive adjectives can be found in the Present Moment chapter when compared to the Post Immigration one.

In the third part of this analysis, we will focus on particular cases, relating them with the results obtained in the questionnaires. As stated above, the majority of subjects experienced the same or more change in the Post-Now transition than in the Pre-Post (narrative disruption). Nevertheless, there are three subjects (subjects 7, 8, and 10) that present more change in the Pre-Post transition than in the Post-Now; therefore, they present higher narrative disruption. Two of them (subjects 7 and 10) have low scores in the Quality Friendship Scale and, according to the results of the Vancouver Index of Acculturation, one of them (subject 10) has a light orientation to the traditional culture and the other has no orientation to any of both cultures, with low scores for both (subject 7). The narrative analysis showed that, for these two subjects, the moment after immigration was hard for them. For example, Subject 10 referred to *"feeling as another person in the immigration moment;"* it seems that

what helped him was to think that the other immigrants in class must feel the same as him, so as to overcome this feeling he decided not to forget or deny his other lives. Subject 7 referred that he missed his friends, that the high school was very big and that he felt alone. The other subject that presents more change in the C-Pre/Post transition (subject 8) than in C-Post/Now presents the peculiarity of having low scores concerning C-Post/Now; therefore, the narrative disruption might have been not high because his scores in the Pre-Post change are not very high when compared to the other subjects. He had high scores in the Friendship Quality Scale and presented a high orientation to the traditional culture.

From the rest of the subjects that stated that they and their lives changed equally or more in the Post/Now transition, there are two subjects (subjects 6 and 9) with specific situations and scores. Both subjects have the maximum score on the change in both themselves and their lives, and in both transitions. Both subjects present a high score in the Friendship Quality Scale, but one (subject 9) presents a high orientation to the traditional culture and the other (subject 6) presents a high orientation to the host culture. This result in acculturation orientation helps to guess why the change has been so high, for one subject because he sticks to his culture and finding himself in a new

culture may represent a big change, and for the other because moving to a new country has meant to stick to a whole new culture.

As for the rest of subjects, they all presented high scores in the Friendship Quality Scale and presented a light orientation to the traditional culture -with high scores in both cultures-, but for one, who presents double acculturation -same high scores in both-. In the narratives, in the Pre-Post transition, as seen in Table 7, they referred to happiness (for seeing a family member again), feeling weird, missing their family in their country of origin, some refer to being proud of their origin and also having curiosity for the new culture. In the Post-Now transition, they refer to changes in their life and their body, feeling more mature, being concerned for their studies, having new friends and love. Their narratives were a bit more elaborated; the setting and the motives were more detailed (Neimeyer, 2000).

3.4. Discussion

According to our hypothesis, in which we expected to find evidence that immigration brings forth a process of narrative disruption and that this process would be related to the perceived quality of life and self-esteem of adolescent immigrants, it seems that, according to our

results, it can be corroborated but with some nuances. According to the results in the BG, we can conclude that immigrated subjects present more narrative disruption than natives taking into account (a) their polarized ratings on the BG, which according to Neimeyer *et al*. (2002) can cause more disruption, and (b) their higher scores in C-Pre/Post. Nevertheless, surprisingly what differs more in both groups is the change they experience in C-Post/Now. Therefore, the adaptation process implies more change for them than the immigration one. Furthermore, in line with results from other research studies related to trauma elaboration and PTSD (Gerrish *et al*., 2010; Neimeyer & Stewart, 1996; Sewell *et al*., 1996; Sewell, 1996), immigrated non-clinical population seem to be characterized by having higher polarized ratings than the control group.

Following with our hypothesis, immigrants refer that their quality of life has decreased. Furthermore, according to the results in the BGM, the dimension Quality of Life is more discriminative of both groups than the narrative disruption dimension. It is important to note that immigrants express more change in their lives than in themselves at both the immigration moment and the Post-Immigration moment. For this reason, the change in quality of life is higher than the change in narrative disruption. Thus, it seems important that subjects attribute that change to

their life and not to themselves so as not to have a high narrative disruption.

According to our hypothesis, immigrants also present a lower self-esteem; this result is in line with what Liebkind (1989) pointed out referring that low self-esteem is not uncommon among minorities. However, this is not one of the dimensions in which both groups differ more. Furthermore, their change in C-Post/Now is higher than the native group and the narratives express a turn to positivity: this seems to suggest that their self-esteem was lower in the Post-Immigration moment, but after that it started to increase.

In line with what was proposed by Adler, Wagner, and McAdams (2007), we have corroborated the relationship between narrative disruption (as life story coherence) and well-being (quality of life).

According to the goals of this study, to assess the applicability of the BGM on analyzing (a) narrative disruption processes in the "normal" population, and (b) the perceived quality of life in immigrant adolescents, the BGM has been discriminative and enough specific so as to perceive differences between both groups.

With regard to the last goal of this study, to correlate the results in the perceived quality of life of adolescent immigrants and narrative disruption, with the results in the Friendship Quality Scale (adapted from Bukowski *et al.*, 1994) and the Vancouver Index of Acculturation (adapted from Ryder *et al.*, 2000), we have obtained some conclusions. First of all, it seems that low scores in the Friendship Quality Scale questionnaire and a low orientation to any of both cultures in the Vancouver Index of Acculturation is related to a higher level of narrative disruption. Moreover, a high acculturation to either the host culture or the traditional one seems to be related to a greater narrative disruption. In contrast, the subjects that seem to experience less narrative disruption present high scores in the Friendship Quality Scale questionnaire and high scores in both cultures, with a light higher orientation to the traditional one. This is in line with other research studies that relate the integration strategy (Berry, 2003), orientation to both cultures, with a higher self-concept and a better integration (Berry & Sabatier, 2011). Therefore, as reviewed in the introduction in line with results obtained by other studies (Castellá, 2003; Lansford *et al.*, 2003), it seems that friendship quality and the acculturation process are related to well-being.

Following Neimeyer's (2006b) thesis, people differ in the degree that they are able to successfully assimilate the sequel of separation into their existing self-narratives or to adequate these same life scripts to what they have suffered and what they must now struggle to change. In this research, such differences have been analyzed both when comparing two groups and also within the same group.

As set in the introduction, most of the studies on immigration find a process of narrative disruption as a consequence of immigration (Manderson & Rapala, 2005; Fog, 2007; Langellier & Peterson, 2006) but unfortunately none of them has studied the narrative disruption process itself. In this study, we have used narrative analysis to understand the narrative disruption process of the immigrant adolescent population, and the BG to assess the differences between two groups, in the integration process of a Life Event in the life-story coherence. As Gerrish *et al*. (2010) reflected, there is little research documenting the utility of the BG with traumatized populations; with this research we tried to collaborate to this lack of research. Furthermore, Gerrish and Bailey (2012) pointed out that, despite the advantages of this method (BG), "*there is no accepted method for comparing grid results across bereaved*

individuals"; this study has proposed a method for comparing the BG results which can be extrapolated to bereavement processes.

According to the only study that has studied the narrative disruption itself by Herrero *et al.* (2006), we have also found a *narrative transformation* in the immigrated group: in spite of the two subjects that experienced more narrative disruption (subject 7 and 10), the others transcended the regressive narrative of their past and moved through a more progressive one (Herrero *et al*., 2006) in which the future starts to be the protagonist and the adjectives used to describe themselves and their lives are more balanced among the positive and the negative. As an example of narrative of growth, two subjects wrote:

- *"Now I am not from here (the host country) or there (the home country) anymore; at the beginning, that was confusing but now I know that I am just myself."*
- *"I am a new person, with more light and stronger."*

For further research, it would be interesting to continue testing the methodology used in this research with a greater number of subjects, and also with clinical population, as differences among groups might be higher.

It is also interesting to think about the implications of these results for psychotherapy; some strategies such as the externalization (White, 1988/9; White & Epston, 1990) may help immigrants to see the change focused on their lives not on themselves. Also, it seems important to promote the integration of the different aspects of their identity and let space for the "shades of gray." This treatment objective can be useful for any traumatic experience as, from Sewell's constructivist perspective (Stewart & Neimeyer, 2010), a traumatic experience could be anything that results in a polarized and fragmented construing. Stewart (1995) recommends using the BGM to treat patients with traumatic processes.

Our work has clearly some limitations, with the representativeness of the sample being an important one as the cases that are thoroughly analyzed are just a few (n=10). However, even if it is not statistically representative, it is psychosocially exemplary. Another limitation may be the loss of immigration profile due to the language barrier; because this research implies a narrative analysis from an interview, language is crucial. Despite this, we believe our work could be a starting point to develop a new growing body of research focused on this new methodological approach to assess narrative disruption and quality of life--narratively and meta-subjectively.

Chapter 4

Complexities of Dialogue in Therapy for Intimate Partner Violence

4.1. Introduction

Psychological Intimate Partner Violence (IPV) is becoming increasingly recognized as a research topic (Yoon & Lawrence, 2013), and there are indications that it has a higher prevalence than physical IPV

(Shortt, Capaldi, Kim & Tibeiro, 2013), among both women and men (Coker *et al*., 2002). Furthermore, there is evidence that the impact of psychological IPV is even greater than that of physical IPV, being more strongly associated with health outcomes such as chronic pain and migraine (Coker, Smith, Bethea, King & McKeown, 2000; Coker *et al*., 2002). In addition to the adverse effects on physical health, the psychological impacts cannot be disregarded, as research has indicated that psychological IPV may in fact be more detrimental to marital satisfaction than physical aggression (Yoon & Lawrence, 2013). According to recent research, psychological IPV can occur as an antecedent of physical IPV. Longitudinal studies support an escalation explanation, in so far as violence between couples tends to escalate over time, moving from verbal to physical abuse (Bograd & Mederos, 1999; Shortt *et al*., 2013; Whitaker, Haileyesus, Swahn & Saltzman, 2007; Yoon & Lawrence, 2013).

Although there is no standard or widely accepted definition of psychological IPV, it can be understood as consisting of offensive and degrading behaviors towards one's partner (Shortt *et al*., 2013), such as to arouse fear and to be perceived by victims as harming their emotional well-being (Yoon & Lawrence, 2013). Unfortunately, psychological IPV

is highly prevalent, with rates ranging from 72%–100% in community samples (Shortt *et al*., 2013; Yoon & Lawrence, 2013). It is also relatively stable, largely bidirectional, and in all likelihood, severe in its consequences (Shortt *et al*., 2013).

Identifying psychological IPV at an early stage might help to prevent physical aggression. Furthermore, there would be possibilities for developing specific interventions that could reduce its mental or physical impacts. Consequently, it seems necessary to extend screening for IPV to include psychological abuse (Coker *et al*., 2002), and to focus on the treatment of psychological IPV as an important preventive measure. This last objective was the focus of the study reported here, which aimed to analyze the process of change in a "real-world setting," within couple therapy for psychological IPV, adopting a dialogical approach.

There is considerable controversy in the field over the indications for couple therapy in cases of IPV. However, there is a growing body of research supporting such therapy, highlighting the notion that couple therapy tends to strengthen each person's willingness to take responsibility and that it places the focus on the couple's relation dynamics (Bograd & Mederos, 1999; Hrapczynski, Epstein, Werlinich & LaTaillade, 2012; McCollum & Stith, 2008; Stith & McCollum, 2011). In

so doing, it can lead to an understanding of how the escalation process takes place (Whitaker *et al.*, 2007). Nevertheless, there are some important concerns regarding couple therapy in IPV, primarily related to safety (i.e. the victim may not speak freely, or the therapy may have bad effects) (Stith & McCollum, 2011). Clearly, minimizing risk and optimizing safety must be central goals in any treatment modality, and this is very much the case in couple therapy (Bograd & Mederos, 1999).

Some authors have also described four main conditions under which couple therapy for IPV is advisable: (i) when there is low-to-moderate violence (the psychological abuse must be infrequent and mild); (ii) when both partners voluntarily agree to participate in therapy and wish to remain together; (iii) when both partners want to end the violence; and (iv) when the violence is reciprocal (Bograd & Mederos, 1999; Hrapczynski *et al.*, 2012; Stith, McCollum, Rosen, Locke & Goldberg, 2005; Stith, McCollum, Amanor-Boadu & Smith, 2012; Whitaker *et al.*, 2007).

Research is scarce and the results diverse regarding the outcome of IPV conjoint therapy. Some studies, mainly focusing on cognitive-behavioral couple therapy and employing a variety of systemic models, have shown good outcomes (Stith *et al.*, 2012). However, no model has

proved to be more effective than any other, since all of them seem to decrease negative communication and psychological and physical aggression, and to increase relationship satisfaction (LaTaillade, Epstein & Werlinich, 2006). In this sense, the findings seem to offer support for couple therapy regardless of the theoretical orientation (Hrapczynski *et al*., 2012; LaTaillade *et al*., 2006). Nonetheless, in a purely meta-analytic study reviewing group therapy (Duluth-type and cognitive-behavioral) and couple therapy, no significant differences were found regarding the outcome--which, according to that study, was still fairly poor (Babcock, Green & Robie, 2004). As far as we know, up to the present no research has been conducted on the specific processes and outcomes of conjoint therapy in psychological IPV. Such research might be of use in identifying particular aspects of the processes that could explain some of the outcomes, thus leading to better explanations overall regarding the conditions for effective therapy. With this aim in view, the study reported here focused on an analysis of the specific processes and complexities displayed in couple therapy for psychological IPV.

The therapy process in conjoint therapy for psychological IPV was approached from a dialogical perspective, under the assumption that focusing not only on *what* is said, but rather on *how* it is said – and what

is *responded* to what is said--can elucidate the co-construction of new and shared meanings, and thus advance the process of change. In dialogical approaches, the focus is on the "outer dialogue"--which includes the couple and the therapists – rather than on the client's "inner dialogue" (Olson, Laitila, Rober & Seikkula, 2012). Such a more qualitative research approach can be expected to provide valuable information concerning the therapists' responses to utterances. Understanding responses as generators of change, and including the views of the therapists as fully embodied persons providing responses (Seikkula, 2008), seemed to have the potential to advance beyond previous research, in which the therapist has tended to be relegated to a secondary position.

In specific terms, the method of analysis used in this research was *Dialogical Investigations of Happenings of Change* (DIHC). This method incorporates a vision of dialogue as a producer of insight, and thus it focuses on the dialogical qualities of conversations in psychotherapy sessions (Seikkula, Laitila & Rober, 2012). As mentioned above, in this context, the dialogical responses of the therapist are seen as fundamental (Seikkula, 2008) in developing polyphony, which for its part is viewed as a basis for creating and co-constructing new meanings (Olson *et al.*,

2012). Furthermore, this method incorporates certain important aspects of the psychotherapy context, and this may make it possible to understand change as a collaborative manifestation, occurring among all the participants in the psychotherapy session. The DIHC method has been applied in family and couple psychotherapy, and has also been applied in a case analysis of Dialogical Therapy in couple therapy for depression, looking at the macro-analytical level (i.e. via analysis of the session as a whole) (Seikkula *et al*., 2012), and also at the micro-analytical level (Olson *et al*., 2012). In the present study, the focus of our analysis was on the start of the therapeutic process. This is an extremely important stage in family therapy and one which, according to Laitila, Aaltonen, Wahlström & Angus (2001), has been frequently overlooked in family therapy research. We anticipated that by analyzing the formation of the therapeutic system, we would be able to arrive at some hypotheses concerning the therapeutic process and outcome. These hypotheses, it was thought, might be helpful in regulating the therapeutic process, and in helping therapists to consider new strategies. Dialogical research within mental health therapy has indicated that dialogical properties seem to characterize good outcome cases (Seikkula *et al*., 2012). Moreover, from a dialogical perspective, focusing on the present moment – i.e.

focusing in the immediate dialogical context- is of great importance (Seikkula, 2008). Other relevant findings include results obtained using the Narrative Process Coding System (which is the last stage of DIHC): there is evidence that the use of the reflexive mode, which refers to the client and therapist's shared, mutual, and reciprocal analysis of experiences and the generation of meanings (Laitila *et al*., 2001), might be indicative of change and a good outcome (Angus, 2012). In this study, we shall present an analysis of how these three dimensions may be related, and how this relationship may produce change within a process of couple therapy for psychological IPV.

A further important aspect of the present research was that it was aimed at filling and diminishing the gap between research and practice in IPV (Babcock *et al*., 2004; Stith *et al*., 2012). Here, it should be noted that two of the collaborators of this research were the therapists in the therapeutic process analyzed.

With regard to the ethical and contextual characteristics of the study, the therapy reported in this research was conducted in a "real-world" setting, and the couple sought couple therapy on a voluntary basis. We consider both aspects to be crucial since very little research has been conducted in the field of IPV under these conditions, even if their

relevance has been repeatedly demonstrated and emphasized (Madsen, Stith, Thomsen & McCollum, 2012; Stith *et al*., 2012).

This exploratory study addressed the following research questions:

1. Adopting a dialogical perspective, is it possible to detect any phenomena specific to couple therapy for psychological IPV?
2. Do dialogicity and a focus on the present moment accompany a shift into the reflexive mode within the therapeutic process?
3. Looking at the analysis overall, what challenges and possible recommendations for clinical practice may be derived from our results?

4.2. Method

Setting

The study reported here formed part of a multi-site research project called "Research on couple treatment in intimate partner violence" conducted within the Psychotherapy Training and Research Centre at the University of Jyväskylä, Finland. The data were collected from couple treatment meetings in which the reason for treatment contact was intimate partner violence, or in which the problem of intimate

partner violence became addressed in therapy for other issues. In this modality, couple therapy is not started if there has been particularly serious or life-endangering violence in the relationship, or if the acts of violence continue. Both partners attending the therapy meetings need to be willing to attend and able to speak openly in conversations. The clients included in the present research gave informed consent for participation in the study and for their conversation to be used as research data. In addition to the audiotaped therapy conversations, the data for the study consisted of an individual interview with both partners at the beginning of the therapy. According to the procedure adopted, during each individual interview the partners are asked to complete the Abusive and Controlling Behavior Inventory (ACBI; Davies, Holmes, Lundy & Urquhart, 1995). Furthermore, after each couple therapy session they are asked to complete the Session Rating Scale (SRS; Johnson, Miller, & Duncan, 2000). Note that the procedure involves also the signing of a non-violence contract by both partners.

Participants: Clients

The couple's characteristics matched the four main conditions under which couple therapy for IPV is indicated, as mentioned in the

introductory section. They presented low-to-moderate violence (in this case psychological violence). Both partners voluntarily agreed to participate in the therapy. They also wanted to remain together, and to end the violence.

The couple in question consisted of a re-married couple. The wife was Finnish and the husband was from the USA; thus the persons were living in an intercultural situation. With regard to the cultural background of the couple, language barriers should be taken into account: within the psychotherapy the husband was the only person speaking in his native language. All the other participants used English, which was not their first language. The husband was an officer in the army, and he had been in international crisis areas. They had met through the Internet two years previously, and they had two children together[2].

At the start of the therapeutic process both spouses were asked to fill in the Abusive and Controlling Behavior Inventory (ACBI) (Davies, Holmes, Lundy & Urquhart, 1995), which assesses various dimensions of violence (emotional and psychological, sexual, physical, and globally impacting). These dimensions are also assessed bi-directionally, i.e. as "violence towards your partner, and violence of the partner towards you."

[2] To protect the confidentiality of the couple, we refer to them as *Husband* and *Wife*. Furthermore, some of the information pertaining to identity has been altered.

The results of these questionnaires showed that the violence was seen as reciprocal by the couple, since both members felt that they had received violence from the partner, and both recognized that they had applied some violence. The most highly rated violence, by both spouses, took the emotional and psychological form, whereas sexual and physical violence had the lowest ratings. As expected, both members rated their use of violence lower than the rating given by the partner, in line with the general tendency for the level of violence applied by oneself to be seen as lower than the level ascribed by the partner.

In addition, after each session both partners filled in the Session Rating Scale (SRS V.3.0) (Scott, Miller, Barry, Duncan & Johnson, 2002), in order to assess the session in terms of (i) the relationship (whether they felt heard, understood, and respected), (ii) the goals and the topic (whether the members had worked on or talked about what they wanted to), (iii) the approach or method (whether the therapist's approach had suited them well), and (iv) an overall assessment (including whether there had been something missing in the session). According to the questionnaire results, the best-rated session was the second one (rated especially highly by the wife, who gave each item a maximum score), followed by the fourth and, finally the first and third (these latter two

having similar ratings). All in all, the four sessions had fairly high ratings, with scores always higher than medium scores (i.e. from 36 to 40).

Participants: Therapists

Two psychologists with more than 25 years of experience participated in the therapy sessions. Both of them are also collaborating on this research.

Participants: Raters

Two raters coded the data. One was a psychologist with more than 25 years of experience. He was one of the originators of the DIHC method; he had also taken a course on the NPCS method. The other rater was a doctoral student who had received training on both the DIHC and the NPCS methods at the University of Jyväskylä[3]. The analytical process, and any disagreements arising, were discussed with the other collaborators in the present study, who were also originators of the DIHC method. The discussion continued until a consensus was reached.

[3] This training took place during a research visit, funded by the CIMO Fellowship program.

Instruments/measures

The design followed in this study was based on the mixed methods approach, in which analysis was conducted on both quantitative data (derived from questionnaires, the DIHC, and the NPCS coding) and qualitative data (derived from psychotherapy vignettes).

The DIHC method follows three different steps (see Seikkula, Laitila & Rober, 2012):

Step I: Exploring the topic episodes in the dialogue. For any given moment, episodes are defined by the topic under discussion. If the topic changes the episode is viewed as having ended.

Step II: Exploring the series of responses to the utterances. In this second step, the responses to each utterance are registered for each topical episode. Thereafter, the response given to the Initiating Utterance is categorized according to (a) the participant taking the initiative (indicating *quantitative*, *semantic*, or *interactional* dominance); (b) what is responded to (in terms of emotions, previous topics, what or how something was said, matters external to the session, other issues); (c) what is *not* responded to (referring to voices that are not included in the response of the next speaker, bearing in mind that a single utterance by a

single participant can include many voices); (d) how the utterance is responded to (monologically or dialogically); and (e) *how* the present moment, *the implicit knowing of the dialogue is taken into account* (manifested in body gestures, intonation, tears, anxiety, and possibly also in comments made on the present situation, for example comments on the emotions felt).

Step III: Exploring the process of narration and the language area. This step is conducted by means of the Narrative Process Coding System (Angus, 2012); thus three types of narrative processes are identified, namely *external language, internal language*, and *reflective language.*

It is important to note that the sub-dimensions analyzed in the dimensions (b) *what is responded to*, (c) *what is not responded to*, and (e) *how the dialogue within the present moment is taken into account* are not predefined categories, but case-specific guiding ideas. Thus, they may vary from one case to another. In the case reported here, the subcategories were drawn from those proposed by Seikkula, Laitila & Rober (2012); however, as the analytical process advanced, more categories were added (see Table 9 for a detailed review of all the categories identified in this study). Moreover, the categories are not

mutually exclusive, as in a topic segment many aspects can be presented simultaneously.

The remaining categories are mutually exclusive categories. These are related to *dominance*, and to *how the utterance is responded to*. In relation to dominance three dimensions were identified: (a) quantitative dominance, identified in terms of who does the most speaking in each topic segment; this was calculated by the number of words used by each speaker; (b) semantic dominance, identified by who introduces new themes or new words in each topic segment (with this individual shaping most of the content of the discourse); and (c) interactional dominance, identified in terms of the influence of one participant over the communicative actions, initiatives, and responses within each topic segment (occurring for instance when a therapist invites a new speaker to comment on what is being said). Finally, the categories relating to how the utterance is responded are also exclusive. Thus, in our analysis we determined whether the utterance was responded to dialogically or monologically in each topic segment.

This meant that we identified as dialogical on the one hand, utterances that were constructed to answer previous utterances, and also utterances that waited for a response in utterances that followed. In such

utterances, there is an emergence of new-shared understandings, and a polyphony of voices is present. When this happens, the speaker includes within his or her utterance what was previously said and ends up with an open form of utterance, making it possible for the next speaker to join in what was said. By contrast, utterances that convey only the speaker's own thoughts and ideas with no adaptation to the interlocutors are understood as monological. In those utterances, questions are presented in a form that presupposes a choice of only one alternative, and few dominant voices are present.

Procedure: Data collection and analyses

The data for this study consisted of the dialogue of the participants (couple plus therapists) throughout the first four therapy sessions. These sessions were video-recorded and transcribed. In total 100 transcript pages were analyzed. The transcriptions were analyzed using the DIHC method, applying a macro-level analysis. Special attention was given to sessions 2 and 3 due to the fact that between these two sessions the wife went to a women's refuge. Consequently, these two sessions were analyzed via a micro-level analysis, following the NPCS method.

As mentioned above, the analysis of the transcript was first coded by two raters. After the preliminary categorization (using the three steps described previously), in order to check on the trustworthiness of the first authors' analysis, the core researchers reviewed the categorization, focusing more on their points of disagreement than on their points of agreement. As has been noted by the developers of the method (Seikkula, Laitila & Rober, 2012), in engaging in this dialogue, the different voices enrich the picture of the dialogue under investigation

The therapy was still in progress at the time when we began to handle the data. Hence, transcription took place while the therapy process was still under way. We chose this procedure so that we could analyze the transcriptions before the end of the therapeutic process, seeking to form some hypotheses about the process and outcome before the therapy had finished.

4.3. Results

Step I: Exploring Topic Episodes in the Dialogue

As mentioned above, the first step involved division of each session into topic segments, according to the change in the meaning and/or the topic being discussed. The first session was divided into 25 topic segments (consisting of 6 734 words), the second was divided into

26 topic segments (consisting of 10 850 words), the third was divided into 45 topic segments (consisting of 11 099 words), and the fourth was divided into 40 topic segments (consisting of 12 299 words).

Step II: Exploring the Series of Responses to the Utterances

The dimensions analyzed and the percentages obtained for each session are presented in Table 9. The main results are in bold.

Table 9. *Dimensions Analyzed and Percentage Results for Each Session*

			Sessions			
Dimensions Analyzed			S1	S2	S3	S4
Dominance*	Quantitative Dominance	Husband	**40**	**54**	**48**	**48**
		Wife	32	42	32	40
		Therapists	28	4	20	12
	Semantic Dominance	Husband	20	34	24	32
		Wife	36	**57**	**44**	**48**
		Therapists	**44**	9	32	20
	Interactional Dominance	Husband	2	0	2	6
		Wife	6	4	2	9
		Therapists	**92**	**96**	**96**	**85**
What is responded to	what is being said at the moment		24	19	24	40
	quarreling of the couple		4	0	**9**	5
	commitment to therapy (expectations, aim, will to continue)		12	4	**18**	15
	previous topics		12	35	9	2
	description of emotions		60	73	73	65
	what or how something was said		4	4	7	7
	both members being heard		20	4	11	17
	exceptions to the problem		8	**15**	7	7
	description of abusive behavior		4	**8**	4	0
	external matters		0	0	0	10
	other issues (women's refuge/future plans: strategies/ divorce)		0	15	**22**	10

Table 9 (continued). *Dimensions Analyzed and Percentage Results for Each Session*

		Sessions			
Dimensions Analyzed		S1	S2	S3	S4
What is *not* responded to	nothing	32	58	60	80
	the couple's conflict	52	27	36	17
	specific issues	8	12	9	5
	the wife's tearfulness	4	4	9	0
	lack of talk by the therapists	4	0	2	10
How the utterance is responded to*	Dialogically	80	**58**	69	73
	Monologically	20	**42**	31	27
How the present moment is taken into account	what is happening in the therapy which can be extrapolated to the couple's lives	**36**	8	9	15
	description of the feelings that the couple experienced in the session	4	0	4	0
	reflections on the session	4	0	**20**	2
	the effect of therapy on the couple's lives	8	8	7	15
	the therapist seeing an indication in gestures	0	0	2	0
	the present moment is not taken into account	44	**81**	67	72

Note: * Exclusive categories; non-overlapping

The participant taking the initiative; dominance results

In terms of dominance three dimensions were analyzed: *quantitative, semantic,* and *interactional* dominance.

As can be seen in Table 9, the husband presented more quantitative dominance in all of the sessions, followed by the wife, and then by the therapists. With regard to semantic dominance, the wife presented the highest scorings in all the sessions except for the first session, in which the therapists had higher scorings than the couple. Finally, in terms of interactional dominance the therapists had higher scorings than the couple in all the sessions. The results regarding dominance give an idea of the way in which power and control, as a male manifestation, seems to be connected to quantitative dominance. On the other hand, as a female manifestation, the power and control element seems to be characterized by semantic dominance. In relation to the semantic dominance of the therapists in the first session, this result is not unexpected, bearing in mind that in this session the therapy and the couple were being introduced. This meant that the therapists initiated a great number of topic segments in order to facilitate the flow of the session and the couple´s assessment. Moreover, the therapists presented more interactional dominance due to the need to conduct/direct the

therapy, and also the need to stop the escalation process (since the couple displayed high levels of verbal conflict throughout the session).

The exploration of the series of responses to the utterances gave rise to some further dimensions, which seemed likely to prove useful in analyzing the therapy process. As shown in Table 9, the first session was characterized by responding to "both members being heard," by *not* responding to "the conflict between the couple," and by responding dialogically. In relation to *how the present moment is taken into account* the first session obtained high scorings, specifically in the subdimension "what is happening in the therapy that can be extrapolated into the couple's lives". In this first session the therapists made an effort to listen to the stories of both members of the couple; thus they tried to remain outside the quarreling of the couple by not responding directly to the propositional content of the quarreling, reflecting rather the relation dynamics. Thus, the therapists reflected the two different realities of the couple and the conflict that this appeared to be generating in their lives. They did so by focusing on the relation that these different realities might have with the abusive behavior.

More than in the other sessions the second session was characterized by responding to (i) "previous topics," (ii) "exceptions to

the problem," and (iii) "description of abusive behavior." Another specific characteristic of this session was that compared to the other sessions it had more topics monologically responded to and fewer topics dialogically responded to. Also important in this session was the fact that the present moment was less taken into account than in the other sessions. In this session the issue of the abusive behavior and the process it followed was addressed. Furthermore, in this session it was revealed that the wife had a neurological illness. This session was characterized by a monological approach, due to the fact that even if the therapists tried to frame questions in an open and dialogical way, many of the responses were specific and closed. This session was also characterized by instances of looking for exceptions to the problem.

The third session seemed to be characterized by responding to (i) "the quarreling of the couple", (ii) "the commitment to the therapy," and (iii) "other issues." Finally, in relation to *taking into account the present moment*, this session was also characterized by "reflections on the session," and "description of the feelings that the couple experienced in the session." This session took place after the woman went to a women's refuge. For this reason the therapists responded to the couple's quarreling directly, so that they could get to know what had happened. The

therapists also addressed the commitment to the therapy, so that they could work on the therapeutic alliance. In so doing they addressed the alliance, as it existed not only between the couple and the therapists, but also the alliance between the members of the couple, which was expected to be broken after the wife's move to the refuge. In so doing, the question of the aim of the therapy was raised several times in the course of the session. Some further issues were brought up in this session, including the couple's future plans, and the possibility of getting divorced. Other aspects included the effects of the session on the couple's lives, how the session had gone, and how the couple felt at the end of it. All these strategies were used to avoid a possible bad effect from the therapy.

The fourth session obtained high scorings in responding to "what is being said at the moment," "external matters," and "other issues." There were more dialogical responses in this session than in the second and third session. This session also had high scorings in "the effect of the therapy on the couple's lives." In this session the couple talked about their conflicts, referring to what each one was saying at the moment about specific conflicts, and also about possible divorce and future plans. They talked about external matters such as their economic affairs, the other children that the husband had had, and other ex-couples. Other

issues were also addressed in this session such as the situation of the children in the refuge. There was a strong focus on the effect of the therapy on the couple's lives, and on trust and communication.

Step III: Exploring the Process of Narration and the Language Area

Results from the analysis of the Narrative Process Coding System (NPCS)

As mentioned above, because of their specificity and interest, the second and third sessions were chosen for analysis at the micro-analysis level, following the NPCS procedure. All the topic segments of both sessions were analyzed according to the dimensions of the NPCS, incorporating the external, internal, and reflexive mode.

As shown in Table 10, both sessions registered the external mode as having the highest presence, followed by the reflexive mode, and finally the internal mode.

Table 10. *NPCS General Percentages for Sessions 2 and 3*

	Session 2			Session 3		
	External	Internal	Reflexive	External	Internal	Reflexive
Husband	49.46	10.22	40.32	56.63	2.01	41.37
Wife	57.14	7.79	35.06	63.02	5.21	31.77
Therapists	44.13	6.15	49.72	38.66	5.88	55.46

The high scorings for the external mode may reveal the defensive positions of the couple in their arguments. Little space is left for internal or emotionally charged speech when one is trying constantly to defend oneself.

With regard to the internal mode, the husband showed the highest percentage, but this percentage decreased notably in the third session. One possible explanation for this shift could be that whereas in the second session the husband had felt sufficiently free and secure to talk about his abusive behavior in the internal mode, in the third session, after the wife had gone to the women's refuge, he defended himself by shifting to the external mode.

The internal speech of the husband in the second session could have alarmed the wife, since that session had been emotionally charged, and this could have led to her decision to go to the refuge. Nevertheless, this decision could be also understood as a strategic move on her part, aimed at increasing her "power," mainly in relation to social workers and to her possibilities for obtaining custody of the children. This factor could have led to the husband changing his internal speech to a more external and defensive form of speech. In conducting the analysis, the coders formed some expectations regarding the positioning of the man at this point in the therapy. We thought that he would present a defensive position, with external speech, in order to defend himself and present himself as a strong individual. However, he presented a more internal mode than the others in the second session. Furthermore, we came to recognize that this internal speech of the husband might reflect the good therapeutic alliance that he had established with the therapists, with whom he felt safe enough to embrace internal speech.

Finally, the results regarding the reflexive mode show that in both the second and the third session the therapists used it to a higher extent than the couple. The therapists used it to try to promote a shift in the couple towards the reflexive mode. According to the findings, the couple

became engaged within this reflexive speech and incorporated it, even though this happened more when they were talking to the therapists than when they were talking to each other. Thus, the interactional dominance of the therapists seemed to be useful in helping the couple to engage in this reflexive speech. There were also interesting results regarding the reflexive mode when the sessions were divided into two halves. It appeared that as the dialogue advanced within the session, there was a corresponding increase in reflexive speech

The DIHC analysis indicated that the dimension "How the present moment is taken into account" can generate important changes and shifts in therapy. Here it should be noted that from a dialogical viewpoint, a focus on the present moment is of great importance (Seikkula, 2008).

Finally, in order to explore whether the responses had a different effect when they were "monologically" or "dialogically" formulated, a comparison was made between the results obtained via the DIHC and those obtained via the NPCS.

To analyze the effect *of taking into account the present moment* both sessions were divided into two blocks. The first of these contained all the topic segments in which the present moment was taken into

account, and the second one all those in which the present moment was *not* taken into account.

As shown in Table 11, when one compares the topic segments in which the present moment was taken into account with those in which the topic segments do not focus on the present moment, one can see that in the "present moment taken into account" segments the external mode increases, and that correspondingly the reflexive mode decreases. To calculate the significance of these differences, Z Tests for the equality of two percentages were calculated, according to the following formula:

$$Z = \frac{P1 - P2}{S_{dp}} \sim N(0,1)$$

The Z Tests for the Equality of two percentages showed that only the differences for the third session were significant, and in particular, the differences in the external mode (p = 0.0184), and in the reflexive mode (p = 0.039).

Table 11. *NPCS and DIHC Percentage Results for Sessions 2 and 3*

	2nd session			3rd session		
	External	Internal	Reflexive	External	Internal	Reflexive
Entire Session	49.90	8.09	42	52.14	4.27	43.59
Present moment	**43.86**	7.02	**49.12**	**41.08***	6.49	**52.43***
All the topic segments that do not relate to the present moment	**51.60**	8.40	**40.00**	**57.27***	3.86	**38.86***
Monologically	**55.93**	5.08	**38.98**	**67.21***	3.24	**29.55***
Dialogically	**46.78**	9.65	**43.57**	**43.52***	4.86	**51.62***

*$p \leq .05$

As can be seen in Table 11, in both sessions in which the topic segments were responded to dialogically there was a decrease in the external mode and an increase in the reflexive mode. This difference is greater in session 3, and it is also significant, with a decrease in the external more (p = 1,8^(-05*)), and an increase in the reflexive mode (p = 0.00182*).

All this would suggest that change-producing topic segments (i.e. those showing increases in the reflexive mode) are characterized by taking into account the present moment, and further, by responding dialogically.

Throughout the analytical process, we had the opportunity to detect some important challenges relating to couple therapy in psychological IPV. The following transcription vignettes exemplify some of those challenges and how they were faced by the therapists.

Challenge 1: Directive approach

#Session3 Topic 11: Separation; future plans (USA, kids)#

T1: And you are thinking of separation or…?

H: Well at this stage I'm really thinking about going for it because, you keep saying things…we can work things out and the thing is that we've

given it a chance to work things out and from what I got it is that I'm always gonna be the guy who there's something wrong with, when I bring up issue it's because I don't understand or it's just my imagination and it does not gonna work, I've told her before it's not gonna work and you said me, I've raised my concern about what can we do about it and you said there's nothing that can be done about it, that's not gonna help

T1: And how your life, to organize your life, the life of foreign…

H: Well…

T1: In the future

H: I would like to be able to talk to you about the children basically and at least have the chance to have one of the kids or something at least and…

W: They are too small to be separated

H: And go home…I can't stay here, this life for me is…there's nothing I can do here

T1: With go home you mean USA?

H: USA

W: He's got a business because her parents, his parents have organized it

(…)

T1: And you would like to have the other kid with you?

H: Yes

T1: Yes, ok

W: The kids are too small to be separated

H: That's…

W: No, that's not my…that's not even my, my…

T2: Let's talk about…I am asking him about…

W: Yes, sorry

This topic segment belongs to the session just after the wife went to the women's refuge (3rd session). The divorce issue was directly asked about by the therapist because in the prior topics the husband had been talking about his concern for the custody of the children. The husband gave a long explanation (quantitative dominance) answering the therapist, but also addressing the wife directly in his speech (they had not yet talked directly to each other in the session). The therapist kept asking (interactional dominance), and the husband talked about the children, directly addressing the wife once again (the therapist was more or less neglected). At this point the wife interrupted the husband's speech, but the husband and the therapist continued the conversation. Later on, the wife interrupted the conversation again when she talked about the business run by the husband's parents. At the end of this topic, the

husband repeated that he would like to have one child with him, this time addressing the therapist, and the wife interrupted again (semantic dominance). On this last occasion the therapist asked her not to interrupt (interactional dominance).

The initial utterance of the husband presented a mix of external and reflexive shifts. This allowed him finally to express his concerns about the wife's non-accountability during the previous session. The therapists presented selective interactional dominance by not responding to the quarreling of the couple, and by talking more dialogically. Both spouses were treated as accountable by the therapists. This directive approach on the part of the therapists helped to create a space for mutual dialogue; hence it became possible to ask each member of the couple about their plans. Note here that the therapists entered into the dialogue with one member of the couple at a time; this strategy was used to prevent an escalation process that might arise from the quarreling of the couple.

An additional point was that the wife seemed to be unable to talk about the children; thus her interrupting acts might indicate that she was feeling panic at the idea of separation from the children. When the wife interrupted she addressed both the husband and the therapists. She

addressed the therapist because he had opened up a space for both spouses to think about their future.

The wife's utterance pointing out that the children were too small to be separated was an important utterance in terms of meaning, with a mix of reflexive and external shifts. This utterance, though not typically reflexive, has some "flavor" of reflexivity, since the wife is not just pointing out a fact, but also implying some thoughts and feelings.

Although what one might regard as the myth of motherhood in western society was not present in the conversation, one can detect it within the context. Moreover, later in the conversation, the husband expressed his concerns about the children's custody. He believed that in the event of a custody battle the woman would be favored; thus he was aware of the broader social context. The stronger position of the woman permitted her this "invisible power" and hence semantic dominance. This power was also increased by the fact that the wife was in the women's refuge, with the result that most subsequent decisions would depend on her.

This vignette also reflects the difficulties of an intercultural couple and highlights the immigrant status of one of the members. The husband shows his difficulty in adapting to Finnish culture; he does not

seem to have assimilated it. Furthermore, he presents himself as being in a hopeless position when he affirms that there is nothing that he can do in Finland. In fact, both spouses tend to present themselves as non-accountable; hence the directive approach of the therapists acquires special relevance.

Challenge 2: Accountability

#Session 2 Topic 8: Defining abusive behavior; stresses in tolerating the other's behavior, losing respect#

T1: Coming back a bit to this stress, do you think that…or…sleeping five hours, two hours…do you think that this is in any way related with if you are relaxed or if you feel yourself being rest?

H: No, because my "abusing behavior" (he puts it in quotes though a gesture with his fingers) it does not come about me being stressed about…I think it's…I'd say is the reaction to what she's doing and that I feel helpless in changing something about it…

T1: And your stress for tolerating what Wife is doing is the same

H: Is the same for everybody, it doesn't matter who it is, people with I'm working if they're doing something that I don't want I'm gonna tell them "don't do that" and they still keep doing it, I'm just gonna say ok that's it,

stop it…and if they're not listening then the cycle goes on, you have lost respect on me I lose respect on you, that's how it is to me (…)

T2: You said, I heard you said helpless, you do feel helpless in that situations?

H: Yes, in a way, yes…

T2: And that kind of feelings are difficult to tolerate

H: Yes, helpless in a way that…what you're gonna do next, what's…how do you deal with this thing…and actually I have included helpless (…)

T2: and then, you said also that you lose respect

H: Yes, to me, it is about respect that certain things that I expect from the other person and that…they are acknowledging that…and to me that's disrespectful and my behavior will perform the same thing

T2: These are connected to this kind of abusive behavior?

H: Yes, pretty much, I'd say so (…)

This vignette exemplifies how the abusive behavior is defined dialogically. The husband presented his concerns about the messy habits of the wife at home. They had been arguing about that during the session, and the wife had said that it was because of her neurological illness that she was like that. The husband was angry at the refusal of the wife to take

responsibility, after she had indicated that she could not do anything about it. At the same time, the husband tried to present himself as non-accountable by attributing his abusive behavior to the wife's messy habits. In this context, this vignette reflects the therapist's efforts to make the husband accountable via a dialogical manner of speaking, being aware that the topic of the abusive behavior is very sensitive.

This is an interesting example, since the husband connected with the dialogicity of the therapist and entered into the dialogue, while talking about such an emotionally charged issue as his abusive behavior. This was despite the fact that he had initially presented some concerns or defenses when he was talking about his abusive behavior (since he put it into gestural quotes, and made the wife responsible for his behavior). At the end, an explanation for his abusive behavior was given, related to feelings of helplessness, his difficulty in tolerating the behavior of others, and the importance of respect for him. Thus, the therapist helped the husband to become aware of his role in the interactional cycle. In fact, this is a common phenomenon when one is working with couples, and one that we will deal with in the Discussion section.

The therapists' open dialogue allowed talk in the internal and reflexive mode concerning the difficult issue of violence, without the

husband feeling blamed. By focusing on the present moment and thus by relating and connecting important ideas that the husband was mentioning, a dialogue was reached. This dialogue helped in achieving a co-construction of a new shared meaning relating to the husband's abusive behavior, and a point of understanding.

Challenge 3: Help for both

#Session 2 Topic 15: A new perspective: help for both#

T1: Perhaps it can be rehabilitation for both, to both of them, both to Wife but also to Husband, doing that perhaps he'll become more used to that, thinking that "ok, this is part of our life"

T2: Uhuh.

T1: And after that it's not so much a thing that annoys so much, perhaps trying to find a way, to make it in a way that it's not that kind of giving order like it was in a military and perhaps finding a way to do it in a much more in a joint pleasant way…so perhaps the rehabilitation can be a rehabilitation to both

T2: Yes, yes…

H: I think that looking at it from that perspective you will probably have to go to that way to accept this part of how she is (…)

Before this vignette the husband was complaining about having to help the wife with her neurological illness. At one point, the therapist changed the focus of the conversation to both spouses and introduced the idea of rehabilitation for both, that is rehabilitation for the wife's illness but also for the husband's difficulties in helping her. This reflexive shift was very significant for the husband, as it allowed him to see the recovery as a conjoint process. By treating both couple members as accountable at the same time (multivoiced addressees), the therapist introduced the idea that both needed to change, and that both needed to think what they would have to modify in order to make the relationship work.

Furthermore, this strategic move of interrupting the couple's conflict and focusing on the present moment (in other words, stepping out from the quarreling of the couple and bringing the conversation back to the "now") was useful in introducing new elements into the interaction. As this was done openly and dialogically, during honest reflection on the couple's interaction on the part of the therapists, it helped to promote change and to achieve reflexive speech.

4.4. Discussion

In this research we focused on the process and outcome of conjoint therapy in psychological IPV. The results seemed to indicate some distinctive aspects of this particular therapeutic process. The results led us to a better and deeper understanding of some of the challenges presented by couple therapy for psychological IPV – features that could explain some of the outcomes and point towards better explanations of what constitutes effective therapy. First of all we shall refer to our research questions. Thereafter we shall discuss some of the benefits and challenges pertaining to couple therapy in IPV, and finally we shall derive some clinical implications.

Before revisiting our research questions, it is important to emphasize the importance of prior assessment of the couple in IPV conjoint therapy. This was done in the present case by conducting an individual interview with each member of the couple and asking them to complete the Abusive and Controlling Behavior Inventory (ACBI) (Davies, Holmes, Lundy & Urquhart, 1995). Through this assessment we were able to decide if the couple matched the conditions for couple therapy, as recommended by several authors (Bograd & Mederos, 1999; Hrapczynski *et al*., 2012; Stith, McCollum, Rosen, Locke & Goldberg, 2005; Stith, McCollum, Amanor-Boadu & Smith, 2012; Whitaker *et al*.,

2007). In addition, the Session Rating Scale (SRS V.3.0) (Scott, Miller, Barry, Duncan & Johnson, 2002) enabled us to assess the couple's perceptions of the therapy process in each session.

Regarding our first research question, we wished to detect the specific phenomena that might arise in couple therapy for psychological IPV, applying a dialogical perspective. Some specificities did indeed seem to emerge. One such was the "control and power game" engaged in by the couple, involving male and female expressions of power and control, identifiable in findings for dominance results. Whereas the female expression of power seemed to take on the character of "invisibility," manifested through *semantic* dominance, the male expression of power was characterized more by *quantitative* dominance. The findings for dominance also seem to indicate that the therapists' interactional dominance was an important strategy in the couple therapy applied. It was a strategy that proved useful in putting a stop to the escalation process – a crucial measure in preventing physical abuse, as has been demonstrated in previous research (Bograd & Mederos, 1999; Shortt *et al*., 2013; Whitaker, Haileyesus, Swahn & Saltzman, 2007; Yoon & Lawrence, 2013). Furthermore, the evidence of our study suggests that in initial therapy sessions, when the couple are more

trapped in a distressed interactional cycle (Sprenkle, Davis & Lebow, 2009), the therapist's interactional dominance can be helpful in interrupting the cycle, with only one member of the couple being addressed at a time. The therapist's directive approach also seems to work towards each spouse becoming more accountable. If this approach is conducted dialogically, it has the potential to prevent the couple from developing feelings of guilt or blame. In this way it may focus on how each member of the couple may take up a position of responsibility. A further advantage of the directive approach is that it permits strategic decisions such as avoiding a response to the bickering of the couple. In terms of the couple becoming aware of their communication pattern and reflecting on it, our results indicated that a focus on the present moment (the immediate dialogical context) can be helpful to the couple.

The second research question concerned whether dialogicity and a focus on the present moment would parallel a shift into the reflexive mode within the therapeutic process. Our results seemed to support this relationship. From the combined results of the DIHC and the NPCS it appeared that focusing on the present moment, in conjunction with dialogical responses, increased the amount of reflexive talk.

This study aimed to contribute to a deeper understanding of the process and outcome of couple therapy in psychological IPV, bearing in mind that the topic has been overlooked in current research. Overall, the specificities identified in this therapy may be helpful in understanding the "relation dynamics" in psychological IPV.

Although we are aware of the concerns expressed concerning the use of couple therapy in IPV, we wish to point out some important benefits which we detected during the therapeutic process, and which were highlighted by the results obtained with the DIHC instrument. Conjoint therapy makes it possible to work on the therapeutic alliance, not just between the therapists and the couple, but also between the spouses. Having the couple together in therapy helped us to become aware of the couple's relation dynamics and to detect the escalation process. Furthermore, the issue of abusive behavior can be discussed in couple therapy. As was noted in the present therapy, it was possible to define the nature of the violent behavior and to discuss strategies to work on it. This process had the potential to help the couple to understand the cycle of the violence process, and to take responsibility for it. The willingness to take responsibility was also strengthened by the therapists' on-going efforts to make both spouses accountable for the situation.

Finally, in order to maintain safety throughout the therapeutic process, the therapists repeatedly asked about the effects of the sessions, and about safety issues. It proved possible to discuss these issues conjointly with the couple, in a safe context, and without aggravating the violence cycle.

In addition to the research implications, it was possible to derive from the study certain clinical implications, and also some important challenges. First of all, it seems important that the therapists should be direct in their approach, or at least adequately directive. This would seem to be important irrespective of the therapist's orientation, particularly in cases of psychological IPV, in which the tools of acting out violence are indirect tools (i.e. consisting of language).

Secondly, the dialogical approach makes it possible to avoid blame and to facilitate the accountability and responsibility of both members of the couple within the therapeutic process. Furthermore, the use of multivoiced addressees emerges as a powerful tool in couple therapy, advancing accountability in an indirect way.

Thirdly, of special relevance in couple therapy for psychological IPV is the achievement of new understandings of the abusive manifestations and interactional problems of the couple. When new

understandings are achieved, the distressed interactional cycle (Sprenkle, Davis & Lebow, 2009) can be understood, and replaced with new and shared understandings. The couples trapped in those distressed interactional cycles are themselves aware that they usually spend an inordinate amount of time trying to control each other.

Fourthly, tolerance of uncertainty, which is a challenge present in all kinds of psychotherapy (see Laitila, 2004; Seikkula *et al*., 2003), is especially relevant in couple therapy for IPV, and in particular, psychological IPV. In psychological violence such a therapeutic challenge is of extreme importance, since the interactional dynamics are delicate, sensitive, and complex. Within the interaction, the couple may try to immerse themselves in various "games," attempting to minimize the threat, or blaming and counter-blaming each other. Moreover, because of its private character, language that may superficially have an everyday form can in fact entail a threat, or arouse fear. Because of this, the therapists face the challenge of becoming involved in the couple's speech dynamics. Here the dialogical approach shows its merits, since it allows the therapists to enter the couple's discourse but in a gradual manner, sensitive to the dialogue, and responsive to the outer dialogue. Another challenge relating to the tolerance of uncertainty mentioned

above is the difficulty of differentiating between normal quarreling and abusive behavior (behavior which is carried out with symbolic and semiotic tools). Thus, therapists have to be constantly aware of the lurking issues of fear, humiliation, and shame.

All in all, good recommendations for couple therapy in psychological IPV could include (i) being directive, (ii) stepping out from the quarreling of the couple by focusing on the present moment, seeking to reflect the interactional pattern, and (iii) looking for a new and shared understanding of the problem. Finally, all these actions should be impregnated by a dialogical and open approach, one that might help towards reaching new and shared understandings, achieving personal responsibility, and avoiding blame or pressure

Some limitations of this research are related to the cultural differences between the couple, and between the couple and the therapists. These were not taken into account in the actual analysis. However, the therapists did take the cultural factor into account during the therapy sessions, commenting on the possible difficulties of a couple with different cultural backgrounds. Although we consider it to be an important and interesting issue – and one that seems to be gaining

increasing attention in couple therapy for IPV (for a review see Horst *et al*., 2012) – it was beyond the scope of this research.

Future research might go on to analyze the entire therapeutic process, seeking to detect the patterning of the specificities identified in this research (including whether they are repeated throughout the therapeutic process or change over time), and further, seeking to detect any new specificities that might emerge. For example, in the later stages of the psychotherapeutic process, once the distressed interactional cycle has been detected and overcome, one could anticipate that the therapists might adopt a less directive approach, and that the couple would present more dialogical utterances.

Chapter 5

Increasing Responsibility[4], Safety, and Trust through a Dialogical Approach:

A Case Study in Couple Therapy for Psychological Abusive Behavior

[4] Fundamental to the context of couple therapy is the notion of *accountability*, which refers to holding responsibility of one's actions, and being honest and trustful with each couple members' role. A common feature of couple therapy is the existence of *non-accountability* (i.e. a refusal to see oneself as having agency or responsibility regarding one's actions or roles) on the part of one or both partners. In this research the notions of responsibility and accountability (in its longer meaning) will be used as similar ideas.

5.1. Introduction

In the field of intimate partner violence (IPV) there is considerable controversy concerning the indications for treatment of the couple as a couple, with safety issues emerging as paramount. At the same time, there has been a paradigm shift in research, with an increasing focus on the role of dyadic interactions in the production of violence (Langhinrichsen-Rohling & Capaldi, 2012). Recently a special section of *Prevention Science Journal* was dedicated to this dyadic focus shift in IPV (see Prevention Science, 2012). Some evidence in favor of a dyadic view was presented, including evidence that IPV is predominantly bidirectional, contextual, and situational, and that it can change from one relationship to another, even for the same individual (Langhinrichsen-Rohling & Capaldi, 2012; Langhinrichsen-Rohling, 2010). It should be emphasized that this is a highly critical point, in so far as it might be seen as tending to "absolve" the abusive partner from his/her violent behavior. Nevertheless –with the need for caution always in mind – we would suggest that a dyadic focus may indeed provide some novel and deep explanations for abusive relationships.

Up to the present time, four main conditions have been described under which couple treatment for IPV is indicated: (i) when there is low-

to-moderate violence (with any psychological abuse also having to be infrequent and mild); (ii) when both partners voluntarily agree to participate in the therapy and wish to remain together; (iii) when both partners want to end the violence; and (iv) when the violence is reciprocal (Bograd & Mederos, 1999; Hrapczynski, Epstein, Werlinich & LaTaillade, 2012; Stith, McCollum, Rosen, Locke & Goldberg, 2005; Stith, McCollum, Amanor-Boadu & Smith, 2012; Whitaker *et al*. 2007). One key issue must also be the ending any physical abuse, and the ensuring of safety for the victim. An important question here is the cessation of violence for a sufficiently long period between sessions: the cessation has to be such that any positive changes in ideas or feelings developed in the course of the session will be amplified and lead to lasting changes (Gorell Barnes, 1994).

In interventions with IPV perpetrators, a focus on one side only has been shown to be relatively ineffective (Babcock, Green & Robie, 2004); however, research is scarce and results diverse regarding the outcome of IPV conjoint therapy. Some studies (mainly involving cognitive-behavioral couple therapy and a variety of systemic models) have shown good outcomes (Stith *et al*. 2012). However, no single model has proved to be more effective than any other: all seem to decrease

negative communication and psychological and physical aggression, and to increase relationship satisfaction (LaTaillade *et al*. 2006). In this sense, the findings seem to offer support for couple therapy regardless of the theoretical orientation (Hrapczynski *et al*. 2012; LaTaillade *et al*. 2006). Furthermore, all the treatment modes contain specific strengths and weaknesses. For example, group interventions provide a new speech community for perpetrators and peer support, but at the same time, they have the potential to be "academies" for the teaching of skillful abuse.

Whatever the approach, there seems to be agreement in the research community concerning some important aspects and/or goals when one is dealing with couple therapy in IPV; these have to do with (i) developing visions of healthy and violence-free relations; (ii) assessing affection, reciprocity, and marital satisfaction; (iii) developing trust and reestablishing safety (Bograd & Mederos, 1999; Stith *et al*. 2005); and (iv) the use of a *metadialogue*, i.e. dialogue among the therapists in the presence of the couple (Cooper & Vetere, 2005; Stith *et al*. 2005). Furthermore, a growing body of research has indicated that couple therapy can lead to (i) the strengthening of each person's responsibility (with the focus on dyadic interactions allowing a more agentic and more powerful vision of the woman than has traditionally been put forward)

(Langhinrichsen-Rohling & Capaldi, 2012); (ii) a focus on the couple's relationship dynamics (Bograd & Mederos, 1999; Hrapczynski *et al*. 2012; McCollum & Stith, 2008; Stith & McCollum, 2011); and (iii) an understanding of how the escalation process takes place (Whitaker *et al*. 2007). Bearing all this in mind, core goals in conjoint treatment for IPV would include getting people to take responsibility, optimizing safety, and developing trust. Here it has to be emphasized that irrespective of the therapeutic approach, safety issues must be the paramount concern.

From a dialogical perspective, in which the therapist is included as a prime focus, *responsiveness* acquires great significance – since for words to have meaning they require a response (Seikkula & Trimble, 2005; Seikkula *et al*. 2003). Applying this perspective, dialogue is indeed communication, but it is also *the relation and process of forming oneself* (Seikkula, 2008). From a dialogical viewpoint, the more one can include different voices within a polyphonic dialogue, the greater are the possibilities for emergent understanding. Thus, team members strive to draw out the voices of every participant in the room (Seikkula & Trimble, 2005).

As indicated above, in this approach there is a special focus on the therapists. One has to look closely at the dialogue and the response(s)

between the therapist and the patients; hence the focus of the research moves away from the inner experiences of the patients and towards the actual dialogue – *and it is the dialogue itself that constitutes the trigger for change* (Seikkula, Laitila & Rober, 2012; Olson *et al*. 2012). In order to achieve dialogue, team members try to: (i) ask for information in a way that allows the telling of stories in as easy a manner as possible, without causing distress; (ii) practice fully engaged and compassionate listening with each speaker, making space for every utterance; (iii) conduct a reflective dialogue among team members (in which the clients are invited to comment on what they have heard); and (iii) at the end of each session, form a summary of what has been discussed, and suggest courses of action for the future (see Seikkula 2008; Seikkula & Trimble, 2005).

In the study reported here, a dialogical approach was followed in order to analyze the therapy process in conjoint therapy for psychological IPV. Psychological IPV has been shown to have higher prevalence than physical IPV (Shortt, Capaldi, Kim & Tiberio, 2013; Yoon & Lawrence, 2013) among both women and men (Coker *et al*. 2002). Furthermore, psychological IPV has been shown to have an even greater impact on health and on psychological well-being than physical IPV (Coker, Smith,

Bethea, King & McKeown, 2000; Coker *et al*. 2002; Pico-Alfonso, 2005; Yoon & Lawrence, 2013). There is also evidence that psychological IPV can be an antecedent of physical IPV (Bograd & Mederos, 1999; O'Leary, 1999; Shortt *et al*. 2013; Whitaker, Haileyeses, Swahn & Saltzman, 2007; Yoon & Lawrence, 2013). Nevertheless, although psychological IPV is becoming increasingly recognized as a research topic (Yoon & Lawrence, 2013), few studies have been conducted on the conjoint treatment of psychological IPV. This being so, it seems necessary to focus on the treatment of psychological IPV as an important preventive action that may minimize or decrease the risk of physical violence. This is the focus of the present study, which analyzed the process – in a "real world" setting – of couple treatment for psychological IPV via a dialogical approach. Here it should be emphasized that the emphasis on communication should not be regarded as a return to a systemic perspective on IPV.

We believe that a focus on dialogue may be especially relevant in cases where the tool of violence is language-based, i.e., existing on a symbolic and semantic level rather than as actual physical harm. Hence, by looking at the voices, addressees, and positioning of the couple in the session, it may be possible to understand the dynamics of the

relationship, and specifically, the dynamics associated with violence. Such an analysis makes it possible to focus, first of all, not just on the meaning of what is said, but also on the sense of the words in the actual present moment (the voices). Secondly, in this procedure, one will look closely at the persons to whom the words are addressed, considering them to be not just addressees within the present moment, but also addressees in the person's past. Finally, such an analysis will examine how the couple members position themselves in the present moment of the session (positioning) (Seikkula *et al*. 2012).

In looking at the main goals in couple treatment for IPV (see below), in this study we shall focus on the issues of *responsibility*, *safety*, and *trust*, as aspects that acquire particular importance in this kind of therapy. In fact, these aspects were identified throughout the case therapy, and we shall here explain how they were understood and dealt with from a dialogical point of view. Because of the special relevance of the therapist (as mentioned above), the present study will emphasize this aspect, and highlight the use of reflective dialogues.

Because no single treatment model or research method has demonstrated better results than any other we believe that adding a dialogical view may help in understanding the process of change in

therapy, which research has so far failed to elucidate fully (Stith *et al*. 2012). The qualitative research approach used here has the potential to provide more information on the role of dyadic interactions in the production of violence, and thus to provide a better understanding of the context of violence – a need that has been identified by several authors (Madsen *et al*. 2012; Whitaker *et al*. 2007; Yoon & Lawrence, 2013). With these aims in view, the analytical method used in our study was *Dialogical Investigations of Happenings of Change* (DIHC) (Seikkula *et al*. 2012), which was the first research method to focus on multi-actor dialogue settings. The method allows for a general categorization of the qualities of responsive dialogues at both the macro- and micro-analytical level, and it includes all the members present in the psychotherapy setting (i.e. not just the family members but also the therapists). The couple therapy talk which we analyzed, and which we report here, does in our view provide a fairly typical representation of situational couple violence in psychological IPV – a phenomenon which has wide prevalence (Langhinrichsen-Rohling, 2010), but which has not been much researched in terms of treatment. It is worth emphasizing that the study reported here addresses the recognized gap between research and practice in IPV (Babcock *et al*. 2004; Langhinrichsen-Rohling & Capaldi, 2012;

Stith *et al*. 2012). It does so from a position of some closeness to the topic, given that two of the collaborators on this research were also the therapists in the therapeutic process analyzed.

With regard to the ethical and contextual characteristics of the study, the therapy was conducted in a "real world" setting, and the couple sought couple therapy voluntarily[5]. We consider both aspects to be crucial since very little research has been conducted in the field of IPV under these conditions, even if the relevance of these aspects has been repeatedly demonstrated (Madsen, Stith, Thomsen & McCollum, 2012; Stith *et al*. 2012).

All in all, this study aimed to address the following research questions:

1. How are the issues of responsibility, safety, and trust dealt with in conjoint therapy for psychological IPV via a dialogical approach? Can the dialogical approach adopted offer some strategies for dealing with these issues?

[5] Both partners in the study gave their informed consent for participation in the study, and for their conversations to be used as research data.

2. What can we learn from the complex positioning of the therapists in this kind of treatment? Can some potentially useful dialogical strategies be detected?

5.2. Method

Setting

The study reported here formed part of a multi-site research project called “Research on couple treatment in intimate partner violence” conducted within the Psychotherapy Training and Research Centre at the University of Jyväskylä, Finland. The data were collected from couple treatment meetings in which the reason for treatment contact was intimate partner violence, or in which the problem of intimate partner violence became addressed in therapy for other issues. In this modality, couple therapy is not initiated if there has been particularly serious or life-endangering violence in the relationship, or if the acts of violence have continued. Both partners attending the therapy meetings need to be willing to attend and able to speak openly in conversations. The clients included in the present research gave informed consent for participation in the study and for their conversation to be used as research data. In addition to the audiotaped therapy conversations, the data for the

study consisted of individual interviews with both partners (at the beginning and of the therapy,). According to the procedure adopted, during each individual interview the partners are asked to complete the Abusive and Controlling Behavior Inventory (ACBI; Davies, Holmes, Lundy & Urquhart, 1995). Furthermore, after each couple therapy session they are asked to complete the Session Rating Scale (SRS; Johnson, Miller & Duncan, 2000). Note that the procedure involves also the signing of a non-violence contract by both partners.

Participants: Clients

The couple's characteristics matched the four main conditions under which couple therapy for IPV is indicated, as mentioned in the introductory section. They presented low-to-moderate violence (in this case psychological violence). Both partners voluntarily agreed to participate in the therapy. They also wanted to remain together, and to end the violence.

The couple in question consisted of a re-married couple. The wife was Finnish and the husband was from the USA; thus the persons were living in an intercultural situation. With regard to the cultural background of the couple, language barriers should be taken into account: within the

psychotherapy the husband was the only person speaking in his native language. All the other participants used English, which was not their first language. The husband was an officer in the army, and he had been in international crisis areas. They had met through the Internet two years previously, and they had two children together[6].

At the start of the therapeutic process both spouses were asked to fill in the Abusive and Controlling Behavior Inventory (ACBI) (Davies, Holmes, Lundy & Urquhart, 1995), which assesses various dimensions of violence (emotional and psychological, sexual, physical, and globally impacting). These dimensions are also assessed bi-directionally, i.e. as "violence towards your partner, and violence of the partner towards you." The results of these questionnaires showed that the violence was seen as reciprocal by the couple, since both members felt that they had received violence from the partner, and both recognized that they had applied some violence. The most highly rated violence, by both spouses, took the emotional and psychological form, whereas sexual and physical violence had the lowest ratings. As expected, both members rated their use of violence lower than the rating given by the partner, in line with the

[6] To protect the confidentiality of the couple, we refer to them as *Husband* and *Wife*. Furthermore, some of the information pertaining to identity has been altered.

general tendency for the level of violence applied by oneself to be seen as lower than the level ascribed by the partner.

In addition, after each session both partners filled in the Session Rating Scale (SRS V.3.0) (Scott, Miller, Barry, Duncan & Johnson, 2002), in order to assess the session in terms of (i) the relationship (whether they felt heard, understood, and respected), (ii) the goals and the topic (whether the members had worked on or talked about what they wanted to), (iii) the approach or method (whether the therapist's approach had suited them well), and (iv) an overall assessment (including whether there had been something missing in the session). According to the questionnaire results, the best-rated session was the second one (rated especially highly by the wife, who gave each item a maximum score), followed by the fourth and, finally the first and third (these latter two having similar ratings). All in all, the four sessions had fairly high ratings, with scores always higher than medium scores (i.e. from 36 to 40).

Participants: Therapists

Two psychologists with more than 25 years of experience participated in the therapy sessions. Both of them are also collaborating in this research.

Participants: Raters

Two raters coded the data. One was a psychologist with more than 25 years of experience. He was one of the originators of the DIHC method; he had also taken a course on the NPCS method. The other rater was a doctoral student who had received training on both the DIHC and the NPCS methods at the University of Jyväskylä[7]. The analytical process, and any disagreements arising, were discussed with the other authors of the present research, who were also originators of the DIHC method. The discussion continued until a consensus was reached.

Instruments

Several stages were followed, in line with the DIHC method, which follows three different steps (see Seikkula, Laitila & Rober, 2012):

[7] This training took place during a research visit, funded by the CIMO Fellowship program.

Step I: Exploring the topic episodes in the dialogue. For any given moment, episodes are defined by the topic under discussion. If the topic changes the episode is viewed as having ended.

Step II: Exploring the series of responses to the utterances. In this second step, the responses to each utterance are registered for each topical episode. Thereafter, the response given to the Initiating Utterance is categorized according to (a) the participant taking the initiative (indicating *quantitative*, *semantic*, or *interactional* dominance); (b) what is responded to (in terms of emotions, previous topics, what or how the utterance is spoken, matters external to the session, other issues); (c) what is *not* responded to (referring to voices that are not included in the response of the next speaker, bearing in mind that a single utterance by a single participant can include many voices); (d) how the utterance is responded to (monologically or dialogically); and (e) *how the dialogue within the present moment is taken into account* (manifested in body gestures, intonation, tears, anxiety, and possibly also in comments made on the present situation, for example comments on the emotions felt).

Step III: Exploring the process of narration and the language area. This step is conducted by means of the Narrative Process Coding System (Angus, 2012); thus three types of narrative processes are

identified, namely *external language*, *internal language*, and *reflective language.*

Procedure: Data collection and analyses

The data for this study consisted of the dialogue of the participants (couple plus therapists) throughout the first four therapy sessions. These sessions were video-recorded and transcribed. In total 100 transcript pages were analyzed. The transcriptions were analyzed using the DIHC method, applying a macro-level analysis. Moreover, as commented above of especial attention were the topics related to responsibility, safety and trust, which were identified through the macro-level analysis and, then analyzed in the micro-level analysis. Thus, results will focus on the micro-level analysis of specific topical episodes related to these dimensions. Altogether with a focus on the therapists responses guided the analysis of the data.

As mentioned above, the analysis of the transcript was first coded by two raters. After the preliminary categorization (using the three steps described previously), in order to check on the trustworthiness of the first authors' analysis, the core researchers reviewed the categorization, focusing more on their points of disagreement than on their points of

agreement. As has been noted by the developers of the method (Seikkula, Laitila & Rober, 2012), in engaging in this dialogue, the different voices enrich the picture of the dialogue under investigation

The therapy was still in progress at the time when we began to work on the data. Hence, transcription took place while the therapy process was still under way.

5.3. Results

Step I: Exploring topic episodes in the dialogue

The first step was to divide each session into topic segments, according to the change in the meaning and/or the topic under discussion. Thus, the first session was divided into 25 topics, the second into 26 topics, the third into 45 topics, and the fourth into 40 topics. The third session, though not the longest or the one with the most words, was the one with the most topic segments. From the total of 136 topic segments in this session, 19 were related to responsibility, 17 were related to safety, 30 were related to trust, and 17 were related to the therapists' reflective dialogue. The other topic segments were related to communication problems, to looking for exceptions to the problem, to future plans, and to reflecting on the past and current situation of the couple. Two

representative vignettes for each dimension were chosen. The results from the dialogical analysis are presented below.

Step II: Exploring the series of responses to the utterances, and Step III: Exploring the process of narration and the language area

Exploring the dimensions of responsibility, safety, and trust

Responsibility

Throughout the four sessions both members of the couple tried to absolve themselves of responsibility for the situation, through blaming and counterblaming. The therapists tried to make both members accountable (i.e. willing to accept responsibility) by asking them to think about their position. They did so by discussing how they saw the situation, why the situation was what it was, and what they could do to change it.

The interactions presented below exemplify the importance of responsibility in couple therapy in psychological IPV. In the first interaction, the conversation started with the husband being totally helpless and non-accountable. It finished with a focus on responsibility and choices.

#Session 2; Topic 6: Differentiating types of stress (crisis situations vs. present stress) = responsibility, worries about the future#

T1: Uhuh…can you help me understand a little bit more about what the difference is between this type of stress?

H: With all the places I've been in the military I find that it's less stressing than dealing with an argument with her and with all the situations that we've been (…)

T1: Yes, and how do you explain that to you, that this is more stressful compared to the extreme situations you were in?

H: It's probably the mindset, the mindset that you're going there and your expectations that these things could happen (…) in a way I sort of think that it should be under my control, that I should be able to affect the outcome of it in comparison with being in a combat that I can't affect it…so that's what stresses me up…

T1: So now you are two of you who are defining the outcome and affecting this compared to…

H: In combat that no…it's their decision if they blow you up, in here it's my decision how we're gonna go forward it with the next (…)

T2: So, you feel you have more responsibility now?

H: Yes, I'd say so (…)

T2: The responsibility is much bigger…you don't have accepted rules, there are many possibilities…you have to make a choice (…)

As reflected in this interaction, the husband presents himself as a capable agent when in a combat situation but as totally incapacitated and helpless at home. The therapist tries to make the husband an accountable agent through the invitation to explain the stress he feels in the domestic situation. The first question, which makes the husband accountable by asking him for clarification of his stress, is posed in an open and dialogical way. The husband does not feel pressure to produce an answer, since the question is phrased as an invitation to help the therapist understand the issue.

The fact that the therapist includes the wife as an addressee is also important: it emphasizes that there are two of them defining the outcome. Hence, the wife, too, is invited to take a responsible role.

Later in the conversation the therapist introduces the actual word "responsibility." At this point the husband does not feel blamed, since the conversation is already moving into the issue of responsibility. Also important is the word "choices." This is introduced by the therapist in order to exemplify the idea that whatever the husband does is in fact a choice, and that he is capable of making other choices.

The use of the reflexive mode is predominant in this topic segment. Within it, the therapist starts with a question in the reflexive mode and the husband answers in the reflexive mode, interpolating some utterances in the external mode so as to explain the external issues to which he is referring. A new meaning is achieved, as the husband reaches towards an understanding that what is worrying him is the responsibility, and the choices that he has to make, given the situation they are in.

The following interaction took place after two topic segments in which the wife was explaining her neurological illness and the incapacity that it had provoked in her. She had been presenting herself as non-accountable. That seemed to annoy the husband, who had been asking her for collaboration in home duties.

Session 2; Topic 14: Strategies for the illness; help from the husband#

T1: Could he help?

W: Well, I think he's (…) starting to be a little bit more tolerant about it (…)

H: Well, something's gotta be done about it (…)

H: Well, if she seems that she cannot do anything about it, then if no one gets something done about it then the frustration is still going to be there so (…)

In this example the therapist starts with a question that has multivoiced addressees. The question is addressed to the wife, but also to the husband, so as to point out to him that he could help. The husband feels that he, too, has been addressed, and he interrupts the wife. In his last utterance his annoyance with the wife's non-accountability is apparent, as are also the feelings of frustration that it produces in him.

The therapist's question is posed in the reflexive mode, thus inviting the wife to continue with this reflexive mode. The husband's intervention, showing his anger, is displayed in the external mode.

Nevertheless, at the end of the topic segment the husband explains his frustration; he is able to explain the process that it follows, and the reason why he feels as he does. Via a combination of internal and reflexive modes he is able to reach towards a more profound explanation of his feelings.

In these two interactions the importance of responsibility and accountability is revealed, as viewed not just by the therapists, but also by the couple. Each couple member seems to seek the commitment and accountability of the other, and indeed, both state as much.

This dialogical approach, focusing on open-ended questions, and incorporating multiple addressees, broaches the responsibility issue without being too intrusive. This has the potential to help clients to feel safe and not under censure, thus allowing them to be more open. Questions are also posed in a reflexive mode, and this helps the couple to think about themselves in a more reflexive way. Through a combination of the external and reflexive modes in the first interaction, and of internal and reflexive modes in the second interaction, a new and shared meaning is achieved.

Safety

Safety has been noted as a crucial issue in couple therapy for IPV. Here we present two interactions which reflect how the safety aspect was addressed within this therapy, taking a dialogical perspective.

The first interaction focuses on the effect of the previous session, and the effect that the current session might produce.

#Session 2; Topic 24: Effect of the therapy on the relationship#

T2: I think, how this conversation now here is going to affect your life? (…)

H: It should be all right, this is the conversation we had the last three to four weeks

T2: Yes

T1: You have these kind of conversations?

H: Yes, these kinds of conversations it's what I've been saying, that a third party observing us is probably good for conversation skills, to actually communicate

T2: When we last met did it affect you somehow or…?

H: It probably affected us in a way that we started thinking about the things that we're doing to each other (…) I don't know what she thinks about it, but…the more we keep doing this I think it's only a benefit to us

T2: What about you W, how do you think this conversation, discussion here is going to affect you?

W: Well, hopefully better than the last time because I…he was a little bit aggressive after that but he seems to be quite calmed, and I think he talks about important things so (…)

T2: It's very…from my point of view it's very important this question because there's also quite a lot of criticism against couple meetings when there's aggressive or abusive behavior, we have to be aware that this is not going to go to a worse situation

H: No, no, no it shouldn't, I can guarantee you that because it shouldn't and that's the reason why we're here (…)

The therapist asks in an open manner how this conversation will affect their life. An interesting point here is that the husband, avoiding responsibility, answers that no bad effect is expected, since this is the kind of conversation they have been having at home (referring to arguments that have tended to escalate). He also points out that having

these conversations under the scrutiny of a third party may be good for learning communication skills. The husband is in this instance pointing out two of the main strengths of couple therapy in IPV (also referred to in research), namely the possibility of, on the one hand, detecting the escalation process in the conversation and stopping it (in other words, disrupting the dysfunctional interactive cycle) and, on the other hand, helping the couple to improve their communication skills. At this point, the therapist asks about the effect produced by the previous session. The wife indicates that it did not have a good effect, because the husband did not have the experience of being heard. This comment underlines the importance of both members of the couple feeling heard. Having listened to this answer the therapists continue with the safety topic, focusing on the effect that the current session may have, and seeking to pre-empt any possible bad effect. In a thoroughly open and dialogical way the therapist explains the controversial nature of couple meetings – the fear that such meetings may actually worsen the situation. Listening to this, the husband tries to assure the therapist that there is not going to be any harmful effect. He points out that stopping this behavior is precisely the reason why they are attending therapy.

By talking openly about the dangers of couple therapy in IPV and about the effect that the therapy could have in their lives, the couple become more aware of the importance of safety. Because of this open dialogue the husband reaffirms his commitment to the therapy and to the non-use of violence. This happens spontaneously: he is not pushed to do so.

The next vignette presents some extracts from different topic segments, all of which belonged to the first session. In this vignette we see how the therapists ask about the "abusive behavior." Together with the couple, the behavior is defined and explained. Finally, the participants discuss some strategies to avoid the abusive behavior.

#Session 1; Topic 6, 7, 8: Defining abusive behavior; process; stress for tolerating the other's behavior, losing respect #

H: (…) I think I get pissed off very easily and when that happens I just shut off any normal reasoning, not in the way that I start actually beating on people because that's not the case with…when she says abusive…

T2: You haven't been physically abusing?

H: No, no…

T1: What does she mean by abusing?

H: I'm not quite sure exactly when she says that…it's probably when I cut off she feels threatened, when I raise my voice she feels threatened (…)

H: (…) when a contentious issue comes in we're in a lot of tension about who could be right, who could be wrong I think that personally on me I say I'm right to the point that I could be yelling at her or saying something that she does not accept, I think that's the point where we could say it becomes abusive (…) it's a gradual thing where nothing is going through and then I feel hurt and then just one day I feel fed up in a way that nothing is happening in that direction (…)

H: (…) It's the same for everybody, it doesn't matter who it is, people I'm working with if they're doing something that I don't want I'm gonna tell them "don't do that" and they still keep doing it (…) then the cycle goes on, you have lost respect on me I lose respect on you, that's how it is to me…

In this vignette the issue of the abusive behavior is approached openly. In trying to explain the process it follows when he gets angry the

husband makes a remark about the nature of the abusive behavior, which does not include physical violence.

The husband uses the term “cycle” for their problem. He explains that when they argue they both want to be right, and gradually he gets hurt and frustrated because things do not move in the direction that he would like. He also points out that his behavior is not focused merely on the wife; it also happens to him with other people, and he refers to the factor of losing respect.

It is apparent that within this cycle that the couple have entered, their interactional pattern follows a sequence in which they argue about (i) something that happened in the past (each one of them with their own version of truth, as we shall see in the next vignette), or (ii) something that should be done in a specific way, a matter about which both want to be right. As neither of them gives way, and as each keeps insisting on his/her truth, nothing changes. They cannot move forward; nor can they go through past events in such a way as to solve them, since they cannot agree on the nature of these events. Thus, they repeat the same patterns and argue about the same issues over and over again. It is for this reason that the husband says he feels that nothing is happening. As a result, he feels frustrated and loses respect.

Trust

Trust is a very important issue in couple therapy for IPV. Since it can be assumed that trust had been broken within the case couple's relationship, the building up of trust was an important target for the therapy. One of the main issues of the couple was mistrust, and in conjunction with it, the issue of lies. They spent a great deal of time discussing specific events from the past – with totally opposed visions of what had actually happened. Furthermore, the couple had pointed out "regaining trust" and "building up communication" as their goals for the therapy. The next vignette shows how the trust issue was discussed in the therapy. It illustrates the therapists' reflective dialogue concerning the issue of trust.

#Session 4; Topic 31:Therapists' reflections; mistrust without betrayal (cheating)#

T2: (…) I'm asking this question about them, for them too, is this conversation going to build up trust? Because it seems it's not going to and there's so many small details – that we can argue about these things, and they can argue about these things…

T1: Yes, I, I hear them speaking of very important issues and with very many details of what happens (…) and at the same time (…) I'm surprised, in myself, that, that even if both of them keep to the truth…prove how he or she is right in this position, I didn't hear any kind of a great betrayal or great kind of a (…) cheating (…) I was thinking that for some reason (…) the issue of mistrust has become bigger than the things itself have been (…) and then I hear a bit of a kind of desperate need for having the trust that they had in each other and both of them are trying so hard to make the other listen (…) and it always fails, and of course that's a very painful situation (…)

T1: (…) I would even think that that people coming from social different parts of the world, they would be used to…used to different cultural ways of dealing with issues in the family, concerning money and economic issues and there would be a lot of need to discuss and to be a family, about how you do this (…)

In the first utterance the therapist expresses his doubts about the usefulness of the conversations of the couple in therapy, regarding the building up of trust. The couple have been arguing for an extended time during the therapy and the arguments have been framed in a monological manner. They have both tried to make their own story be the truth,

without listening to the story of the other. Furthermore, they seem unable to find a meeting point, one on which they both agree. For this reason, in the reflective dialogue at the end of the session, the therapist presents this reflection, in a clear and open manner, sincerely showing his doubts. This reflection has multivoiced addressees, since though it is said to the other therapist, it is also directed at the couple (as the therapist makes clear when he says “for them too”).

The other therapist, while recognizing the importance of the details that the couple have been arguing about, indicates his surprise that none of the conflicting issues have anything to do with betrayal or cheating: they are concrete issues, mostly economic. For this reason, the therapists introduce the idea that the mistrust has become more important than the original problems that created it. Thus, the couple has acquired a burden of mistrust, even if the issues that provoked it are not that big, and furthermore belong to the past, so that one might think that solutions should be possible. In this utterance, the therapist reframes the meaning of these unproductive arguments, defining them as the need for both members of the couple to regain the trust of the other. The point here is that this reframed way of understanding the position of defending one’s

own truth might be more pleasant for the couple, and more easily accepted by them.

Finally, at the end of this topic segment, mention is made of the differing cultural backgrounds of the members, and how this may affect their daily organization of things. This culturally sensitive approach is very important, as the importance of differences in cultural backgrounds should not be underestimated.

Therapists

Due to its importance, the final part of our analysis focused on the therapists' responses. Here we present two vignettes from the reflective dialogue between the therapists.

In the first of these, the therapists reflect on the self-protective behavior of both members of the couple, and how it makes them enter a cycle.

#Session 1; Topic 21: Therapists' reflections: previous experiences, defensive behavior, frustration, a cycle#

T1: Yes, I was thinking of, that there are very big issues of life in this…in this…if I say game, or what H was speaking about his previous

experiences, that it was very painful divorce and he tries to do everything to avoid it, and W was telling of her experiences going to USA the last days of their period of pregnancy in which there is probably a concern about the health of the baby and also (…) that in my mind seems quite reasonable reasons to start to defend myself, but I also thought that it's not constructive defending myself and starting to speak of the other, it's not seem to…it does not seem to help to proceed in the relationship (…)

T2: Yes…of course frustrated in the same way that she's tried to do many things and H too, and both know…don't know what to do, how to stop the cycle, they started to call it like this

T1: Yes, cycle seems to be quite good word because a kind of cycle that starts over and over, this happened already here in our conversation here (…)

In the first utterance the therapist reflects on the need for the members to protect themselves, and thus on the protective/defensive position adopted by both spouses, which derives from previous experiences that have made them become more defensive. The therapist also points out that this defensive behavior is not constructive for the relationship; thus he reflects on the need to change it. Another interesting

point in this first intervention is the description of the interaction between the couple as a "game." The therapists try to evoke the "game" of power and control that has been present in all the arguments between the couple. The main problem (see also below), is no longer the actual problems or issues that they argue about; rather it is the fight they engage in for power and control.

The second therapist's utterance refers to the feelings that both couple members have when they engage in those arguments. Each member feels that he/she should be heard and understood. Furthermore, the therapist uses the word "cycle," introduced by the husband. Both therapists reinforce the idea of a cycle, and point out that it has also happened within the session. This notion of a cycle is important in therapy of this kind, as it encapsulates the escalation process that couples in psychological IPV can enter. The therapists have had the chance to see how this escalation process actually takes place in this couple, and furthermore they are able to reflect on it within the therapy session.

All in all, in this co-construction of a new shared-meaning the therapists underline the non-usefulness of this kind of argument, and point out the feelings of frustration that they can elicit. They also show awareness of the "game" of power and control engaged in by the couple,

and take note of how this can lead to an escalation process and/or "cycle" (as it was called in this session). These distressed interactional cycles are liable to lead the couple to spend a great deal of time on attempts to control each other (Sprenkle, Davis & Lebow, 2009). For this reason, the therapists have adopted a somewhat directive position during the therapy, organizing each spouse's talk, and trying to create space for each of them.

Concerning this reflective dialogue, the wife adds: *"the therapist explains kind of like how we are, we are quite defensive so we might not be ourselves in that sense (…) and one approach to listen to you, discussing with each other, how do you see it, I kind of like it to make it open for us, it's a very nice approach, I like it."* For his part, the husband adds *"Having a third party vision or a perspective on what we are doing is…"*. As we can see here, they both point out the good points of the reflective dialogue. On the one hand, the wife stresses the fact that listening to the therapists' reflections has helped her to become aware of their relational pattern, at the same time as she draws attention to the openness and genuineness of the therapists' reflections and approach in general. The husband reflects on the idea of having a "third party."

Because they are both immersed in a distressed interactional cycle, having the vision of someone from outside seems to be helpful for him.

The next vignette exemplifies a reflection on the course of the therapy and its aim.

#Session 3; Topic 27: Benefit vs. harm of other sessions / importance of feeling safe#

T2: Because I´m just thinking what is beneficial and what is able from this kind of sessions as I heard there´s a lot of mistrust, and I don´t hear the joint or…the shared aim of these conversations, there´s a lot of discussion about what´s the reality, what is happening, how it should be…how things happen and how it should happen (…)

T1: (…) I´m thinking myself, could it be possible to start to speak of the practical issues? How to separate? How to make the separation in the way that the children have the best future and they are not harmed, both W and H? And then still I´m asking, would it still be possible to start to discuss about a recovery in the relation (…) how could it done in the way that both feel safe enough to discuss these issues?

T2: It is very important to feel safe enough to discuss these things

T1: Yeah, because only, only if one feels safe it is possible to start to make some kind of compromises or some kind of negotiations or…actually in both situations, even if you decide to go on with your family, or even if you decide to make a separation, you need to have a safe feeling while you are doing the conversations

This vignette belongs to the third session, which took place just after the wife went to a women's refuge. Throughout the session there were a lot of arguments between the couple. Thus, in the reflective dialogue the therapists reflect on the usefulness of therapy, given that there has been so much mistrust between the couple. Because of these non-productive arguments, the therapist introduces the idea of separation, while leaving the door open for the option of staying together. One of the benefits of couple therapy is the opportunity to talk openly about the possibility of separation and how to deal with it in a way that does not damage the couple or the children.

The issue of safety returns in this reflection. The therapists discuss the importance of feeling safe, so as to be able to communicate, to negotiate, and even to take the decision to get divorced. This link made by the therapist – between safety and the possibility to communicate – is very important, since he couple have not felt safe, and have therefore

tended to speak merely by defending themselves. Conversations of this kind are monological: the spouses do not listen to each other, and there is nothing in the situation that can help to build trust. This may indeed be the problem of many couples who present psychological IPV: the binomial safety-communication factor is a crucial matter, and one that must be taken into account in the treatment of couples seeking couple therapy.

Both spouses go on to indicate the value of the neutrality of the therapy, and the possibility it provides of talking to each other. Thus the husband reflects: *"because we don't talk to each other on the phone the way we normally do, we don't to each other in the safety house, we don't talk anywhere other than this space"*. Because the wife went to the women's refuge after the second session, it has been difficult for them to find a space where they could talk to each other while feeling neutral and safe. In the words of the wife: *"To me it's a nice place to come, and the biggest part of it is that in here we don't need to use an interpreter, because that's the biggest problem anywhere else that we need to use an interpreter"*. Furthermore, conjoint therapy has made it possible to bring up the divorce issue. The husband reflects *"it could also in a way open up things that I would actually see that, ok, this is not actually gonna*

work anymore and so…regardless of the outcome." In fact, in the present case the couple finally separated, but continued with the therapeutic process.

5.4. Discussion

In this study we have focused on a psychotherapeutic process of conjoint therapy for psychological IPV, with special attention to the issues of responsibility, safety, and trust. Moreover, the position of the therapists has also been taken into consideration.

Our first research question referred to the way in which the issues of responsibility, safety, and trust are dealt with in conjoint therapy for psychological IPV under a dialogical approach; it also referred to whether the dialogical approach can offer some strategies that may be helpful in dealing with these issues. Some meaningful results were obtained. First of all, it is important to note the importance of the dimensions we have outlined when one is considering the usefulness of conjoint therapy for psychological IPV, given that in our analysis, almost two-thirds of the topic segments concerned them. With regard to the issue of responsibility, throughout the four sessions both members of the couple tried to avoid responsibility for the situation. As pointed out by

Sprenkle, Davis and Lebow (2009), this is a normal response in couple therapy, in which clients try to use their partner's behavior to justify their own. As noted in the Introduction, the issues of responsibility and accountability are of great importance from a dialogical perspective; hence therapists adopting the Dialogical Investigations approach will strive to incorporate the voices of every participant in the therapy session (Seikkula & Trimble, 2005). Through micro-analysis it has been shown that one very powerful tool of therapists in couple meetings is questions that have multivoiced addressees (Seikkula *et al*. 2012). These questions are helpful in making all the members accountable, perhaps even through just a single question. Thus, via a single utterance the therapists may be able to initiate a shift in all the participants. Furthermore, questions of this kind allow the clients to feel addressed without the addressing being done directly. This means that the person who is indirectly addressed may feel less under pressure, and at the same time, may move towards accepting accountability.

With regard to the safety issue, it is important to note that because of its relevance in conjoint treatment for IPV, it should be openly addressed in the therapy sessions. Within the case therapy, safety was openly addressed (see above) and mention was made of concerns about

the possible dangers of couple therapy in IPV. Discussing this issue with the couple in therapy helped to make then aware of its importance, and of the need to accept responsibility for it. Moreover, it permitted discussion of some possible strategies, aimed at maintaining safety and thus avoiding the possible bad effect of therapy. As illustrated in the present case, this process is potentially helpful, as it can strengthen the couple's commitment to the therapy, and to safety.

Concerning the issue of trust, as illustrated in the present case, in conjoint therapy for IPV it is very likely that trust has broken down and that the couple may come to therapy with a disrupted pattern of communication. This is an especially acute problem in psychological IPV. When couples get lost in their discussions, it can be very difficult to move forward in therapy, and this is indeed what happened in the present case. This situation poses a major challenge to the therapists, and as we have seen, in the present case the therapists repeatedly referred to this difficulty.

One important question that arose in this therapy, in relation to the issue of mistrust, involved the cultural differences between the couple and the added difficulties this posed to their relationship. The cultural sensitivity of the therapists has recently been argued to be an extremely

important factor in conducting conjoint therapy for IPV (Horst, 2012; Timmons, Brian, Platt & Netko, 2010).

Our second research question referred to the insights that can be extracted from the difficult position of therapists who are conducting this kind of treatment, and the identification of dialogical strategies that could address the difficulties. An important strategy identified in the present analysis was that of having a reflective dialogue (Seikkula, 2008; Seikkula & Trimble, 2005) or a metadialogue (Stith *et al.* 2005) between the therapists. This dialogical strategy has the potential to produce important shifts in the couple, and to increase their reflexive positioning. By means of reflective dialogues, the therapists can invite the couple to stand outside both the self and the other. Dialogues of this kind allow reflection on the position that each spouse is taking--an important goal when one is seeking to cause a shift in the cycle, and a common factor in conducting couple therapy (Sprenkle, Davis & Lebow, 2009). Thus, from the perspective of a dialogical approach, this *focus on the present moment* makes it possible to focus on the relational pattern, and on the communication dynamics, with the possibility of meaningful feedback for the couple. Note that in the present case, both spouses pointed out the usefulness of this type of reflective dialogue.

Another important strategy that could be identified was the directive position of the therapists. This allowed them to break down the dysfunctional cycle and to slow down the dysfunctional process. This result is in the line with results that we obtained in a previous study (Vall, Seikkula, Laitila & Holma, 2013). Thus, structuring the amount of time each person talks (Sprenkle, Davis & Lebow, 2009) can be very useful, since in this kind of therapy each spouse tends to enter into discussions that recur over and over again, and it can be very difficult to move forward in the conversation.

Both goals, of standing outside the self and others, and of slowing down the process, have been proposed as common factors in conducting couple therapy, and they have been shown to be important within interventions aimed at shifting the cycle (Sprenkle, Davis & Lebow, 2009). With a view to furthering these goals, in this research we have proposed two dialogical strategies for the conduct of conjoint therapy in psychological IPV, strategies that have been shown to be beneficial in this type of therapeutic process.

Overall, our findings provide support for the use of conjoint therapy in psychological IPV. As already pointed out by a number of authors (Langhinrichsen-Rohling & Capaldi, 2012; Bograd & Mederos,

1999; Hrapczynski *et al*. 2012; McCollum & Stith, 2008; Stith & McCollum, 2011; Whitaker *et al*. 2007), having the couple together in therapy can have the following benefits:

(i) It can strengthen both spouses' responsibility, since the spouses are encouraged to be accountable, through the presence of multivoiced addressees.

(ii) It can provide a focus on the couple's relation dynamics and on their communication pattern, which in the present case was characterized by deep distrust, and by a defensive position that did not allow the spouses to listen to each other. This resulted in a dysfunctional communication pattern.

(iii) It can provide insights into the escalation process (or the cycle, as it was called in the present therapeutic process). The process seemed to start with an argument about a past or present event on which both spouses disagreed and wanted to be right. Thus, they gradually slipped into a "game of power and control" (as the therapists referred to it.) Because they did not agree they felt frustrated and hurt, and they lost respect for the other because they themselves felt disrespected.

Relevant here is the recommendation of some authors that the treatment of IPV must be delivered by providers who understand interpersonal violence, and that it must be provided in concert with key community partners (Stith & McCollum, 2011; Todahl, Linville, Shamblin & Ball, 2012). It is important to point out that in the therapeutic process described here, one of the therapists was an expert in the treatment of IPV; also that communication and collaboration with the social services authorities worked fluently, and that it remained constant during the entire therapeutic process.

A special issue of Prevention Science Journal (2012) takes up the notion that one resolution of the gender symmetry/asymmetry debate emerges via the argument that there are different types of domestic violence perpetrators (Johnson, 2006), or that there are different patterns of violence among relationships characterized by IPV. If this is so, it is suggested, researchers and clinicians will need to work together to determine how to reliably and meaningfully make determinations that can help in preventing and treating all types of IPV (Langhinrichsen-Rohling, Misra, Selwyn & Rohling, 2012). In the research reported in this study we analyzed a case of (probably not untypical) situational psychological IPV, as identified by Johnson (2006). However, we believe that this

couple also presented some specific characteristics. In particular, they did not report violence as having occurred in any other relationship; thus it seemed that the violence was specific to this relationship. Another specificity was that both members of the couple accepted that they were violent, and furthermore they voluntarily sought couple therapy. This might not be a typical situation in the treatment of IPV; however, it is a situation that might actually be highly prevalent in the community at large, without being identified as involving IPV.

The reciprocity of violence is an important aspect in therapy for IPV. As noted in the Introduction, it appears to have high prevalence, but also to have been overlooked in research.

This study represented an initial approach, occurring at very beginning of a challenging course of treatment with a couple presenting psychological IPV. Through an analysis of the first four sessions a great deal of information was gained. Nevertheless, the failure to deal with the entire psychotherapeutic process might be understood as a limitation of the research. Here it should be pointed out that although it might be interesting to analyze the entire therapeutic process, and to focus, for example, on the outcome of the therapy, our objective in this research was rather to address the kinds of challenging situation that are likely to

arise in couple therapy for psychological IPV, related to the responsibility, safety, and trust of the members of the couple.

In addition to the above, this couple presented a number of specific challenges, including the fact that the wife went to a women's refuge after the second session. This situation might be present in many IPV couple treatment processes, and (as the couple mentioned during the therapy) the therapy session may be the only place in which the couple can actually talk to each other. The case couple stressed the fact that in other places where they might see each other, they would only talk through "interpreters." Thus, the therapy room was the only neutral location for them. Nevertheless, in this specific case the move to the refuge was a complicating factor, as no acute physical threat seemed to be present. The social services explained to the therapists that this decision had been made because it was not possible to rely on the wife's ability to take care of the children.

Another limitation or specificity in this treatment was the decision, ultimately, to proceed with divorce. This could perhaps be interpreted as a failure of the couple in dealing with their marital problems. It could also be interpreted – depending on one's definition of success and failure – as a failure of the therapeutic process. From our

point of view, what was most important was that the couple decided to continue with the therapeutic process, seeing it as important to make decisions concerning their children and their future plans. In fact, at the time of writing this study, the therapeutic process is still taking place.

In conjoint treatment for psychological IPV the dimensions analyzed in this research emerged as extremely important. In future investigations it would be interesting to examine the entire therapeutic process in order to analyze the changes occurring in these dimensions over the complete course of therapy.

Chapter 6

Conclusions

This dissertation combines two integrative approaches when dealing with human meaning-making processes with a narrative focus; the relational constructivist approach and the dialogical approach. Within this framework, four different studies have been developed

Chapter 2 and 3 focused on the first of these two approaches; the study presented in chapter 2 looked for the prototypical narratives of

depressed and anxious patients while the one developed in chapter 3 analysed narrative disruption processes and quality of life of immigrated adolescents. Finally, chapter 4 and 5 focused on the second approach by analyzing a psychotherapeutic process in IPV with the DIHC.

In this final chapter, we highlight the main conclusions and clinical implications of the four studies presented in each of the previous chapters.

6.1. Narrative Assessment: Differences between Anxious and Depressed Patients

According to data presented and discussed in Chapter 2, when trying to distinguish depressed patients from anxious ones, only in six (out of 22) of the categories assessed was there a clear difference between the high scores for both groups (anxious and depressed). It was quite salient that none of the rest of the 22 dimensions of narrative analysis allowed for the establishment of a marked distinction between the two groups. This lack of general differentiation gave the impression that anxiety and depression are likely to share a common ground of psychological processes.

This finding is coherent with a narrative theory approach. As mentioned, a pervasive notion in the constructivist and narrative realm is that anxiety and depression introduce an episode of coherence invalidation in the person's narrative, leading to the need to reconstruct one's own self-narrative by an active process of meaning making so as to recover the lost sense of coherence and a newly found narrative position (see Neimeyer & Mahoney, 1995; and Angus & McLeod, 2004).

Furthermore, this thesis also proves that the NA-Grid can be considered as a very useful tool for conducting an initial, general narrative screening.

6.2. Making sense of immigration processes

Results form this study corroborated our hypothesis that immigration brings forth a process of narrative disruption and that this process is related to the perceived quality of life and self-esteem of adolescent immigrants, although this general statement has to be nuanced. Immigrated subjects were more affected by narrative disruption than natives, but surprisingly the adaptation process entailed more changes than the immigration one.

Immigrants refer that their quality of life has decreased, moreover they referred more change in their lives than in themselves at both the immigration moment and the post-Immigration moment. For this reason, the change in quality of life is higher than the change in narrative disruption. Thus, it seems important that subjects attribute that change to their life and not to themselves so as not to experienced a high narrative disruption.

Following Neimeyer's (2006b) position, people differ in the degree that they are able to successfully assimilate the sequel of separation into their existing self-narratives or to adequate these same life scripts to what they have suffered and what they must now struggle to change. In this study, we have used the BG to assess the differences between two groups, in the integration process of a Life Event in the life-story coherence, and moreover we have used narrative analysis to understand the narrative disruption process of the immigrant adolescent population. Through the Grounded Theory analysis specific cases within the immigrants groups were analyzed and some possible explanations about the results obtained with the BG were reached.

6.3. Complexities of Dialogue in Therapy for Intimate Partner Violence: Addressing the Issue of Psychological Violence

In this chapter, a study focused on the process of a conjoint therapy in psychological IPV, has been presented. The results indicated some distinctive aspects of this particular therapeutic process, which led us to a better and deeper understanding of some of the challenges presented by couple therapy for psychological IPV.

Regarding our first research question, we wanted to detect the specific phenomena that might arise in couple therapy for psychological IPV, applying a dialogical perspective. From the discussed results several conclusions can be established:

First, whereas the female expression of power seemed to take on the character of "invisibility," manifested through *semantic* dominance, the male expression of power was characterized more by *quantitative* dominance.

Second, the therapists' interactional dominance was an important strategy in the couple therapy applied, specially in putting a stop to the escalation process

Third, the therapist's directive approach, conducted dialogically, has the potential to prevent the couple from developing feelings of guilt or blame, and permits strategic decisions such as avoiding a response to the bickering of the couple.

Regarding the second research question concerned whether dialogicity and a focus on the present moment would parallel a shift into the reflexive mode within the therapeutic process, results seemed to support this relationship.

This study aimed at contributing to a deeper understanding of the process and outcome of couple therapy in psychological IPV, bearing in mind that the topic has been overlooked in current research. Overall, the specificities identified in this therapy may be helpful in understanding the "relation dynamics" in psychological IPV.

6.4. Increasing responsibility, safety, and trust through a dialogical approach: a case study in couple therapy for psychological abusive behavior

In this study we have focused on a psychotherapeutic process of conjoint therapy for psychological IPV, with special attention to the

issues of responsibility, safety, and trust. Moreover, the position of the therapists has also been taken into consideration.

Through the analysis the importance of responsibility emerged, not just because it is a crucial matter in the couple treatment for IPV, but also because it is noted how accountability might be negotiated trough language, as already discussed in the introduction section.

One important question that arose in this therapy, in relation to the issue of mistrust, involved the cultural differences between the couple and the added difficulties this posed to their relationship. The cultural sensitivity of the therapists has recently been argued to be an extremely important factor in conducting conjoint therapy for IPV (Horst 2012; Timmons, Brian, Platt & Netko 2010).

Our second research question referred to the insights that can be extracted from the difficult position of therapists who are conducting this kind of treatment, and the identification of dialogical strategies that could address the difficulties. Results revealed the importance of the following strategies:

-Having a reflective dialogue (Seikkula, 2008; Seikkula & Trimble, 2005) or a metadialogue (Stith *et al*. 2005) between the therapists.

-Establishing a therapist directive position which allowed them to break down the dysfunctional cycle and to slow down the dysfunctional process.

Overall, findings from this study provide support for the use of conjoint therapy in psychological IPV. As already pointed out by a number of authors (Langhinrichsen-Rohling & Capaldi, 2012; Bograd & Mederos, 1999; Hrapczynski *et al*. 2012; McCollum & Stith, 2008; Stith & McCollum, 2011; Whitaker *et al*. 2007), having the couple together in therapy can result in important benefits regarding responsibility, relation dynamics and communication and the escalation process.

6.5. Main Clinical Implications, Limitations and Further Work

As we have summarized in this concluding chapter, each of the topics analyzed throughout this book has resulted in a number of clinical

implications. The main conclusions that can be extracted from this thesis can be summarized as follows.

Results from the study of patient's narratives suggest that:

a. As traditionally highlighted by major therapeutic traditions, depressive patients need help in gaining a deeper sense of meaning and richer emotional nuances in their lives.

b. Also, they need to be able to cope with the complexities of emotional meanings in their lives and in others' and to do so by making their self narratives more tolerant to ambivalence, more emotionally laden, flexible and even incoherent sometimes (at least temporarily).

c. Some depressive patients may have decreased the perceived inconsistencies in their interpersonal world not by excluding whole areas of experience but by focusing only on superficial features of them. Thus, psychotherapy could help them overcome this constriction by widening their perceptual and emotional field of experience in a secure interpersonal environment.

d. Anxious patients tend to "think too much" and in a too detailed and hyper-reflective way. This is likely to be due to their need to

avoid uncertainty, but leads them in the long run to a for of living markedly addressed at being too vigilant.

e. Mindfulness-based interventions or similar techniques could be potentially useful in helping anxious patients gain distance from their ruminative thinking patterns. This has been repeatedly demonstrated by outcome research in mindfulness-based therapies—see for a detailed review of outcome studies the systematic revisions included in www.mindfulexperience.org.

f. Gaining a proactive feeling of agency and control over one's own life and self narrative is crucial to good psychotherapeutic outcome—especially with anxious patients.

Results from the study of immigrants narratives and narrative disruption indicates that:

g. Some strategies such as the externalization (White, 1988/9; White & Epston, 1990) may help immigrants see the change focused on their lives not on themselves.

h. It seems important to promote the integration of the different aspects of their identity and let space for the "shades of gray." This treatment objective can be useful for any traumatic

experience because a traumatic experience could be anything that results in a polarized and fragmented construing.

i. Patients with traumatic processes can be helped by the use of Biographical Grids, as already anticipated by Stewart (1995).

Results from the study of couples therapy suggest that:

j. It seems important that the therapists should be direct in their approach, or at least adequately directive. This would seem to be important irrespective of the therapist's orientation, particularly in cases of psychological IPV, in which the tools of acting out violence are indirect tools (i.e. consisting of language).

k. The dialogical approach makes it possible to avoid blame and to facilitate the accountability and responsibility of both members of the couple within the therapeutic process. Furthermore, the use of multivoiced addressees emerges as a powerful tool in couple therapy, advancing accountability in an indirect way.

l. Of special relevance in couple therapy for psychological IPV is the achievement of new understandings of the abusive manifestations and interactional problems of the couple. When new understandings are achieved, the distressed interactional

cycle (Sprenkle, Davis & Lebow, 2009) can be understood, and replaced with new and shared understandings. The couples trapped in those distressed interactional cycles are themselves aware that they usually spend an inordinate amount of time trying to control each other.

m. Tolerance of uncertainty, which is a challenge present in all kinds of psychotherapy (see Laitila, 2004; Seikkula *et al*., 2003), is especially relevant in couple therapy for IPV, and in particular, psychological IPV.

n. Having the couple together in therapy can have the following benefits:

    (i) It can strengthen both spouses' responsibility, since the spouses are encouraged to be accountable, through the presence of multivoiced addressees.

    (ii) It can provide a focus on the couple's relation dynamics and on their communication pattern, which in the present case was characterized by deep distrust, and by a defensive position that did not allow the spouses to listen to each other. This

resulted in a dysfunctional communication pattern.

(iii) It can provide insights into the escalation process (or the cycle, as it was called in the present therapeutic process). The process seemed to start with an argument about a past or present event on which both spouses disagreed and wanted to be right. Thus, they gradually slipped into a “game of power and control” (as the therapists referred to it.) Because they did not agree they felt frustrated and hurt, and they lost respect for the other because they themselves felt disrespected.

This thesis has clearly some limitations. Firstly, in both the study of patient’s narratives and the study of immigrants’ narratives and narrative disruption (chapter 2 and 3) the sample size and its representativeness might be argued as limitations. However, even if the sample of both chapters was not statistically representative, it is important to mention that in both cases the sample was psychosocially exemplary.

Secondly, and regarding the study presented in chapter 2, it

should be accepted that although it was possible to test the applicability of the NA-Grid according to different "variables" and its discriminative power with respect to the patients' complaints, further research with a bigger sample is needed before reaching any conclusions. Furthermore, as already discussed, although the NA-Grid has been very useful for conducting a general narrative screening in that it allows for the study a great number of narratives due to its format, in order to reach a deeper understanding of these narratives other techniques, such as Grounded Theory Methodology, might be more useful (e.g., Hardtke & Angus, 2004).

Thirdly, the loss of immigration profile due to the language barrier may be also understood as a limitation of the study of immigrants' narratives and narrative disruption, since in this case the narrative analysis was done from students' discourse provided by interviews. Despite this, we believe this study could be a starting point to develop a new growing body of research focused on this new methodological approach to assess narrative disruption and quality of life -narratively and meta-subjectively-.

Fourthly, the first study of couples' therapy (chapter 4) limitations are related to the cultural differences between the couple, and between

the couple and the therapists, which were not taken into account in the analysis. However, the therapists did take the cultural factor into account during the therapy sessions, commenting on the possible difficulties of a couple with different cultural backgrounds. Although we consider it to be an important and interesting issue – and one that seems to be gaining increasing attention in couple therapy for IPV (for a review see Horst et al., 2012) – it was beyond the scope of this study and this issue was incorporated in the study in chapter 5.

Fifthly, in both studies of couple therapy the failure to deal with the entire psychotherapeutic process might be understood as a limitation of the research. Here it should be pointed out that although it might be interesting to analyze the entire therapeutic process, and to focus, for example, on the outcome of the therapy, our objective in these studies was rather to address the kinds of challenging situations, the specificities and complexities, the dialogue, and the therapists role that are likely to arise in couple therapy for psychological IPV.

Sixtly, the decision to proceed with divorce in both studies of couple therapy might also be considered as a limitation, since it could be interpreted as a failure of the couple in dealing with their marital problems. It could also be interpreted – depending on one's definition of

success and failure – as a failure of the therapeutic process. From our point of view, what was most important was that the couple decided to continue with the therapeutic process, seeing it as important to make decisions concerning their children and their future plans. In fact, at the time of writing this thesis, the therapeutic process is still taking place.

Apart from all these, the use of qualitative methods for analyzing textual material, despite this was not the only methodology used in this thesis, presents some specific challenges that are also worth mentioning.

Among the most acknowledged ones is the bias that occurs when the researcher unintentionally influences the study findings in some way. For example, a study participant may say only what they think the researcher wants to hear, not what they really believe. Or, during data analysis, the researcher may leave out information if those findings contradict the researcher's view of the issue. Bias can occur during study design, data collection and data analysis. These biases have been kept to a minimum by adopting a neutral stance towards the object of inquiry and by having all stages of the research project supervised by the thesis director and other academic authorities.

One of the major goals of research is to generalize the study

findings to a broad group or population. In order for this to be possible, it is necessary that participants enrolled in the study are representative of the broader population being studied. Because qualitative research does not involve random sampling from the population to recruit research participants, it is challenging to get a sample group that is representative of the population. As a result, qualitative researchers have to be careful about making broad conclusions from their research. Not overgeneralizing the thesis results and keeping them grounded to their originally clinical basis are useful measures to avoid this pitfall.

Finally, both data collection and analysis can pose logistical challenges to qualitative research teams. Qualitative research techniques are time consuming and demand a lot of means. Successful qualitative research relies on high levels of trust between the research team and study participants, which also takes some time to develop. Because of these logistical challenges, qualitative studies usually involve fewer participants than quantitative research. This has been visible in all the studies presented in this thesis, and has been dealt with by incorporating reliability measures regarding collecting and analyzing data that have been detailed in each case.

As for future work, it might be interesting to increase the study of

patient's narratives through the use of self-characterizations among the host of patient-generated narratives since only a few studies have included them to study selfhood constructing processes. We agree with Leite and Kuipper (2008) that self-characterizations may help to get to know the client's "self-concept clarity"—i.e., the internal consistency and temporal stability of the self. Knowing a client's level of self-concept clarity might help predict the extent to which (a) he or she may have difficulties in clearly defining and understanding personal problems or (b) he or she is aware of the need for change. For these reasons we believe that it is important to do further research on self-characterizations because they provide potentially useful information for therapeutic practice.

For further research, related to the study of immigrants' narratives and narrative disruption, it would be interesting to continue testing the methodology used in this study with a greater number of subjects, and also with clinical population, as differences among groups might be higher.

In the study of couple therapy in psychological IPV future research might go on to analyze the entire therapeutic process, seeking to detect the patterning of the specificities identified in this study (including

whether they are repeated throughout the therapeutic process or change over time), and further, seeking to detect any new specificities that might emerge. For example, in the later stages of the psychotherapeutic process, once the distressed interactional cycle has been detected and overcome, one could anticipate that the therapists might adopt a less directive approach, and that the couple would present more dialogical utterances. Another possibility would be to analyze the changes occurring in the dimensions of responsibility, safety, trust, and the role of the therapist over the complete course of therapy.

Chapter 7

Closing Remarks

In this thesis we have analyzed meaning making trough narratives as the bridging point of the constructivist and constructionism approaches. We have discussed that when focused on narrative and relation both approaches share some common grounds that are crucial for understanding meaning making. Two main approaches have been presented as integrative efforts for bridging these two paradigms: the

relational constructivist approach and the dialogical approach, focusing specifically on the DIHC.

Strongly relaying on the narrative focus (as an important integrative feature), this thesis has presented a set of four studies focused on both approaches, the Relational Constructivist approach (chapter 2 and 3) and the dialogical approach (chapter 4 and 5).

In chapter 2 the use of self-characterizations has been helpful to analyze the relation of the person with him or herself and with the way that others may see him or herself. Furthermore, the narrative analysis performed in this chapter, has allowed us to analyze the narrative at the macro-level and, thus, to address the narrative as a whole. This emphasis on the relational focus and the macro-analysis of the narrative are not common characteristics among the studies developed from a constructivist approach (Avdi & Georgaca, 2007), as already discussed in the introduction section. However, they are distinctive features of the relational constructivist approach.

In chapter 3, taking into account the importance of the relational aspect, as well as the participants' age (adolescents), we collected data trough interviews. This decision was made under the strong belief that in

the particular scenario created in the interview, the person might feel more comfortable to explain important aspects of his or her life. As author of the interviews I can fully certify that this was the case, and that all the participants could feel comfortable. Moreover, keeping in mind the importance of language as constitutive and not merely representative, the immigrant population that were not native Spanish speakers were left out of the study. All the immigrants could have perfectly understood and followed the interview, as they are schooled in both Catalan and Spanish language. However, we wanted the participants to be able to express on their own language and their own words, as words are symbolic means to create meanings. Finally, the Grounded Theory allowed us to develop a macro-analysis of the narratives. All these characteristics account for the Relational Constructivist approach followed in this chapter.

Finally, studies presented in chapter 4 and 5 focused on the Dialogical Approach, which seemed the most appropriate when dealing with family and couple therapy as it allows for the analysis of the dialogue among the members and the therapists in the therapeutic setting. With this method we had the opportunity to focus not only on what is said but also on how it is said and on what it is not said. We focused, for example, on what the therapists didn't respond to, on what were the

members responding to, on how did the members answer to each other (whether it was dialogically or monologically). This analysis allowed for a deep comprehension of the therapeutic encounter and the dialogue among the members. Moreover it allowed incorporating the therapists in the analysis instead of just focusing on the client. In this dialogue we could look for the dominance, the quality of the responses, and definitely, we could analyze the relation that was taking place on that very moment. Instead of focusing on the inner dialogue of the client, this method allowed for an analysis of the outer dialogue generated in the session. This strong focus on the relation, the dialogue (or outer dialogue), and the therapists are not common features in a traditional constructivist approach as discussed in the introduction section (Avdi & Georgaca, 2007), but are the main integrative contributions (McNamee, 2000) of the Dialogical approach.

As already discussed in the introduction section those approaches entail a shift in the focus of the narrative, since they allow for a combination of macro- and micro- analysis of the narrative, follow an open-ended analysis (except the study in chapter 2), are exploratory, and discovery oriented and their last aim was to enrich understanding taking into account both, interactional and cultural aspects. For the amount of

information and the meaningful understanding obtained, we expect to encourage researches to embrace an integrative approach of both constructivism and constructionism, instead of focusing on the differences. We hope that this thesis might have shed some light on the ways to achieve this goal.

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Aquesta Tesi Doctoral ha estat defensada

el dia ____ d _____ de 2013 al Centre

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de la Universitat Ramon Llull

davant el Tribunal format pels Doctors sotasignants, havent obtingut la qualificació:

President/a

_____

Vocal

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Secrtari/ària

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Doctorand/a

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