Towards self-discovery:

Elucidating adolescent intra-psychic tensions

By

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Towards Self-discovery

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Declaration of Powers of Discretion

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SECTION A: PREFACE

This portfolio is divided into three sections: firstly, a research component exploring young adult narratives of recovery from adolescent depression; secondly, a critical literature review investigating the role of perfectionism in the onset and maintenance of eating disorder symptoms; and finally, a combined process report and client study examining the manifestations of perfectionism in a therapeutic context. Each separate component of the portfolio shares a commitment to elucidating adolescent intra-psychic tensions.

In the research piece I set out to shed light on narratives of recovery from adolescent depression. I interview ten adults in their twenties, both male and female who deem themselves to have recovered from adolescent depression, and I analyse their stories from the perspective of Narrative Oriented Inquiry (Hiles & Cermak, 2008). A full picture emerges of individuals who have come to make sense of their experiences of teenage depression by casting their recovery in terms of processes of self-discovery. I specify that participants universally evoke a sense of themselves as being composed of various constituent "parts". Recovery, for participants, involves a redefinition of how one relates to one's vulnerable parts within the context of a multifaceted sense of identity. I conclude the research by situating this finding in its socio-cultural context and by relating it to existing theory pertaining to the phenomenon of multiplicity of mind.

I was motivated to carry out this research by both professional and personal considerations. From a professional perspective my role as a trainee Counselling Psychologist working with teenagers was instrumental in bringing to my awareness the need for such a project. On a personal level, as someone who has experienced adolescent and adult depression, I found myself believing passionately that people

who have experienced, or are currently experiencing, mental health difficulties – just like all of those who have not and are not - are experts on the topic of their own experiences, needs, and preferences. I therefore believed that they would in all likelihood have important insights into what might be helpful, or not, in promoting their own recovery. Consequently, I believed that it was my duty as a mental health professional to elicit and take note of this information and that is what I set out to do in this research project.

I found the process of carrying out the research tremendously inspiring. It has challenged my thinking in ways of which I could not have conceived prior to immersing myself in participants' narratives. On several occasions, in elucidating their own intra-psychic processes, participants clarified and deepened my own understanding of the experience of depression. This has had inevitable ramifications for the ways in which I conceive of my future professional practice as well as for the manner in which I relate to myself. Overall, conducting the research has enabled me to move towards a more flexible and creative understanding of human beings' fundamental depth. The Internal Family Systems (IFS) model, to which I refer in my discussion, provides me with a framework within which to understand and celebrate human complexity.

The component parts of this portfolio chart the evolution of my process as a Counselling Psychologist over three and a half years: from an overriding concern with precise definition in the critical literature review, to an acknowledgement of the potential limitations of cognitive-behavioural therapy in the client work, to embracing the flexibility of an explicitly compassionate model in the research piece. Whilst I am committed to exploring adolescent intra-psychic conflict in each piece of work, the vantage point and paradigm from within which I do so gradually shift.

Thus, in the critical literature review I am very much a scientist-practitioner. I refer to "onset" and "maintenance factors", bemoan the methodological inconsistency of various studies reviewed, and draw attention to a need for clarity in perfectionism studies. In particular, I highlight the desirability of adopting a standardised conceptual definition of perfectionism in which this does not become confused with its methods of measurement. My epistemological stance in the literature review is consistent with that of my therapist persona in the client work. Thus in this latter piece, I am committed to consistently developing and testing hypotheses with my client as part of a cognitive-behavioural process of formulation, intervention and reformulation.

The client work also shows me moving towards the adoption of a more reflective-practitioner stance however, as I attempt to reconcile the cognitive behavioural orientation with my sense of the humanistic and existential roots of counselling psychology. This shift in thinking was informed by Proctor's (2008) warning of an uneasy ethical marriage in CBT between the principles of beneficence on the one hand and respecting a client's autonomy on the other: "respecting the client's autonomy is directly opposed by the belief that the therapist has rationality…on their side, and therefore knows what is best for the client, whatever they may believe" (p.250). I address this potential dichotomy in my client work by developing my compassion and by challenging a tendency to position myself as an expert in therapy.

The client work paves the way for my espousal of qualitative research's collaborative approach to data generation in the research project and for my acknowledgement of my influence as a researcher on the research process. In showcasing my awareness of the epistemological tensions inherent in CBT, the client work also paves the way for my exploration of IFS in the research project. This ideological transition from CBT to IFS was facilitated by qualitative research's vision of knowledge as fluid and relative.

The principles of qualitative research, and of Narrative Oriented Inquiry in particular, gave me the freedom to move beyond my perception of the rationality and compartmentalisation of CBT and to embrace what to my mind appears to be a more flexible and creative outlook in IFS.

Thus the process of compiling this portfolio has afforded me some invaluable space for reflecting upon the nature and potential future directions of my professional practice as a Counselling Psychologist. To quote a leading proponent of the consumer-led recovery movement in the US, it has very much been the case that compiling this portfolio has taken me on "a journey of the heart" (Deegan, 1996).

SECTION B: RESEARCH

"Exploring Narratives of Recovery from Adolescent Depression"

Abstract

In this research piece I set out to shed light on narratives of recovery from adolescent depression. I interview ten adults in their twenties, both male and female who deem themselves to have recovered from adolescent depression, and I analyse their stories from the perspective of Narrative Oriented Inquiry (Hiles & Cermak, 2008). A full picture emerges of individuals who have come to make sense of their experiences of teenage depression by casting their recovery in terms of processes of self-discovery. I specify that participants universally evoke a sense of themselves as being composed of various constituent "parts". Recovery, for participants, involves a redefinition of how one relates to one's vulnerable parts within the context of a multifaceted sense of identity. I conclude the research by situating this finding in its socio-cultural context and by relating it to existing theory pertaining to the phenomenon of multiplicity of mind.

Introduction

Overview of literature review

"Depression is a prison where you are both the suffering prisoner and the cruel jailer."

-Dorothy Rowe

Although much research has been conducted into the phenomenology and treatment of depression over the past decade, according to Koplewicz (2002) "while we know what works best for adults, we're still very much addressing that question for adolescents" (p.7). Meanwhile, Evans, Van Velsor, & Schumacher (2002) have called adolescent depression "one of the most overlooked and undertreated psychological disorders within this period of development" (p. 211). Like its adult counterpart, adolescent depression has been described as "self-limiting" (Schreiber, 1996) in the sense that it alleviates over time, even if people experience subsequent episodes. Despite depression's being limited in this way, very little is known about what people who experience depression understand by "recovering", nor how they go about recovering. The present study will aim to fill the gap in the literature by looking at the concept of recovery as it applies specifically to experiences of adolescent depression.

I begin the literature review with an examination of the aetiology of the recovery orientation in mental health before going on to introduce the recovery-as-outcome vs. recovery-as-process debate, so central, in my opinion, to any study of the concept. This in turn prompts me to engage in a reflexive examination of my own epistemological assumptions relating to recovery and enables me to situate the present study firmly within the context of qualitative research into recovery as a process.

Unlike previous work in the area however, my study is concerned with recovery from adolescent depression. This marks a departure from previous recovery-as-process work which has principally been concerned with recovery from schizophrenia, perhaps because a focus on "the most severe of the mental illnesses with the poorest prognosis" (Davidson & McGlashan, 1997, p.36) was a sure way of definitively refuting exclusively medical conceptions of mental illness. The dearth of research into the process of recovery from depression, let alone recovery from adolescent depression, enables me to make a claim for the expediency of the current project which fills an important gap in the literature.

In the second part of this chapter I hone in on research concerned with the phenomenon of adolescent depression, reviewing findings on clinical features, prevalence, aetiology, prognosis, and treatment, all of which play a role in assisting me to make a case for the timeliness of my study. Finally I review the handful of qualitative studies conducted in the area of adolescent depression over the past decade and situate the present study as building upon, and as contributing to, this relatively recent tradition.

Recovery

Aetiology of recovery orientation

The concept of recovery from mental illness is by no means new to the mental health field. Definitions of recovery and their origins have, however, changed significantly over the past 200 years. Until recently, the definition of recovery was restricted by the medical model and was usually defined as the complete remission of symptoms. The precedent was set in 1812 by Dr Benjamin Rush who argued in his book *Medical Inquiries and Observations upon the Diseases of the Mind*, that mental illness was

curable through medical treatment. Deutsch (1949) argues that this claim has had a long-lasting impact on concepts of mental illness and that it laid the foundations for the biomedical paradigm to become the guiding framework for defining and treating mental illness in the Western world.

Bockoven (1972) ascribes early usage of the term *recovery* to hospital superintendents who reported the treatment outcomes of patients either admitted or discharged from their asylums. Data collection involved simple counts, assembled from hospital records, of people who were discharged as having either recovered or improved. Recovery was usually defined in terms of the elimination of observed symptoms, at least during the hospital stay.

According to Grob (1994) and Pressman (1998) beliefs about the possibility of recovery were affected in the first half of the 20th century by the advent of somatic interventions, in the form of shock therapies, psychosurgery and early psychopharmacology. These measures reintroduced what Pressman (1998) terms the "revived cult of curability" (p.159). Again, in line with the medical model, recovery was understood as being synonymous with the elimination of symptoms during this period and, consistent with this model, the physician or mental health professional, rather than people who were diagnosed with a mental illness, were responsible for defining recovery (Grob, 1994; Pressman, 1998). Accordingly, the methods used to evaluate these interventions focused on observed behaviours, as viewed and interpreted by physicians and other clinicians. Individuals suffering from mental illness were rarely given the opportunity to voice what outcomes were of importance to them or to their experience of recovery.

By the late 1970s limitations in the biomedical model's ability to explain the onset, treatment and potential recovery from mental illness had been made manifest however and this led to the introduction of an expanded bio-psychosocial model of mental illness. This incorporated the dynamic interactions among biological, psychological, and environmental or socio-political factors that influence the labelling, diagnosing, treatment, and course of any non-acute illness (Engel, 1977; Smith & Nicassio, 1995; Kiesler, 2000). According to this model, individuals are not diagnosed with a mental illness, nor do they recover from it, in a biological vacuum, but rather, interpersonal, contextual, socio-political, and socioeconomic factors influence the interpretation, onset, and course of their illness (Kiesler, 2000).

Engel (1977) argues that this paradigm of illness suggests that methods used in researching the recovery process need to capture the multidimensional and transactional nature of the process, such as measuring changes in biological (e.g., access to effective psychosocial rehabilitation programs and supportive social networks), and socio-political factors (e.g., impact of stigma from the community, attributes of the treatment system, and the impact of consumer advocacy) over time. The bio-psychosocial paradigm of mental illness has gained acceptance among mental health researchers (US Department of Health and Human Services, 1999). It has proved more difficult to examine as a heuristic than the biomedical model however, and therefore, Kiesler (2000) argues that it has been minimally tested as a paradigm for assessing the process of recovery from mental illness. Whilst a number of longitudinal evaluations of clinical interventions have included multidimensional measures to capture changes in people's lives beyond symptom reduction, such as employment and quality of life, only Strauss, Hafez, Lieberman & Harding (1985) have attempted to examine the relationship among these domains and this in respect to

diagnoses of schizophrenia. No such studies exist to date with respect to diagnoses of depression, and let alone with respect to diagnoses of adolescent depression.

A final, more recent model of recovery has been introduced through the rise of consumer advocacy movements in the UK. As consumers of mental health services have asserted themselves over issues impacting on their lives, a new understanding of recovery has emerged based on the lived experience of people with mental health difficulties (Deegan, 1988). This understanding of recovery was introduced in the 1970s with the rise of the consumer/survivor/ex-patient movement (Chamberlin, 1990; Frese & Davis, 1997; Kaufmann, 1999) and is the only one of the three paradigms discussed that is not based on a disease model framework. Within this consumer-led model, a number of theories of recovery from mental illness have been derived from the vantage point of those who are experiencing it (Davidson & Strauss, 1992; Morse, 1997; Ralph, 2000; Strauss & Carpenter, 1981; Weaver Randall, 2000; Young & Ensing, 1999). Recurrent themes include:

- the active role played by individuals in the recovery process
- the non-linear, ongoing nature of recovery
- the essential role of hope
- the importance of a sense of purpose and meaning
- the acceptance that relapse is part of the process and not a failure

In all of these studies, to which I shall return below, recovery is defined as a process rather than as an outcome.

Recovery: outcome vs. process

Both the biomedical and the bio-psychosocial models of recovery described above have tended to subscribe to a definition of recovery as an outcome. Viewed as such, recovery represents a shift from a previously maladaptive state to a position of "normality". Results of a clinical trial may be applauded, for instance, if symptoms of depression are reduced significantly after a trial of a new antidepressant medication. Although recovery, from this perspective, does not necessarily mean being symptom-free, descriptions of recovery as an outcome typically include accomplishing life goals in important life domains such as work and housing, as well as reporting both psychological well-being and improved quality of life.

From the perspective of consumer advocacy movements however, this notion of recovery as an outcome is unsatisfactory. As an alternative, this group proposes recovery as a process: namely, people who are concerned about their psychological well-being, struggling with their symptoms, and attempting their life goals are "in recovery" regardless of where they fall in terms of any outcome criteria.

Recovery as outcome

Concurrent with the growing movement towards recognising recovery throughout the past decade has been a call for evidenced-based treatment in all areas of mental health which is particularly relevant to the medical model of recovery (Drake & Goldman, 2001; Torrey, 2001). In response to government imperatives, clinical and services researchers have declared that the body of interventions made available for people with mental illness should be limited to those that have survived rigorous empirical testing.

Evidence-based approaches yield both benefits and limitations. In terms of advantages, a focus on evidence-based approaches ensures that consumers will only be involved in services that have been shown to be effective. This is reassuring to potential patients who may have witnessed a mental health system pursuing ineffective treatments in the past. Ralph & Corrigan (2005) give the examples of psychoanalytic therapy for schizophrenia, or even the actively harmful insulin shock therapy in this regard. Hence, a list of evidence-based treatments is undoubtedly an invaluable tool at the National Health Service's disposal. This may be especially so in the current climate of public sector spending cuts in the UK which may have a lasting impact on funding the mental health service needs of the future.

Amongst the disadvantages of evidence-based approaches opponents have noted that the criteria for identifying a service as effective and worthwhile- an empirical evidence base- reflect the priorities of the research community, rather than those of the community of consumers, survivors and ex-patients (Fisher & Ahern, 2002; Frese, Stanley, Kress & Vogel-Scibilia, 2001). Furthermore, Corrigan (2002) and Van Tosh (2000) have argued that empirical research does not necessarily include the kinds of epistemologies that led to the development of such important ideas of the consumer movement as empowerment and recovery. And moreover, according to Plante & Sherman (2001) empirical research approaches do not easily crosswalk with issues related to spirituality. Finally, the excitement about evidence-based approaches makes several potential intervention programs that may be effective means of treating people with mental illness redundant. Davidson (1999) and Solomon & Draine (2001) offer examples here of consumer-operated services, including support groups, drop-in centres, and education programs, that are developed by people with mental illness for people with mental illness

Recovery as process

According to proponents of the recovery as a process orientation, recovery as an outcome means more than an improved state. It represents some kind of end point that approximates "normality". And this, they argue, begs several important questions, notably: How many goals must be achieved for an individual to be considered to have recovered? And, for that matter, how much life success is considered "normal"? For its critics, the recovery as outcome view incorporates an evaluative component; the patient is only a person if he or she meets some arbitrary and externally imposed criterion.

One of the purposes of recovery as a movement that emerged from consumers, survivors and ex-patients was to re-inject hope into the lives of people diagnosed with mental illness. Recovery from this perspective is less concerned about outcomes- whether the person achieves some kind of symptom-free end point- and more concerned with process. The key question for proponents of this vision is: what actions and activities foster an environment in which a person's search for a meaningful life can be supported? I include some quotes here from champions of the recovery as process orientation to elucidate what they understand by the concept:

Recovery is a process, a way of life, an attitude, and a way of approaching the day's challenges. It is not a perfectly linear process. At times, our course is erratic and we falter, slide back, regroup, and start again...The need is to meet the challenge of the disability and to re-establish a new and valued sense of integrity and purpose within and beyond the limits of the disability; the aspiration is to live, work and love in a community in which one makes a significant contribution. (Deegan, 1988, p.15)

One of the elements that makes recovery possible is the regaining of one's belief in oneself. (Chamberlin, 1997, p. 9)

Having some hope is crucial to recovery; none of us would strive if we believed it a futile effort...I believe that if we confront our illnesses with courage and struggle with our symptoms persistently, we can overcome our handicaps to live independently, learn skills, and contribute to society, the society that has traditionally abandoned us. (Leete, 1989, p.52)

To return renewed with an enriched perspective of the human condition is the major benefit of recovery. To return at peace with yourself, your experience, your world, and your God, is the major joy of recovery. (Granger, 1994, p.10)

All of these quotes share a sense of the fundamental role played by inspiration in the process of recovery. It would seem that an important component of recovery envisioned as a process is psychological well-being. Rather than necessarily being symptom-free, recovery has to do with a sense of meaning in life and personal comfort. Research in this area has focused on such important concepts as validation of personhood, recognition of common humanity, and tolerance for individual differences (Campbell, 1992; Campbell & Schraiber, 1989). Ralph & Corrigan (2005) note that although these are important concepts in the study of human development, they are strikingly under-represented in the psychological and psychiatric literature.

Another key component to emerge from the literature on recovery as a process is empowerment. Sufferers must have the power to act on their decisions to produce an optimistic future that reflects their personal goals. Research has demonstrated that empowerment is a multi-faceted phenomenon that includes a sense of personal control over one's environment and a feeling of agency in one's world (Rogers, 1997; Segal,

Silverman & Temkin, 1995). Studies have also shown that these forms of empowerment are highly correlated with measures of recovery that reflect process (Corrigan, Giffort, Rashid, Leary, & Okeke, 1999; Corrigan, Salzer, Ralph, Sangster, & Keck, in press).

Researching recovery as process: qualitative studies reviewed

Thus far, recovery as a process has been explored as a phenomenon through qualitative research focused on eliciting the perspectives and stories of people with psychiatric difficulties through open-ended narrative interviews and ethnographic observation. Before engaging in a discussion of the reflexive process through which I uncovered my own epistemological assumptions surrounding recovery, I briefly review the findings of those studies concerned with investigating aspects of the process of recovery in the following subsections. All of these studies involve analysing narrative interviews from an IPA perspective and all are concerned with recovery from schizophrenia, perhaps because a focus on "the most severe of the mental illnesses with the poorest prognosis" (Davidson & McGlashan, 1997, p.36) has been a sure way of definitively refuting exclusively medical conceptions of mental illness. Nonetheless, they shed light on important aspects of recovery as a process, and as such, their findings have broadened my understanding of the phenomenon of recovery and consequently informed the present study.

Accepting Illness and redefining self

There appears to be a consensus amongst qualitative researchers that the most overarching aspect of recovery as a process involves the redefinition of oneself as a person of whom mental illness is only one part (Sullivan, 1994; Fisher, 1994; Deegan, 1996; Young & Ensing, 1999; Smith 2000; Munetz & Freze, 2001; Davidson, 2003).

Estroff (1989) has described mental illness as a disease of the self, given its tendency to subsume the entirety of the person experiencing it. Not only does an individual experience the symptoms of a mental illness and its resulting impairments, but he or she may be socialised into assuming the identity of a "mental patient". According to Munetz & Freze (2001) recovery involves an acceptance of illness as a part of the self, but does not necessarily entail accepting a particular conceptual model of illness. Neither, and emphatically, does it mean accepting the identity of the "mentally ill person". Rather, accepting one's illness, according to these researchers, involves redefining how an individual negotiates this particular life challenge within the context of a multifaceted life and sense of self.

Being supported by others

Smith (2000) found that having supportive others around, be these professionals, family members or friends, to provide unconditional love and encouragement through the difficult times, is critical to recovery in that it bolsters the individual's self-worth in spite of the ravages that mental illness can reap. These findings are corroborated by Davidson (2003) who emphasises that participants frequently refer to the importance of having someone believe in them when they could not believe in themselves, or of having a supportive other stand by them when they felt that they had been subsumed by their illness.

Mead & Copeland (2000) and Young & Ensing (1999) draw attention to the significance in recovery of having another person, also in recovery, as a mentor. These researchers explain that participants had found that such role models had given them a sense of what to hope and strive for in the recovery process. Finally, Davidson (2003) and Sullivan (1994) point out that these supportive others do not necessarily have to

be human; they can also be pets or abstractions, such as God. Sullivan (1994) emphasises that many individuals in recovery stress the importance of having faith in God when everything else seems hopeless.

Renewing hope and commitment

As these studies suggest, the importance of having hope and believing in the possibility of a renewed sense of self and purpose is an essential component of recovery. Smith (2000) points out that without hope, sufferers remain lost to their illness, whilst hope without renewed commitment can result in passivity and a sense of impotence. Young & Ensing (1999) emphasise that in order for hope to be directed into effective efforts towards improvement of one's situation, it must be translated into a desire and a commitment to recover.

Being involved in meaningful activities and expanded social roles

Once an individual feels supported, hopeful and capable of recovery, Young & Ensing (1999) emphasise that he or she must then have something to do. A significant part of recovery in this regard involves engaging in meaningful activities and developing and expanding upon valued social roles. Rogers (1995) points out that this kind of involvement also provides the person with a sense of direction and purpose. Sullivan (1994) remarks that in addition to an individual's own specific interests, education, employment, and spirituality are some of the fundamental, socially sanctioned means through which a person can gain a sense of meaning and purpose in life.

Managing symptoms

Whilst complete remission of symptoms is not a pre-requisite to recovery, Fisher (1994) argues that individuals frequently do report that being able to manage

symptoms in some way is fundamental in enabling them to take an active role in their own recovery. He stresses that the means by which a person manages symptoms, be these through medication, psychotherapy, or their own coping strategies, are not as important as the freedom the individual gains by bringing these symptoms under some degree of control. In this regard, Deegan (1996) has argued that recovery is about individuals using coping skills and services in an active way as a fundamental force in their own process of recovery, rather than being passive recipients of these services. Thus a person's attitude towards managing his or her symptoms has implications for his or her recovery process.

Resuming control and responsibility

Baxter & Diehl (1998) and Frese (2001) have argued that just as recovery is about what a person *does* rather than something that can be *done to* a person, individuals must assume responsibility for their own transformation from a person with a mental illness to a person in recovery. Lovejoy (1982) and Walsh (1996) have argued that taking back control of one's life helps to reduce perceptions of victimisation thereby increasing one's sense of agency and self-efficacy.

Overcoming stigma

As Walsh (1996) emphasises, recovery involves more than overcoming the personal ravages of one's mental illness. For many, it also involves recovering from the lasting impact of the stigma associated with mental illness. In refuting the notion of recovery as involving a return to a premorbid state, Walsh (1996) argues that "we can never go back to our 'premorbid' selves. The experience of disability and the stigma attached to it, changes us forever" (p.87). According to Corrigan (2003), an especially problematic consequence of the impact of stigma is the process of internalisation

certain individuals go through in accepting their community's notions of mental illness and withdrawing into a "mental patient" role and identity. Recovery, according to these authors, involves developing resilience to stigma or actively combating it.

Exercising citizenship

Finally, Rowe (1999) argues that recovery involves a resumption of the responsibilities associated with community living. He argues that this may require advocacy as well as activity however, given the numerous legislative and attitudinal obstacles to full participation in civic life for people with disabilities.

My process in researching recovery

The humanistic values underpinning this wealth of research into recovery as a process echo those of Counselling Psychology as a discipline. As such, they correspond to my growing questioning, as a Counselling Psychologist, of the medical model with its emphasis on responding to sickness and pathology as opposed to facilitating well-being. These studies are therefore in tune with my professional commitment to seeing human beings in a holistic manner, rather than as a mechanistic collection of psychological parts.

Notwithstanding my intuitive sense of this philosophical concordance, I felt it important, in considering my specific study, to ask myself the following reflexive questions as recommended by Shadish (1990) for researchers planning to engage in studies on recovery. These were instrumental in elucidating my epistemological and consequent methodological assumptions with respect to the concept of recovery from mental illness:

1. ***What is my implicit theory of recovery from mental illness?***

I believe that people who have experienced, or are currently experiencing, mental health difficulties – just like all of those who have not and are not - are experts on the topic of their own experiences, needs, and preferences, and thus may have important insights into what might be helpful, or not, in promoting their own recovery. Consequently, I believe that it is the duty of mental health professionals to elicit and take note of this information and to recognise that people suffering from mental health difficulties can do things to help themselves.

This belief is derived both from my professional experience of working as a trainee Counselling Psychologist and from my personal experience of having suffered repeated bouts of depression in adolescence and adulthood. From a personal perspective, I find myself siding with proponents of the recovery as a process orientation, in that recovery makes sense for me less as an end product and more as a redefinition of one's illness- if one accepts the conceptualisation of depression as an illness- as only one aspect of a multidimensional sense of self. I feel that it is critical for me to openly acknowledge the fact that I am intuitively biased towards viewing recovery as a process, so that I can strive, in so far as this is possible, to bracket off my personal assumptions and to champion my participants' voices in the analysis and discussion phases of this project.

2. What values are implicated in my theory?

My implicit theory of recovery obviously differs from that used in clinical research, in which recovery involves alleviation of distressing symptoms and a return to a pre-morbid level of functioning. This model of recovery as an outcome is defined by an absence of illness, or the removal of something, such as medication for instance, that was not part of the person's life prior to the illness. From my perspective however,

recovery does not have to be 'synonymous with cure' (Deegan, 1988, p.15) nor does it have to involve a return to a pre-morbid state. Rather, it is a life-long process that involves an indefinite number of incremental steps across a multitude of life domains. In the words of one proponent of the recovery as a process orientation: "Recovery does not necessarily mean the disappearance of suffering and symptoms or the complete restoration of functioning; rather it means living a meaningful life beyond the restrictions of the illness" (Anthony, 2000, p.159).

3. *What are the epistemological assumptions built into my conceptualisation of recovery?*

My definition of recovery reflects a constructivist epistemology and, as such, I will be committed to uncovering aspects of the recovery process through qualitative interviews. These will be highly individualised and thus suited to the purposes of my exploratory research. Furthermore, my definition of recovery implicitly promotes a vision of change in terms of nonlinear, reciprocal transactions that are nested in context. I will therefore need to pay heed to the particular transactions both verbal and nonverbal between myself and participants in the context of the interview process. Finally, my definition of recovery will require me to adopt a collaborative approach to my project and to acknowledge my influence as a researcher on the research process.

4. *How could the resulting research be useful in helping people to recover from adolescent depression in the future?*

I hope that my findings will assist future adolescent depression sufferers in enabling Counselling Psychologists and other mental health professionals and clinicians to appreciate the complexity and richness of an individual's movement towards recovery. I also hope that the interpersonal and societal perspectives of the analysis will enable

clinicians to see beyond the one to one relationship with clients and to advocate for and support changes to potentially disempowering and stigmatizing dominant narratives.

So, to recapitulate, I situate the present study firmly within the above tradition of qualitative research into recovery as a process. I break new ground in terms of content however by focusing on recovery from adolescent depression, rather than on recovery from schizophrenia.

Adolescent depression

Both "adolescence" and "depression" are multifaceted constructs in their own rights and are open to a multiplicity of interpretations. I endeavour to gesture towards this complexity before proceeding with a literature review of the area.

The question of adolescence

Whilst, over two thousand years ago, Aristotle and Plato wrote of the problems and characteristics of post-pubertal youth (Schofield, 2005), it was not until 1904 that *adolescence* received its first full definition with the publication of G. Stanley Hall's *Adolescence: Its Psychology and Its Relations to Physiology, Anthropology, Sociology, Sex, Crime, Religion and Education* (1904). In this work Hall famously describes adolescence as a period of "storm and stress" during which each individual develops from a primitive to an advanced condition within the theoretical context of evolutionary recapitulation. Research interests since Hall have ranged from focusing on puberty and its neuro-biological foundations (Turkheimer, 2000), to rejecting the notion of adolescence as a particularly turbulent period (Adams & Berzonsky, 2006),

to elaborating stage models of development within which to study the concept (Piaget, 1932; Freud, 1937; Erikson, 1968).

In an age of contextual, narrative and post-modern influences in psychology, Kroger (2004) notes that organismic stage models of adolescent development have increasingly come under fire from researchers more interested in attempting to understand how young people come to construct themselves in a world that is constructing them. A variety of theoretical orientations to identity are represented under this general socio-cultural approach, ranging from proposals that identity is a reflection of individual adaptation to context (Baumeister & Muraven, 1996; Cote and Levine, 2002) or a reciprocal interaction between person and context (Lerner, 2003) to more radical suggestions that one's identity is merely an imprint of one's social and cultural surroundings (Gergen, 1991; Slugoski & Ginsburg, 1989).

I align myself with Lerner (2003) and Kroger (2004) to adopt a developmental contextualist approach to adolescence in this research study. While I acknowledge the contributions of society to creating the phenomenon of adolescence with its concomitant questions of identity, I am also interested in the intra-psychic restructuring which the challenges of this phenomenon may bring. I view the experience of what is termed "depression" as just one such challenge.

Depression: a multi-faceted experience

Despite its being the most common presentation that clinicians are likely to encounter (Fee, 2000), there are many different approaches to understanding depression and its variants.

Depression as chemical imbalance

From a traditional psychiatric or "medical model" perspective depression is at base viewed as being caused by biological, physiological, and genetic factors, whilst "environmental" conditions exist primarily as mediating triggers for the condition. From this perspective, social processes constitute variables within an overall biomedical problem and antidepressants are prescribed as the treatment of choice to correct perceived imbalances of neurotransmitters.

Depression as an act of mourning

In classic Freudian-analytic theory meanwhile, depression involves a psychodynamic process implicitly connected with the activity of mourning. Following the loss of a love-object- most often a person- feelings of helplessness and dependence are repressed and transformed into self-directed anger or rage (Freud, 1963; Klein & Wender, 1993), hence the popularised idea of depression as "anger turned inward." Others after Freud have attempted to make the theory more amenable to include the importance of self-esteem within everyday transactions with the object world.

Depression as "learned helplessness"

The central notion in cognitive-behavioural perspectives of depression is that one's thoughts and beliefs either cause or influence depressive experience- and that these often "irrational beliefs" (Ellis, 1962) or distorted or "negative schemata" (Beck, 1967; Sacco & Beck, 1995), especially when mediated by stressful life events, can "bias" one towards a pattern of pessimistic cognitions that lead the way to depression. In this sense, one might become socialised into "learned helplessness" (Seligman, 1975) adopting a passive stance towards life events that require normative coping skills.

Beyond objectification

As different as these approaches are, and these are by no means exhaustive, one could argue that they all share a tendency towards objectifying the experience of depression. As such, they reflect a modern, Enlightenment understanding of mental disorder as "alien"- an external and irrational malady to be fathomed and hopefully rectified by the scientific expert, imbued in the words of Fee (2000) with "mysterious powers of moral adjudication". This positivist objectification of depression is very much reflected in those quantitative studies reviewed below. The qualitative pieces, by contrast, attempt to reflexively engage with clinical understandings of depression, whilst looking at ways in which the experience during adolescence, might be, in a sense, unmastered and removed from its objective and oppositional status.

Quantitative studies

Clinical features

The quantitative literature on adolescent depression's clinical features shares a common preoccupation as to whether it parallels the phenomenology of adult depression (Roy & Parker, 2001). The Diagnostic and Statistical Manual of Mental Health Disorders (DSM-IV-TR, American Psychiatric Association, 2000) does not differentiate between adolescent and adult depression. In both adult and adolescent depression five or more of the following symptoms must be present during the same two-week period and mark a change from previous levels of functioning:

- Depressed mood most of the day
- significant weight loss or weight gain / decrease or increase in appetite
- Insomnia or Hypersomnia

- Psychomotor agitation or retardation
- Fatigue or loss of energy
- Feelings of worthlessness or excessive guilt
- Poor concentration and indecisiveness
- Recurrent thoughts of death, suicidal ideation or suicide attempt.

Of the eight DSM-IV-TR symptoms, only one specifically mentions adolescents: under *depressed mood most of the day* a subsequent note indicates that this can appear as an irritable mood in the adolescent population. In their review looking at the characteristic "illness course" of adolescent depression, Roy & Parker (2001) claim that this feature of irritability is interesting because of Rosenbaum's (1993) identification of a subgroup of "hostile and irritable" depressed adults who experience anger attacks and have distinct psychological and neuroendocrine profiles and for whom there is some suggestion of a different biological "type". Roy & Parker (2001) go on to argue that such a pattern could reflect a common non-melancholic subgroup (i.e. "irritable hostile depression') being overrepresented in adolescence, and either mirror the impact of "immature psychosocial, cognitive and coping repertoires on clinical patterning or such a pattern being biologically destined to exceed threshold at an early age" (p.573).

The International Statistical Classification of Diseases and Related Health Problems' 10th Revision (ICD-10, 1996) lists virtually identical criteria as the DSM- IV- TR for depression with the exception that it draws particular attention to the fact that atypical presentations are especially common in teenage depression and that symptoms for this age group are often masked by such behaviours as excessive consumption of alcohol,

drug-taking or exacerbation of pre-existing phobic or obsessive symptoms in adolescence.

Brent & Birmaher (2002) observe that depression in adolescents is not always characterised by sadness, but that it can instead manifest itself as boredom and anhedonia. These authors also note that symptoms of depression can vary depending upon the stage of adolescence, with younger adolescents showing more anxiety-related symptoms, and older adolescents experiencing a greater loss of interest and pleasure. Mondimore (2002) corroborates this differentiation between younger and older onset adolescent depression by noting a more marked prevalence towards morbid thinking in older adolescent depression. Lewinsohn, Rhode, & Seeley (2000) note that nearly 89% of depressed adolescents report disturbances in sleep whilst other symptoms that are frequently reported include a disturbance in weight/appetite (79.5%) and anhedonia (77.3%).

This body of research into the clinical features of adolescent depression provides me with helpful parameters within which to proceed with both participant recruitment and analysis of the phenomenon from which participants deem themselves to have recovered.

Prevalence

Although considerable research has been conducted into the symptomatology of adolescent depression, it remains a pervasive and increasing problem. According to Koplewicz (2009) "The truth is that while we know what works best for adults, we're still very much addressing that question for adolescents" (p. 7). And somewhat more emphatically, Evans, Velsor, & Schumacher (2002) have called adolescent depression

"one of the most overlooked and undertreated psychological disorders" within this period of development (p. 211).

Unfortunately teenage depression is a pervasive problem. According to Brent & Birmaher (2002), at any given time, about 5% of adolescents are depressed, and, without professional help, a major depressive episode can last approximately eight months. Angold & Costello (2001) found that in UK community samples prevalence rates of depression in teenagers 19 and under range from 2-9%. They found that about 2% of adolescents under 19 suffer from severe depression and 4% have mild to moderate depression. They also emphasise that adolescent depression is an increasing problem. According to the National Institute of Clinical Excellence's (NICE) 2005 guideline on adolescent depression, contrary to the marked prevalence of female over male depression amongst adult populations, research into sex differences in manifestations of adolescent depression, yield only inconclusive results. The guideline cautiously notes that the prevalence in females may be higher than that in males, whose prevalence appears to be continuing to rise but at a slower rate. Finally, there is widespread evidence that adolescent suicide rates are rising after an apparent decline between 1997 and 2003 (Grohol, 2007; Flament, 2002) and Brent & Birmaher (2002) arrestingly describe adolescent depression as "a chronic, recurrent, and serious illness associated with substantial morbidity and mortality" (p.670).

Researchers have offered many hypotheses as to why this might be. Amongst these Jacobson, Churchill & Donovan (2002) have questioned General Practitioner (GP) training in adolescent mental health arguing that only a small proportion of teens present explicitly to their GPs with symptoms of psychological disorder and stressing that depressive features are often misinterpreted in primary care as characteristic of

normal adolescent development. These authors also speculate that GPs might feel hampered in assigning diagnoses of depression by reluctance to stigmatise the adolescent with the diagnosis, particularly if they judge that there would be no therapeutic benefit in doing so. Jacobson et al. (2002) wonder whether there might be an inherent GP hope that this is a transient phase which will resolve spontaneously. They argue that the stigma could potentially be attached both to the diagnosis of depression and the involvement of secondary mental health services, or to the need for antidepressant medication.

The impact of primary care training limitations and the potential role of stigma could be responsible for teenagers slipping through the systems' net and experiencing an escalation in depressive symptoms resulting in increased vulnerability and suicide risk. Others have drawn attention to broader societal changes- notably the influence of the media and the growing cult of celebrity in Western culture- as contributing to rising instances of teenage depression and increasing the possibility of suicide amongst this age group (Tyrrel & Griffin, 2003).

The assembled literature on the prevalence of teenage depression enables me to make a strong case for the timeliness and expediency of my study, situating it firmly within its socio-cultural context.

Aetiology

Aetiological theories of depression abound and include genetic, biochemical and endocrine, psychological, social and socioeconomic theories. Whilst none has gained universal wide-ranging acceptance, Nuechterlein & Dawson's (1984) "Stress-Vulnerability" model, integrating these various theories, is cited in the National Institute of Clinical Excellence' (NICE) 2005 guideline on adolescent depression, as

being the model most widely subscribed to amongst mental health professionals on account of its broad clinical utility.

According to this model, young people (or adults) will, to varying degrees, possess a vulnerability to depression that has its roots in genetic, endocrine and early family factors, such as emotional deprivation or physical abuse. This vulnerability will interact with present social circumstances, such as poverty, social adversity or family discord and, ultimately, a stressful life event or succession of events will act as the trigger for an episode of depression (Harris, 2000).

According to NICE's adolescent depression guideline (2005) more than 95% of major depressive episodes in young people arise in teenagers with long-standing psychosocial difficulties, such as "family or marital disharmony, divorce and separation, domestic violence, physical and sexual abuse, school difficulties, including bullying, exam failure, and social isolation" (p. 31). The guideline further specifies that a minority of instances of adolescent depression arise in the absence of prior difficulties, in consequence of an acute, or even a potentially traumatic, life event, often involving serious personal assault.

Goodyer (2000) argues that the vast majority of cases emerge more slowly against a backdrop of family disharmony and/or friendship problems. Kendler (2002) further cautions, that just as there are multiple pathways to the onset of adult depression, the same should be considered to be true for depression manifesting across the lifespan.

This aetiological material crucially sheds light on, and situates within its bio-psychosocial context, the phenomenon under investigation in this study.

Treatment

According to multiple psychopharmacological trials, the only antidepressant perceived to have a positive balance of risks and benefits in the treatment of adolescent depression is fluoxetine (Duff, 2003a, b, c). The NICE guideline on adolescent depression (2005) specifies that this can be used in combination with psychological therapies in the treatment of teenage depression. A multitude of psychological therapies have been considered in the acute treatment of adolescent depression. These include cognitive behavioural therapy (CBT) in individual and group formats (Clarke, 2002) interpersonal psychotherapy (IPT) (Lewinsohn, 1990) , nondirective supportive therapy (Khan & Todd, 1990), psychoanalytic/psychodynamic adolescent psychotherapy (Asarnow et al., 2002), family therapy (Diamond, 2002; Beardslee, 2003), self-modelling (Borzekowski & Rickert, 2001), counselling, guided self-help (Ackerson, 1998), art therapy, and control enhancement training (Christensen & Griffiths, 2003). The 2005 guideline reviews these and a wealth of other studies and rather discouragingly concludes that the evidence base for the majority of these therapies is 'extremely limited' (p.101).

I feel that it is important to point out at this stage that all of the studies reviewed in the guideline evaluating the efficacy of psychological interventions, including those referenced, reflect a positivist epistemology and are designed as randomised control trials (RCTs). As such, I feel that they reduce the concept of recovery to its measurable components which means that they can more easily compare recovery

stages within people over time and across people, but that they cannot examine the individual process of recovery. The studies rely on surveys and other "reliable" and "valid" measures of recovery, using the classic measurement definitions of reliability and validity (Nunnally & Bernstein, 1994), which enables them to usefully and inexpensively evaluate treatment programmes, but which also has the disadvantage of reducing the dynamic, individualised nature of the recovery process into static, general measures and thus, I would question the extent to which these measures are indeed objective, or, for that matter, whether any measure can realistically make claims to objectivity. Furthermore, the studies measure recovery outcomes in short periods of time, all of them in less than two years, which has the advantage of generating a great deal of information over a short period of time but which may also, and crucially in my opinion, truncate the actual process of recovery. An additional point is that the studies reviewed in the guideline view change in terms of linear movement, lending themselves to establishing linear models for statistical analyses, but making it impossible for them to detect non-linear, reciprocal, nested or dynamic trends in their data. And finally, these studies adopt a value-free stance towards participants and towards the phenomenon of adolescent depression under investigation. This might be construed as being impartial and unbiased and thus as potentially being of use to multisite studies and to the assessment of program fidelity, but has, in my opinion, the significant disadvantage of representing a completely unrealistic expectation. I would also argue that it constitutes a disempowering practice for research participants and that it is border-line unethical in that it is potentially misleading.

I would also like to argue, with reference to the particular studies I have referenced above, which were all impeded by high treatment dropout rates, that their findings

need not necessarily unduly discourage us as to the usefulness or otherwise of these interventions. Rather, it is possible that findings primarily shed light on the methodological limitations of the random assignment of potential participants to various treatment conditions. I would argue that it is possible that this process itself sets up a conflict between random assignment and aspects of the recovery process, such as participant choice and self-determination. It is therefore my sense that this research design in itself could be self-defeating in that it could lead to treatment dropout and research attrition.

Prognosis

Quantitative studies reviewed have also reported a poor prognosis for teenage depression. Brent & Birmaher (2002) have emphasised that within two years, about 40% of individuals will have another major depressive episode and that within five years, this statistic increases to 72%. Added to this, there is a large body of evidence indicating a high risk of relapse in adulthood (American Academy of Child and Adolescent Psychiatry, 1998; Goodyer, 2001; Hammen & Rudolph, 2003; Harrington, 2002; Park & Goodyer, 2000). Carr (2006) summarises current evidence on prognosis by stressing that: "while the majority of teenagers recover from a depressive episode within a year, they do not grow out of their depression- major depression is a recurrent condition and depressed teenagers are more likely than their non-depressed counterparts to develop episodes of depression in adulthood" (p.720).

I would argue again that such findings are perhaps unduly pessimistic hinging as they do on questions of definition- how is depression being defined? And how is recovery being conceptualised? Perhaps this pessimism is primarily reflective of

epistemological and methodological limitations rather than constituting an accurate representation of the status quo.

For these reasons I feel that it is critical and long overdue that research adopting a constructivist view of recovery, and collaboratively acknowledging the influence of the researcher on the research process, should be carried out. I hope in this study to uncover aspects of the recovery process through qualitative interviews which will be sensitive to context and which will facilitate exploratory research.

Qualitative studies

Notwithstanding the preponderance of quantitative research into adolescent depression over the past decade, a handful of qualitative studies have been carried out, and these, by definition, adopt a constructivist epistemology since they emphasise knowledge from the participant's perspective or the perspective of the person experiencing the phenomenon of adolescent depression. An advantage of this group of methods is their ability to richly depict the experiences of people and to identify complex, dynamic interactions between people and their environments (Maton, 1990).

Clinical features

According to Farmer (2002), approximately 70% of adolescents suffering from major depression are not receiving adequate assessment and treatment owing, in part, to an incomplete picture of the disorder. He argues that current conceptualisations of teenage depression have failed to fully address "the integration of developmental principles, salient contextual events and the adolescent viewpoint of precipitators, symptoms, and treatments" (p. 567). To improve this situation, Farmer conducted in-depth interviews of five teens diagnosed with depression and analysed interview

transcripts from an interpretative phenomenological perspective (IPA). He found that amongst those symptoms experienced as most characteristic of depression by adolescents, are anger, fatigue and interpersonal difficulties. He notes that anger was the feature of depression most frequently used by participants to measure the depth of their depression. This is an interesting finding which helpfully corroborates Roy & Parker's (2001) investigations into irritability as a particular characteristic of adolescent depression (see quantitative clinical features of adolescent depression, p. 34). Farmer argues that his results demonstrate the need for a heightened awareness of aspects of development unique to adolescence. He also calls for an examination of adolescent-accessible services and urges further clarification of the roles played by friends and siblings in potentially alleviating the burden of adolescent depression.

In a recent study into how adolescent girls understand and manage depression within their peer-group, Pinto-Foltz (2010) seeks to shed light on the role played by friends in potentially assisting sufferers. The findings suggest that when depressive symptoms are present in their peers, teenagers struggle to link the symptoms to depression. Consequently, the authors call for more psycho-education for teenage girls about mental health.

Broadly- speaking, I will bear these findings in mind in the analysis and discussion sections of my study, should participants shed further light at interview on those phenomena identified by Farmer as requiring further study.

Experience of diagnosis

In a similar vein, but with a specific focus on the experience of being diagnosed with teenage depression, Wisdom & Green (2004) emphasise that depressed teens are tending to obtain professional treatment for depression at rates far below the

prevalence of the disorder. These authors draw on a previous study by Wisdom, Clarke & Green (2003) to argue for the probability that low service use is related to numerous teen-specific obstacles to treatment, including anxiety around parental involvement and the meaning of a mental illness diagnosis on a developing identity. Wisdom, Clarke & Green (2003) cite studies by Estroff (1991) and Rogers (2001) to support claims that those teenagers who accept the term *depression* as congruent with their experiences are likely to experience shifts in self-image and identity that might affect both their current functioning and their subsequent follow-through with health-care. More generally, they emphasise that the development of depression typically involves individuals' attempts to attribute their symptoms to either situational or organic factors.

In their 2004 study, Wisdom & Green used a modified grounded theory approach, based on the work of Strauss & Corbin (1998) to specifically address adolescents' processes of coming to terms with explanations for their experience and look at how teens interpret their medical diagnoses. Because they could not find any prior qualitative research addressing the topic of diagnosis, they began by conducting a preliminary focus group with adolescents recruited from the community. This allowed them to gather basic ideas on teens' experiences of health-care and assisted them in drawing up interview schedules. They drew on both focus group interviews and on individual interviews with 15 adolescents who had received a diagnosis of depression to formulate their findings. These revolved around the discovery that adolescents relate to their diagnosis of depression in one of three ways (Wisdom & Green, 2004, p.1235):

1. *"Labellers"* relate to it as a useful way of describing their constellation of feelings. They tend to integrate diagnostic information as a temporary life challenge rather than as an aspect of identity and they take responsibility for their experiences and actively choose how to respond to them.

2. *"Medicalisers"* take on a patient role consistent with a medical approach to depression. This group tends to view the health care provider as responsible for "fixing" the problem and does not take responsibility for its remedy.

3. *"Identity Infusers"* tend to agree with the diagnosis and immediately integrate it into their self-image. This group is most likely to suffer from severe and enduring depression.

Although not directly focusing on the phenomenon of recovery, these findings have important implications for the present study: teens who tend to view a diagnosis as a helpful label are less likely to report wanting to engage in health care services but more likely to report recovery. The findings suggest that, to the extent that helping professionals and family members can assist adolescents in the process of understanding their depression, teens may be likely to feel better. Furthermore, the results challenge traditional positivist conceptualisations of diagnosis. Although some teens seem to find it helpful to label and to name their particular symptoms, the data indicates that for many, such labelling might be at best irrelevant and at worst, harmful, transforming attributions about symptoms into an illness identity that effectively impedes recovery. These findings add an important dimension to the body of quantitative research on the diagnostic criteria of adolescent depression. They remind me of the sensitivity that I will need to employ around the question of

diagnosis in participant recruitment, pertaining as this does, to fundamental questions of identity.

Suicide-related studies

Recent suicide-related studies have examined both teens' and mothers' perspectives on adolescent depression, both analysing data from an IPA perspective. Bostik & Everall (2006) interviewed 50 Canadian teenagers and young adults between the ages of 13 and 19 who were suicidal and found three categories linked to their perceptions of attachment relationships: parental insecurity, peer insecurity, and perceptions of self. Daly (2005) conducted interviews with mothers of suicidal teenagers and identified a recurrent theme of feeling like a failure as a parent.

These studies provide me with interesting insights into those factors which might potentially have impeded participants' recovery processes in my research.

Role of relationships

In another IPA study, Draucker (2005) points out that no prior research had investigated in-depth patterns of interaction between depressed adolescents and significant adults in their lives. In interviews of 52 young adults aged 18-21 who had suffered from depression in adolescence, she found a commonality in their efforts to "feel connected with, anchored by, or guided by important people in their lives." The participants who came to a "positive resolution" with depression were also the ones who spoke of the development of a "meaningful connection" with at least one other significant person in their lives (p. 948).

This is one of the two studies preceding my own to employ a retrospective design, looking back at adolescent depression from the perspective of young adulthood. In

justifying her decision to select young adult participants, Draucker (2005), expresses a belief that participants are thus "close enough to their teen years to have robust memories of how they experienced and managed their distress" (p. 945). As such, she provides me with a methodological precedent for replicating this design in my study. This study also has implications for understanding the recovery process, although it does not address this explicitly, in highlighting that it is not a solitary endeavour, but rather an inevitably social one.

Looking back at adolescent depression

Finally, McCarthy, Downes & Sherman (2008) conducted a modified grounded theory study on "looking back" at adolescent depression from the perspective of early adulthood, which, again, methodologically most approximates my study. Their study was extremely broad in scope, its aim being to "increase the understanding of adolescent depression by interviewing nine formerly depressed young adults regarding their adolescent experiences with depressive symptoms, the help-seeking process, and treatment for this disorder" (p.1). The following five themes emerged from their data:

1. talking was helpful
2. relief was obtained from adolescents' work with counsellors
3. parental (and adult) support was significant
4. friends were most often helpful
5. a realistic optimism was present when looking back at the experience of adolescent depression

These findings again have implications for the study of recovery as a process, and for those factors which might assist participants in this process. Again, however, the study is not specifically focused on recovery, indeed I would argue that its very breadth detracts from any particular in-depth focus on any aspect of the phenomenon of adolescent depression.

The present study

I situate the present study within this relatively recent tradition of qualitative research into adolescent depression. My research will be methodologically distinct from previous studies however. Whilst research to date on adolescent depression has employed either IPA or a modified grounded theory approach to data analysis, I will analyse interview transcripts through the lens of Narrative Oriented Inquiry (Hiles & Cermak, 2008). As well as being part of a tradition of research into adolescent depression, the present study also adds to the body of existing qualitative studies on processes of recovery from mental illness.

Lead-in to Methodology

It has been my aim in this introduction to situate the present study in relation to both traditions of quantitative and qualitative research into the phenomenon of adolescent depression, and in relation to existing research into the phenomenon of recovery from mental illness more broadly. I hope that it has become clear that whilst there is a wealth of literature in these various domains, the present study is original in terms of its content, with its exclusive focus on the phenomenon of recovery from adolescent depression. It is also unique in approaching this phenomenon from the perspective of Narrative Oriented Inquiry. It is to this particular approach that I now turn in chapter

two in which I propose to outline the epistemological rationale for my choice of methodology in detail.

Methodology

Introduction to Methodology

In this chapter I will begin by reiterating my research aims and I will move on to make explicit the process by which I arrived at a consideration of Narrative Oriented Inquiry (NOI, Hiles & Cermak, 2008) as the optimal methodology through which to explore narratives of recovery from adolescent depression. I will lead the reader through my reflexive process commencing with an exposition of the rationale for the qualitative nature of the study. I will then move on to provide an overview of narrative theory and to make explicit my epistemological position in relation to the project. Broadly speaking it will be my contention that a narrative approach will allow me to uphold a social constructionist commitment to the culturally situated nature of individual experience without losing sight of the experiential, phenomenological reality of my participants' self-experience. Following this epistemological discussion, I will describe the research design with specific emphases on participant selection and data collection and move on to delineate the process of NOI in action. Finally, I will address issues surrounding the ethical concerns of the research.

Research aims

This project purports to explore narratives of recovery from teenage depression, which is an increasing (Carr, 2007) and pervasive (Flament, Cohen & Choquet, 2002) problem in the UK. Whilst there is an extensive evidence-base examining the causal and maintenance factors of teenage depression, there is comparatively little research focusing on the process of recovery from depression in adolescence. I aim to re-dress this balance in the present study by filling the gap in the literature.

I am interested in how adults in their twenties, both male and female, who have experienced an episode of depression at a time of heightened self-definition and identity formation (Erikson, 1968), tell stories of reclaiming a sense of self, or otherwise, from their illness. I am also interested in how, and whether, participants' accounts can elucidate the interface between internal and interpersonal and social components of recovery processes.

Narrative Inquiry -a qualitative methodology

The rationale for using a qualitative methodology arose from my reflexive consideration of epistemological concerns. As recommended by Willig (2008), I asked myself a series of reflexive questions to tap into my epistemological stance. Answers to these questions are reproduced here in brief by quoting from my reflexive log (Extract 2.3.1) and I expand upon them throughout the chapter. Given my answers to these preliminary questions, and my desire to elicit rich and textured personal descriptions of recovery processes, I align myself with qualitative research's understanding of the subjective nature of truth, and with its view of knowledge as fluid and relative (Jarvis, 1999).

Extract from reflexive log

1. What kind of knowledge do I aim to create?

"... knowledge that reflects the reality of my participants' worlds and experiences."

2. What are the assumptions that I make about the (material/ social/ psychological) world(s) which I study?

"That there are a number of truths for each person and that the truth that is presented to me in an interview will perhaps vary from another truth."

"The narratives that are shared with me in interviews will have been influenced by the social world and experiences of the participant and notably the experience of recovery from teenage depression."

3. How do I conceptualise the role of the researcher in the research process?

"The researcher is an active instrument in the research process."

"The researcher does not attempt to deny the role/influence that she will inevitably have on the interview/analysis and the whole process."

"The researcher recognises that purely inductive research is not possible due to the active and present role of the researcher in the research process and that the "truth" is viewed through many lenses, including: the participant's (which is already filtered both through their experiences and through their recollection of their experiences) and the researcher's own beliefs and experiences."

4. What is the relationship between myself and the knowledge which I aim to generate?

"My challenge will be to balance subjective beliefs/experiences via reflexive awareness and to allow the data to demonstrate its own points without being unduly steered by my assumptions."

Following the acknowledgement that a qualitative approach would be best suited to the requirements of the study, I engaged in an exploration of the various epistemological orientations within the qualitative methodologies. Amongst these, I identified narrative approaches as corresponding most closely to my epistemological stance, which is both social constructionist and phenomenological in nature (I will expand upon this in a later section of this chapter).

I reached the conclusion that a narrative method would facilitate an exploration of the *what*, *how* and *why* aspects of my data, namely: *What* are young adults' narratives of recovery from teenage depression? *How* are they told? And *Why* are they being told in this way at this point in time to this particular audience? Narrative researchers believe that there are "individual, internal representations of phenomena– events, thoughts and feelings – to which narrative gives external expression" (Squire, Andrews & Tamboukou, 2008, p.4). I deemed that a narrative methodology would allow me to shed light on individuals' internal representations of recovery processes through exploring their externally expressed narratives about this experience.

Narrative Analysis

Defining Narrative

By "narrative" I refer to a particular type of discourse, that is "the story", "the type of discourse that draws together diverse events, happenings and actions of human lives" (Polkinghorne, 1996, p.5). Before proceeding to specify the definition of narrative upheld in the current study I find it apt to point out that a range of definitions of the term exist in the literature and that these vary according to theoretical discipline (Riessman, 2008). Riessman, one of the chief proponents of narrative analysis, proposes the following definition of narrative for the purposes of sociological and psychological research: "long sections of talk – extended accounts of lives in context that develop over the course of single or multiple research interviews or therapeutic conversations" (Riessman, 2008, p. 6). She elaborates that, in a narrative, "a speaker connects events into a sequence that is consequential for later action and for the meanings that the speaker wants listeners to take away from the story. Events perceived by the speaker as important are selected, organized, connected and

evaluated as meaningful for a particular audience" (Riessman, 2008, p.3). I align myself with Riessman and Polkinghorne in understanding narrative as a constructed and organised interpretation of a sequence of events.

Narrative Functions

Central to the narrative approach is the elaboration of a phenomenological appreciation of the exclusive "order of meaning" constitutive of individual human consciousness (Crossley, 2000; Polkinghorne, 1988). Salient to this "order of meaning" is the human experience of temporality. Crossley (2000) emphasises that this understanding of time differs markedly from that predominating in the natural sciences. Polkinghorne (1988, p.4) specifies that this realm of meaning is not related to a "thing" or to a "substance" but to a dimension of "activity" which incorporates both "time" and "sequence".

It is by taking this fundamental notion of activity as a starting point that MacIntyre (1981), Carr (1986) and Sarbin (1986) have formulated the idea that human psychology is basically narrative in structure to the extent that individuals constantly project themselves backwards and forwards in a way that maintains a sense of coherence, meaning and identity. Along similar lines, Polkinghorne (1988) defines narrative as a fundamental scheme for linking individual human actions and events into a contextualized and integrated whole and Hiles & Cermak (2008) argue that human beings' urge to narrate constitutes "a basic property of the human mind" (p.149). Bruner (1990) expresses a variation of the same idea when he describes narrative as having "a dual landscape- events and actions in a putative real world occur concurrently with mental events in the consciousness of the protagonists" (p.51).

Common to all of the above and succinctly expressed by literary theorist Ricoeur, is the idea of narrative's primary purpose being to "synthesize the heterogeneous" (Ricoeur, 1991, p.23) and to bring order to disorder. Situating this claim in the context of other qualitative methodologies, Crossley (2000) argues that "the characterisation of human experience as one of constant flux, variability and incoherence, as manifest in many discursive and postmodern approaches, fails to take sufficient account of the essential unity and integrity of everyday lived experience" (p.11). According to these theorists, narrative plays a central role in the construction and maintenance of self-identity (Gergen & Gergen, 1993; Linde, 1993; Crossley, 2000; McAdams, Josselson, & Lieblich, 2006).

This claim is especially pertinent to the current research project, committed as it is to exploring the identity implications of recovery from teenage depression. McAdams (1993) presents a narrative theory of human identity and argues that each of us discovers what is true and meaningful, in our lives and in ourselves, through the composition of "heroic narratives of the self" (p.11). This challenges the traditional view that our personalities are formed by fixed, unchanging characteristics, or by predictable stages through which every individual travels. According to McAdams (1993), human beings *are* the stories that they tell and, crucially for the purposes of the current study, "we first become self-conscious myth-makers in our adolescent years, when we confront head-on the problem of identity" (p.36). As such, McAdams emphasises that the transition from adolescence to young adulthood is a particularly pertinent stage in the development of human identity.

In addition to this already normative heightened phase of narrative identity construction in adolescence, Murray (2008) suggests that human beings' instinct to narrate becomes particularly pronounced when individuals experience disruption to

their everyday routines which instigates a desire to regain control over an ever-changing world by making sense of it. The current research project is interested in the experience of adolescent depression as just such a departure from the norm and endorses Jacobson & Greenley's (2001) suggestion that, key to recovery processes, is the regaining of an internal locus of control which allows individuals to become active agents in their own lives. As such, I will be particularly interested in ways in which participants endeavour to bring order to disorder and to "synthesize the heterogeneous" through narrating recovery. I am interested in Crossley's (2000) claim that "the experience of traumatic events, such as serious illness is instrumental in facilitating an appreciation of the way in which human life is routinely narratively configured ... throwing into radical doubt our taken-for-granted assumptions about time, identity, meaning, and life itself " (p.11). Thus I will be interested in how participants' lives will be narratively configured as "normal" prior to their disruption through depression. I will also be interested in how participants might then go on to restore a sense of order and connection through narrative, and thus to re-establish a semblance of meaning in their lives.

Sikes (1997) maintains that telling stories is a fundamental form of human communication and that they "let us know we are not alone, that other people have gone through the same things and have felt like we have" (p.23). Riessman (2008) argues that, as such, human beings' narratives are not static stories but rather dynamic formulations which are uniquely individual while also being influenced by society, culture and interpersonal relations. Taking this point further, Crossley (2000) emphasises that individuals' narratives should always be viewed as strategic and be situated within broader structures of discourse and power in order to ensure a comprehensive understanding of their implications and ramifications. Thus it would

be erroneous to conceive of human beings' narratives as uniquely individually authored. I will rather conceive of my participants' narratives as products of broader historical and discursive factors and will therefore interpret them as being both collaboratively and individually generated, an outcome of complex interactions between the individual and his or her circumstances.

The Rise of Narrative in Research

It is only since the mid 1980s, following a greater acceptance of postmodern research methods in the human sciences, that narratives have come to be viewed as a valid means of knowledge production (Riessman, 1993; Skeggs, 2002). Challenging traditional positivistic research philosophies, Sarbin, a chief proponent of the "narrative turn" in psychology, claims that: "to have any success in understanding human action, a completely new approach, closer to the way in which historical events are explained and understood is needed" (In Hiles & Cermak, 2008, p.148).

Broadly speaking, narrative analysts are interested in how individuals use language to assemble and sequence events and to communicate meaning to a particular audience. Attention is paid not only to *what* is said, but also to *how* and *why* it is said. In a broad description of narrative analysis, Riessman (2008) deems the following questions to be especially pertinent to the narrative analyst: "For whom was this story constructed, and for what purpose? Why is the succession of events configured in this way? What cultural resources does the story draw on, or take for granted? What storehouse of plots does it call up? What does the story accomplish? Are there gaps and inconsistencies that might suggest preferred, alternative, or counter-narratives?" (p.11). I will be guided by these questions in the present study. The weight placed on each will vary in accordance with research aims.

Epistemological Positioning

It became quickly apparent as I reviewed the literature in the areas of both recovery in mental health and adolescent depression, that the dominant epistemological perspective that has guided research in these fields over the past decade has been a positivist, conventional or scientific one. This differs from the epistemological assumptions of the present study which are reflected in the exploratory tone of my research title: "Exploring Narratives of Recovery from Adolescent Depression."

I was guided by Willig (in press) as I subjected my ideas to reflexive scrutiny early on in the research process (see Extract 3.1) in order to stake my epistemological claims. These are both social constructionist and phenomenological in nature.

I adopt a social constructionist position because I view individual participants as creating their own reality. I assume a phenomenological stance in that I am exploring this reality. The assumption of this combined position was influenced by Hiles & Cermak's (2008) claim that narrative, whilst rooted in a social constructionist ideology, is progressively moving "towards a more inclusive view that incorporates both a rich description of socio-cultural environment *and* the participatory and creative inner world of lived experience" (p. 151). I align myself with Crossley (2000) who upholds an equivalent epistemological stance halfway between realism and constructionism. She maintains that it is possible to believe that what respondents say carries some significance and "reality" for them beyond the boundaries of the specific interview context, and that this is part of their "ongoing story" which is itself a manifestation of their psychological and social worlds.

My epistemological position is also situated midway between relativism and realism. In the words of Schafer (1992) I believe that "it is especially important to emphasize

that narrative is not an alternative to truth or reality, rather, it is the mode in which, inevitably, truth and reality are presented. We have only versions of the true and the real. Narratively unmediated, definitive access to truth and reality cannot be demonstrated. In this respect, therefore, there can be no absolute foundation on which observer or thinker stands; each must choose his or her narrative" (pp. 14-15).

I believe that the epistemological perspective that guides researchers has implications for how research is carried out and that certain tacit assumptions and common practices, such as the tendency for researchers to assume the scientific neutrality of the third person in referring to themselves in their research, implicitly reflect a positivist or conventional perspective. I thus refer to myself in the first person throughout this study.

Reflexivity in Narrative Research

According to Hiles & Cermak (2008), researcher reflexivity and transparency are essential and can become "a means for critically inspecting the entire research process" (p. 152). Bearing this in mind, I kept a detailed reflexive research log throughout the research process in which I took the time to reflect on how my personal life, expectations and experiences would influence the collection and interpretation of the data. This practice obliged me to consciously challenge pre-conceptions, beliefs, and expectations derived from my personal experiences and to evaluate how these might impact on research procedure.

With respect to data collection, I noted that my very presence at interview would influence narratives told. As Murray (2008) notes: "although the narrator tells the story, the character of the story told will depend upon to whom the story is being told, the relationship between the narrator and the audience and the broader social and

cultural context" (p. 116). Bearing this in mind, I acknowledged that my active participation in the narrating process through the use of body language, reflections and questioning would all contribute to shaping the data collected.

I also deemed reflexivity to be essential to the analysis stage of the research where I would further contribute to shaping the data by "giving meaning" to it (Willig, in press) and by viewing the narratives told through the lens of my own beliefs, knowledge and experiences (Riessman, 2008). I believe that my continuous commitment to reflexively examining the impact of my presence at interview on stories told will enable me to "bracket off" this impact at the analysis stage and free me up to explore participants' contexts, and their place within and negotiation of these contexts, more successfully.

Validity in Narrative Research

In positivistic research methodologies rooted in realist philosophies validity refers to the extent to which research findings reflect certainty, truth and reality. As outlined above, however, narrative research takes issue with notions of absolute objective truths. Consequently, in line with Riessman (1993) and Webster & Mertova (2007), I feel that the notion of validity needs to be redefined for the purposes of narrative research.

Polkinghorne (2007) argues that the validity of narrative research lies in the strength of its data analysis and in the reliability of its data. I support this view and believe that the degree of validity given to claims in narrative research should be proportionate to the strength, power and soundness of the arguments and theoretical underpinnings provided to support them. Bearing this in mind I will endeavour to maintain transparency at all stages of the research process. I will provide word-for-word

excerpts from transcripts to support my analysis and be open about the impact of my own background and experiences on my interpretations throughout the research process.

Research Design

Participants

Ten participants were recruited to tell their stories because I deemed this to be a sufficient number to be able to engage deeply with the interview transcripts in the time frame available. Participants were adults in their twenties with a history of adolescent depression from which they deemed themselves to have recovered according to Anthony's (2000) definition of recovery: "Recovery does not necessarily mean the disappearance of suffering and symptoms or the complete restoration of functioning; rather it means living a meaningful life beyond the restrictions of the illness" (p.159). My decision to confine the sample to this age group was based on research indicating that, with the passage of time, memories of emotional events and responses are increasingly reconstructed and inferred on the basis of current appraisals of events (Wessel & Wright, 2004; Levine, 1997). This was in keeping with the concepts outlined above of story-telling and recovery as dynamic, ever-evolving processes. Since the research was specifically concerned with exploring experiences of recovery from adolescent depression, recruitment was aimed at adults in their twenties.

Both male and female participants were recruited. Whilst there is evidence to show that women are twice more likely than men to experience depression in adolescence and adulthood (Nolen-Hoeksema, 2002), there is also evidence to indicate that the experience of depression in adolescence is more likely to lead to suicide in males than in females (Schaffer & Gutstein, 2002; Murphy, 1998). Thus it is difficult to make

assumptions as to whether depression is more widespread among females than males. It may be the case, although this is both a stereotype and a generalisation, that internalised socio-cultural constructions of femininity and masculinity influence men and women's help-seeking behaviours and make it more likely that women will receive formal diagnoses of depression than men, whilst the latter's symptoms may be more likely to remain undiagnosed, but no less real. In addition to this argument, which warned against discriminating between men and women in recruitment, I was primarily concerned with exploring the language and narrative structures used to relay the phenomenon of recovery from teenage depression rather than in focusing on a specific population per se.

Recruitment

Participants were recruited via the snowballing technique. The recruitment flyer, outlining research aims and participant inclusion criteria (Appendix A, p.174), was attached to an email and sent to various private contacts. This email was then forwarded by these contacts to potentially interested individuals. The individuals who received this email were asked to contact me directly via telephone or email if they wished to take part and dates and locations for the research interviews to take place were agreed. The participants who volunteered to partake in the research were in turn asked to email the flyer to any other individuals they knew who would be eligible and might like to participate in the research.

Data Collection

Half of the interviews were conducted at the participants' homes, one was conducted at my home and four took place in a research room at City University. Upon meeting

at the agreed location, I presented participants with an information sheet detailing the research aims and proposed procedure (Appendix B, p.175). I then asked them to sign a consent form (Appendix C, p.176) confirming their awareness of being a voluntary participant in the project and outlining their rights as a participant. I subsequently asked them to sign a consent form regarding the confidentiality agreement on the use of audio tapes (Appendix D, p.177). These initial measures, aimed at protecting participants, were also important in terms of reducing "researcher power" (Bannister, 2006) in making it clear that the data material was owned by the participant.

Once the initial brief had taken place, semi-structured interviews were conducted. I adopted the topic-focused interview style recommended by Langdridge (2007) which consists of asking an initial broad and open question aimed at facilitating narration and then intervening with appropriate probes throughout the interview in order to encourage participants to expand on their narratives (See Appendix F, p.179 for an outline of the interview schedule). Whilst a list of potential probes was drawn up prior to interviewing, some probes arose spontaneously in response to particular narratives. I felt this to be in keeping with the flexibility deemed by Riessman (2008) to be a prerequisite of narrative interviewing.

I conducted a pilot interview to practise my narrative interviewing technique and reflected upon this experience in my research log. This enabled me to become aware of the fact that I was perhaps intervening excessively with probes and helped me to minimise this tendency in subsequent interviews. I continued to learn from each interview as the research process progressed, and, as I became more practised, I felt that my technique improved.

I kept a reflexive log throughout the interviewing process in which I recorded ways in which I could have shaped and influenced participants' accounts (i.e. how had I listened, encouraged, interrupted, digressed, initiated topics and terminated responses?). I expanded on these notes by also detailing my thoughts, feelings and initial reactions after each interview. The reflexive log was used to shed light on my role as "co-producer" of each narrative and was used to inform and enrich data analysis.

Interviews were between fifty and eighty minutes in length. At the end of each interview, I thanked the participant, switched off the equipment and then held a conversation with self-disclosure, in order to debrief. Josselson (2007) suggests that an interview should always end in this way because inviting participants' reflections on their experience is a way of beginning to say goodbye. Thus participants were asked how they had found the process and were given the opportunity to voice any concerns and discuss any issues that may have arisen. Most of the participants described the interview process as having been an interesting, albeit an unexpectedly emotional, experience. I had anticipated this eventuality by providing participants with a list of contact details for psychological resources/support agencies (Appendix E, p.178) should this be required.

Self-care

I was also mindful of the importance of self-care throughout the data collection process and bore in mind Rager's (2005) observation that research topics that are emotionally laden can have a powerful impact on the researcher. As such, I ensured that I had time to debrief myself after each interview and to write in my reflexive diary. This enabled me to work through any difficulties I might have encountered

should my own beliefs have been activated during interviewing. It also enabled me to become aware of, and, where appropriate, to challenge my own assumptions and ideas as to the meaning of the interview, and to acknowledge instances in which these might have been excessively influenced by my own experiences and beliefs. Keeping a reflexive diary in this way enabled me to employ the idea of 'bracketing' off any processes that were occurring for me in further interviews.

Data Protection

The interviews were digitally recorded and the sound files were stored in protected folders on a personal laptop and on an external hard drive and kept for the duration of the research process. These files will be destroyed upon completion of the research project. I then transcribed the interviews verbatim into written word documents and stored them in protected files on my personal laptop and an external hard drive. All identifying information, such as names of individuals and places, was changed in the transcripts of the interviews in order to increase participant anonymity. Given the personal nature of individual narratives however, I felt that it would detract from their rich content were all identifying information to be omitted. And so, as an extra precaution to ensure participant anonymity, full interview transcripts are not provided in the appendices of this research and all the direct quotes drawn from the interviews to highlight and support the analysis are sufficiently anonymised to ensure participant confidentiality. Clandinin & Huber (2010) recognise this issue and emphasize that narrative inquiry research texts demand a high level of attention to ethical matters. Further ethical considerations are addressed in the final section of this chapter.

Data Analysis

Within the field of narrative research Plummer (2001) has identified thirteen different theoretical approaches to data analysis. These vary according to theoretical discipline and definition of narrative upheld (Riessman, 2008). Given this potentially bewildering array of choice, Riessman (1993) emphasises the importance of selecting the method of analysis most suited to the specific aims of the research question.

Upon detailed discussion with Riessman herself following her lecture on narrative research at the Institute of Education in London (February 2010), I identified Hiles & Cermak's (2008) method of Narrative Oriented Inquiry (NOI) as most aptly meeting my research aims. NOI (Appendix G, p.181) is a psychological approach to narrative research which "explicitly strives towards transparency, inclusivity and critical pluralism in the collection and interpretation of narrative data" (Hiles, 2007, p.3). Deeply rooted within the hermeneutic tradition, NOI posits that narratives, rather than simply offering accounts of events, actually highlight the human perspective and interpretation of these events, i.e. what matters to a particular individual, and Hiles (2007) observes that it is useful to think of stories as "matterings". Moreover, NOI posits along with Ricoeur, that this reflects an implicit narrative intelligence that is foundational to our engagement with life. Of paramount concern in NOI is the role of narrative intelligence in actively constructing an individual's reality and identity (Bruner, 1990). Hiles and Cermak's situated-occasioned action perspective, incorporating Mishler's (1986) idea of a joint construction of meaning as well as his premise that narratives powerfully reflect a crucial means of knowledge production corresponds well to my epistemological stance outlined above.

Echoing my commitment to reflexivity at every stage of the research process, Hiles & Cermak (2008) argue that their overriding concern in the development of NOI was in making its procedures and underlying assumptions transparent. Far from constituting merely a consideration of potential sources of bias, they argue that reflexivity effectively promotes transparency. In this vein the authors stress that "not only must we be clear to others about what we have done and what we have found, but we must also be clear to ourselves, at every step and at every stage, about what it is that we are doing" (Hiles & Cermak, 2008, p.161).

Hiles & Cermak (2008) describe NOI as having emerged from the integration of three significant sources. The first of these is Herman & Vervaeck's (2001) argument for the distinction between *sjuzet* and *fabula* in narrative discourse. Hiles (2007) argues that this distinction is crucial to understanding "the role that narrative plays in the construction of identity." The fabula is the "content" of a story, i.e. the original events as they might actually have occurred and consists of bounded motifs that are fixed by the story being retold. This is in contrast to the sjuzet which is the "form" of the narrative, i.e. the window onto the events offered in the re-telling of the story. The sjuzet consists of unbounded motifs, defined as not essential to the story but determining how the story is being retold. The point is that stories are not simply related as events but are retold in a particular way, in a particular sequence, from a particular point of view. The participant "positions" him or herself in relation to these events, and this positioning is coded not simply in the selection of the story (i.e. content) but in the sjuzet, in the particular way in which it is being retold. Hiles & Cermak (2008) do not recommend simply analyzing sjuzet and fabula separately, but recommend using this basic division to help create the appropriate focus for further analysis.

In exploring the distinction between sjuzet and fabula Hiles (2007) suggests that an analysis of the sjuzet is especially important in understanding the ways in which participants construct their own identities. Hiles (2007) introduces the idea of *identity positions* and contrasts this with the idea of subject positions. He accepts that, as human beings, we live in a socio-cultural reality and that a consequence of this is the subject positions that we are placed in. But he argues that the social-constructionist approach fails to take account of personal agency, of what Foucault (1984) calls "practices of the self". Borrowing Jean-Paul Sartre's (1943) terminology, Hiles aligns subject-positioning with "being-for-others" but insists that human beings can "endorse, celebrate, resist and contest" the subject-positions offered to them (Hiles 2007, p.34). He terms *identity positioning* an individual's capacity to position him or herself in relation to the socio-cultural practices which surround him or her. For Hiles (2007), through its emphasis on analysing the sjuzet, NOI facilitates a subtle examination of the expression of identity positions.

The second key source informing NOI is Lieblich, Tuval, Mashiach & Zilber's seminal text *Narrative Research* (1998). These authors' approach to narrative analysis offers four interpretive perspectives based upon the recognition of two underlying dimensions: *Holistic and Categorical.* This corresponds to Allport's distinction between "idiographic" and "nomothetic" types of research (1962). In working from a categorical perspective, the original story is dissected and sections or single words belonging to a defined category are collected from the entire story or from several texts belonging to a number of narrators. In contrast, in the holistic approach, an individual's narrative is taken as a whole and sections of the text are interpreted in the context of other parts of the narrative. Combining these two dimensions, Lieblich et al. derive four approaches to analysis: *Holistic-Content, Holistic-Form, Categorical-*

Content and Categorical-Form. These constitute perspectives (ii) to (v) in the NOI model (Appendix G, p.181).

In the Holistic-Content stage the researcher takes the research interview/narrative in its entirety and focuses on the content presented by it. When looking at separate sections of the story the researcher analyses the meaning of the part in view of content that emerges from the rest of the narrative. This kind of reading is familiar in clinical "case studies". The Holistic-Form based mode of analysis finds its clearest expression in looking at the plots or structure of the complete narrative. Does the narrative develop as a comedy or tragedy, for example? Does a story ascend toward the present moment in the narrator's life or descend toward it from more positive periods and situations? The researcher may search for a climax or turning point in the story, which sheds light on the entire development. The Categorical-Content approach is more familiar as "content-analysis". Categories of the studied topic are defined and separate utterances of the text are extracted, classified and gathered into these categories. The Categorical-Form mode of analysis focuses on discrete stylistic or linguistic characteristics of defined units of the narrative. For example, what kind of metaphors is the narrator using, or how frequent are his passive versus active utterances? Defined instances of this nature are collected from a text or from several texts as in the Categorical-Content mode of reading.

The third key source informing NOI is Emerson & Frosh's *Critical Narrative Analysis in Psychology* (2004). These authors offer the approach of critical narrative analysis which they stress is "sensitive to subject meaning-making, social processes and the interpretation of these in the construction of personal narratives around 'breaches' between individuals and their social contexts" (Emerson & Frosh, 2004, p.9). They characterize this as psychosocial, embracing: "the critical gains of discourse

analysis…but combining it with a focus on the active constructing processes through which individual subjects attempt to account for their lives" (Emerson & Frosh, 2004, p. 7).

NOI in action

Steps one to seven below illustrate NOI in action. Each step brings subtly different perspectives to understanding narrative research but interpretive overlaps also occur. Hiles & Cermak (2008) argue that rather than constituting a problem, such overlaps constitute a strength of NOI.

1- Persistent engagement with *raw transcript* through repeated readings. Involves returning to audio recording to clarify details.

   Arrangement of *working transcript:* text arranged down left-hand of each page with a wide margin to the right where notes and annotations can be made. Text is broken down into segments- a segment being roughly a self-contained episode, or "move" in the telling of the story.

2- Identification of sjuzet, i.e. single words, phrases and sometimes entire segments that are concerned with emphasis, reflection, asides, interruptions, remarks and various expressions representing the sequence/causality/significance of events being related in the story. Result is a transcript in which the sjuzet seems to bracket the fabula. A good test of this phase of analysis is to read through the non-underlined text, ignoring the sjuzet entirely. The fabula will then read as a simple coherent story, albeit rather "flat" in presentation.

3- Holistic-Content perspective: focus on fabula in a holistic reading of the text. Identify turning points in story as a whole and formulate core

narrative- i.e. identify broad perspective of most predominant theme that permeates entire text.

4- Holistic-Form perspective: focus on fabula. Consideration given to narrative typology- genre, narrative progression and narrative cohesion. Decide whether story is romance, comedy, tragedy or satire. Identify whether plot is progressive, regressive or steady. Establish overall progress and shape of narrative.

5- Categorical- Content perspective. Focus on fabula. Break text down into self-contained areas of content and submit each to thematic analysis. Equivalent to content analysis (Riessman, 1993). Definition of themes running through the text which will emerge in grounded theory manner. Involves identifying meaning-bearing utterances pertinent to the original research question.

6- Categorical-Form perspective: focus on sjuzet. Choose a theme for analysis and carefully explore the linguistic features and plot devices that offer emphasis and style in retelling the story. Such features might include: adverbs, mental verbs, denotations of time and place, past/present/future forms of verbs, passive and active verbs, intensifiers, disruptions of chronological and causal progression, repetitions, etc…

7- Critical Narrative Analysis- exploration of functionality of narrative. How do participants position themselves in relation to their narrative?

Ethics

General ethical considerations

The current research adheres to the ethical guidelines outlined in the British Psychological Society's "Code of Conduct, Ethical Principles and Guidelines" (2005) which lays out acceptable research practice and protects the rights of participants involved. In accordance with these guidelines, all participants involved in the current study will have the right to the following:

Informed Consent – Information on the aims, procedures and use of findings will be provided. The consent process will be formalised by asking the participant to sign a consent form before the interview takes place.

No deception – Any questions that the participants have regarding the research will be invited and answered fully.

Right to withdraw – Participants will have the right to withdraw from the research at any time, even after an interview has taken place. No questions will be asked regarding reasons for withdrawal and all the participants' data (i.e. interview tape and transcript and consent form) will be destroyed upon withdrawal. Participants will also be informed that certain interview questions need not be answered and that they can terminate the interview at any point.

Debriefing – Participants' views of the interview process and content will be sought at the end of the procedure. Participants will be provided with a list of contact details for psychological resources/support agencies.

Anonymity – Participants will be advised that all identifying information will be removed from interview transcriptions or changed considerably.

Confidentiality – Participants will be advised that all materials will be stored securely and that tapes and transcripts will be destroyed at the end of the study.

Ethical approval was sought and granted from the Department of Psychology at City University following the submission of a research proposal outlining the aims and procedure of the research. Ethical approval from other agencies was not required.

Ethical considerations in narrative research

Clandinin & Huber (2010) maintain that, in addition to compliance with the above legal and procedural aspects, narrative researchers should also adhere to additional ethical considerations given the relational nature of their research. Of paramount importance, in ethical terms, is the respect the researcher should at all times demonstrate towards participants' stories. Given that these stories are viewed by narrative theory as reflections of personal identity, Clandinin & Huber (2010) stress that it is essential for narrative researchers to express "an attitude of empathic listening" in attending to them. They argue that this can be achieved "by not being judgmental and by suspending their disbelief as they [narrative researchers] attend to participants' stories" (p.15). Respect for participants' stories continues to form an ethical imperative throughout the research process in both the analysis and write-up phases so as to ensure that the research text respectfully represents participants' lived and told stories (Clandinin & Huber, 2010).

Further, it is noteworthy that narrative research is interpretative in nature suggesting that the researcher will formulate meanings for participants' narratives which might deviate significantly from participants' understandings' of their narratives. This issue of interpretation is thought to be the central ethical problem in narrative research (Clandinin & Huber, 2010; Squire, 2008). Acknowledging this issue Smythe &

Murray (2000) assert that "given the [narrative researcher's] unique perspective on people's stories, it is imperative that they claim some ownership and control over the narratives they study" (p.325). This echoes Bar-On's (1996) claim that interpretative responsibility should be assumed by the researcher in that, once a narrative had been analysed, the text belongs equally to the researcher and to the participant. Bar-On (1996) further emphasises that researcher interpretations are merely this, interpretations, owned by the researcher. In order to address this issue in the current project, I will attend to the interview texts with the utmost respect and attempt to accurately relay participants' told stories by presenting word-for-word excerpts from the transcripts highlighting and supporting the analysis. I will also state clearly throughout the analysis stage that interpretations made are my own and do not reflect any form of absolute truth.

Analysis

Introduction to Analysis

In this chapter I strive towards transparency in closely adhering to Hiles & Cermak's (2007) model of Narrative Oriented Inquiry (NOI) in order to analyse transcripts gathered. The primary paradigm assumption informing data analysis is the fusion of a situated-occasioned action perspective with a view of the individual as actively engaged in processes of meaning-making, organisation and agency. The model is illustrated in Appendix G and I will now offer a brief recapitulation of the steps entailed in NOI, and implemented in this chapter, prior to presenting findings.

Following the implementation of the narrative interview (Appendix F) and the transcription of audio texts to produce raw transcripts, I read through the material several times. The purpose of this persistent engagement with the written transcript was to build up a picture of both the emerging themes, as well as a picture of the story as a whole. Each text was then broken down into segments. Whilst some approaches advocate presenting the transcript simply as numbered lines, I am of Hiles & Cermak's (2007) opinion that such lines are more or less arbitrary, and that, since narratives are basically a sequence of episodes, or events, it makes more sense to set out the transcript as a numbered sequence of segments, these being self-contained micro-episodes, or "moves", in the telling of the story. This was relatively straightforward and transparent and merely required a little practice. The text was then arranged down the left-hand side of each page with a very wide margin to the right where annotations were made.

Appendix H provides a typical demonstration of a working transcript, with the highlighted colours representing particular themes pertinent to the excerpt.

NOI differs from discourse analysis and thematic analysis in that there is a need to do justice to the story as a whole as well as to the elements that make it up. The point is that stories are made up of two inter-related and inter-penetrating parts: i.e. *what* is being re-told (the content or *fabula* in NOI) and *how* it is being re-told (the form or *sjuzet* in NOI). I agree with Hiles & Cermak (2007) that, from a psychological perspective, both of these require close attention, and thus, in step two of the analysis I divided working transcripts into sjuzet and fabula, by convention underlying the sjuzet in the working transcript. The result was a transcript in which the sjuzet seemed to bracket off the fabula, the fabula then reading as a simple, coherent story, albeit rather flat in presentation (Appendix H). This initial separation of form and content enabled me to proceed with subsequent stages of NOI which alternate in turn between a focus on content or fabula, and form or sjuzet.

In the Holistic-content phase the focus was on the fabula. I identified a core, overarching theme within each transcript and then compared this across transcripts, with a view to establishing a communal theme. This, in turn, led on to the next stage, in which the focus was on formal issues, but with a focus on the plot rather than on the fine details of the sjuzet. Issues of overall narrative typology were considered in this phase, before then proceeding to a Categorical-Content perspective. At this stage, the focus returned to the fabula as I utilised the earlier divisions of working transcripts into segments, to submit each to thematic analysis. In the Categorical-Form perspective, I selectively honed in on the particular stylistic device of personification to explore ways in which this

was employed across transcripts. This, in turn, opened the way for a more detailed micro-analysis of formal issues, in which I carried out a thorough critical narrative analysis.

Holistic-Content perspective

In this phase of the analysis I engaged in holistic readings of each transcript to identify participants' broad perspectives of the most predominant theme permeating their stories. Central themes were subsequently compared across transcripts and a salient communal theme was established.

Formulation of core narratives

Identity development emerged as a pivotal theme within and across participant narratives. Participants are keen to communicate how the experience of teenage depression has contributed to shaping their sense of self in adolescence and beyond, to early adulthood, and to the time of interview. All participants conceive of recovery as being synonymous with a process of developing self-awareness and as involving an element of self-discovery.

Table 1- Towards Self-discovery

P1	p. 21 It's that journey through form depression to who I am now, that's created the person I am…I feel richer because of it
P2	p. 90 I feel like I was changing all the time until I got to about 23. I think it was a massive identity crisis. I didn't really know who I was and what I should be and what made me happy, but I do know now.

P3	p.47 I think it's been part of the creation of me as a person.
P4	p.38 For me, recovery was about definitely going back to that sense of almost reconnecting with myself, almost recovering that part of myself that had got lost.
P5	p.22 I think I'm very emotionally mature, and from what I've been through I think I'm very aware of my mind now.
P6	p.56 Rather than playing with the raw material of my life, I found it was better to put it onto canvas, onto a page. It kind of helped me to find a way to self-actualise.
P7	p.3 it's taken me so long to discover myself and sort of figure out who I am.
P8	p.37 I have spent a lot of time trying to understand myself
P9	p.26 I guess maybe I just got better at reading myself
P10	p.31 I think I just became more honest with myself and started to relate to parts of me that had always been there in a different way.

Holistic-Form perspective

Turning my attention to issues of form, I proceeded to consider narrative typology in order to establish an overall sense of the progress and shape of each narrative. This was informed by Frye's seminal *Anatomy of Criticism* (1957) in which the literary critic argues for a finite number of basic story forms that people tend to adopt in narrating life experiences. Frye's discrimination between comedy, romance, tragedy and irony enabled me to focus specifically on each

interview's overall narrative tone and to conclude that each was predominantly a Romance or quest narrative.

In accordance with the conventions of the genre, participants' narratives are typically optimistic in tone and celebrate a process – often conceptualised as a journey- whereby protagonists embark on quests to "navigate" (P8), "explore" (P9), and ultimately conquer their demons, thereby triumphing over adversity. Struggles to master those aspects of identity experienced as problematic are vividly conveyed in expressions of confrontation and, even, by P6, through martial imagery of fortifications and battles. Common to all transcripts is a sense of this journey's being arduous and requiring effort and a degree of commitment to self-exploration. For this reason several participants describe the importance of enlisting support- usually in the form of therapeutic guidance- to assist them along the way.

Table 2- Romances

P1	p.13 the effort I put in and the strength I've gained through the journey mean that I guess I'm glad it's happened.
P2	p.90 I had to work really hard to get here and I don't think I would have if I hadn't gone and gotten help.
P3	p.54 I went from attacking it, to exploring it and at some point along the way I transcended it.
P4	p.8 I didn't know who I was when I was a teenager, I sort of knew where I wanted to get to, but I didn't know how to get there p.39 But there's definitely, you definitely know if you're on the right path I think.

P5	p.34 So recovery for me, the way I see it now is that erm I've gone from a point of complete loss, like limbo and I've now reached this kind of fortress, I've reached this point where I've got this this wall and I can still see the limbo behind but there's just no way I could fall behind that wall, that wall is there. p.36 An ongoing journey, but it's not a losing battle. It's now very much a winning battle.
P6	p.30 I think ultimately I came off it because I wanted to make a bare fist of things.
P7	p.4 it was all a bit of a rocky ride all the way through my teens
P8	p.31 it did just feel like something that I had to negotiate and navigate for myself. p.41 It's likely that I will always have to cope and grapple with these things inside of me.
P9	pp.4-5 Constantly I was trying to fight it… then I started kind of exploring p.39 it feels like this is just my path, these are just the obstacles that I have to cross
P10	p.17 There are times when it's felt like a bit of a battle to be honest, but then I reached a sort of truce with myself and I'm much calmer now.

Notwithstanding their emphases on an ultimate transcendence of difficulties, at several points, in a couple of narratives in particular, there are passages more suggestive of an Ironic than a Romantic genre. In these instances sadness, and

apparent resignation, predominate. The protagonists become antiheroes as they feel temporarily defeated by the ambiguities of their situations, which feel insurmountable.

Table 3- Antiheroes

P1	p.6 I guess It didn't feel like it was happening to me it's just that that was my existence, there was an inevitability to it.
P3	p.14 you could fight something if you could feel that actually one day you'd be able to put it behind you, but because I felt like it was an integral, a physical part of me, it would be like cutting off my own leg, you just couldn't do that, cut that part out of me, it would just keep coming back.

For these participants, the journey towards self-acceptance entails a shift to a less ironic perspective. As P3 eloquently puts it: "There was no way to either switch those feelings off or to logically counter-argue them or to counter-attack…but the point is, you know, why have the argument? I think intellectually you constantly try and make sense of everything around you and accepting things does not come easily." Such insight enables these participants to regain an ultimate mastery over their own narratives concordant with the Romance genre.

Categorical-Content perspective

Returning to issues of content, I proceeded to identify turning points within each narrative, prior to engaging in a comparison of turning points across transcripts. The working transcripts were broken down into segments, a segment being a

roughly self-contained episode or move in the telling of the story. It emerged during this stage of the analysis that participants' narratives were universally structured temporally as a succession of five self-contained segments, each with its own distinctive themes. Each segment, or self-contained episode, functioned as a turning point or catalyst, propelling the story forwards.

In the first segment the participant speaks broadly about his or her early adolescence and introduces an adolescent self characterised by a sense of internal turmoil. At this stage the participant describes having felt torn between a tendency to want to withdraw, on the one hand, and a simultaneous impulse to strive to fit in, so as to feel socially accepted, on the other. Participants universally refer to having experienced these tendencies as antithetical and divergent.

Table 4- Segment 1: early adolescent experience of tension between withdrawal and inclusion

P1	p.4 I'd get to school and be like a child, it was like I didn't want to speak. But then I was also like, pushing 'Come on! Go out and don't be so miserable'.
P2	p.2 I tended to leave myself on the periphery, although I was always part of the group that was quite popular
P3	p.1 I would withdraw a lot, but I also felt as if I had to do an awful lot in order to try and fit in
P4	p.2 When I was about 14 or 15 I felt more isolated. I dunno the sense of people not really understanding me or feeling different to other people… I did try to fit in though, because that was very

	important to me to feel that everyone accepted me, everyone liked me.
P5	p.1 I always for some reason alienated myself from people… I was part of a group of people, but I was kind of not really one of the flock.
P6	p.3 I isolated myself, while at the same time I was still trying to be social, and to be, you know, fun and creative.
P7	p.1 It was like this tug of war, there were times when I was really good at covering it up and I'd be able to be outgoing, but then I'd just go home and just feel awful again.
P8	p.6 friendships were really important to me but I would feel like I had nothing to offer socially and, you know, I wasn't, there was no point me spending time with friends because I had nothing to offer them.
P9	p.2 I'd gone from being quite popular and outgoing and then I just kind of shrunk you know a bit into myself.
P10	p.2 It's like I was torn between feeling like I wanted to be on the outside and also desperately wanting to be accepted.

This leads on to a second segment in which participants describe having experienced an external event, most often a particular instance of interpersonal difficulties, as having thwarted their attempts at social inclusion. This, in turn, leads to an intensification of feelings of isolation accompanied by a mounting sense of crisis. Participants describe these feelings as building to a point at which they are experienced as overwhelming and unbearable.

Table 5- Segment 2: attempts at inclusion thwarted, intensification of feelings of isolation

P1	p.5 I'd try to talk to people but it was almost like having weights attached to my mouth and the thought of trying to smile was just impossible…Things culminated and became this blanket cloud.
P2	p.9 those were actual times of real despair, like I just didn't know what to do and I felt completely drowning, like drowned in this, I don't know, feelings of just, I was completely at a loss of what to do.
P3	p.5 I felt as if I was cut off from everyone else around me, that I wasn't part of sort of the normal flow of activity, particularly social activity around me. I felt very vulnerable and I felt as if nobody understood me.
P4	p.5 I felt like there was no way out of it. There was no way to figure it out and make everything right. I didn't know how to match up these feelings of kind of disconnection and not feeling kind of normal
P5	p.10 I didn't have any of my friends anymore, so what I did, I locked myself in my room at home, for months and just kept to myself, I wouldn't go outside or talk to anyone.
P6	p.2 I didn't feel the same as anybody else, I felt like I was kind of…I dunno I suppose I felt thwarted really.
P7	p.6 It felt like quite a big thing to explain to him what was happening and yeah he didn't get it, he was sort of like you know

	'what have you got to be depressed about?' and didn't understand, and that was hard. It made me just want to pull back and not be around anyone.
P8	p.7 So I went through a particularly bad phase of not engaging socially with anyone at all because I just couldn't see the point.
P9	p.2 And my friends couldn't, they didn't know quite how to deal with that and it was almost then like the rejection from them because it was just like 'that's too much for us to handle'. Then the lows were a lot deeper and a lot longer and kind of you know, literally, I mean not being able to actually get out of bed you know.
P10	p.3 They didn't get it and I grew tired of trying to explain. We grew apart and I sunk further and further down.

The sense of building to a crisis ushers in phase three in which participants describe outside intervention being sought, often at the behest of concerned friends or family members. Outside intervention is variously described as GP diagnosis of depression, and/or, prescription of medication, and/or, initial encounters with mental health professionals.

Table 6- Segment 3: seeking help

P1	p.9 there was one friend, she understood better, and she said- 'you have to see a counsellor'…
P2	p.14 a couple of my friends were really worried about me at the time, so I decided to go and talk to my uncle cos he's a doctor and he then had a friend who works at the Priory…, so I went and

	spoke, saw this psychiatrist.
P3	p.13 I voluntarily committed myself to a psychiatric unit.
P4	p. 12 So I took myself to the university counselling services
P5	p.10 I decided that I needed help…I was classified as clinically depressed by a couple of doctors.
P6	p.9 I went to the GP and I told him what had happened and he put me on Seroxat.
P7	p.7 My mum said 'look, you're not yourself, you're completely, just completely withdrawn, you're not very happy at all and I think you need to go to the doctors'… I went to the doctors and they said 'You've got depression'.
P8	p.15 Me and my mum went to see someone then. To be honest I can't remember whether they were, yeah it was just our GP.
P9	p.7 It was there that I started seeing a counsellor and that I went to the doctors.
P10	p.8 So I went to the GP and he said I had depression.

In the fourth segment, participants describe their reactions to the outside intervention sought in segment three. Broadly speaking, these reactions are characterised by emotions ranging from defiance, indignation and a measure of aloofness, to perplexity and a sense of confusion and disorientation.

Table 7- Segment 4: reactions to help received

P1	p.14 It was a rocky start, I went to counselling but I thought 'Oh

	this won't work', it was fucking horrid, just sitting there... I was so uncomfortable talking about myself
P2	p.16 I'd gone to the counselling people just to say you know 'I've had these problems' and actually they were really shit and this woman basically told me she didn't think anything was wrong with me...I felt it was quite judgemental at the time. p.17 He put me on Prozac, which I had the most awful reaction to ever, I became a complete insomniac, I didn't sleep for about 5 months.
P3	p.13 I got up the following day, the following morning and they'd put me on anti-depressants for the first time in my life. I'd never been on anti-depressants, er, and it was horrendous, the side effects were terrible... I actually thought I was going mad for the first time.
P4	p.12 with the counsellor, it was almost like a 'Oh I can ignore that part of me for the moment, no one needs to know about that part of me.'
P5	p.18 They're a really funny thing anti-depressants because you take them and it's almost like it just shuts the negative voice up...but weirdly I kind of now wanted to hear what it had to say.
P6	p.29 I was on Seroxat for a while. I came off it- why did I come off Seroxat? Because I didn't like the idea of taking drugs that affected your brain in the way that Seroxat affects your brain.
P7	p.8 When I started taking the anti-depressant it completely lifted me out of it but I think it made me a bit numb to everything else.

	So I went back to the doctor and I said 'I think you've given me too much, I think I'm a bit too uplifted' and she went 'you can't take too much'. It was strange.
P8	p.16 We only went once and erm and it doesn't live in the memory as being something that was particularly significant or helpful
P9	p.8 I remember just trying to off-load troubling incidents from my childhood and he was like half-asleep… So I was a bit like 'ok' but then I'd go to the doctors to try and see if I could get like CBT… but inevitably it was like 'oh she's a student' so they just kind of immediately put down the 10mg of Citalopram and they'd be like 'Oh take that'. And I didn't really want to do that at all, because it was almost like I wanted to properly fix myself, I didn't want like a short-term fix. I didn't want to then come off them and be confronted with…
P10	p.11 The GP diagnosed me with depression and it felt strange. I wasn't sure what to make of it, it didn't really feel right.

Finally, in phase five, participants speak of having attempted to come to terms with their various experiences by synthesising them. Participants unanimously refer to recovery in terms of an attempt at integration of divergent aspects of themselves. Rather than becoming a 'different person' participants speak of feeling "fuller" and "richer" (P1). Key to this process, for many participants, is a commitment to increased self-honesty which facilitates a transition from an antagonistic relationship with depression to a more accepting one. Participants also universally relate to depression as an aspect of identity rather than as a

medical phenomenon, as P3 puts it "you never recover from it in any sort of medical sense, because it's not, it doesn't feel like an illness, it's a part of you."

Table 8- Segment 5: attempt at synthesis of divergent experiences

P1	p.19 It has to be a changing point when I went to see this second therapist…somewhere in there I must have gained the belief that 'I can change'. For me now looking back I really feel like I'm almost a different person or actually a fuller, richer person.
P2	p.46 I then went to see another therapist who was a, she was a humanistic therapist who I saw for two years, and she was a bit of a god-send. p.65 I feel like I'm sort of recovered now from, basically, my life being completely ruled by a horrible voice inside my head always telling me to sort of destroy myself…I think that whole part of my personality and my life is definitely still there but I've accepted it and almost forgiven it, I'm more honest with myself, so now I feel like I can stop fighting it and I'm able to actually focus on what I'd like to do with my life.
P3	p.54 personal therapy helped me to be open about it, it's not a secret anymore. p.49 you never recover from it in any sort of medical sense, because it's not, it doesn't feel like an illness, it's a part of you, although I must say that… as I'm getting older I feel a lot more comfortable with it, I'm less overwhelmed by it because you know I've become used to it.

	p.51 before the depression would just overwhelm me, push me so far that that would be it, all meaning would be taken from you know, both rational and emotional, and spiritual would be taken from the world around me. But now it wouldn't, I've kind of accepted it and got to know it and it can't push me that far. It can only push me as far as a deep melancholy.
P4	p.31 I think for me it's been a bit of a slow development. I would have liked to have thought that I could've figured it all out in my teenage years and got sorted by the time I was 18 and then gone 'I'm an adult', but it doesn't work like that I don't think. p.33 I had to learn to acknowledge what I was actually feeling and listen to myself, trust myself. p.38 for me recovery was about definitely going back to that sense of almost reconnecting with myself, almost recovering that part of myself that had got lost. It was an actual effort to rescue it, in a way, recover it, bring it back, hold it and get to know it and reincorporate it into myself.
P5	p.12 He was amazing basically, he built an unbelievable rapport. And I trusted him. He said to stop taking the anti-depressants so one day I just stopped. p.29 it's almost like me and my, the voice in my head, we work things out together now. I have got to know other parts of me as well and they have enriched me and given me more values in my life…It's an ongoing process.
P6	p.49 CBT helped despite myself especially as the therapist was

	quite hard on me, so I found that really, really helpful. p.56 rather than playing with the raw material my life, I found it was better to put it onto canvas, onto a page. It kind of helped me to find a way to self-actualise.
P7	p.29 I don't think you can ever be completely better from it. I think it's something within you that's always there but it's learning how to deal with it p.36 the counsellor made me realise that it's about getting a balance. p.58 It was very much a learning curve. And it's taken me so long to get that balance.
P8	p.15 My mum is a psychotherapist so I guess I ended up turning to her for a bit of informal, in-house therapy. p.24 I don't see it as something which started at 17, 18 and had to be gotten rid of to go back to how I was before. I think it's something that has always been a part of my nature and character and for a period I wasn't able to control it. It expanded and reflected my whole life.
P9	p.26 So I created an acceptance of the depression and I kind of liked that idea because now I know that it is, it is just part of me and I can't you know, I don't think it will ever disappear… I guess maybe I just got better at reading myself p.39 I've tried to become a bit kinder to myself and not feel so hung up that there's something desperately wrong with me. You know just kind of relax a bit about it. You know not be so, I don't

	know, not be so embarrassed by my reflection.
P10	p.28 The depression is a part of me and rather than shutting that part out now, or being ashamed of it, I listen to it and try to love it a little bit more. It wasn't easy getting to know that part of me though, and it's still a work in progress.

Categorical-Form perspective

In this section of the analysis, I focus in on the ways in which participants use personification to dramatic effect in communicating a sense of depression as an aspect of identity. Participants universally and repeatedly refer to their sense of themselves as being composed of multiple elements or "parts", a word that recurs frequently (see red highlighted sections below).

Recovery is typically conveyed in terms of integrating multiple parts or mastering particularly troublesome parts. Participants alternatively personify depression as a vulnerable and child-like entity (see yellow highlighted sections below) in need of nurturing and protection (see pink highlighted sections below) or as a demonic, tyrannical voice (see green highlighted sections below) which must be confronted and mastered (see blue highlighted sections below), but ultimately however, also listened to and understood (see dark green highlighted sections below).

Table 9- personification of depression as an aspect of identity

Vulnerability

'Part'

Nurturing and Protection

Inner demon

Listening and understanding

Confrontation and mastery

P1	p.27 I think of the part of me that gets depressed as a child part within me. It got so lonely, so frightened, like a kid hiding away. It's me and my child now.
P2	p.65 I feel like I'm sort of recovered now from, basically, my life being completely ruled by a horrible voice inside my head always telling me to sort of destroy myself…I think that whole part of my personality is still there but I've stopped fighting it.
P3	p.30 there was this part of me that had been completely suppressed by the depressed bit that just spoke up inside me, I could almost hear it saying 'what the fuck are you doing? this isn't you actually. This isn't who you are.'
P4	p.17 I had to define myself, I had somehow got to tame that character in me who felt different… I felt like I was on stage and I didn't want anyone to really notice me…yeah, it was a performance. p.38 For me recovery was about definitely going back to that sense of almost reconnecting with myself, almost recovering that part of myself that had got lost. It was an actual effort to rescue it, in a way, recover it, bring it

	back, hold it and get to know it and reincorporate it into myself.
P5	p.19 I saw my mind as this kind of, this room full of people, full of… different parts of me. There was one in particular, telling me the most awful things, horrible, horrible things, all day every day literally, telling me how useless I was, how everyone hates you
P6	p.46 I used medical knowledge of depression in quite a lazy way to rationalise some of the less edifying parts of my personality
P7	pp.28-29 I think it's a part of you that's always there but it's learning how to deal with it
P8	p.32 if feels like there is just one part of my character that's quite destructive (laugh). And at some stage you know I had to, god I make it sound like a scene out of Star Wars or something, but you know I had to face the destructive element of my character and find a way to cope with it.
P9	p.16 It's almost like a self-protective thing… If people don't want to see that part of me then I'd rather, if I'm on some ridiculous like hyper, I'll let that person out but the other end of the spectrum is not quite so pleasant so, you know…
P10	p.37 The depression feels like a really young, frightened part of me that needs to be looked after. I ignored it for a while but it started crying louder and louder.

These metaphorical representations of depression as an aspect of self possessing its own feelings and behaviour bring the idea of depression vividly to life. The struggles depicted are intensely dramatic, as P8 remarks "I make it sound like a

scene out of Star Wars", and, as both listener and reader, I was captivated by what seemed to amount to each participant's "performance" (P4) of identity through narrative.

Critical Narrative Analysis

At this stage of the analysis, I turned my attention to a broader consideration of formal issues in order to shed light on the functionality of participants' narratives. A key consideration, with this in mind, was the examination of how participants positioned themselves in relation to their narratives.

Who is telling this story and how is it being told?

Participants universally tell their stories in the first person, predominantly from the perspective of the recovered adult situated in the present of the interview, and retrospectively narrating events from memory.

Table 10. Retrospective narration

P1	p.24 stepping back now I can see that…
P2	p.1 looking back now I suppose I think 'god I'm quite glad this is all over'
P3	p.4 From where I stand now it's clear to me that…
P4	p.6 Actually, I think I'll now go back a little bit earlier than that…
P5	p.13 It seems obvious to me now as I sit here remembering
P6	p.27 Thinking about it now, I was certainly unhappy then…
P7	p.1 It might be a bit easier to go back a little bit further.
P8	p.2 looking back now it's obvious that it was related to pressure

	and stress.
P9	p.2 obviously in hindsight now I can see it.
P10	p.9 Looking back I can understand now.

This adult first person narrator is omniscient in the sense that he or she knows all the facts of the story being told and is able to create characters – such as those personifications presented in the Categorical-Form section- and to report on their thoughts and feelings in the third person.

Table 11. Narrator reports on characters' internal states

P1	p.27 That child was so frightened, it needed some support.
P2	p.65 That horrible part felt completely useless.
P3	p.30 and the little voice rebelled and finally stood up for itself.
P4	p.16 it was like that character was on stage, she'd put on a great performance.
P5	p.20 God I could be lazy when I was like that, lying in bed all day
P6	p.12 And that kid just pulled away and did his own thing
P7	p.18 There was nothing I could have said to me back then, I was stubborn.
P8	p.23 My therapist explained that I had been ignoring that part of me and it had become upset.
P9	p. 41 it was unwise to let her out, she was dangerous, she could ruin things.
P10	p.43 I guess there was a fear that it was angry and might sabotage

	my efforts.

Omniscience is further conveyed in the narrator's propensity to suspend the action described in order to comment on it, or to summarize what is happening, giving his or her own interpretations and evaluations of events.

Table 12. Suspension of action and commentary

P1	p.24 And that's where it all came from.
P2	p.6 So those were difficult times.
P3	p.9 I can see that I must have been very depressed then.
P4	p.6 That's probably been quite a key feeling
P5	p.12 I think that sums things up really.
P6	p.21 So, from the outside you could say that things were looking up.
P7	p.14 I would say that many teenagers go through similar things.
P8	p.29 Perhaps there was a logic to it I guess.
P9	p.28 I guess I was sort of leading a double life at the time.
P10	p.32 Well, it was a good way to get through that phase anyhow.

Alongside these pauses for reflection, the narrator is adept at pacing the events of his or her story to dramatic effect, often portentously presaging occurrences to come.

Table 13. Dramatic pacing

P1	p. 6 And I remember, I mean this is, well we'll come onto this…
P2	p.32 And then things became more complicated.
P3	p.27 and it would get worse, I mean it would really get worse
P4	p.19 That was just the start.
P5	p.21 When I think of what was to come, oh dear…
P6	p.27 I suppose that was a precursor for what happened next.
P7	p.13 And then, as quickly as that had kind of started it suddenly stopped.
P8	p. 47 It was so abrupt, I didn't know what to say.
P9	p.32 there are so many things to say, so much happened.
P10	p.43. Oh, where to start? It all happened very quickly, but it's confusing.

This omniscient narrator is quite self-consciously telling a story, applying literary terminology to life events and engaging directly with the interviewer to offer reflections on the generation of new insights through the process of narrating itself.

Table 14. Self-conscious literariness and reflections on process of narrating itself

P1	p.4 So the beginning is a bit of a mess.
P2	p.4 I think that's been a kind of theme, a predominant theme, even into my adulthood

P3	p.57 I can give you pithy aphorisms
P4	p.27 it's only talking about it now that I kind of am really thinking about how much I kind of struggle in my own head all the time.
P5	p.45 So I guess, there's a beginning, middle and, a sort of, end.
P6	p.51 it means that I construct Grand Narratives like the one I'm telling you to justify things
P7	p.19 So I think that's kind of my story
P8	p.36 as I've said a couple of times when I've been answering questions, I'd never thought, you know I'd find myself coming to realisations that I'd never had in telling you this.
P9	p.13 it's kind of strange to now feel totally comfortable talking about it in the past tense
P10	p.30 But now I'm backwards-projecting. Maybe that wasn't what I thought at all.

And finally, this narrator is relational in that he or she directs the story being told at the interviewer, the audience in this context. In doing so, the narrator often sheds light on issues of power- as the interviewer is both implicitly and explicitly- cast as an "expert" (P.10) on the area under investigation. Narrators alternatively propose a species of co-authorship (P1) or lead a co-exploration (P6), invite reassurance as to the status of their narrative as valuable (P2, P9), position themselves, occasionally defiantly, as "rival" experts (P3, P10) second-guessing the interviewer (P7), or explicitly celebrate the opportunity to share their stories in this context (P4, P5).

Table 15. Stories in context

P1	p.12 I mean what I'll say, shall I say what had the most impact for me and whether you want to explore it?
P2	p.32 I often feel quite stupid saying these things because I feel like a cliché
P3	p.53 I know a bit about CBT treatments of depression
P4	p.54 I felt like 'yeah great, this is brilliant, this is the voice I never had, this is the chance I've got I guess to explore that a bit'
P5	p.44 Thank you because I like, you know I like talking.
P6	p.2 Well, I'll take you through critical life events.
P7	p.35 I don't know whether you were kind of psychoanalysing it you'd wonder if it was because I didn't have that much control when I was younger
P8	p.104 I feel like I have something that I have something that I could talk to you about, whether it's been 100% right or whatever (laugh), I don't know,
P9	p. 57 I hope this has been helpful for you.
P10	p. 38 You're the expert, but that's my story.

In sum, authoritative and masterful first person narrators with omniscient attributes are telling these stories. These first person narrators correspond to participants' adult sense of themselves as individuals who have recovered and are telling their stories to the interviewer in the present. Whilst certain participants demonstrate a measure of unease in attempting to ascertain the status

of their particular story as valuable research material, this is fleetingly expressed, and is universally outweighed by a passion for events narrated.

Obstacles to smooth narration

Direct quotes and syntax disruption: the effects of passion

Narrators commonly employ direct quotes to convey the felt nature of moments of particular emotional intensity. These bring the past vividly to life and convey immediacy and passion as the audience is taken straight to the heart of the action. Interestingly, however, such moments tend to be either preceded, or followed, by a disruption in syntax, specifically- a shift in verb tense, from a prevailing, and grammatically correct, past tense (highlighted below in pink) to an incongruous present tense (highlighted in yellow). Such disruptions in the smooth telling of the story are fleeting but, nonetheless, have the effect of temporarily blurring boundaries between past and present, as confusion momentarily prevails and the past becomes present. It is as if the narrator has gone from being a poised observer of this story, to being an active participant within it- has been, in a sense, sucked in to the drama evoked. Such an illusion is quickly dispelled, however, as the quotations come to an end, distance is reinstated and the past tense is once again appropriated.

Table 16. Direct quotes and syntax disruption

Past tense

Present tense

P1	p.8 that kind of brought me down to the idea that, 'is this the way

	that it's always going to be?' That was the big thing, mmm I mean because I look into the future and go well 'If this is exactly how things are then it looks quite a bleak future'.
P2	p.69 whilst I was trying to get better she was always so supportive of me but I sort of feel like 'fuck off, why are you trying to tell me what to do and you're not doing anything'
P3	pp.19-20 'What's the point of, what is the, the point of going up every time if you're going to come down again? You know, it's not worth it. Going up is not worth the coming down afterwards, it's just not worth it. And it's never going to change' and that's the worst thing, feeling that it will never change.
P4	p.13 I'd be like, it's like, 'why can't you just feel normal?', 'Why can't you just fit in?' you know 'That's how you should be.'
P5	p.42 I told tell myself to be strong, yeah, I say 'be strong and believe that you're going to be powerful and strong and happy one day because it will come'.
P6	p.40 and there was a sheer drop and I thought, I'm thinking 'I'm having a lovely time but all the things that have happened in the last few years are never going to go away, I could just, when he goes to the bar, I could just, whoosh, off the edge. It would be beautiful, it wouldn't hurt that much'
P7	p.22 People would phone up and say 'do you want to go for a drink' and I'm like 'I just don't want to see anyone'
P8	p.11 he doesn't, he didn't, he was sort of like you know 'what have you got to be depressed about?'

P9	p.3 I thought it was just, kind of you know, I'm ,'maybe it's just teenagey angsty stuff', you know and like, 'I'm just going through a depressing time or whatever and it'll be fine'
P10	p.51 That's the way it was and it just makes me think, you know, 'I'm fed up with this, I won't put up with it anymore'.

Narrator's resistance to 'depression' as external phenomenon

Participants universally display a measure of unease in relating to depression as an external phenomenon imposed from without. This would appear to involve a discrepancy between participants' felt sense of the experience of depression on the one hand, and their assumptions, and internalisations, of what the term might or should mean, more objectively, on the other. Participants seem to struggle with objectifications of depression, which are typically portrayed as the preserve of doctors or mental health professionals, the researcher, possibly, being conceived as one of these, as suggested by certain participants in Table 16 above. Participants' attempts at narrating depression as an external phenomenon range from attempts at making their experiences fit with objective understandings of the term, albeit jarringly, to outright rejections of any valid notion of exteriority.

P1 and P2 both attempt to assimilate their experiences of depression with more objective understandings of what this might constitute. In doing so, however, expressions of hesitation are juxtaposed with declarations of certainty and the overall effect is to create a sense of vacillation and confusion. Moments of hesitation are highlighted in pink in Table 17 and remarks conveying emphatic self-assurance are highlighted in green.

Table 17. Juxtaposition of hesitation and certainty

Expressions of hesitation

Expressions of certainty

P1	p.1 I'm just wondering whether it was depression when I was in Australia… No, I think university was where it really kicked in.
P2	p.34 I would consider myself definitely kind of recovered from symptoms of depression

For P3, P5, P6 and P7 there is a sense whereby receiving a diagnosis of depression renders them temporarily passive. Participants go from being active agents in their own stories and the subjects of their own sentences, to being passive objects or recipients of information, or medication, from professionals. This sense of passivity and objectification is underscored in several cases by verbs employed denoting a cold impersonality. These are highlighted in blue in Table 18. Participants respond to their sense of objectification either, by communicating defiance, as is the case for P3, or by expressing a sense of disorientation and confusion.

Table 18. From active agents to a sense of passivity

Verbs denoting impersonality

P3	p.32 And they came and told me that I had chronic depression and that you know, and I said, almost instantly I said 'I'm not mentally ill, I want to leave'.

P5	p.19 I was classified as clinically depressed by a couple of doctors.
P6	p.29 I went to the GP and I told him what had happened and he put me on Seroxat.
P7	p.7 I went to the doctors and they said 'You've got depression'. And it was weird because they gave me, I can't remember at all, but they gave me an anti-depressant.

This sense of tension and confusion is taken further by P5, P7 and P9 who express a sense of conversations at cross purposes and misunderstandings culminating in a sense of discombobulation and absurdity, expressions of which, both verbal and non-verbal, are highlighted below in red. There is the sense of a gulf between how participants feel and what is important to them, and the help that is offered to them. This chasm, apparent in the quotes below, sheds further light on tensions between felt-experiences of depression and external understandings of the condition.

Table 19. At cross-purposes

Expressions denoting a sense absurdity or discombobulation

P5	p.40 they're a really funny thing anti-depressants because you take them and it's almost like it just shuts the negative voice up… but weirdly I kind of now wanted to hear what it had to say.
P7	p.8 when I started taking the anti-depressants it completely lifted me out of it but I think it made me a bit numb to everything else. So I went back to the doctor and I said 'I think you've given me too much,

	I think I'm a bit too uplifted' and she went 'you can't take too much'. It was strange.
P9	p.12 you know when you have that thing at the doctor's where you have 'how depressed are you?' down to 'do you want to kill yourself?' I'd always be like 'no, no, I'd never want to kill myself' and they'd be like 'Oh, well you're not that bad'. *(laugh)* And I'd be like 'But I am, just because I don't want to kill myself', they'd be like no, no you're fine, you don't want to kill yourself'.

Finally, P4 and P8 explicitly take issue with the notion of depression as an external phenomenon, as being something that "happened to" them. This refutation is emphatic and is rhetorically underscored through repeated negative assertion, as highlighted in yellow below. Instead, the felt-sense of depression as an aspect of identity, as distinct from the connotations of its 'label', is reiterated.

Table 20. Refutation of depression as outside occurrence

Negative assertions

P4	p.2 I didn't necessarily think that anything major was happening to me, I didn't identify with anything about the word 'depressed'. I couldn't have that as part of me, to kind of label it in such a way, it's so constricting. It feels so wrong and it feels so negative. There's this real negative association, 'people who are depressed' like they're separate from, from the normal people. p.15 Rather than saying 'Oh you had depression as an illness' or

	something like that, it felt like 'No, there's something wrong with me'.
P8	p.25 it's not like something, I mean it is in a way, but it's not like a big event happened at 17,18 that then changed me.

Obstacles to narration transcended through expressions of interiority

All of these stylistic features, from disruptions in syntax preceding or following direct quotes, to instances of juxtaposition of hesitation and certainty and emphatic repetitions of negative assertions, function to somewhat disrupt narrative flow across participant narratives. The narrator fleetingly flounders as his or her position of polished omniscience is momentarily impinged upon by a sense of prevailing confusion and uncertainty.

But such stumbling is very much temporary, and is amply compensated for, as the narrator overcomes any confusion pertaining to the nature of depression, by expressing an often lyrical, and always fluent and absolutely confident, sense of depression's fundamental interiority as an aspect of identity.

Table 21. Reclaiming depression as an aspect of identity

P1	p.12 it was very much an internal thing for me.
P7	p.48 I think that it's interwoven into who I am in the same way that my positive emotions and my other emotions, you know my feelings and characteristics are. It's woven into you like a tightness, like a strand, It's a rope, they're all just woven in rather than an event or something that happens and changes you. It doesn't feel like an illness.

P8	p.37depression isn't, for me it isn't something that, I was a person and then depression came along and now I'm a different person. Depression has probably been there I imagine ever since I was a small baby having a mother who had chronic depression. I imagine that depression's been a part of me since I was unable even to realise that that was my mother.
P9	pp.28-29 I think it's something within you that's always there
P10	pp.52-53 I needed to learn to actually experience it and not be overwhelmed by it as opposed to not actually experiencing the feelings. That's what I needed. Erm, so it's interesting I don't see myself as having depression, I don't see myself as someone with depression, it's just that sometimes, I am depressed.

There is a passion and a sense of flow to participants' speech as they expound their thoughts on this notion. For all of these participants, depression is an intimate, private experience and, in the words of P10, there is nothing generic about it "I don't see myself as having depression." The lyricism and poetry of the imagery, employed by P7 and P8 in particular, potently convey this sense of intricate intimacy, as they refer to depression's being "interwoven like a rope" into the very fabric of identity and evoke the image of the "small baby" helplessly intertwined with its mother.

In a variation on the same theme, other participants contrast notions of depression as an illness, with a sense of its' constituting a vision of reality, or a way of being in the world. The implication seems to be to equate the state of depression with an existential stance, one which is thrust upon the participant,

rather than freely chosen, although P5 implies that depression is something that she has almost brought upon herself "I've always chosen to go there and look at these things." Whilst this is the exception, rather than the norm, participants do share a sense of depression's residing in an expansive and spacious "realm", "that's not easily defined by labels" (P6) and all participants convey this sense with absolute clarity and lucidity.

Table 22. Depression as existential stance

P2	p.17 he told me I was suffering from symptoms of depression but I didn't, and don't, really know what that is or means. I just knew that it was real, I knew how much it was affecting me.
P3	p.31 All throughout the depression I never felt that I was going mad at all, in fact I felt like I was absolutely clear as anything. I never felt it was a mental illness, I thought it was just a state of being and I was attuned to the reality of what my life was going to be like.
P5	p.44 I don't feel like it was a medical thing, I feel like it was very much an existential struggle. You know these things are real, they're there for everyone to look at and very much I've always chosen to go there and look at these things.
P6	p.44 For me personally it was less medical and more philosophical and existential. You're actually going to a realm that's not easily defined by labels. Maybe labels are there to make things easier to cope with but for me, I think part of me's always known that that's not how I feel.

Conclusion

In sum, the model of Narrative Oriented Inquiry has permitted a thorough exploration of participants' narratives and has enabled me to shed light on experiences of recovery from adolescent depression.

A full picture has emerged of individuals who have come to make sense of their experiences of teenage depression by casting their recovery in terms of a process of self-discovery. Key to this process, for all participants, is a commitment to increased self-honesty which has facilitated a transition from an antagonistic relationship with depression to a more accepting one.

Participants use the trope of the journey to refer to this process, and all make it clear that it has been a challenging one. Amongst the most difficult obstacles encountered along the way are experiences of initially self-imposed withdrawal from peers which culminate in an eventual sense of rejection through instances of misunderstanding. This can give rise to painful feelings of shame and further disconnection as participants' sense of isolation intensifies. And whilst, in the re-telling, these events are located firmly in the past, there are instances in which formal factors, such as disruptions in syntax, function to blur boundaries between past and present and belie the quasi-traumatic intensity of emotions undergone.

It is at this point of crisis that external intervention is sought in order to alleviate, and in a sense, explain, the intensity of participants' feelings. And it is in participants' reactions to help received that I first came across what I have come to consider as a fundamental discrepancy between medical, and perhaps more objective and generic understandings of depression as a set of symptoms, on the one hand, and participants' felt sense of depression as an aspect of identity,

irreducible and resistant to such explanations, on the other. This tension was initially made manifest in participants' extreme sensitivity to having their depression cast in terms of illness. Ironically, in seeking to help participants by providing them with an explanatory framework for their experience, such assistance would seem to have ultimately been experienced as counter-productive in that it removed participant's sense of ownership of their experience, rendering it somehow external to themselves. As explored above, this discrepancy finds interesting formal expression in the contrast between a hesitant and ultimately uncertain tone in references to depression as an external phenomenon, and a confident, almost lyrical one in expressions of depression's fundamental status as an aspect of identity.

Participants' sense of depression as an integral aspect of identity also finds notable expression through its personification, which brings the idea of depression vividly to life. Participants relate to depression as a part of themselves with its own way of seeing and being in the world. It is a part that has often been ignored and is often unwelcome, but it is one which they must gradually get to know, and ultimately accept on their journeys of recovery.

Reflections

Throughout the data collection and analysis phases I fully acknowledged and embraced my own position as actively shaping interviewees' narratives through my body language, reflections and questioning. My decision to keep a reflexive diary throughout the data collection and analysis processes was based on this awareness of a collaborative dimension to data generation. The diary's principal function lay in assisting me to evaluate the ways in which the pre-conceptions and beliefs derived

from my own story may have impacted on my approach to analysis. Thus, for example, I recorded instances in which I caught myself nodding emphatically at particular points when I felt I could most empathise with what participants were saying. Recording such instances of potential over-identification enabled me to guard against the eventuality of being unduly selective in the analysis phase. Similarly, I recorded instances in which my attention may have momentarily wandered and I carefully examined the potential causes of such distraction. I hoped that by being aware of my own process as I collected and analysed the data I would be able, to a certain extent, to "bracket" off my own story and to maximise my commitment to exploring my participants' narratives.

As stated in the preface to the portfolio (p.11), given my own personal experience of having struggled with repeated bouts of depression over the years, I have gradually developed an intuitive bias towards conceptualising recovery in mental health as a process rather than as an outcome or end-state. Furthermore, I believe that my experience of depression has had implications for my sense of my own identity. The notion of recovery as a return to a pre-morbid sense of self feels incongruent with this perspective. Instead, for me, recovery has involved accepting depression as an aspect of myself and redefining how I negotiate the challenges that it can pose, within the context of a multifaceted life and sense of self.

I felt confident, by the time of data collection, that I had fully formulated these ideas to myself and that I had thought through their implications. Rather than make assumptions about any aspect of my participants' experiences I resolved to always obtain further clarification whenever necessary throughout the course of the interviews. I also resolved to guard against a tendency to be "on the look-out" for aspects of my participants' experiences that might resemble my own, by being careful

to examine my own assumptions even more vigilantly at points of concordance between my story and theirs.

Within the parameters of this framework, I felt free, at interview and during the analysis stages, to immerse myself fully in my participants' narratives. I found their stories at once familiar and illuminating and both moving and inspiring. On a personal level it felt moving to hear of other people's struggles to come to terms with their experiences of depression. I felt moved because aspects of my participants' stories certainly chimed with my own experiences, stirring both my empathy and my sympathy. I also noted in my reflexive diary that the experience of synthesising participants' narratives through data analysis proved to be extremely validating on both personal and intellectual levels. On a personal level I felt a validating sense of identification and connection with participants. On an intellectual level I felt heartened and inspired to find support for the recovery-as-process orientation.

Whilst I felt keen, at the time of data collection and analysis, to "bracket off" my own personal experience so as to ensure the prioritisation of participants' narratives, I feel, in hindsight, that this was both unrealistically naive and ideologically misguided on a number of levels. For one, my actual participation in interviews was certainly more relational and interactive than such a representation would imply. I intervened with prompts, fluidly adapted the interview schedule as appropriate and generally responded to participants in more flexible and humane a manner than such "bracketing off" would imply. I feel that this relating elicited elaboration on a number of occasions, whilst also being conducive to facilitating the expression of emotion, which in turn led to richly textured accounts of experience with which to engage creatively at analysis.

Furthermore, with the benefit of hindsight it appears clear to me now that in aspiring to a position of apparent objectivity at interview and at analysis I could also be interpreted as having implicitly bought into a positivist role of researcher as dispassionate observer. Indeed, Newman (2000) argues that much of postmodern-inspired narrative theory, as divergent as it is from rationalist, deductive models, remains entangled with scientifically based explanatory frameworks, and thus runs the risk of becoming as dogmatic and stultifying as the old externalising and categorical models. Whilst I do not conceive of my actual participation at interview and analysis as having been either rigid or stultifying, I do at present believe that it would have been desirable for me to have more explicitly acknowledged the actual relational fluidity with which I embraced the interactive dimensions of my role as researcher both in my reflexive diary and in the analysis section of this report.

Discussion

Introduction to Discussion

In this chapter I engage in a discussion of the findings outlined in the analysis section. I start off by drawing attention to the fact that participants typically cast their experiences of recovery from teenage depression in terms of self-discovery. I specify that participants universally evoke a sense of themselves as being composed of various constituent "parts". I go on to situate this finding in its socio-cultural context and to relate it to existing theory pertaining to the phenomenon of multiplicity of mind. This in turn leads me to the consideration of Richard Schwartz' Internal Family Systems (IFS) psychotherapeutic model, based as this is on just such a premise of intra-psychic multiplicity. Following a brief exposition of the model, I go on to engage in a discussion of my findings from an IFS perspective. I subsequently consider the clinical implications of my interpretations for Counselling Psychology and I engage in an evaluation of the project, making recommendations for future research in the field. I conclude the chapter and the research project with some retrospective reflections on my own process in conducting the study.

Discussion of findings and theory

Towards multiplicity- the many within the one

> Which one of the many people who I am, the many inner voices inside of me, will dominate? Who, or how, will I be? Which part of me decides?
>
> *-Douglas Hofstadter (1986, p.782)*

Participants universally describe their experiences of recovery from teenage depression in terms of journeys of self discovery. They speak of gradually having "started to relate to parts of me that had always been there in a different way" (P10, p. 31). The notion of being composed of "parts" is one espoused by all participants as they strikingly cast selfhood in terms of multiplicity. *The Compact Edition of the Oxford English Dictionary* (1971) contains a definition of the word part that yields some validation for this usage: "A personal quality or attribute, natural or acquired, esp. of an intellectual kind (as a constituent element of one's mind or character)" (p.2084). In *Much Ado about Nothing* (1598/1974) Shakespeare has Benedick ask Beatrice, "For which of my bad parts didst thou first fall in love with me?" (V.ii.60-61), and Ben Jonson, in 1598, speaks of "A gentleman ...of very excellent good partes". There is also an apt reference in the Bible: "Our bones are dried, and our hope is lost: We are cut off from our parts" (Ezekiel 37:11). Thus there are honourable precedents for conceiving of ourselves as being composed of various constituent parts.

And yet most of us in Western society have been socialised to believe that a person has one mind. We are taught that whilst a person may have disparate thoughts and feelings, they all emanate from a unitary personality. And yet, in discussing their experiences of recovery from adolescent depression my participants suggest that they have achieved recovery by shifting from just such a unitary conception of personality to a more complex and multiple one. In speaking of the parts that constitute their personality participants seem to suggest that these are more than just temporary emotional states or habitual thought patterns. Instead, they present them as discrete and autonomous mental systems prone to idiosyncratic displays of emotion, styles of expression, skills, desires, and views of the world. One participant sums up his sense

of the complexity of his psyche by describing his mind as a "room full of people, full of different parts of me" (P5, p.19). Of course, whilst one does not have to believe in an ontological sense that these parts are real people, the notion that one contains within one's personality a society of people each with his or her own interests, talents and temperaments, is at the very least an interesting metaphor.

Participants describe having initially striven, in their early teens, to maintain a monolithic view of themselves by ignoring or blocking out undesirable parts of their personalities. The following is typical for instance: "I'd get to school and be like a child, it was like I didn't want to speak. But then I was also like, pushing 'Come on! Go out and don't be so miserable" (P1, p.4) The words of Herman Hesse are apt in this regard: "it appears to be an inborn and imperative need for all men to regard the self as a unit, however often and however grievously this illusion is shattered" (Hesse, 1975). My participants are no exceptions to this imperative as they desperately seek to conform to their adolescent environments. And yet their drive to see themselves in a unitary way culminates in a poor self-concept as they come to believe that, since they cannot altogether silence the urge to withdraw, they must be fundamentally defective at their core- "I didn't feel the same as anybody else, I felt like I was kind of…I dunno I suppose I felt thwarted really" (P6, p.2).

In addition to our cultural bias for viewing ourselves as consistent, unitary individuals, Elizabeth O'Connor (1971) argues that our language in itself conditions us to uphold a monolithic view of personality: "If I say 'I am jealous,' it describes the whole of me, and I am overwhelmed by its implications. The completeness of the statement makes me feel contemptuous of myself." Similarly my participants describe having felt overwhelmed by the sense of defectiveness triggered by the absoluteness of such statements as: "I am different" (P4, p.2).

Broadly speaking, participants endeavour to see themselves monolithically until their sense of themselves becomes so polarised that they feel forced to contemplate the possibility of multiplicity. As one participant puts it: "recovery was about definitely going back to that sense of almost reconnecting with myself, almost recovering that part of myself that had got lost" (P4, p.38). Recovery would appear to be synonymous with a process of integration of different aspects of oneself. Thus one participant explains that "the depression is a part of me and rather than shutting that part out now, or being ashamed of it, I listen to it and try to love it a little bit more. It wasn't easy getting to know that part of me though, and it's still a work in progress" (P10, p.28). Integration would seem to occur when different parts of oneself come into harmonious relationship with each other. In the words of another participant: "it's almost like ...we work things out together now. I have got to know other parts of me as well and they have enriched me and given me more values in my life...It's an ongoing process" (P5,p.29).

Multiplicity in context

Notwithstanding our cultural bias for viewing ourselves as unitary individuals, many models of the mind exist that posit some degree of multiplicity. Freud drew attention to concealed, mysterious aspects of personality that communicate symbolically- he paved the way for explorations of multiplicity with his descriptions of the id, the ego and the superego. Since then, regardless of orientation, most theorists who have investigated intra-psychic process have described the mind as possessing some degree of multiplicity. Scanning the currently influential psychotherapies we find that object relations refers to internal objects (Klein, 1948; Gunthrip, 1971; Fairbairn, 1952; Kernberg, 1976; Winnicott, 1958, 1971); self psychology describes grandiose selves versus idealising selves (Kohut, 1971, 1977); Jungians speak of archetypes and

complexes (Jung, 1968, 1969); transactional analysis works with many different ego states (Berne, 1961, 1972); Gestalt therapy is concerned with the top dog and the underdog (Perls, 1969; Fagan & Sheppard, 1970) and cognitive-behavioural therapists posit a variety of schemata and possible selves (Markus & Nurius, 1987; Dryden & Golden, 1986). Whilst these theories differ concerning the extent to which the inner entities are treated as autonomous and endowed with a full complement of emotions and cognitions, as opposed to being specialised, interdependent, and essentially one-dimensional mental units, they all suggest that the mind is far from unitary.

Moreover, the notion of sub-personalities is not the sole preserve of specialised, academic psychological theorising. It has been widely popularised in both the UK and the US by the twelve step addiction movement and its well-known injunction to "heal the injured child within". Whilst what precisely is meant by the "child within" varies from writer to writer, it tends to be interpreted as a metaphor for a child-like state of mind, although some conceive of it as a child-like sub-personality. In another domain, Multiple Personality Disorder (MPD) movements in both the UK and the US are increasingly training therapists of all theoretical persuasions to become more comfortable in working with sub-personalities. From these movements' perspectives, their MPD clients are not the only ones who have parts. We all, in a sense, possess multiple personalities. People diagnosed as having MPD are merely those who have been hurt so badly that their parts have become polarised to the point of complete isolation from one another. Their parts exist in less cohesive and more tortured relationships, but are otherwise no different from those of people who have not been hurt so badly.

Thus, our culture seems to be gradually coming to terms with the idea of multiplicity. Another indication of this is that the postmodernist movement, which is currently

exerting a powerful influence on virtually all of the social sciences, has rejected the idea of a unitary self. Alternatively many postmodern writers champion multiplicity, celebrating the virtues of a self that encompasses a plurality of distinct personalities, just as they promote a pluralistic view of society. For instance the French feminist Helene Cixous (1974) implores us to "Understand it the way it is: always more than one, diverse, capable of being all those it will at one time be, a group acting together, a collection of singular beings that produce the enunciation. Being several and insubordinable, the subject can resist subjugation" (p.397). Sandra Harding (1986) echoes this view in arguing "for the primacy of fragmented identities...within a unified opposition, a solidarity against the culturally dominant forces of Unitarianism" (p.247). Pluralism from a postmodern perspective comprehends an endeavour to hold unity and diversity in equilibrium, to prize the many within the one, to settle conflict without enforcing synthesis or exiling groups, and to celebrate difference. I would argue that multiplicity of the mind involves just this kind of pluralism.

Beyond this evolution within academia and society, there have been parallel shifts toward a multiplicity-based view of the mind within the fields of psycho-neurology and artificial intelligence. In *The Social Brain* (1985) the acclaimed neuroscientist Michael Gazzaniga, suggests that his original 1960s' insights into the various functions of the human right and left hemispheres may have been somewhat simplistic. He posits instead that the human mind is made up of an undetermined number of independently functioning units he calls modules, each of which plays a special role. According to Gazzaniga, our emotional and cognitive lives are shaped by the relationship among our modules.

Meanwhile, in the domains of artificial intelligence and computer science, researchers are likewise converging on a multiplicity-based analogue for the mind. In the Von Neumann model, the initial understanding of the mind upheld by computer scientists, information was believed to be stored in one part of the brain before being processed in another. Only one cluster of information was thought to be processed at any one time. In other words, information was understood to go from one area to another in a serial way, rather like an assembly line in a factory. More recently however, researchers have elaborated parallel processing computers in which many different processors work shoulder to shoulder, communicating with, but staying largely independent of, one another. According to Wright (1986), these parallel computers are able to "think" in a way that approximates human intelligence much more precisely than the earlier serial computers. Marvin Minsky (1986), one of the founders of artificial intelligence, concludes that:

> For finding good ideas about psychology, the single-agent image has become a grave impediment. To comprehend the human mind is surely one of the hardest tasks any mind can face. The legend of the single Self can only divert us from the target of that inquiry. (p.51) ...All this suggests that it can make sense to think there exists, inside your brain, a society of different minds. Like members of a family, the different minds can work together to help each other, each still having its own mental experiences that the others never know about. (p. 290)

Viewing individuals as systems

The psychotherapist Richard Schwartz has elaborated the therapeutic model of Internal Family Systems (IFS) based upon just such a premise of intra-psychic multiplicity. Drawing on his background as a systemic therapist, Schwartz argues that the same systems thinking that has been used to understand families, corporations, cultures, and societies can be applied to an exploration of the human psyche. A "system" being defined here as any entity whose parts relate to each other in a pattern. Echoing Minsky above, Schwartz argues that it is useful to think of an internal system as a collection of family members of different ages. He suggests that some of these inner-family members are young, sensitive and vulnerable children whilst others are older children, adolescents and adults. In addition to being of different ages, according to Schwartz, these inner family members possess different temperaments, talents and desires.

Depending on theoretical persuasion therapists subscribing to a multiplicity orientation have traditionally chosen to refer to such internal entities as sub-personalities, sub-selves, internal characters, archetypes, complexes, internal objects, ego states, or voices. In IFS, however, these inner family members are known simply as "parts" and it is in this use of terminology that I was initially struck by an arresting congruence between my findings and those of Dr Schwartz. In defending his departure from more "professional" terminology, Schwartz argues that the term used clinically should be that with which clients are most comfortable and that an overwhelming majority of his clients had adopted the word "part" in describing their own internal conflicts. As outlined above and in the previous chapter, this observation is consistent with my finding that participants consistently and universally communicate a sense of

inner turmoil in terms of a clash of "parts". Intrigued at this initial parallel, I delved into an examination of my findings from an IFS perspective.

Unsurprisingly, all of the models of psychotherapy that subscribe to a multiplicity paradigm contain similarities to one another and to the IFS model. My decision to interpret results from an IFS perspective however was based on my understanding of several key differences between IFS and other models. Firstly, unlike more traditional models, rather than being exclusively concerned with an individual's parts, IFS also seeks to shed light on the networks of relationships among these parts. That is, it attempts to understand and work with an individual's entire internal system. Secondly, it differs in its emphasis on the connections between external (e.g. family, cultural) systems and internal systems, and in its ability to use the same concepts at both levels. Because of its systemic foundation, it allows a coherent linkage between theory and technique, and thus maintains a high degree of internal consistency and comprehensiveness. Finally, it differs in its assumptions about the qualities and role of what it calls the Self.

A glimpse at IFS

The Self: the 'I' in the storm

IFS posits that every person has at his or her core a true Self that is wise, compassionate, curious and loving. It proposes that this is who we are when we are not blended with our parts. Because, as we develop, we experience pain, trauma, and grief, and these burden us with shame, fear, and negative beliefs, some of our parts are prompted to take over in a bid to protect the Self from harm. Therefore, people are

likely to be identified with their parts and unaware of their Selves. One major goal of IFS is to assist clients in differentiating the Self as quickly as possible so that it can regain its leadership status. Self-leadership from this perspective is a non-coercive, collaborative style of leadership.

From an IFS perspective, a person is organised to protect the Self at all costs. Thus, in the face of trauma or intense emotion, managerial or protector parts of a person (see below) take over in a bid to safeguard the Self. After a person's parts have had to protect the Self in this way, they lose trust in its ability to lead and increasingly believe that they have to take over. One major goal of IFS therapy is to help clients differentiate the Self to the point that the parts can begin to trust it again.

Schwartz notes that when a person is in Self, he or she describes 'being in the present' and feeling centred. He draws a parallel with psychologist Mihalyi Csikszentmihalyi's (1990) state of Flow. This is characterised by an absence of distracting thoughts and a sense of confidence, mastery, and well-being. Csikszentmihalyi found that people involved in focused activities around the world described this same state, and he concluded that it is a universal human experience. Schwartz equates the state of flow with Self-leadership and remarks that this is also what Buddhists describe when they refer to mindfulness.

Patterns of parts

From an IFS perspective, the problems that occur in the human psyche are largely structured around the need to protect ourselves from pain. An understanding of the relationships between parts guides the model, the most important of these being that between those parts that protect us from pain and those parts that are in pain.

Exiles

Commonly, children are taught to fear and hide their pain or terror. They become inclined to forget about painful events as soon as possible which, from an IFS perspective, means that they push their hurting parts out of awareness. Like any oppressed group, these exiles become increasingly extreme and desperate, looking for opportunities to break out of their prison and to tell their stories. As they do so they give the person flashbacks or nightmares, or sudden, fleeting tastes of pain or fear.

Managers

Manager, or protector, parts live in fear of the escape of exiles. They try to avoid any interactions or situations that might activate an exile's attempts to break out or leak feelings, sensations, or memories into consciousness. The manager's main strategy is to pre-empt the activation of exiles by always keeping the person in control or out of danger and by pleasing those on whom the person depends.

IFS posits that most people, even those who never were severely hurt, are organised around a basic division into managers and exiles. This is because most people are socialised to exile various parts of themselves, and once this process begins, the managerial roles become necessary.

Key IFS concepts reviewed

The following is a brief reference guide of key concept definitions to assist the reader in the subsequent section where I will critically examine my findings from an IFS perspective.

Self: The core of a person, which contains leadership qualities such as compassion, perspective, curiosity, and confidence. The Self is best equipped to lead the internal family.

Blending: When the feelings and beliefs of one part merge with another part or the Self.

Managers: Parts that try to run a system in ways that minimise the activation of the exiles.

Exiles: Parts that are sequestered within a system, for their own protection or for the protection of the system from them.

My findings from an IFS perspective

The Five Stages

At this stage I will refer the reader back to the five 'stages' outlined in the Categorical-Content perspective of my Analysis, each of which corresponds to a successive segment of participants' narratives. Whilst I address content and formal issues separately in that chapter, I interweave them below in my discussion of multiplicity as it pertains to participant narratives. All quotes used below correspond to those outlined in the Analysis chapter. In accordance with IFS practice, I use capital letters when I am naming a part directly- as in the subsection below for instance, where I name a Striving Manager and Child Exile. Where I simply refer to characteristics of a part, such as a 'striving' or 'pleasing' manager, or I refer to managers or exiles in the plural, no capital letters are used. Capital letters are always used in IFS practice with reference to the Self.

1. *Early adolescent experience of tension between withdrawal and inclusion: Striving Manager vs. Child-like Exile*

My participants first describe having experienced a challenge to their unitary sense of self in early adolescence when they start to experience a "tug of war" (P7, p.1) between wanting to fit in, on the one hand, and wanting to withdraw, on the other. As one participant puts it "I'd get to school and be like a child, it was like I didn't want to speak. But then I was also like, pushing 'Come on! Go out and don't be so miserable" (P1, p.4). From an IFS perspective we are witnessing the beginnings of a polarisation between two parts: a Child-like exile that wants to withdraw and a Striving Manager pushing for social engagement.

The prevailing tone, as participants seek to convey what it felt like to be at this stage, is one of bewilderment and confusion. They have gone from experiencing themselves as a unit in childhood to feeling fragmented in early adolescence. This does not mean that in childhood they had no parts, but rather it sheds light on the concept that when any system, the mind included, functions well and all its members are in sync, it seems like one unit. Whereas once a system begins to polarise, each individual part stands out in bold relief and a person starts to feel fragmented.

I would argue that adolescence is a particularly perplexing time for most people because it often presents them with their first experience of fragmentation. As such this period of development compounds the sense of confusion inherent in any experience of fragmentation. Thus, irrespective of the degree to which a person's parts exist in polarised relationships, this is a challenging time. An IFS therapist would argue that the success with which a person negotiates his or her initial experience of fragmentation will depend upon whether his or her Self is strong enough at this stage to be able to reconcile various parts' differences. If the young adolescent is helped to understand and to accept what is happening, and is given love and comfort, then his or her Self will be able to respond in the same way towards hurt parts- with love, comfort

and acceptance. In this best case scenario, the hurt parts will heal in the sense that they will know the person appreciates what they are going through and still values them.

If however, the young adolescent does not turn for help but instead seeks to suppress his or her hurting part(s) in an effort to conform socially, as is the case for my participants, then he or she will start to feel dominated by contradictions as his or her parts battle it out and eclipse the person's sense of Self.

2. *Attempts at inclusion thwarted, intensification of feelings of isolation: the exile triumphant*

In this second segment the Striving Manager's attempts to suppress the child-like exile's feelings of painful disconnection are thwarted as its attempts at social inclusion fail. In a couple of instances this sense of failure is exacerbated by participants' sense that their peers simply do not understand the nature of their internal struggles. Consider the following for instance: "And my friends couldn't, they didn't know quite how to deal with that and it was almost then like the rejection from them because it was just like 'that's too much for us to handle'" (P9, p.2). In these cases participants encounter constraints, in the broader social system in which they are embedded, which mirror those being acted out on an internal level. To put this slightly differently, peers are reacting to their friend's expressions of pain and confusion externally in much the same way as participants' managers are responding to their exiles internally- by turning away from them.

I would argue that this reaction is testimony to the way in which children in our society are taught to fear and hide their feelings of pain or terror. Adults tend to react to a hurt child's feelings in much the same way, from an IFS perspective, in

which they react to their own hurt child parts- with impatience, denial, criticism, revulsion or distraction. For this reason, managerial parts of the child soon learn to adopt these attitudes and constrain the Self from taking care of younger, more fragile, parts. This makes many people quite vulnerable to a polarisation of parts which can culminate in mental health difficulties. People become inclined to forget about painful events as soon as possible and therefore push their hurting parts out of awareness. In this way, insult is added to the injury of the child parts. They are like children who are hurt and then are rejected and abandoned because they are hurt.

Each participant's exiled child part responds to the Striving Manager's attempts at suppressing it by becoming increasingly desperate. In the words of one participant "those were actual times of real despair" (P2, p.9). This echoes Schwartz' caution that polarisation in systems tends to be self-confirming. Thus, the more the manager strives to exclude the exile that holds sadness, the more disconnected and hopeless it feels; As a result, the manager redoubles its efforts to exclude it which culminates in a further intensification of sadness, and so on. This is the ubiquitous positive feedback loop or vicious circle that is so central to systems thinking.

Thus, in this second stage, narratives build to a climax as participants describe being overwhelmed by feelings of isolation. In IFS terms, the exile has broken out of its prison and is flooding participants' internal systems with its sense of despair.

3. *Seeking help: a first glimpse of the Self?*

From an IFS perspective, two equally valid hypotheses can be put forward to explain participants' turning outwards to seek external intervention at this stage. On the one hand, what we might be witnessing here is the interjection of another, assuaging,

manager jumping in to limit the damage by offloading its burden onto professionals who might be better placed to deal with it.

Another hypothesis might be that we are presented here with our first glimpse of the Self and that this is initiating the quest for help. Participants describe having become aware, at this stage, of concerned friends and family members reaching out to them and impressing upon them the advisability of professional intervention. One could argue that this experience of solicitude, coming in the aftermath of feelings of intense isolation, could have bolstered participants' sense of Self to the extent that they are now able to respond to the exile in the same concerned way- with an attempt at understanding. Again, we could be witnessing a situation in which a participant's internal system organises to mirror a broader external system - in this case that of the family context or peer-group system.

4. Reactions to help received: the Angry Manager and the Pleasing Manager

Our potential glimpse of the Self is fleeting however, as yet another manager mobilises, in this fourth segment, to shield participants from the pain of having felt misunderstood. This manager is angry and rebels against a mental health system which, it feels, has failed in its duty of care to the exile. Interestingly, the tug of war between the initial, striving, manager and the exile has now been replaced by another tug of war, externally-directed this time, between the Angry Manager and the mental health system surrounding the participant.

Participants typically reference visits to their GPs at this stage, as well as encounters with psychiatrists and initial forays into counselling. The tone is indignant as angry managers rail against their perception of the ineptitude that surrounds them. Consider the following, for instance: "He put me on Prozac, which I had the most awful

reaction to ever" (P2, p.17) or "I remember just trying to off-load troubling incidents from my childhood and he was like half-asleep" (P9, p.8). These rants culminate in impassioned refutations of depression as an external phenomenon: "I didn't identify with anything about the word 'depressed'. I couldn't have that as part of me" (P4, p.2).

The Angry Manager is not the only member of participants' inner families to have been activated at this stage however: a Pleasing Manager also enters the scene. This latest part seems to want to please those professionals upon whom it perceives the internal system to be dependent. The Pleasing Manager might also be trying to alleviate participants' sense of the painful discrepancy between their understandings of themselves and that of the medical system surrounding them. Thus, in endeavouring to understand their own experience at this stage, participants attempt to accommodate the medical discourse by applying it to themselves. In doing so they refer to "depression" for the first time, as opposed to "the child part within me" (P1, p.27). Even as they do this, however, it is interesting to note that they ultimately resort to personifying the concept. As in the following example, for instance, where "depression" becomes conflated with the image of the small baby: "Depression has probably been there, I imagine, ever since I was a small baby having a mother who had chronic depression. I imagine that depression's been a part of me since I was unable even to realise that that was my mother" (P8, p.37).

Ultimately, however, even as they try to appropriate psychiatric terminology, participants' descriptions of their experiences are couched in a lyricism – as evidenced in the quote above- at odds with the cold impersonality which they experience at the hands of the mental health system. A sense of clinical objectification is evidenced in such quotes as "they came and told me that I had chronic depression." (P3, p.32) or "I

was classified as clinically depressed by a couple of doctors" (P5, p.19). These quotes, with their verbs denoting a clinical impersonality, have the effect of presenting participants as disempowered, as they go from being active agents in their own lives to passive recipients of treatment. The Angry Manager rises in revolt at such objectification which is experienced as adding insult to the injury of the internal system. This is a bid to reclaim ownership of the participant's experience.

5. *Attempt at synthesis of divergent experiences: speaking from Self*

Shift in perspective

Stage five ushers in a notable shift in perspective as participants emphasise "looking back" (P1, p.19) at experiences of adolescent depression from an adult vantage point. The "I" here feels different from that in preceding stages. Previously we got a sense that the narrator, or the "I" of the segment, was very much conflated with the particular manager activated in that segment. Whilst participants have referenced their child parts prior to this stage, for instance, they have never sufficiently unblended from their managerial parts to be able to talk about them objectively in the third person. Consider the following, for instance: "I'd get to school and be like a child.... But then I was also like, pushing 'Come on! Go out and don't be so miserable'" (P1, p.4). In this quote the narrator establishes some distance from the exile by means of a simile. The narrator is "like a child" rather than actually being the child part. This is in sharp contrast to the narrator's thorough identification with the managerial part, a blending underscored by the direct quote which vividly conveys a sense of frustration from the manager's perspective.

Assuming control: leading from Self

By stage five however, the narrator has sufficiently unblended from these managerial parts to be able to report on the internal workings of his or her mind from a more objective perspective. The "I" is no longer one of the characters, rather it is commenting on the action, as in the following, for instance: "I saw my mind as this kind of room full of people" (P5, p.19). The narrator is relating to these internal people from a distance and we get the sense that he or she is poised and very much in control. Consider the following for example: "I think it's something that has always been a part of my nature and character and for a period I wasn't able to control it. It expanded and reflected my whole life" (P8, p.15). This notion that the process of recovery involves an element of resuming control over one's mental states is reminiscent of Freze et al.'s (2001) argument that individuals must assume responsibility for their own transformation from a person with a mental illness to a person in recovery. (cf. Introduction, p. 29). Unlike Stage one's Striving Manager who worked to suppress and exclude the child part however, the narrator we are dealing with here is inclusive, compassionate and not in the least bit coercive. It is in these characteristics of the narrator that we are given our first clue that participants are now effectively speaking and leading from Self.

The influence of therapy

Participants universally explain that their shift in outlook has been facilitated by an often "second attempt" at psychotherapy or counselling. One participant refers to his therapist as follows, for instance: "He was amazing basically, he built an unbelievable rapport. And I trusted him" (P5, p.12). Yet again, I would argue that participants are mirroring an external attitude in their relationships towards their internal families at this stage. These findings echo those of Smith (2000) and Davidson (2003) who argued that being supported by others is crucial to the recovery process, in the sense

that it bolsters an individual's self-worth in spite of the ravages of internal discord (cf. Introduction, p.27). Thus, from an IFS perspective, participants' experiences of acceptance and unconditional positive regard in therapy, coming in the aftermath of negative experiences of care, have re-awakened their sense of Self to the extent that they now become able to respond to their own internal dynamics in the same compassionate manner.

Compassionate relating to parts

From the perspective of Self, participants relate to their vulnerable young exiles with moving tenderness and compassion, as in the following, for instance: "The depression feels like a really young, frightened part of me that needs to be looked after. I ignored it for a while but it started crying louder and louder" (P10, p.37). Participants are also empathic towards their fighting and striving managers. They seem to understand that these had been forced into roles which they had not particularly enjoyed but which they had believed to be necessary. The narrator now takes the pressure off these managers however, typically stressing that in the present "we work things out together" (P5, p.29). Speaking from Self, participants display a great humanity as they claim depression as an aspect of identity. They emphasise inclusion and an integration of parts strikingly different from the suppression and exclusion of the Striving Manager. Consider the following, for instance: "I think of the part of me that gets depressed as a child part within me. It got so lonely, so frightened, like a kid hiding away. It's me and my child now" (P1, p.27). These findings echo those of the qualitative researchers referenced in the Introduction (p.26) who found that recovery as a process involves the redefinition of oneself as a person of whom mental illness is only one part.

Depression as existential stance

Participants also display great wisdom and courage at this stage as they speak up for a vision of depression as an existential stance rather than as a purely medical phenomenon. In the following quote a participant eloquently makes a case for self-honesty in staying true to one's experience of depression in all its uncertainty and confusion: "For me personally it was less medical and more philosophical and existential. You're actually going to a realm that's not easily defined by labels. Maybe labels are there to make things easier to cope with but for me, I think, part of me's always known that that's not how I feel" (P6, p.44). This participant resists being socialised into assuming the identity of the "mentally ill" patient. In doing so, she provides support for Munetz and Freze's (2001) view that recovery involves an acceptance of illness as a part of the self, rather than necessarily entailing accepting a particular conceptual model of illness. From this perspective, these findings echo the view that accepting one's illness involves redefining how an individual negotiates this particular life challenge within the context of a multifaceted life and sense of self. (cf. Introduction, p.26).

In this final stage participants speak variously of acceptance – "So I created an acceptance of the depression… I guess maybe I just got better at reading myself" (P9, p.26)- of love – "rather than shutting that part out now, or being ashamed of it, I listen to it and try to love it a little bit more.' (P10, p.28)- and of kindness - 'I've tried to become a bit kinder to myself" (P9, p.39). Recovery, from participants' perspectives, entails a shift towards increased openness, acceptance, compassion and integration- all of which, from an IFS perspective, are characteristic attributes of being in Self.

The Self as particle and wave

Whilst participants are speaking from Self in the final segment, this does not mean, from a formal perspective, that narratives become blandly uniform at this stage. On the contrary, as the Self-narrator engages in a retrospective appraisal of events, he or she alternates dramatically-paced passages with sections in which action is suspended in favour of commentary upon events. Thus, we find juxtaposed sentences such as, "And then, as quickly as that had kind of started it suddenly stopped." (P7, p.13) and, "I would say that many teenagers go through similar things." (P7, p.14).

These findings are consistent with the IFS view that the Self is characterised by both an expansive and compassionate state of mind- an attitude displayed in the second quote- and by an active inner leader- very much present in the first. Some psychotherapeutic models attempt to reconcile these different attributes of the Self by differentiating between a "higher Self" and a more mundane executive Self or ego. Schwartz argues against this dichotomy however by claiming that the Self can at one time be in its expansive, wave-like state, when a person is meditating (fully differentiated from his or her parts) for instance, and then shift to being an individual with boundaries (a particle) when that person is trying to help the parts or deal with other people. For Schwartz, it is the same essential Self, just in different states. My findings would certainly seem to support this view.

Parts in the present

Direct quotes and syntax disruption: the reactivation of an exile?

Notwithstanding the fact that participants seem to be speaking from the perspective of Self by stage five, there are still occasional instances in the latter

sections of their narratives in which parts would appear to manifest. This is especially so in those instances in which participants employ direct quotes to convey the felt nature of moments of particular emotional intensity. These quotes tend to be either preceded, or followed, by a disruption in syntax, specifically- a shift in verb tense, from a prevailing, and grammatically correct, past tense, to an incongruous present tense (cf. Analysis, p.122). Such disruptions in the smooth telling of the story are fleeting but, nonetheless, have the effect of temporarily blurring boundaries between past and present, as confusion momentarily prevails and the past becomes present. It is as if the narrator has gone from being in Self to being temporarily blended with an exile. Participants quickly unblend, however, as the quotations come to an end, distance is reinstated and the past tense is once again appropriated.

Talking to a psychologist: activation of defensive and pleasing managers?

Similarly in those instances in which participants refer, or defer, specifically to me as a potential "expert" on the topic under investigation. I wonder whether a defensive manager might be active in the following quote for instance: "I know a bit about CBT treatments of depression" (P3, p.53). Likewise, it would seem that a manager eager to please might be present in the following: "shall I say what had the most impact for me and whether you want to explore it?" (P1, p.12). Equally, however, it is possible that in both of these examples participants are in fact speaking from Self, simply stating a fact in the first instance, and being considerate in the second. If this is the case, it could be that my interpretation of defensiveness and eagerness to please says more about my assumptions of how it might feel to be confronted with a person of perceived authority in an interview context, than it does about how my participants are actually positioning themselves in relation to me.

In summary: recovery as a process

Notwithstanding these potential instances of manifestations of parts in the latter segments of their narratives, overall, participants are calm and anchored in the present of adulthood as they discuss the concept of recovery from adolescent depression. Participants universally stress that recovery is a process with no fixed goal or outcome. As such their voices echo those of the proponents of the recovery-as-process orientation outlined in the Introduction.

Participants describe having felt confused by the notion of depression as an illness. Up until their encounters with representatives of the mental health system they had conceived of depression as an aspect of identity. Indeed they had not actually labelled it "depression" but rather had referred to a child-like part of themselves which experienced feelings of disconnection. Participants tend to refute notions of depression as an illness, and speak instead of continuing to prefer to relate to it as an aspect of themselves rather than as a medical condition imposed from without. It is because of this preference that I felt the IFS model would be particularly suited to an interpretation of findings. This is not to say however, that looking at the findings through a different interpretative lens, might not yield equally interesting results.

In conclusion, participants describe experiences of recovery from adolescent depression as processes through which they have learned to relate to those parts of themselves that were in pain with compassion and acceptance. Participants stress that such compassionate relating is very much "a work in progress" (P10, p.28). From this

perspective, recovery for participants involves redefining how they relate to their vulnerable parts within the context of a multifaceted sense of identity.

Clinical implications

Clinical implications of multiplicity

Although psychological theories exist that describe human beings complexly, I would argue that in practice our mental health system still has a tendency to operate on a monolithic basis. Diagnostic categories have come to be used as descriptions of a person's one personality. It is not uncommon to hear therapists say, for instance, that they are treating a "borderline" or a "depressive" or some other label, as if the essence of their personalities could be summed up in one or two words. We focus on a person's most extreme feelings or thoughts and consider them to be their most basic ones- manifestations of their essential, often defective nature. My findings suggest that such a way of thinking is fundamentally flawed and that it is inconsistent with how individuals see themselves.

If, as my participants suggest, we are naturally multiple then it is possible that our extreme feelings or thoughts are the results of extremes within just small parts of us, rather than constituting evidence of pathology at our cores. From this vantage point, the clusters of symptoms that have traditionally resulted in monolithic psychiatric diagnoses could be reframed, through the lens of multiplicity, as manifestations of the way a person's system of inner personalities has organised to help the person survive. Rather than diagnosing a person's disease, then, a multiplicity-orientated therapist could help a person to explore his or her system of inner parts so as to understand which of them are distressed and why. I find the non-pathologising implications of

such an orientation tremendously inspiring from both personal and professional perspectives.

Particular implications for diagnoses of Multiple Personality Disorder (MPD)

Subscribing to a multiplicity orientation would obviously have implications for a clinician's understanding of Multiple Personality Disorder (MPD). Since we all, from my participants' points of view, possess multiple personalities, people who are diagnosed as having MPD are merely those who have been hurt so badly that their parts have become polarized to the point of complete isolation from one another. Their parts exist in a less cohesive and more tortured relationship to one another, but are otherwise no different from those of people who have not been hurt so badly.

Clinical implications for working with adolescent populations

Given my participants' experiences of withdrawing rather than seeking help as they started to experience internal conflict, I would argue that there is a need for clinicians to train those working or interacting directly with young people- such as teachers, doctors and parents- to be alert to signs of struggle in this age group. Clinicians will need to tread a fine line between normalising experiences of fragmentation and recommending that those teenagers displaying particularly acute signs of struggle be referred to see a competent, non-pathologising, therapist. This recommendation is based upon my participants' descriptions of the healing initiated in a therapeutic context.

Tackling stigma through psycho-education

Psycho-education would also be valuable for adults working with children. Clinicians could use this opportunity to do some preventative work by intercepting the process by which mental health stigma becomes internalised at an early age. Clinicians might explore with relevant adults the ways in which children in our society are commonly taught to fear and hide their feelings of pain or terror as if these were shameful. Clinicians may want to ask adults to reflect upon the ways in which they tend to react to a hurt child's feelings and to suggest that children be encouraged to sit with, rather than to suppress, their difficult emotions.

In a similar vein, my findings suggest that peer psycho-education would be important in order to encourage those surrounding a troubled teenager to respond to his or her concerns with openness and empathy. Such a response might have the beneficial effect of making a teenager feel included rather than excluded at a critical juncture. It might encourage the young person to model such acceptance and inclusion in relating to those more vulnerable parts of his or her psyche.

Evaluation of project

Strengths

Narrative Oriented Inquiry (NOI) provided me with a rigorous framework within which to creatively explore my data. It required a valuable systematic discipline at the data analysis stage whilst subsequently allowing for scope to engage resourcefully with findings at the discussion stage. Especially pertinent to the aims of my study was NOI's emphasis on the interrelation of *fabula* and *sjuzet* which enabled me to avoid reducing participants' narratives to a set of themes. Thus, my chosen methodology

assisted me in paying heed to the ways in which formal issues elucidated the functionality of participants' narratives. Furthermore, the small scale of the study enabled me to adhere to a rigorous implementation of NOI and facilitated an in depth engagement with the data.

Finally, the study's broad exploratory focus enabled participants to fully develop their narratives of recovery from adolescent depression- *it* allowed their recovery processes to really emerge from their narratives. This may not have been the case had I isolated and set out to elucidate one particular facet of the recovery experience.

This study builds and expands upon previous qualitative research into the experience of adolescent depression. It responds to Farmer's (2002) injunction for researchers to increase awareness of aspects of development unique to adolescence. It also provides support for Farmer's (2002) contention that interpersonal difficulties are particularly characteristic of depression in adolescence. The study likewise corroborates Pinto-Foltz's (2010) finding that when depressive symptoms are present in their peers, teenagers struggle to link the symptoms to depression. These authors call for psycho-education for teenage girls about mental health. My findings enable me to expand upon this recommendation and to make a case for peer psycho-education irrespective of sex.

Similarly, my findings provide support for Wisdom & Green's (2004) contention that although some teens may find a diagnosis of depression helpful, for many, such labelling might be, at best, irrelevant and at worst, harmful. My findings expand upon this in suggesting that participants conceive of depression as an aspect of identity rather than as an external phenomenon imposed from without. Finally, my study

builds significantly on McCarthy, Downes & Sherman's (2008) retrospective study on looking back at adolescent depression from the perspective of young adulthood by refining the focus of investigation to an examination of recovery processes. As such I am able to elaborate on these authors' rather general findings and to break new ground in specifically elucidating the nature of intra-psychic tensions in the process of recovery from adolescent depression.

This study also builds importantly on the literature addressing recovery in mental health, specifically providing support for the recovery as process orientation. I lend my voice to that of previous researchers in the field (Sullivan, 1994; Fisher, 1994; Deegan, 1996; Young & Ensing, 1999; Smith 2000; Munetz & Freze, 2001; Davidson, 2003) to argue that the most overarching aspect of recovery as a process involves the redefinition of oneself as a person of whom mental illness is only one part. My findings likewise particularly endorse Munetz & Freze's (2001) observation that recovery involves an acceptance of illness as a part of the self, but does not necessarily entail accepting a particular conceptual model of illness.

Limitations

> "I didn't identify with anything about the word 'depressed'. I couldn't have that as part of me, to kind of label it in such a way, it's so constricting." (P4, p.2).

In view of such participant iterations, I wonder in hindsight whether the very use of the word "depression" in my recruitment flyer (Appendix A) carried with it implicit assumptions redolent of a medical discourse. Perhaps I should have referred instead to experiences of a deep sadness, or a melancholy in adolescence. Alternatively, I could

use this opportunity to make a case for the importance of reclaiming the word "depression'' for Counselling Psychology, rather than allowing the word to be hijacked by proponents of a medical orientation.

Conversly, I wonder whether criticism might be levelled at this study for a potential lack of specificity in its inclusion criteria and a consequent heterogeneity in its sample. I did not, for instance, specify that participants must have received an official diagnosis of depression in order to participate in my study. I feel that it would have been epistemologically incongruent for me to do so. Instead, I trusted participants' understanding and definitions of what adolescent depression had meant to them. As it turned out, all my participants had, in due course, received a diagnosis of depression as part of their experiences, and reacting to this had constituted an interesting facet of their recovery processes. But I felt that specifying that participants must have received a diagnosis of depression in my inclusion criteria would have run the risk of excluding people who may not have received such a diagnosis and may thus have provided a biased account of recovery processes.

The above critiques, drawing attention as they do to my attempts at circumnavigating the pitfalls of categorisation, are instrumental in elucidating the extent to which we, as human beings, are potentially constrained by our use of language. This is an important observation, striking as it does at the heart of narrative psychology, and one which is perhaps not adequately represented in the analysis section of my study. Whilst I take language as a starting point to explore intra-psychic reality in that chapter, I categorically do not deny, as certain narrative psychologists certainly do, the existence of extra-linguistic psychological reality. Indeed, I would go so far as to uphold

neuroscientist Pinker's (2008) contention that our cognitive processes need not be shaped by the language that we use in everyday interaction. I believe that we think in visual and auditory images, as well as in abstract propositions. Whilst I think that language is a tool for communicating thoughts and emotions, I also believe that at times words fail us and that we need to look elsewhere to apprehend a person's meaning. Whilst I gesture towards the unsaid in my exploration of juxtapositions of expressions of hesitation and certainty, and in my examination of syntax disruption, I should have made explicit the possibility that these instances were illustrative of participants' struggles to adequately represent their thoughts and feelings linguistically. In a similar vein, it might have been interesting to devote a section of the analysis to an exploration of participants' body language. This might have enabled me to challenge what Hevern (2008) terms the "lingering Cartesianism" with which narrative psychology approaches human beings as storied selves.

On a slightly different note one could also argue that the current study is perhaps overly intra-psychic in its focus and that this precludes an objective exposition of what precisely constitutes the process of recovery. Participants universally cast depression as an aspect of identity and speak of recovery as a process of redefinition and integration through which they have learned to relate to parts of themselves that were in pain with compassion and acceptance. They stress that whilst such compassionate relating is very much "a work in progress" (P10, p.28), it can be facilitated by positive experiences in therapy and impeded by self-imposed withdrawal from peers and by undue medicalisation. Whilst I was guided by participants' evocation of multiplicity towards an exploration of intra-psychic tensions, I do feel that this may have been somewhat at the expense of a fuller consideration of contextual and external factors

impeding or assisting the process of recovery. Although I discuss the roles of stigma, peer relations, and perceived medicalisation as exacerbating experiences of isolation for instance, I come at these topics primarily from an intra-psychic perspective. I would argue that these are important topics in their own rights however, and that they require further elucidation. Such a focus might enable future researchers to flesh out the process of recovery outlined in the current study whilst yielding suggestions for the implementation of more practical steps by which to actually assist and support young people in recovery.

Finally space and time constraints prevented me from engaging in a fuller exposition and discussion of IFS in this chapter with the result that I may have somewhat oversimplified the model.

Recommendations for future research

Future research may wish to address these limitations and to concentrate, for instance, on those external systems surrounding participants. Further clarification is required, for instance, of the roles played by friends and siblings in potentially alleviating the burden of adolescent depression. There is also a need for work looking at the manifestation of mental health stigma in adolescent populations and its influence upon peer relations. Future research may also wish to elucidate the processes by which such stigma is internalised resulting in intra-psychic tension in adolescence.

There is likewise a need for prospective researchers to devise psycho-education programmes aimed at those adults coming into frequent contact with teenagers. They

may also wish to examine the means by which to disseminate such programmes. In a similar vein, peer psycho-education programmes will need to be devised, elaborated and disseminated.

Research building directly on my study may wish to interpret the phenomenon of recovery from adolescent depression from an alternative theoretical perspective. Whilst IFS was an interesting lens through which to examine the multiplicity phenomenon, it is possible that additional theoretical perspectives might shed further light on the experience of adolescent intra-psychic tensions.

It would also be extremely interesting, however, for future researchers to look further at IFS in relation to adolescent mental health as very little work has been done to date in this area. I feel that there is great potential, as yet untapped, to adapt the model for the purposes of working with teenagers. Future researchers may wish to consider the means by which this might be achieved.

Reflections: evaluation of my process in conducting the research

Whilst I had a sense, as I embarked on this study, that work was needed to elucidate the experience of recovering from adolescent depression, I felt uncertain of what might emerge from such an endeavour. My work as a trainee Counselling Psychologist in the Child and Adolescent Mental Health Service, to which I refer below in Section D, was instrumental in bringing to my awareness the need for such a project, although I felt very uncertain about how best to approach the topic. As such, I initially approached the project with some degree of trepidation. This gave way to a sense of excitement however as my ideas for a prospective study design took shape and I submitted my research proposal.

Once I was given the go-ahead to proceed with data collection, I found myself pondering the possibility that immersing myself in a study about depression might well have the effect of stirring up my own thoughts and emotions on the subject. It was at this early stage that I began to keep my reflexive diary. In this diary I expressed my sense of the importance of self-honesty and transparency in this regard and very early on in the research process I asked myself the following questions: Did I perceive the research project as constituting a potential threat or trigger for my own depression? Did I think that I myself had sufficiently "recovered" to be able to carry out a project of this kind without sacrificing the objectivity that I felt was owed to my participants? i.e. could I faithfully endeavour to communicate what participants had to say without this being distorted by my own biases? After subjecting my thoughts to scrutiny in the diary, I felt that I could, without a doubt, answer these questions in the affirmative. For the purposes of self-care, however, and with a view to protecting the integrity of my findings, I gave myself the following caveat- should I, at any stage, feel that I had both feet in the research so to speak, rather than one foot in and one foot out – the optimum position- I would take a step back, if necessary distancing myself from the project for as long as it would take for me to feel that I could resume a high standard of work.

I did, in effect, take advantage of this caveat but for reasons indirectly connected to the research. Life events conspired to make the time between writing up the methodology chapter and performing the analysis a difficult one for me. An experience of family bereavement triggered feelings of depression which made me decide to put the research on hold for the reasons outlined above. When I returned to

the research a couple of months later, I felt that I could give it the appropriate degree of commitment.

I found the analysis stage of the project extremely interesting and enlightening on both personal and professional levels. On several occasions, in elucidating their own intra-psychic processes, participants clarified and deepened my own understanding of the experience of depression. This has had inevitable ramifications for the ways in which I conceive of my future professional practice as well as for the manner in which I relate to myself. Thus, participants' universal resistance to the medicalisation of depression for instance, prompted me to reflect on the relationship between the conception of depression as an aspect of identity and the notion of depression as a biological illness. My participants seem to suggest that depression is first and foremost an aspect of identity and that this is to a large extent irreconcilable with a more medical conception of the phenomenon. Strikingly, none of my participants describe anti-depressants as helpful for instance, instead prising their ability to achieve 'recovery' without recourse to such medication.

This is in contrast to my own experience of having used anti-depressants to what I had thought was beneficial effect in the past, prior to completing this research project. During the analysis stage of the project, I speculated in my diary that it might be possible for depression to be both an aspect of self and a biological illness when these aspects of self experienced overwhelming degrees of suffering. I reflected that such suffering might be so intense as to elicit chemical changes in one's body which would respond to medication. Medication would thus alleviate the acuteness of one's suffering and in this sense depression could be conceived of as a biological illness. By

the time I wrote my discussion, however, the implications of these reflections had begun to sink in and, guided by my participants, I had reached the personal realisation that, whilst, of course, medication could potentially be helpful in taking the edge off one's suffering, it would never be able to cure the underlying vulnerability of a fragile part, a vulnerability that we term 'depression'.

This example of my reflections around the particular question of medication illustrates one of the many ways in which I was able to learn from participants throughout this study, drawing on their wisdom and insight to elucidate my own intra-psychic processes. Thus, for me, engaging in this research project has entailed a process of personal self-discovery paralleling that of the participants of my study. I feel deeply indebted to participants for sharing their stories with me and I feel confident that their insights will govern my future professional practice as a Counselling Psychologist working with adolescents.

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Appendices

APPENDIX A

Exploring Stories of Recovery from Teenage Depression

WOULD YOU LIKE TO SHARE YOUR STORY?

As part of my Doctoral Research in Psychology at City University I am researching adult experiences of recovery from adolescent depression. I am looking for participants in their twenties from a variety of backgrounds to share their stories with me. In providing an opportunity for your voices to be heard I would like the work we do together to make a difference to Psychologists' and others' awareness and understanding of the potential impact of depression at this age and of the complexity of the recovery process.

The research will involve a loosely structured interview with me and then your checking and approval of the written transcripts of our conversation. Confidentiality and privacy will be assured and each person may leave the research at any stage.

If you are interested in participating please contact me by email on Stephanie.moorsom@googlemail.com or on my mobile on 07837998540 and if I'm not there please leave a message giving your name and a contact number and I will contact you.

I very much look forward to hearing from you.
With thanks, Stephanie Moorsom.

APPENDIX B

INFORMATION SHEET FOR PARTICIPANTS

Research Project

Exploring adults in their twenties' narratives of recovery from teenage depression

Aims of the Study

- To understand how participants make sense of their experiences of adolescent depression.
- To gain insight into how participants feel the experience of depression at this time impacted on their developing sense of self and on their sense of self in adulthood.
- To gain insight into how external conditions- other people, organisations etc...- are perceived to have helped or hindered an individual's recovery process.
- To shed light on the complex process of recovery from depression experienced at a time of identity formation.

Procedure

- Consent form and explanation of the Research Aims, Procedure and Potential Risks associated with the research.
- Semi-structured interview lasting approximately one hour consisting of exploratory questions about recovery from teenage depression.

Possible Risks of the Research

Should you have any questions or require any information relating to the issues raised by the study, please do not hesitate to let the researcher know. Likewise, should any of the material in the study cause you any anxiety or distress, please feel free to discuss this at any time with the researcher who will provide you with the details of appropriate counselling services. As stated on the Consent Form, should you at any point in the research process wish to withdraw you will be at liberty to do so and you will in no way be compromised.

APPENDIX C

CONSENT FORM

EXPLORING NARRATIVES OF RECOVERY FROM ADOLESCENT DEPRESSION

This form will at all times be kept separately from all other research documents and at no point will I be identifiable by name in any part of the findings. The researcher's supervisor will be the only person who has access to this form in order to confirm that all participants have given consent.

I understand that my participation in this project will remain anonymous and consent to the session being recorded.

Yes No

(Please circle as appropriate)

Should this document be published in some form, I consent to the researcher using the material on the understanding that I will at no point be identifiable in any part of the document or findings.

Yes No

(Please circle as appropriate)

I have been informed of the purpose of this study and understand that the data collected will remain strictly confidential. I also understand that I may withdraw at any point during the session without any prejudice to me. I understand that the researcher conducting this study is abiding by the Ethical Principles of conducting Research with Human Subjects set out by the British Psychological Society (2004).

Signed by:

Researcher's Name: Date:

Participant's Name: Date:

APPENDIX D

CONFIDENTIALITY AGREEMENT ON THE USE OF AUDIO TAPES

This agreement is written to clarify the confidentiality conditions of the use of audio tapes by Stephanie Moorsom for the purposes of psychological research.

The participant gives Stephanie Moorsom permission to tape the interview on condition that:

- The permission may be withdrawn at any time
- The tapes are used solely for research analysis by Stephanie Moorsom
- The tapes will not be heard by any other person other than Stephanie Moorsom unless shared in confidence with the research supervisor or the DPsych Examiner
- The tapes will be stored under secure conditions and destroyed at the appropriate conclusion of their use
- This agreement is subject to the current Code of Conduct and Ethical Principals of the British Psychological Society and adherence to the law of the land in every respect

I have read and understood the above conditions and agree to their implementation.

Signed (Participant)
.....Date.....

Name (Block Letters)
.....

Signed
(Psychologist).....Date.....

APPENDIX E

RESOURCE LIST

If, after having participated in this research, you feel that the issues raised have caused you any form of distress, please refer to the below resources where help and support are available should it be required.

- www.bps.org.uk
  - You can click on the link titled 'Find a Psychologist' in the right-hand column of this website to search the directory of Chartered Psychologists. For convenience, you can enter your postcode and search for qualified therapists in your area.

- www.harleytherapy.co.uk
  - Independent practice of therapists offering short-term and long-term Counselling and Psychotherapy
  - Based in:
    - Central London - Harley Street, W1G 9QD
    - West End London - Portman Square, W1H 6HN
  - For appointments please ring 0845 474 1724 **(Mon-Sun 9am-10pm)**

- www.londonpsychologists.com
  - A group of Chartered Psychologists offering private and confidential therapy in a number of London locations
  - Please refer to website for list of therapists and relevant contact details

APPENDIX F

SEMI-STRUCTURED INTERVIEW

1) **Could you take me through your journey of recovery from depression starting at the beginning and ending at the present day?**

2) **What do you understand by the concept of recovery from depression?**

3) **How do you view adolescence?**

Within this general premise, as and when is deemed appropriate by the researcher, the following are questions that will be borne in mind:

4) **Could you tell me a little bit about your experience of teenage depression?**
   Probes: How old were you when you became aware that something was wrong?
   Who did you share this information with?
   Did you seek help? What form did this take?
   What treatment, if any, did you receive?

5) **How do you feel your experience of depression impacted on your life at the time?**
   Probes: How did you view yourself and feel about yourself?
   How were your relationships with peers affected?
   How were your relationships with family affected?
   What about romantic relationships?
   Was there an impact on academic performance?

6) **In hindsight how do you make sense of your experience of teenage depression?**

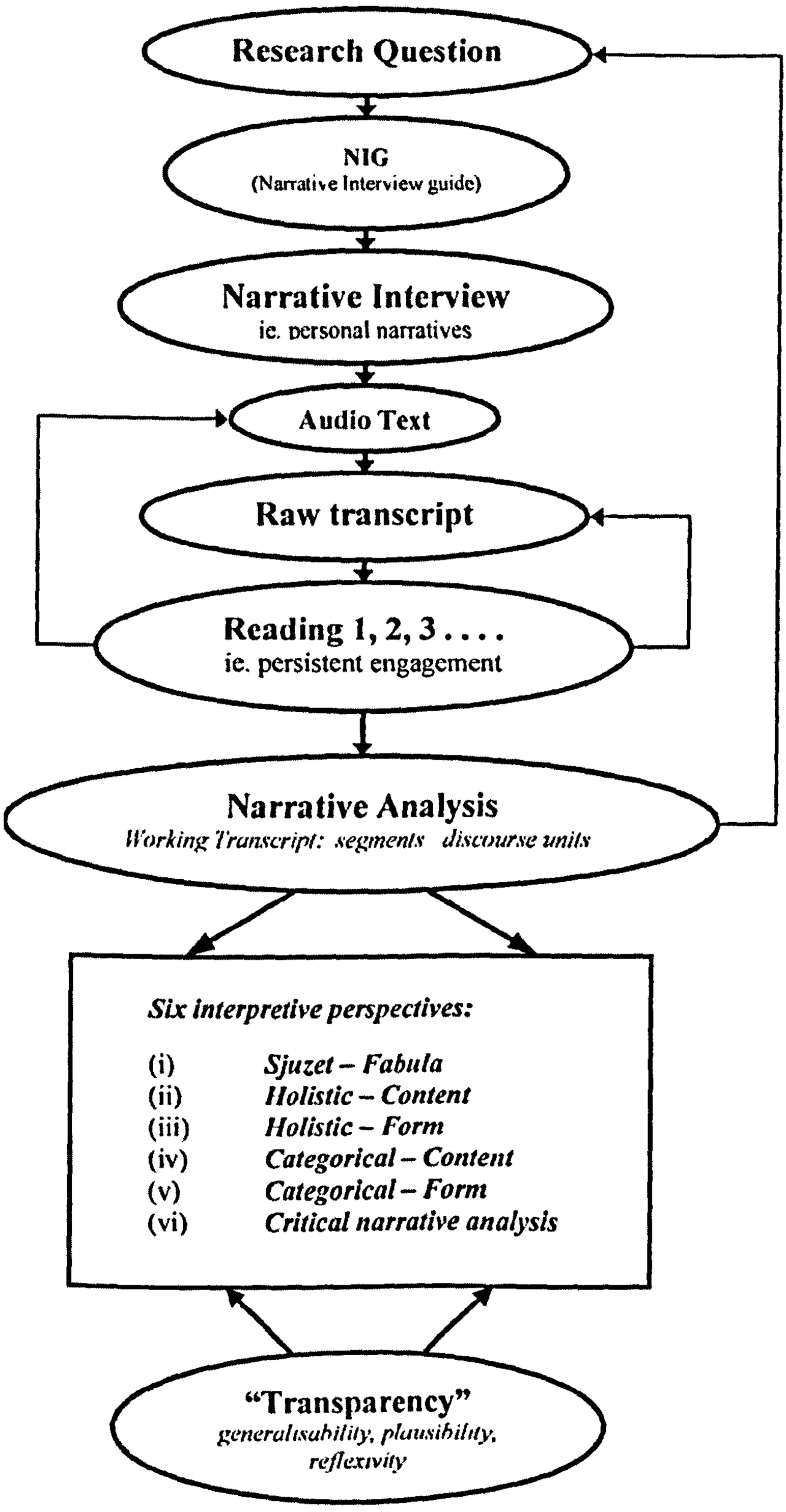
7) **How do you feel that the experience of depression at this time impacted on your development?**

8) **Do you view your experience of teenage depression as integral to your sense of self in adulthood or is it something you feel you have left behind?**
Probes: If you feel that the experience remains in some way integral to your sense of self, could you tell me more about what this means for you? How has the experience left its mark?

9) **What, if any, are the ramifications of the experience of teenage depression on your adult life now?**
Probes: occupational, relationships, social roles adopted…

10) Is there anything you would like to ask me?

APPENDIX G: Hiles & Cermak (2008) model of NOI



Appendix H: extract from working transcript

szujet — withdrawal vs. inclusion

fabula — isolation

Interviewer — stylistic devices

It was almost like I was stuck in this bubble and I couldn't quite communicate with any of my friends and I was quite withdrawn and kind of in my own world. And I'd gone from being quite popular and outgoing, and then I just kind of shrunk you know a bit into myself. And my friends couldn't, they didn't know quite how to deal with that and it was almost then like the rejection from them because it was just like 'that's too much for us to handle'. **Right, so that was something that you felt you experienced- rejection from them.** Yeah. Because it was like, obviously in	Segment 1 *early adolescent experience of tension between withdrawal and inclusion* Segment 2 *intensification of feelings of isolation as experiences rejection from friends* *Retrospective narration* *Narrator: conveys perspective of recovered adult situated in present and*

hindsight now I can see it. There wasn't really anybody, you know, because we all had difficult families and stuff but everyone took it in their stride. **It felt like that to you.**	*retrospectively narrating events from memory.*

SECTION C: CRITICAL LITERATURE REVIEW

What role does perfectionism play in the onset and maintenance of eating- disorder symptoms?

Overview of literature review

In contrast to the research piece, this literature review was written at the beginning of my training as a Counselling Psychologist. I am very much on the scientist-practitioner end of the spectrum in this piece of work as I strive to explicitly differentiate and compartmentalise "onset" and "maintenance" factors. My overriding concern is to promote increased clarity in the field by adopting a standardised conceptual definition of perfectionism within which all facets of the phenomenon might be rendered duly accountable.

Such rigorous evaluation notwithstanding, this review also shows me moving towards an acknowledgement that my positivist approach may have prevented a sufficiently in depth exploration of the specific and different ways in which perfectionism manifests itself in each eating disorder. Thus, even at this early stage in my development, it is possible to see my process evolving from a scientist-practitioner orientation, to a more reflexive yearning for increased depth in my work. This is a trend that will eventually culminate in my espousal of qualitative research's vision of knowledge as fluid and relative in the research project, and which will in turn facilitate my paradigm shift from CBT to IFS.

Introduction

The National Institute for Clinical Excellence (2004) specifies that twenty four in a thousand women and girls today suffer from Anorexia Nervosa (AN) and Bulimia Nervosa (BN). These eating disorders tend to run an intense and protracted course

and, characteristically, 35 % of women treated for eating disorders tend to relapse after recovery. The American Diagnostic and Statistical Manual (DSM-IV, 1994) describes Anorexia Nervosa (AN) as being characterized by emaciation, intense fear of gaining weight, undue influence of body shape and weight on self-evaluation and amenorrhea in post-menarchal females. It distinguishes between Restricting (no regular binge eating or purging behaviour) and Binge eating/Purging types of AN. It describes Bulimia Nervosa (BN) as being marked by recurrent episodes of binge eating, compensatory behaviour to avoid weight gain, e.g. self-induced vomiting, and undue influence of shape and weight on self-evaluation. It specifies Purging (self-induced vomiting or abuse of laxatives after eating) and Non-purging types of BN.

It is only relatively recently that research attention has shifted from an external focus on the socio-cultural pressure to be thin as a risk and maintenance factor for AN and BN to consider the role of intrapersonal factors in the onset and maintenance of these disorders. This shift in emphasis was gradually effected in response to research illustrating that eating disorders, and especially AN, are not Western culture-bound syndromes. Keel & Klump (2003) showed that there are many descriptions of AN from non-Western cultures and that there are well-documented cases dating back to the middle ages, whilst Ravin (2009) highlighted that in China and in Ghana, AN is as prevalent as it is in the United States. Psychopathology and justification for weight loss in these cases is not based on the current slim body ideal and concerns about weight or shape. Rather these cases complain of an inability to eat and may justify their food restriction in terms of ascetic or religious ideals. Moreover, in a study of risk factors for AN, Fairburn, Cooper, Doll, & Welch (1999) found that factors which increased the likelihood of dieting, such as weight-shape related criticism by family members, had no independent effect. These studies' findings imply that cultural and

familial pressures to be thin form only a part of the story of how eating disorders originate and develop.

Various intrapersonal factors have been found to be implicated in the onset and maintenance of AN and BN. Researchers have investigated the roles of low self-esteem, and what Schmidt and Treasure (2006) term *experiential avoidance* and Fairburn, Cooper, & Shafran (2003) call *mood intolerance*, as well as the function of perfectionism, in triggering and perpetuating these disorders. Perfectionism stands out in the eating-disorder literature as the causal and maintenance factor which has received the majority of research attention to date. Many researchers have suggested that the common central features of both AN and BN (in particular striving for a perfect weight and body shape) are inherently perfectionistic (Goldner, Cockell, & Srikameswaran, 2002; Fairburn et al., 2003; Wade, Tiggeman, Bulik, Fairburn, Wray, & Martin, 2008). Some questionnaires to assess eating disorders have a subscale to assess perfectionism, such as the Eating Disorders Inventory (Garner, Olmstead, & Polivy, 1983), the Setting Conditions for Anorexia Nervosa Scale (Slade & Dewey, 1986) and the Eating Disorder Examination Questionnaire (Lavender, Kyle, & Anderson, 2009). Patients with AN have been described as "perfectionistic, compliant and isolated girls" (Vitousek & Manke, 1994, p. 138).

The most recent comprehensive review of the current status and future directions in perfectionism and eating disorder research was conducted by Bardone-Cone, Wonderlich, Frost, Bulik, Mitchell, Uppala, S., & Simonich (2008). Upon reading Bardone-Cone et al's review I was struck by the way in which each study reviewed seemed to adopt a different definition of perfectionism and seemed to measure the concept in a different way. Furthermore, findings seemed to be dependent on the mode of assessment employed in each individual case thus making it very difficult to

establish correlations between the results of different studies. The fact that Bardone-Cone et al. did not draw explicit attention to the lack of clarity in the field led me to hypothesise that the confusion inherent in perfectionism studies has become the accepted status quo. This highlighted the need for a review which would challenge this state of affairs by exploring the research to date, whilst simultaneously exposing the confusion in the field. I hope that by making the inconsistencies and disparities between studies on perfectionism in eating disorders apparent, an argument will be made for adopting a standardised conceptual definition of perfectionism in which this does not become confused with its methods of measurement.

I feel that this review will have important implications for the field of Counselling Psychology. If practitioners could understand exactly how the phenomenon of perfectionism functions, the types of insights and interventions on offer to eating-disordered patients could be improved. A clearer understanding of perfectionism, based on a standardised definition, would enable Counselling Psychologists to discriminate more precisely between the causal and maintenance factors at work in each individual eating-disordered patient's presentation. I hope that increased accuracy at the assessment and formulation stages of therapy would in turn be likely to generate better treatment outcomes. Increased conceptual clarity might also shed light on the question of why, in spite of extensive research on causal and maintenance factors in eating disorders, people continue to remit after treatment.

Defining Perfectionism

Perfectionism has been defined in a multitude of ways in the literature. It has been described as "the tyranny of the shoulds" (Horney, 1950, p. 175). Hollender (1978, p. 94) defined it as "the practice of demanding of oneself or others a higher quality of

performance than is required by the situation". Shortly after this trait-based account, Burns (1980, p. 43) described perfectionism as a "network of cognitions" that includes, "interpretations of events, and evaluations of oneself and others". Frost, Heimberg, Holt, Mattia, & Neubauer (1990, p. 451) extended Burns' understanding of the concept to include an emphasis on "overly critical self-evaluation" as an essential component of perfectionism.

Whilst the above descriptions might not seem particularly revelatory to the Counselling Psychologist working with this population, Antony & Swinson (1998) have added some interesting behavioural insights to the field. They have argued that perfectionism can manifest itself in terms of careful checking, reassurance seeking, correcting others and excessive consideration before making a decision. They argue that these may all be motivated by a fear of failure. Alternatively they argue that perfectionism may be exhibited as avoidance of situations in which an individual feels pressure to meet his/her high standards or as prematurely ending tasks because these standards are unlikely to be met. This suggests that it might be extremely helpful for counselling psychologists to look out for signs of avoidance behaviour in therapy as potential indicators of perfectionist tendencies.

According to the definitions considered so far, perfectionism is self- defeating. However, Hamaeck (1978) has suggested that perfectionism can be normal. He believes that people with normal perfectionism set high standards in a similar way to people with neurotic perfectionism but, unlike the latter, they feel satisfied once the standards have been achieved. For this reason it has been suggested that perfectionism can be divided into categories of positive and negative (Slade & Owens, 1998) corresponding to Hamaeck's (1978) normal/ neurotic categories. These distinctions are complicated, however, in the case of AN which, it has been hypothesized, is

associated with positive perfectionism (Mitzam, Slade, & Dewey, 1994; Terry-Short, Owens, Slade, & Dewey, 1995). This hypothesis was based upon clinical observations that AN patients feel morally superior due to their food restriction and that successful restriction makes them feel triumphant, powerful and proud (Vitousek & Manke, 1994; Ravin, 2010). These authors conclude that although positive perfectionism is reported as being rewarding, it may have detrimental effects on the physical health of an individual, on their long-term well being, and on those surrounding the patient.

Measuring Perfectionism

The perfectionism subscale of the Dysfunctional Attitudes Scale (DAS; Weissman & Beck, 1978) was an early attempt to measure perfectionism and this was adapted by Burns (1980). These scales both regard perfectionism as being unidimensional. They focus on seeking to ascertain the relationship between "the dependence of self-evaluation on attainment" (Shafran, Cooper, & Fairburn, 2002, p. 774). A similar unidimensional measure of perfectionism developed in the early 1980s forms a subscale of the widely-used Eating Disorder Inventory (Garner et al, 1983). Both of these scales are still used today in spite of a shift originating in the early 1990s towards considering perfectionism as a multidimensional phenomenon.

This shift in perspective occurred as a result of clinicians' observations that perfectionist people's concern about making mistakes and preoccupation with cleanliness had been over-emphasized. It was also felt that research had neglected to focus on perfectionism's interpersonal aspects which played an important role in adjustment difficulties (Hewitt & Flett, 1991). In response to this, Frost et al. (1990) and Hewitt & Flett (1991) each developed self-report measures of perfectionism both called the Multidimensional Perfectionism Scale (MPS).

Frost et al's measure covers (i) Concern over Mistakes (viewing errors as indicative of personal failure) (ii) Doubts about Actions (iii) Personal Standards (a tendency to set the bar very high in terms of personal achievement) (iv) Parental Expectations and (v) Parental Criticism. Hewitt & Flett's measure consists of three subscales (i) Self-oriented perfectionism (this addresses most of the clinical features of Frost et al's measure), (ii) Other-oriented perfectionism (setting high standards for others to live up to) and (iii) Socially-oriented perfectionism (the tendency to believe that others are judging one against their own high standards).

The literature today broadly represents perfectionism as a multidimensional construct, no doubt as a result of the prevalence of these two measures. Shafran et al. (2002) suggest that these scales do not reflect the original construct of perfectionism, however, which was primarily concerned with the pursuit of excessively high personal standards and rigid adherence to them. They argue that socially prescribed and other-oriented perfectionism are not part of this original construct but are simply associated with it. For these authors, the core feature of clinical perfectionism is "the overdependence of self-evaluation on the determined pursuit of personally demanding, self-imposed, standards in at least one salient domain, despite adverse consequences" (Shafran et al., 2002, p. 778). Perfectionism is described as clinical in this case because, in spite of being considered positive by sufferers, it has adverse physical and psychological consequences.

In the current review I will seek to clarify the exact role played by perfectionism in the onset and maintenance of AN and BN. By looking at the ways in which researchers have defined and measured the existence of perfectionism in eating disorders to date, I hope to highlight particular aspects of the concept of which Counselling Psychologists should be aware when working with anorexic or bulimic clients. I will also compare

and assess studies for the emergence of trends, or for the presence of inconsistencies which might either contribute to or hinder progress in this field of enquiry.

The Current Review

Method

A comprehensive search of the *PsycInfo, Medline* and *ScienceDirect* electronic databases was conducted for studies on perfectionism and eating disorders. The literature search was limited to studies published since 1998. Eating disorder-related keywords used were eating disorder, anorexia, anorexia nervosa, bulimia and bulimia nervosa. Studies of interest which could not be accessed online were located in the Journal Room of The Institute of Psychiatry, Denmark Hill. Articles selected for review all used participants with diagnosed eating disorders. I felt that reviewing the multitude of studies of eating and perfectionism among nonclinical participants might have presented an inaccurate picture of perfectionism in eating disorders. I organised articles to be reviewed in terms of the research question they addressed. I identified three broad research questions pertinent to this study's inquiry and in this review I will examine each in turn.

Does premorbid perfectionism predispose people to suffer from eating disorders?

Fairburn et al. (1998) assessed perfectionism in childhood in a large-scale community study that examined risk factors for patients with BN and AN using Frost's multidimensional scale. Along with Shafran et al. (2002) they identified high "Personal Standards" as a specific risk factor for AN and BN in eating disorder patients, compared to healthy controls. It should be borne in mind, however, that this

study depended heavily on data supplied by the participants since researchers were aware that a high degree of secrecy characterizes both disorders and that few of their subjects would have given them permission to contact other informants. This exclusive focus would have introduced an element of subjective bias into the results.

Karwautz, Rabe-Hesketh, Collier, & Treasure (2002) employed the Hewitt and Flett scale to assess perfectionism in anorexic individuals and used the patients' healthy sisters as the control group. They found that the ill sister reported having elevated rates of premorbid perfectionism, specifically on the self-oriented perfectionism dimension, which includes a "Personal Standards" component, compared to her never-ill sister. I feel that the use of sister- pairs is a particular strength of this study which overcomes some of the cultural and familial biases inherent in Fairburn et al's (1998) case-control design where unrelated controls were used. In spite of the fact that these two studies employ different scales to measure perfectionism, they both find this to be characterised by a tendency to set oneself high personal standards. This is found to precipitate the development of both AN and BN.

Both of these studies recruited their subjects directly from the community. They were thus more broadly representative, and less affected by referral bias, than studies which recruit samples from specialist clinics whose eating disorders might be expected to be more severe. However, the data in each of these studies is derived from self-report measures which have been shown by Stone, Bachrach, & Jaylan (1999) to amplify the potential for misunderstanding, the exaggeration or underrepresentation of symptoms and the influence of social desirability. I recommend that the findings of these two studies be interpreted with this in mind.

Fairburn et al (1999) attempted to circumvent the limitations inherent in self-report by employing an interview method with interviewer-based ratings (i.e. categories to assess perfectionism designed by the interviewer). They assessed a broad range of risk factors for AN and BN by interview using a case-control design involving the comparison of female subjects with a history of AN with healthy control subjects, subjects with other psychiatric disorders, and subjects with BN. They found that *negative self-evaluation*, the interviewer-designed category most akin in my opinion to the *doubts about actions* of Frost's scale, was particularly elevated in patients with a history of AN whilst patients with a history of BN tended to be particularly susceptible to the criticism of others, especially of other family members.

These results were echoed in Striegel-Moore, Fairburn, Wilfley, Pike, Dohm, & Kraemer's (2005) study which used a similar interview-based case-control study design to find that individuals with non-purging BN reported higher levels of perfectionism fuelled by perception of parental expectations than a healthy control group, but comparable levels to a general psychiatric control group. These studies' findings suggest that the premorbid perfectionism associated with AN differs from that associated with BN. Whilst girls who go on to develop AN tend to experience negative self-evaluation and self-criticism, girls who go on to develop BN tend to exhibit an external locus of control and to respond principally to the perceived criticism of others. I would argue that additional research employing larger sample sizes is required to further explore this emerging distinction.

Anderluh, Tchanturia, Rabe-Hesketh, & Treasure (2003) also used interviews and interviewer-based ratings to assess premorbid perfectionism. They found evidence that

people with AN had higher childhood levels of certain obsessive -compulsive personality traits including perfectionism -which they defined in terms of cognitive rigidity- than did healthy controls and they found that the onset of AN led to a worsening of this rigidity.

I would argue that a significant limitation of these three studies is that they all use their own interviewer-designed categories to both define and assess perfectionism. This makes it very difficult to generalise from their findings with any degree of accuracy. I feel that a further limitation of these studies is that it would have been impossible for interviewers to be blind to the severity of an AN diagnosis when they were confronted with severely emaciated subjects. Indeed Schmidt & Treasure have described AN as perhaps the only psychiatric "spot diagnosis" (Schmidt & Treasure, 2006, p. 343). This would have introduced the possibility for interviewer-bias in the interpretation of results. A possible way around this might have been to tape interviews and to have someone blind to the subjects' appearance rate them, or to conduct interviews by telephone. A limitation specific to the Anderluh study is that subjects were undergoing simultaneous medical treatment which may have had an impact on the reliability of their accounts and thus undermined the validity of the findings.

Most of the work addressing the question of whether premorbid perfectionism predisposes people to suffer from eating disorders involves retrospective assessments of perfectionism. As Kazdin (2003) has made clear, inherent in a retrospective study design are problems related to accurate recall, subjectivity in reporting, selective recall, and recall biased by outcome. In this respect it should be stressed that such

problems are to do with the retrospective nature of the design rather than the nature of the population upon which the study is carried out. To quote Brewin, Andrews, & Gotlib (1993, p. 82) "there is little reason to link psychiatric status with less reliable or less valid recall of early experiences." Nevertheless in order to determine whether perfectionism is a true risk factor for eating disorders, assurances of precedence are crucial, and this, as argued extensively by Jacobi et al. (2004), in their bulletin exploring appropriate study designs for the identification of risk factors in eating disorders, requires prospective, longitudinal designs.

Tyrka, Waldron, Graber, & Brooks-Gunn (2002) temporally structured assessments in an attempt to predict onset of eating disorders. They collected data on young females across three time points by interview: T1 (ages 12-16), T2 (two years after T1- ages 14-18), and T3 (eight years after T1, ages 20-24). High school onset (i.e. by T2) of an AN or BN syndrome was not predicted by perfectionism assessed at T1 after controlling for initial eating disorder symptom levels. However, for young adult onset (i.e. by T3) of AN, EDI- Perfectionism, assessed at either T1 or T2, was a significant prospective predictor. Perfectionism did not significantly predict young adult BN syndrome. A significant strength of this study, identified by its authors, is that interviews at all three stages were conducted by telephone thus eliminating interviewer-bias based on the potentially emaciated appearance of subjects. Given my observation that different facets of perfectionism seem to be associated with the development of AN and BN, this study's choice of the EDI to assess premorbid perfectionism for both AN and BN seems misjudged. The EDI is a unidimensional measure which conceives of perfectionism in terms of negative self-evaluation. It would therefore be unlikely to capture effectively those shades of perfectionism

apparently associated with the development of BN and concerned with responding to the perceived criticism of others.

In Santonastaso, Friederici, & Favaro's (1999) study, premorbid perfectionism, measured prospectively with the EDI-Perfectionism, was not one of the variables that predicted which asymptomatic girls subsequently developed an eating disorder (AN or BN) across a year's time. These authors concluded that rather than representing a risk factor, perfectionism appeared to be a maintenance factor for subjects who presented a full or partial eating disorder at baseline. I suggest that this study would benefit from replication with a larger sample size. It would also benefit from being more explicit about how risk and maintenance factors are defined.

Vohs, Bardone, Joiner, & Abramson (1999) found that perfectionism assessed by interview with interviewer-based ratings during the senior year of high school predicted the development of bulimic symptoms during the freshman year in college. Importantly, however, perfectionism functioned as a risk factor only when the individual considered herself to be overweight and also had low self-esteem. This is an interesting finding which seems to support my observation that premorbid perfectionism in BN seems to be characterised by a hypersensitivity to the perceived criticism of others. I would argue that a significant limitation of this study, as with the previous Fairburn et al. (1999) and Anderluh et al. (2003) studies, is its use of interviewer-based ratings to assess perfectionism. Another limitation of this study, overlooked by its authors, is that the possibility that subjects may have had an eating pathology while their "premorbid" personality assessment was conducted was not

ruled out. Thus I feel that this cannot be considered to be a true prospective longitudinal design.

Overall, the existing evidence supports the hypothesis of a predictive relationship between premorbid perfectionism and eating disorders. The research suggests that a predisposition to strive for high personal standards underlies both disorders, that AN patients report a premorbid tendency towards negative self-evaluation and self-criticism and that BN patients tend to be particularly hypersensitive to the criticism of parents and close others prior to the onset of their disorder. Given the differences noted between the experiences of premorbid perfectionism of AN and BN sufferers, I would suggest that future research focus on the aetiology of each disorder separately so as to generate more specific understandings of how each develops.

In synthesising results significant difficulties arise in pinpointing which specific aspects of perfectionism predict onset of eating disorders and whether these differ significantly between AN and BN samples. These difficulties arise principally from the fact that no two studies assess perfectionism in the same way. Multidimensional scales, interviewer-designed ratings, unidimensional scales- all imply a different understanding of the concept being measured. This makes it difficult to compare findings and to determine the correlations between the results of different studies. This points to the overwhelming need for clarity in the field and for the desirability, as I argued in the introduction, and as argued by Shafran et al. (2002), of adopting a standardised conceptual definition of perfectionism in which this does not become confused with its methods of measurement.

What role does perfectionism play as a maintenance factor in eating disorders?

According to Schmidt & Treasure (2006), interesting as they are, accounts of the aetiology of eating disorders are less likely to generate specific treatment advances than specific models of the maintenance of these disorders. I would agree with this and argue that, especially from a Counselling Psychologist's point of view, given that the current therapeutic interventions of choice in the treatments of AN and BN are Cognitive Behavioural in nature, a focus on the here and now in research may be of more direct relevance to practice than research investigating the role of precipitating factors. Before reviewing the studies that have considered the role of perfectionism as a maintenance factor in AN and BN I must point out that in selecting articles for review I adopted the following definition of a *maintenance factor*: "a factor that predicts symptom persistence over time versus remission among initially symptomatic individuals...if an experimental increase or decrease in a factor among initially symptomatic individuals results in symptom expression or suppression, respectively, it may be referred to as a causal maintenance factor" (Stice, 2002, p. 827).

Sutandar-Pinnock, Woodside, Carter, Olmstead, & Kaplan (2003) examined the relationship between perfectionism and outcome in AN. Participants, all of whom were receiving inpatient group treatment for AN, were asked to complete the EDI at admission, at discharge, and half way through treatment. At follow up they also completed Frost et al's scale and their scores were compared to those of healthy controls. The authors concluded that the EDI measures an aspect of perfectionism that is sensitive to illness status and that some aspects of perfectionism represent a transient state associated with clinical status. They argued that Frost et al's

multidimensional scale by contrast "is less dependent on clinical state and may reflect a common personality trait that persists with remission of disease" (p.225). These are interesting hypotheses which support Hamaeck's argument for differentiating between normal and neurotic perfectionism in defining the concept (see Introduction).

This study also has implications pertinent to the kind of treatment best suited to highly perfectionistic individuals with AN. Its results suggest that individuals who are highly perfectionistic may find it harder to engage in a treatment program that relies primarily on group therapy. The authors do not elaborate on this but this review speculates that this might be because this type of therapy requires sufferers to share their problems and therefore reveal themselves as imperfect to other patients. Because of the rigidity in their thinking they may not be able to make the psychological adjustments that would be necessary for them to recover from their eating disorder with this type of treatment. I think that these findings are extremely interesting and that they consequently deserve replication and elaboration in a larger, more representative sample. A more complete understanding of perfectionism in this population might lead to improved treatment outcomes by enabling counselling psychologists to provide interventions tailored specifically to the needs of their more perfectionistic patients.

Bizeul, Sadowsky, & Rigaud (2001) found that higher initial levels of EDI-Perfectionism were significantly associated with a poor prognosis 5-10 years post-inpatient admission in patients with Restricting AN. They demonstrated that the higher the scores of perfectionism and of interpersonal distrust on the EDI, the worse the prognosis. The authors interpret the data as indicating that, in these severe patients,

the prognostic value of the psychological background remains preponderant over the severity of the body weight loss. Again I feel that this work should be considered preliminary because of the small sample size. In particular I think that it would be desirable to study a larger group including Binging/Purging AN sufferers and BN patients before concluding that high levels of perfectionism are predictive of bad outcome in eating-disordered populations. I feel that it should be borne in mind, as observed previously, however, that the EDI is a somewhat narrow measure of perfectionism since it principally assesses negative self-evaluation. If research were to be extended to consider BN patients therefore, I recommend that a multidimensional measure of perfectionism be used. An important insight gleaned from this study is that it might be helpful in future prospective studies, and for therapeutic approaches, to classify patients into two classes: those whose cognitive symptoms are moderate or slight, who are likely to recover, and those whose cognitive symptoms are severe and who are likely to remain chronically ill.

Santonastaso et al. (2001) investigated whether medication might influence perfectionism levels in AN patients. They found that the SSRI sertraline was associated with decreased EDI perfectionism between baseline and 14-week follow-up among AN patients; no significant perfectionism change was reported in the placebo group. The authors concluded that offering medication to those AN patients with particularly high EDI-Perfectionism scores might enable them to engage more successfully with treatment. Yet again I would argue that this study would benefit from replication with a larger sample size. Furthermore, no such study has been carried out with patients with BN and I strongly recommend this as an area for future

research although again, I would stress that a measure other than the EDI be used to assess perfectionism in BN patients.

Mussell, Mitchell, Crosby, Fulkerson, Hoberman, & Romano (2000) found that EDI-Perfectionism did not predict treatment completion or bulimic symptom remission at the end of cognitive-behavioural therapy above and beyond bulimic severity levels and depressive symptomatology. Nor did it predict remission at a six month follow-up above and beyond symptom remission status at end of treatment. Again this may have had more to do with the measure used to assess perfectionism in BN than with the actual manifestations of the concept. I feel that the generalisability of this study's findings is further limited by the homogeneity of the sample demographics.

In summary, perfectionism appears to be a negative predictor of outcome for AN, but to be less of an influence on BN outcome. However this could well be because all of these studies assess perfectionism using the EDI which relies upon a rather narrow understanding of the concept, based on negative self-evaluation. Overall, the studies investigating perfectionism's role as a maintenance factor in AN and BN, like those concerned with its role as a risk factor, seem to rely on indiscriminately applied assessment measures to define the concept for them without giving this due consideration in and of itself. Maintenance models by Fairburn et al. (2003) and Schmidt & Treasure (2002) are exceptions to this critique however.

According to Fairburn et al. (2003) a network of four inter-related maintaining mechanisms including clinical perfectionism interact with a central cognitive disturbance characterised by the over-evaluation of eating, shape and weight and their

control, to account for the persistence of both AN *and* BN. This study has important implications for the treatment of eating disorders and is thus of particular importance for the Counselling Psychologist working with this population. These authors outline a *transdiagnostic* theory of the maintenance of eating disorders and explain how the existing Cognitive-Behavioural treatment of BN might be extended to accommodate treatment of AN.

All of their suggestions, derived from years of clinical experience of working with eating disordered populations, are based on the observation that while the theory underpinning CBT for BN is valid, the existing treatment procedures are not sufficiently potent. They argue for a need to focus specifically on clinical perfectionism in treatment and they explain that in both AN and BN the patient's perfectionist standards are applied to the attempts to control eating, shape and weight, as well as to other aspects of their life (e.g. their performance at work or sport). Fear of failure (fear of overeating, 'fatness', weight gain); frequent and selective attention to performance (repeated calorie-counting, frequent shape and weight checking) and self-criticism arising from negatively biased self-appraisals of performance all result in secondary negative self-evaluation which in turn encourages even more determined striving to meet valued goals – striving to meet goals in the domain of controlling eating, shape and weight- thereby serving to maintain the eating disorder. Therefore these authors predict that were these patients' clinical perfectionism to be corrected, a potent network of maintaining mechanisms would be removed, thereby facilitating change. Treatment would also focus on three other identified maintaining mechanisms including core low self-esteem, mood intolerance and interpersonal difficulties. Given my observation that AN and BN sufferers' experiences of premorbid perfectionism

seem to be qualitatively rather different, I am cautious in endorsing such a transdiagnostic approach which does not differentiate between the disorders. I would recommend a transdiagnostic treatment trial in order to test not only this relatively recent treatment but also the theory upon which it is based.

Meanwhile Schmidt & Treasure (2006) reject this proposal of a transdiagnostic approach to the treatment of AN and BN. They argue that evidence supports the notion that the Restricting type of AN should be considered a distinct and separate phenotype. They propose a model of the maintenance of AN which combines intra- and interpersonal maintaining factors. These include clinical perfectionism, which the authors argue is especially prevalent in the Restricting type of AN. They quote the Anderluh et al. (2003) study reviewed above as evidence that people with AN have higher levels of childhood rigidity and perfectionism than those with BN and that the onset of AN leads to a worsening of this rigidity and perfectionism. Perfectionism for these authors is defined in terms of the setting of high personal standards and the fear of making mistakes. These are believed to interact with avoidant personality traits (manifested in terms of pulling away from intimacy and close interpersonal contact), pro-anorectic beliefs and reactions to the responses of close others to maintain the illness. Whilst these authors concede that clinical perfectionism is not entirely specific to AN, they argue that what *is* specific to AN is the way in which it meshes with these other factors and becomes associated with the avoidance of food. As of yet no studies have been conducted to test Schmidt and Treasure's model and future research should consider taking up this challenge. The detail with which these authors outline those specific aspects of perfectionism which interact with other factors to maintain AN marks a contrast with studies previously reviewed which lack this degree of precision.

Schmidt & Treasure outline some important treatment implications of their study of which I feel that Counselling Psychologists should take note. Existing CBT models and interventions for AN have tried to build on the success of CBT for BN by adopting a similar treatment focus (i.e. weight and shape concerns) and structure (i.e. using self-monitoring of food intake and cognitions related to eating, weight and shape as a key therapeutic tool, introduced early on in treatment). Schmidt & Treasure's model, however, suggests that, given the AN patient's combination of being both perfectionistic and emotionally avoidant, a somewhat different style, focus and structure of treatment may be more appropriate. I would suggest that the more empathic, reflective style of motivational interviewing, for instance, where the patient is seen as the expert and the therapist adopts a curious, patient 'one-down' position, might be very helpful in engaging the person with AN. This would also be particularly suited to the reflective-practitioner, humanistic ideological background of the Counselling Psychologist. I would recommend that future research focus on testing the efficacy of such an approach with patients with AN.

Do relatives of eating disordered individuals have elevated perfectionism?

So far I have looked at studies concerned with the role of premorbid perfectionism in predisposing individuals to suffer from eating disorders and studies focussing on the role played by perfectionism as a maintenance factor in AN and BN. I now move on to consider research looking at whether the perfectionism of relatives and close others affects the onset of eating disorders. Studies addressing this question are responding to the heritability of personality traits and the hypothesis outlined by Lilenfeld, Wonderlich, Riso, Crosby, & Mitchell (2006) that eating disorders and personality

traits may share an underlying familial liability.

Kaye, Lilenfeld, Berrettini, Strober, Devlin, & Klump (2000) reported on probands with AN and siblings who had a lifetime diagnosis of AN or BN. They found that the strongest vulnerability factor for the development of AN was a combination of five personality traits, one of which was perfectionism measured multidimensionally on Frost's scale. This study's comprehensive recruitment of in excess of 500 subjects, consisting of affected subjects and relatives, as well as their biological parents, provides an excellent basis for future research to investigate genetic transmission of eating disorders.

Lilenfeld, Stein, Bulik, Strober, Plotnicov, & Pollice (2000) used a smaller sample of women with BN, matched control women and first-degree female relatives, and found that female relatives of bulimics had elevated perfectionism on the Frost's scale, regardless of whether the relatives themselves had an eating disorder history. Unlike Kaye et al. however, Lilenfeld et al. assessed a relatively small number of recovered BN probands and relatives and thus we suggest that the research would benefit from replication with larger numbers. A further limitation, identified by the study's authors, is that not all affected relatives were directly interviewed, nor completed all assessment questionnaires.

Studies of the personality of parents of individuals with AN and BN are rare. Other than these two studies, there has been essentially no examination in parents of affected individuals of those dimensions of temperament believed to be important in the development of eating disorders. Clearly I feel that this is an area which would benefit from extensive further research.

Summary

Overall my literature review supports the notion that premorbid perfectionism predisposes individuals to suffer from eating disorders. Broadly the research suggests that a predisposition to strive for high personal standards of achievement underlies both AN and BN. I would argue that differences emerge however in the facets of perfectionism associated with each disorder. AN patients tend to report a premorbid tendency towards negative self-evaluation and self-criticism whilst BN patients tend to be particularly hypersensitive to the criticism of parents and close others prior to the onset of their disorder. I recommend that the different experiences of premorbid perfectionism of AN and BN sufferers be investigated more fully in future. I would also like to suggest that a qualitative methodology might be well suited to capturing the nuances of experience associated with each disorder. I feel that such a study would be especially welcome given the dearth of qualitative studies in the field.

The research reviewed places differing emphases on the influence of perfectionism as a maintenance factor in eating disorders. Whilst the majority of studies indicate that perfectionism appears to be a negative predictor of outcome for AN, it is deemed to have less of an influence on BN outcome. A counter-argument is presented to this in Fairburn et al's (2003) study however in which the authors stress that clinical perfectionism is a key maintenance factor in both disorders.

I would argue that the degree to which individuals' predisposition to suffer from eating disorders is genetically or environmentally determined requires further exploration. Kaye et al. (2000) have set the scene for investigation of genetic transmission of eating disorders but as of yet no such research has been executed.

Conclusion

In synthesising and summarising the results of studies for review, I encountered significant difficulties in pinpointing which specific aspects of perfectionism predicted onset and maintenance of eating disorders and whether these differed significantly between AN and BN samples. Inconsistencies in results between studies might in part have been derived from the fact that they all sought to measure such a multifaceted construct. No two studies adopted the same conceptual definition of perfectionism. They all assessed the construct differently and findings seemed to be dependent on the mode of assessment employed in each case. This made it difficult to compare findings consistently and to determine the correlations between the results of different studies. Undertaking this review has highlighted an overwhelming need for clarity in the field of perfectionism studies. It has also made explicit the desirability, as argued repeatedly above, of adopting a standardised conceptual definition of perfectionism in which this does not become confused with its methods of measurement.

An additional point that has emerged from carrying out this review is that all of the research considered exclusively focuses on female subjects. This is due to the fact that the prevalence of eating disorders is approximately nine times higher in women than in men. I would argue however that further studies that include male subjects are needed to better understand the role of perfectionism in the onset and maintenance of eating disorders.

In this review I focused on perfectionism's role as an onset and maintenance factor in both AN and BN because I felt, in line with Fairburn et al. (2003), that a more transdiagnostic approach might be helpful in terms of generating treatment

interventions. In hindsight I feel that this broad focus may have prevented a sufficiently in depth exploration of the specific and different ways in which perfectionism manifests itself in each disorder. I would encourage future researchers in the field to further explore these differing manifestations. I would furthermore make this incitement all the more urgent given the dearth of new research in this particular area over the last two years.

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SECTION D: CLIENT WORK

Deconstructing Perfectionism:

A Combined Advanced Cognitive Behavioural Process Report and

Case Study

Introduction to the therapeutic work

Overview

I have chosen to present my work with Juliette[1] because it shows me beginning to wrestle with my ideological sense of the limitations of second-wave CBT. In this process I strive to incorporate third-wave innovations into my practice, thus consistently and reflexively developing my compassion. This marks the beginning of my paradigm shift away from cognitive behaviour therapy and towards the adoption of a more systemic approach in the research piece. This ideological transition was significantly influenced by Proctor's (2008) argument that CBT is saturated with what are normally unarticulated and even contradictory conceptions of power which, at worst, can cultivate client compliance rather than autonomy. In showcasing my awareness of the epistemological tensions inherent in CBT, this piece of client work lays the foundations for my exploration of IFS in the research project.

I begin by introducing the case and I go on to discuss the development, beginning and middle stages of therapy. I then present a micro-analysis of a ten minute segment of my work with Juliette to examine in detail the therapeutic process and to evidence the application of skills that helped us to meet Juliette's therapeutic goals. Finally, I present the therapeutic ending and my evaluation and reflections on the work.

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[1] For the purposes of confidentiality all names and identifiable details have been changed and individuals are referred to by pseudonyms only.

Ethics

After I had explained the potential uses of the recording, Juliette considered and signed the consent form.

The context of work

This work was undertaken in the context of a Tertiary Care Child and Adolescent Mental Health team.

The referral and convening the first session

Juliette had been referred to the team by her GP who explained that she had initially presented to him complaining of a sore throat. He had ascertained that she was indeed suffering from a throat infection which appeared to have been exacerbated by injury to the back of the throat. Upon careful questioning, Juliette had tearfully confided problems of gorging herself with food and scratching the back of her throat to induce vomiting. She explained that she had been engaging in this behaviour for some time but that it had recently become worse.

Following discussion at the team referral meeting it was agreed that Juliette might benefit from engaging in one to one CBT work and she was allocated to my caseload.

The presenting problem

Juliette explained that she was currently bingeing 4-5 times a week on over 2500 calories' worth of high- sugar and high-carbohydrate foods per binge. She described occasionally making herself vomit up to four times following a binge. She also spoke of being aware of over-exercising regularly to compensate for her sense of having over-eaten.

Summary biographical details of client

Juliette is an 18 year old girl of white, French ethnicity. She is an only child. She has always lived in London although she explained that her parents travel a great deal for work and are often abroad for months at a time. Juliette explained that this had been the case since childhood and that she had therefore been under the care of a succession of live-in nannies until the age of 14. Juliette is currently in her final year at school and preparing for her A-Levels.

Summary of the theoretical orientation

In my work with Juliette I draw upon Fairburn, Cooper & Shafran's (2003) extended Cognitive behavioural model of Bulimia Nervosa (BN). This particular model, from which other CBT models, such as Spangler's (2004), have been elaborated has been demonstrated to work significantly faster in decreasing binge eating and vomiting than other forms of treatment such as interpersonal psychotherapy (Wilson, Fairburn, Agras, Walsh & Kraemer, 2002) and psychodynamic therapy (Nathan & Gorman, 2007).

The theory posits that BN typically arises against a back-drop of core low self-esteem and that it is principally maintained by the undue influence of body shape and weight on self-evaluation (DSM-IV, 2000). The authors specify that this influence tends to be particularly pronounced in individuals exhibiting more global signs of clinical perfectionism, which itself functions as a maintaining factor for BN (Shafran, Cooper, & Fairburn, 2002).

Extreme dietary restriction is periodically undermined in sufferers by mood intolerance and physiological energy deficits to result in episodes of binge eating.

These, in turn, maintain the fundamental psychopathology by exacerbating patients' worries about their ability to control their eating, shape and weight which encourages yet more extreme dietary restraint, thereby further increasing the risk of binge eating in future. Compensatory methods, such as vomiting, laxative abuse and over-exercising are employed to reduce anxiety triggered by binge-eating. Individuals' faith in these methods' ability to minimise weight gain then results in a further deterrent against binge-eating being undermined.

Treatment is aimed at addressing each of these maintaining processes.

Initial assessment and formulation of the problem

Initial assessment

The assessment took place over two consecutive weeks in two one hour sessions.

Juliette presented as a neatly-dressed girl of average height and weight. [2] She initially came across as rather reserved and quite reluctant to engage, answering questions in monosyllables and telling me that she felt that she was "fine" and that her GP had over-reacted in referring her.

I attempted to put her at ease by emphasising that she would be in charge of any decisions to pursue treatment or otherwise and that I fully appreciated the difficulties involved in "opening up" to a complete stranger. I wondered aloud whether she might feel more comfortable telling me anything that she felt I should know rather than answering questions, and, tentatively at first but with increasing confidence, albeit emotionally, Juliette began to talk in an intelligent and insightful manner of how

[2] BMI of 23 and thus in the normal range.

lonely she had always felt, both at home and at school. She explained that she believed that being thin, and thus, to her mind, attractive, might alleviate her sense of isolation by making her more self-confident and thereby facilitate her social inclusion amongst her peers.

She explained that for as long as she could remember she had found it difficult to get close to people and to forge lasting friendships. She said that she found it painful to observe that her peers had "best friends" and "friendships groups" from which she had always felt excluded. She explained that it wasn't that she had ever been bullied or actively marginalised, rather that she felt that she had a tendency to cut herself off from people by not letting them get to know her.

Juliette explained that the closest she had ever felt to anyone was to her nanny Marie who had looked after her from birth until the age of seven. Marie had one day inexplicably disappeared, or so it had seemed to Juliette at the time. She had not understood her parents' explanation for her dismissal and described subsequently having felt rejected and abandoned and having found it difficult to become close to any of her subsequent carers.

Juliette spoke adoringly of her parents whom she described in glowing terms. She explained that they were both extremely successful in their fields of work and expressed some anxiety that she herself might be unable to match their success. She explained that as a child she had missed them acutely when they were away but that gradually she had gotten used to their prolonged absences and had learned not to impose upon them when they returned home. She spoke of always having been aware of wanting to win her parents' approval and overt confirmation of affection, in

particular her mother's, whom she described as beautiful and clever but emotionally distant and occasionally critical of Juliette's appearance.

Juliette explained that her concerns around weight and shape dated back to the beginning of Secondary School when she described having become "obsessed" with dieting and exercise. At 14 she binged and purged for the first time and described feeling furious with herself for failing to uphold her dieting standards. Alongside this she described having experienced great relief at the discovery of purging.

This initial episode had coincided with Juliette's parents' deeming that she was old enough to look after herself at home without a nanny (with either one of them, or both of them, living there but keeping late hours). This meant that Juliette often prepared her own meals and she explained that she had increasingly come to seek solace from loneliness in comfort eating. Juliette explained that she was currently bingeing 4-5 times a week on over 2500 calories' worth of high-sugar and high-carbohydrate foods per binge. She described occasionally making herself vomit up to four times following a binge. She also spoke of being aware of over-exercising regularly to compensate for her sense of having over-eaten. Juliette described feeling disgusted with herself following episodes of binge eating and stressed that her top priority for treatment would be to eliminate bingeing behaviour.

A tension was manifest throughout our sessions between Juliette's tendency to rationalise and to intellectualise, "I shouldn't feel upset", and her apparent desire to let go and cry. She said that she felt that if she were more beautiful and as clever as possible, as evidenced through academic performance, her parents would love her more and she would have "real" friends.

Formulation

At the end of our second assessment session Juliette and I worked on a collaborative formulation of her difficulties (Appendix A). This initial formulation assisted us both in understanding her problems and helped to guide our therapeutic work. It was continually and collaboratively refined over the course of our sessions.

At the time of Assessment Juliette met DSM IV and ICD 10 criteria for a diagnosis of Purging type BN (DSM IV, 2000; ICD 10, 1996). Recurrent episodes of binge eating and inappropriate compensatory behaviours, specifically self-induced vomiting, fasting and excessive exercise, had been occurring, on average, twice a week for the past three months.

Upon consultation with my supervisor I decided to draw upon Young, Klosko & Weishar's (2003) Schema theory alongside Fairburn et al's (2003) extended model of BN to formulate Juliette's case. I hypothesized that her eating behaviour was being fuelled and maintained by a profound sense of ineffectiveness and core low self-esteem. These had taken hold in the context of a climate of persistent isolation and a painful experience of sudden abandonment and had been powerfully maintained by Juliette's sense of her parents as fundamentally emotionally unavailable. Against this background I hypothesised that Juliette may have displaced her need for perceived control (Dalgleish, Tchanturia, Serpell, Hems, de-Silva & Treasure, 2001) onto dietary self-control.

This would seem to have occurred against a family back-drop of what Young et al. (2003) term "deprivation of empathy" (pp.14-15). I speculated that this had given rise to a form of "mood intolerance" (Fairburn et al, 2003) whereby Juliette neutralised her awareness of adverse mood states and cognitions through her eating behaviour.

I further hypothesized that Juliette sought to compensate for her perceived defectiveness, and to win a sense of her parents' affection, by continually putting herself under pressure to meet extremely high standards of achievement. Over time this had generalised from academia to eating behaviour and had given rise to a rigid clinical perfectionism which powerfully maintained her eating disorder.

Due to Juliette's evident sadness in contemplating her sense of isolation, I decided to carry out a precautionary suicide risk assessment (Peruzzi & Bongar, 1999). Whilst Juliette did report fleeting thoughts of death as an end to her painful loneliness, she stated that she never paid attention to these because of the pain that acting on them would cause her parents. I viewed this as a strong protective factor for her. Juliette also spoke of future plans to go to university and become a doctor and demonstrated good problem solving skills which reassured me that she was not at high suicidal risk.

Negotiating a contract

I explained that we would be working from within a Cognitive Behavioural framework and described the rationale behind this and what the work would entail. In accordance with Fairburn et al we agreed to meet weekly for 20 sessions.

Therapeutic aims

Using the "SMART" framework devised by Westbrook (2007) to ensure therapeutic goals are specific, measurable, achievable, and realistic within the timeframe, Juliette and I collaboratively agreed on the following goals for treatment:

1) Reduce dietary restraint through self-monitoring of eating patterns

2) Explore binge-triggering thoughts and feelings and identify high-risk situations

3) Reduce hyper-criticalness in relation to weight and shape

4) Explore broader concerns around low self-esteem, perfectionism, mood intolerance and interpersonal difficulties.

The Development of therapy

After Juliette and I had collaboratively decided on our therapeutic goals and following consultation with my supervisor, I drew up a therapeutic plan, the details of which are outlined below.

Beginning stages of therapy (Sessions 1-6, including Assessment Sessions)

The initial stage of therapy spanned a four week period during which time the focus was very much upon relationship building and obtaining maximal early behavioural change. Working on our initial personalised formulation was instrumental in enabling me to engage Juliette and overcome her initial reserve. From early on however I was aware of Juliette's reluctance to sit with difficult emotion and I got the impression that she associated feelings of sadness and loneliness with a sense of failure. In contrast, she was keen to engage with the arguably more rational and intellectual issues involved in psycho-education about BN and the CBT framework (Fairburn et al, 2003).

Upon consultation with my supervisor however I decided that this was completely understandable at this early juncture. I felt that the most important factors at this stage were Juliette's enthusiasm about the CBT model and her hope for change, the importance of which are discussed by Snyder, Michael & Chearvens (1999). We

started by developing a situational conceptualisation using the "Hot cross bun model", suggested by Greenberger & Padesky (1995), to help Juliette begin to differentiate between her thoughts, feelings, behaviours and physiology in particular situations which triggered the urge to binge (Appendix B). We then proceeded to examine the causal links between them. We continued to use this skill throughout the course of our work together, until I felt confident that its implementation had become automatic.

Juliette was quick to understand the link between thoughts, feelings and behaviour as evidenced by her meticulously-kept therapeutic food diary (Appendix C). We used this diary collaboratively throughout this stage to assist us in monitoring eating behaviour and establish a sensible meal plan to which she felt she could adhere. We then used the diary to explore the types of circumstances eliciting Juliette's urge to binge. These typically involved situations in which she felt lonely, isolated or "not good enough" both on academic and personal levels. Following this we introduced problem-solving techniques to explore the sorts of things Juliette could do to prevent binges from occurring.

By the end of this initial phase significant progress had been made towards reducing bingeing to one episode a week and virtually eliminating dieting. We had also seen a dramatic decrease in purging episodes and instances of over-exercising. I felt that these successes were of paramount importance in boosting Juliette's self-esteem. As she became progressively more confident regarding the possibility of change, so her trust in me seemed to grow, and her reserve gave way to a greater willingness to explore some of the beliefs underlying her difficulties with eating.

Middle stages of therapy

Sessions 7&8: Review

These sessions were occupied by a detailed review of progress to date and the collaborative creation of a revised and extended formulation. We revisited our goals in view of Juliette's successes thus far and agreed to work towards an elimination of both bingeing and purging behaviours. Juliette drew my attention to what she had come to regard as a distinction between what she felt constituted a binge and what she thought might more accurately be described as "overeating". As a revised goal she explained that she would be willing to allow herself to occasionally overeat without engaging in the self-criticism which characteristically followed a binge and without having recourse to compensatory vomiting. I encouraged her to celebrate this as evidence of a shift in outlook towards a more flexible and compassionate approach to her difficulties.

Sessions 9-14

This stage occupied the largest part of the treatment and its content was dictated by our revised formulation.

We agreed that keeping a therapeutic food diary had been extremely helpful in facilitating Juliette's recognition of how her experiences of interpersonal difficulties at school had taken their toll in undermining her self-esteem which in turn had fuelled her binge eating and purging behaviours. Once these links had been established Juliette was gradually able to replace bingeing and purging with occasional over-eating. Whilst Juliette was able to relax her ideas around controlling her eating, she found it more challenging to relinquish her hypercritical stance towards her weight and shape. This was symptomatic of a more global perfectionism which I felt was the single greatest obstacle to further change in our work.

Juliette had engaged well in therapy thus far and had gradually demonstrated her growing trust in me by becoming less emotionally reserved. She had several times explained that she looked forward to our sessions because they were the only forum in which she felt able to talk freely about her problems. These factors notwithstanding, Juliette's barriers were swiftly reinstated when I addressed the issue of perfectionism directly. She became more reserved and rather defensively expressed her sense that her standards of achievement seemed normal to her.

These standards manifested themselves problematically in two specific and inter-related domains- in Juliette's attitude towards interpersonal relationships and in her hyper-criticalness towards her weight and shape. The family context in which she had grown up had fostered a belief in Juliette that one was only worthy of acceptance and love if one appeared to be perfectly contented and beautiful. As such she had become intolerant of experiencing adverse mood states, seeing these as manifestations of weakness and, by extension, of failure. This had led to a growing disparity between how Juliette actually felt- often isolated, sad and lonely- and how she thought she *should* feel- happy and uncomplaining. As these sessions progressed we began to slowly explore this disparity.

I was not least motivated in doing so by a consideration of what felt to me like important process issues, namely that I sensed that there was a danger of Juliette's adopting the role of perfect patient in her relationship with me, just as she had taken on the role of perfect pupil at school. She had so far executed all homework tasks meticulously and had a tendency to occasionally re-iterate phrases I had used in previous sessions. I felt that these tendencies needed to be addressed so as to ensure that Juliette could get the most out of therapy for herself in future.

Presentation of segment

Rationale for the choice of session and lead-in to segment

The following ten minute segment is taken from thirteen minutes into my fifteenth session with Juliette.

I have chosen it because it clearly demonstrates the potential pitfalls and complexities inherent in working with perfectionism. In so doing it supports Fairburn's contention that, were a sub-group of BN sufferers' clinical perfectionism to be corrected, "a potent additional network of maintaining mechanisms would be removed thereby facilitating change" (Fairburn et al, 2003 p. 516). In Juliette's case I feel that her perfectionist standards are negatively impacting on her self-esteem, experience of interpersonal difficulties and experience of adverse mood states. In examining the ways in which it does so the following extract provides support for Fairburn's argument that an understanding of these four maintaining mechanisms is of paramount importance in working with the subtleties of the phenomenon that is BN.

Transcript and commentary[3]

C 1 I felt like…like I said it in a positive way when it wasn't really positive.

Juliette is referring to her preceding answer to my question "How has this week been?" She had quickly answered "really good" and then there had been a pause during which time she had become increasingly tearful. It is a measure of how far Juliette has come in our work that she is able to allow herself to be emotional here,

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[3] This extract is taken between the 12th and the 22nd minutes of our 15th session. T- Therapist (author), C- Client (Juliette) and italicised font- author's commentary.

without apologising for her tears, and that she is able to comment on her own process in this courageously honest and insightful way.

T1 And that's something that you do, almost every session…that you come in and you start off by saying how good things are and how…

I work with Juliette's insight into her process by elaborating on it and generalising it to a tendency to want to "keep up appearances" in therapy. I believe this to be an extension of her desire to appear perfectly together and well both at home and at school and a manifestation of her deeply held belief that people only have time for you if you make things easy for them by appearing to be perfectly well. I knew from our previous work that this belief in turn had taken root in a childhood context of absentee parents who emphasised the need for good behaviour and quiet on their scarce returns home.

My tone and pace are deliberately measured and are intended to convey an objectivity consistent with the tenets of collaborative empiricism (Beck, Rush, Shaw & Emery 1979; Beck & Emery, 1985). In contrast, I can sense Juliette's anxiety rising and attribute this to her heightened sensitivity around fearing failure and to her bias towards interpreting personal observations as admonitions or negative judgements.

C2 When it's really bad!

Juliette's tone is bordering on hysterical as she interrupts, half laughing, half-crying. It strikes me that it is almost as though she is trying to spare herself the pain of my incipient criticism by anticipating it. Notwithstanding the progress she has made to date in sitting with emotion, this interjection is symptomatic of her tendency to occasionally veer in therapy between adopting alternate positions of either- denying

negative emotion or explosively "admitting" to it, as though it were something to be ashamed of. This strikes me as being in keeping with Fairburn's (2003) observations around mood intolerance, whereby a client responds to incipient mood change by thinking that he/she will not be able to cope with the feelings and thoughts it triggers, a reaction that paradoxically amplifies the mood state. In this case Juliette's fear of negative criticism is such that she anticipates it to prevent the intensity of the feelings it might trigger. Paradoxically, however, she does so in an intensely anxious manner, verging on panic.

This interjection is also characteristic of Juliette's tendency to express herself in dichotomous terms- things are either excellent or terrible. I wonder whether this might reflect an impulse to insure or buffer herself against disaster by anticipating it, as well as a black and white style of cognitive distortions.

T2 Not necessarily bad but I think that you come in and you're very keen to… convince me that everything's absolutely fine, that everything's absolutely under control, and then if I probe a little bit further, you resist for a while and then you give in, well to you it feels like giving in… And then you become more emotional.

My tone is smiling and empathically teasing in an acknowledgment of her laugh and of her exaggeration. I go on to become more serious however and return to my measured and deliberate pace and tone. I am careful to pause and search for the right word and to refine clauses that I find lack specificity in an attempt to reaffirm my commitment to a collaboratively empirical stance. Juliette's outburst has positioned her as subordinate to my authority and I want to bolster her sense of agency by redressing the dynamics of power in our relationship. My constancy is intended to be containing- as she veers between alternate emotional states I provide a dependable

anchoring point. With this in mind I positively reframe her exclamation of things being really bad in terms of keenness to keep up positive appearances. I am mindful in doing so of not colluding with perfectionist notions of "good" and "bad". In reframing my understanding of her process I am hoping to model an alternative, more subtle, value system.

In demonstrating my familiarity with these internal processes an atmosphere of intimacy is created which Juliette seems to find reassuring. My tone is gently teasing as I say "well to you it feels like giving in" and this use of humour, taking Juliette's self-defeating idea to an extreme conclusion, is aimed at gently showing up the inherent absurdity of the idea. This prompts Juliette to laugh, which in turn facilitates a release of some of the pressure which has built up so far, and seems to free her up to tentatively explore her process further.

C 3 It's because at school maybe it's because, you're just in your routine so it's easy but then afterwards…

Juliette typically comes to therapy after school, as she has done today. She appears to be setting up a contrast between ways of behaving at school and ways of being in therapy. She is extremely emotional however so I am finding it challenging to ascertain exactly what she is saying.

T3 So at school you don't feel that it's, that people…

In paraphrasing I intend to communicate my keenness to honour her emotion. I convey that I am listening intently and that we are in this together, collaboratively, working towards an understanding.

C4 As in it's easy for me to…

T4 fool people?

She appears to be suggesting that keeping up appearances is easier at school than in therapy but, in my eagerness to communicate my understanding, I slightly jump the gun and use the word "fool" which has negative, manipulative connotations. I immediately regret this. Juliette surprises me however by displaying the confidence to qualify my assertion.

C5 Not,Yeah. Not fool but…

T5 Mmm

I am encouraged to notice that, rather than reverting to a more characteristically self-critical stance (as in C2), Juliette can reject the word.

C6 Because if I have more practice I'll be able to… not cry

Juliette appears to be saying that she is more practised at putting up a façade at school than in therapy and that, as such, she is able to keep her emotions in check more easily at school. I sense her valuing of the "ability to not cry" reminiscent of earlier stages in therapy and feel that it is significant that in using the verb 'to be able' she casts such emotional reserve in terms of achievement- this being in spite of her opening insights into her tendency to dissimulate (C1) which had seemed to suggest that she recognised the limitations inherent in such a position. I am, however, aware that such apparent contradictions are not unusual in working with Juliette- she is, after all, crying as she tells me how hard she generally tries not to cry, and I am hopeful that such confusion might be the by-product of a transition to a more flexible relationship with emotional expression.

T6 Mmm, mmm… And does, I mean, I suppose… the thing that comes to mind for me is the amount of pressure…the huge amount of pressure that must come from putting on this kind of good, happy face.

I feel a little disappointed that we are back here, having been led by C1 to hope that we might have reached a point from which to consider the potential redundancy of dissimulation, but I strive to maintain my objectively empathic stance by communicating a desire to enter and understand her worldview. I want to avoid sounding judgemental or critical as to do so could either trigger another anxiously self-critical outburst or lock us into an unhelpfully polarised 'right' and 'wrong' scenario. Nonetheless I feel that I must comment on my sense of the pressure involved in adhering to such standards of strictly "happy" behaviour, with no signs of weakness allowed, and in doing so, gently but firmly, I make it clear where I stand.

C7 It doesn't really feel like pressure

Juliette is still upset and tearful but her tone here is also defensive. I feel that, in this moment, she is both unable and unwilling to concede a challenge to her standards around dissimulation. To do so would entail letting go of a strategy that guards her against perhaps too painful a contemplation of her sense of isolation.

T7No? Ok.

I absolutely do not want to pressurise Juliette into accepting my view-point. I feel that this would be to compound the pressure to which I allude in a therapeutically self-defeating manner. Juliette is emotional and vulnerable and I trust her to go at her own pace and to set our agenda. In so doing, I am mindful of Luke's (1974) caution against colluding with CBT's "second dimension of power" (p.78) i.e. a situation of

"you can make the decision as long as you decide what I think is good for you". Proctor (2008) builds on this by referring to an uneasy ethical marriage in CBT between the principles of beneficence on the one hand and respecting a client's autonomy on the other: "respecting the client's autonomy is directly opposed by the belief that the therapist has rationality...on their side, and therefore knows what is best for the client, whatever they may believe" (p.250). In order to work ethically with Juliette, and given my hypothesis that her mood intolerance and perfectionism have arisen in response to feelings of powerlessness and a limited sense of perceived control (formulations), I feel that it is crucial to avoid positioning myself as the expert in our work.

C8 Sometimes, sometimes I think 'Oh, I wish…', 'I wish people didn't always think of me as happy' but then I start thinking 'well', they see unhappy people, in my school anyway, when someone's not very happy they tend to sort of well, not everyone but some of them be like 'Oh are you ok?' but then not really talk to them or just leave them until they get better so…I'm glad I can pretend to be happy because then, I dunno, at least I won't have bad attention, so…

These considerations are repaid as Juliette relaxes and looks behind the coping strategy to express a poignant wish that people might be able to see through her façade and recognise the unhappiness within. She has generalised her own intolerance of adverse mood states to others and assumes that her peers would not care how she truly feels.

I am mindful of dual impulses in Juliette pulling her in apparently contradictory directions and giving rise to a sense of pressure and strain- on the one hand she wants to convince me that her coping strategy is sensible, whilst, on the other, she wishes

people would see through it to the loneliness within. I am reminded of the importance of my upholding a constant and empathic position amidst these conflicting impulses. A characteristic tension is manifest here between how Juliette feels, her "wish", and her tendency to cover up these feelings with rationalisations, like quickly administering a bandage to a wound.

T8 Do you feel that if you show vulnerability people are interested in the sense that it's, they kind of go through the motions of being interested but that people don't really care, or…that it's just a source of gossip, or?

I want to expand on the idea of "bad attention" to check that I fully understand her reasoning. In doing so I am seeking to balance a non-judgemental and accepting approach to her rationalisations with a recognition and acknowledgment of her fears. My tone is exploratory and my interrogation mark at the end is intended to convey a willingness to understand as well as an invitation to be led further. The "or" qualifies this invitation with the reassurance that I won't coerce her into saying anything she doesn't want to.

C9 yeah, I don't , I don't really think…Well obviously not all of them but – I'm not close to anyone so... yeah, whereas if, if I look happy people will talk to me and then at the end of the day I'll end up thinking I had a good day

I feel huge sadness and empathy with Juliette as she expresses this extremely painful sense of isolation. As she says "I'm not close to anyone" she bends over in her chair and her whole body appears contorted with grief. It is as though she is trying to physically protect herself from her sense of other people's indifference. She does not allow herself to sit with this emotion for long however and, instead, quickly sits up and embarks on a reiteration of the importance of keeping up happy appearances. Her

scrabbling to regain control over her emotions is conveyed linguistically in the repetition of 'if, if' above.

T 9 Hmm

She is speaking quickly and anxiously now and I am keen to convey that I am paying close attention.

C 10 And I'll be ha…, I'll be sort of, I dunno... 70% really happy because I had a good day. And then, whereas if I start the day being not really happy but just pretending , and then you know at the end of the day I end up being actually happy...

As Juliette continues, her quickened pace and hesitant tone communicate an urgent desire to regain her self-possession. As she enters a phase of intense rationalisation she seems to sense an element of absurdity in quantifying her degrees of happiness, laughing briefly after "70% happy". I inwardly reflect that this attempt at compartmentalising emotion is part of a broader attempt to render it safer and more manageable.

T10 Mmm

The echo of Juliette's statement of loneliness is still resounding between us and I communicate my empathy that she should wish to alleviate its pain.

C11 Because I pretend to be happy and then people are acting happy around me and then in the end it makes me happy. I don't know if you…?

T11 Yeah

T10 is not enough however and I sense that Juliette is searching for more reassurance of my understanding to alleviate some of her anxiety.

C 12 So it's not, I dunno it's not, it doesn't put pressure.

In harking back to my initial reference to pressure in T6, and in refuting my speculations, it feels as though Juliette is keen to close this particular avenue of exploration. From C10-C12 I feel that she has been striving to cover up the exclamation of isolation that escaped her in C9. She is doing this through elaborate and anxious rationalisation. Juliette's rationalisations per se are not illogical- one could argue that her strategy to appear happy at school is an extension of early discussions in therapy around behavioural experiments involving exposure to anxiety-provoking social situations. I feel that she has slightly lost the point of such experiments however by rendering them both pressurising and self-denying.

Primarily though I feel that Juliette is emphasising her dissimulation strategy as part of an attempt to make up for her exclamation of loneliness in C9. I sense that she wants to convince me, and in so doing convince herself, that she is behaving in this way because it works, rather than that she is behaving in this way because she is terrified that if she didn't, if she showed weakness, people wouldn't care and she would not be able to tolerate the feelings of loneliness and rejection triggered.

T12 Ok. How about, hmm, so you say you don't feel close to anyone at school…Now I was under the impression that you felt that you were getting somewhere with a few people at school? Is that, not really the case?

I remain mindful of the balancing act it is imperative that I perform (C8) - I must both accept that her strategy is sensible and hear that she is lonely. As in T6 and 7 I am careful not to enter an 'argument' scenario which would undermine progress through collusion with the binary thinking so characteristic of perfectionism.

I let go of arguments around the strategy of dissimulation and I am mindful in doing so of modelling the flexibility appropriate to my duties of limited re-parenting. I am aware that this strategy is serving a protective and reassuring function for Juliette, making her feel that she is in control of her emotions. I feel that it would be both irresponsible and unethical to undermine this coping mechanism before we had safely explored the emotions giving rise to it and in so doing hopefully rendered them less frightening.

In returning to the theme of Juliette's sense of isolation, I am again engaging in limited re-parenting by conveying that I am not afraid of exploring such painful emotions further and that these do not need to be shunned. In keeping with my collaboratively empirical stance, I situate Juliette's expression of loneliness within the broader context of our previous discussions of progress made in the area of developing social relationships- Juliette had previously spoken of having made considerable headway in this domain. Although I am keen to honour Juliette's emotional pain, I want to balance this with a collaboratively empirical commitment to "getting our facts straight". As noted in C2 Juliette exhibits a perfectionist tendency to veer between adopting extreme dichotomous positions of things being either "excellent" or "terrible". In so doing she characteristically engages in self-criticism and dismisses all progress made to date. I am keen to model the importance of searching for a middle ground.

C13 Well, not really

I wonder whether this suggests a shift to a slightly less extreme view-point- rather than "not being close to anyone", she is "not really" making head-way.

T13 Ok

This is intended as accepting and facilitative of expansion.

C14 It's just because sometimes I have really optimistic views

Juliette dismisses any headway made in addressing interpersonal difficulties, recasting any progress achieved as unfounded optimism in a characteristically self-punitive way. Such self-criticism arising from negatively biased appraisals of her performance is typical and has the effect of further undermining her self-esteem.

T14 Hmm

This is both empathic and gently challenging- accompanied as it is by a slightly sceptical raised eyebrow.

C15 And, I dunno, I sort of I, I believe that I'm getting somewhere, so....I dunno

Juliette responds to my scepticism by qualifying her previous attribution of progress to mere optimism. Instead she admits to some ambivalence in this area. Expressing ambivalence is painful however and Juliette becomes tearful once more as she evokes the confusion of "not knowing".

T15 Mmm... Shall we come back to this idea of you feeling terribly...sad and disappointed... about the idea of not having made progress.

I deliberately sit in silence for a moment, acknowledging Juliette's tears and empathising with her pain by nodding slowly. In so doing I am conveying that I feel the ambivalence she has touched upon to be important and deserving of our attention. In steering our exchange back to a more global consideration of progress made in therapy, I am harking back to the opening few minutes of this session and to the beginning of this segment. I am "zooming out" from an exclusive focus on

interpersonal difficulties to an overview of where we currently stand in our therapeutic journey. I am responding to Juliette's expression of emotion in C15 and explicitly naming the sadness and disappointment expressed through her tears. In doing so I seek to legitimise and validate her emotion and to express empathy with the pain of ambivalence and self-doubt.

C16 Well… I still weigh myself. Now it's not because I don't really want to because I'm scared because I might put on weight …

My explicit naming of feelings of sadness leads to a release of pressure as Juliette allows herself to cry more freely. As in C9's 'I'm not close to anyone' however, this- "I still weigh myself" has a confessional quality to it, as though I have wrested from her an admission of failure.

T16 Mmm

I empathise with her pain and give her the space to expand on these fears.

C17 And so, I dunno ... I keep on eating , even though, especially recently, I don't know why, and I keep on over-eating and then I get frustrated because I overate and I don't know, I don't know why I eat in the first place.

Juliette's expression of sadness has an urgency to it as she tearfully, as if to get it over and done with, admits to her frustration. Even though we had agreed repeatedly in previous sessions that occasional episodes of over-eating represented a great improvement on what would previously have been binges, Juliette castigates herself here for over-eating. Her frustration here is symptomatic of her tendency to continuously raise the bar in terms of goals she expects of herself. Having achieved occasional over-eating rather than bingeing, she has now shifted the goal post to-

eliminating over-eating and feels a sense of failure at not having met this goal. Instead of acknowledging and exploring this sense of failure, she distracts herself from it by trying to find rational explanations for why things are going wrong.

Although I am tempted to draw Juliette's attention to the unrelenting nature of these shifting goal-posts, I refrain from doing so because attempts at challenging her standards directly in previous work have had the potential to lock us into a confrontational scenario whereby Juliette denied being hard on herself. Instead I choose to chip away at her tendency towards excessive rationalisation in the hope that this will lead us to a contemplation of her perfectionism from a different angle.

T 17 Mmm, Mmm

I calmly contain Juliette's heightened emotion and again model an open and tolerant approach to emotional expression.

C18 And it's not even because I'm... Sorry, it's not, it doesn't feel like it's because I'm feeling bad or…

Juliette continues to put pressure on herself to find reasons for having over-eaten. There is a growing discrepancy between what she is saying, as she denies feeling bad, and how she is saying it- in tears and highly emotional. As she is racked by a particularly painful sob, she apologises in what I feel constitutes an attempt to disown and suppress her tears. Having done so, she continues to strain after reasons to make sense of her overeating.

T18 It just feels a bit out of the blue?

I deliberately steer clear of entering an intellectual discussion as to the origin of her behaviour and instead choose to normalise and legitimise her experience of

randomness and disappointment. Experiences of setback are normal and par for the course, rather than evidence of failure.

C19 Yeah, but not and, yeah…

T19 That must be quite scary, that must feel like you can't really control it.

I go on to speculate that such randomness must feel frightening and in so doing I legitimise the experience of anxiety. I also raise the issue of control which I feel is an important one. Juliette finds it difficult to relax her standards because she fears being flooded by the anxiety and feelings of sadness that a contemplation of "failure" might trigger. These feelings feel dangerously uncertain and uncontrollable. I feel that we must move towards an acceptance of such uncertainty and gradually increase her tolerance of such emotions.

C20 Mmm, yeah, I dunno….it's ,It keeps on making me think maybe I don't , I dunno, maybe I don't, I don't know, have enough will power or I don't want it as much as I think I do or sub-consciously I want to be fat ... or something like that.

As she strains for the certainty and familiarity of cognitive understanding, Juliette suddenly becomes aware of the absurdity of what she is saying and starts laughing.

T20 How likely is that?

I take my cue from her laughter and, smilingly, challenge these rationalisations using humour to expose their inherent absurdity. In reality-checking through humour I am upholding my commitment to a cognitive-behavioural rationalist position, albeit from within a humanistic counselling perspective.

C21 I dunno ... I just want to self-defeat or… I really don't why.

Juliette continues to laugh but simultaneously continues to cast about for 'reasonable' explanations and I sense that she is looking to me as the 'expert' to either endorse or disconfirm her hypotheses.

T21 It sounds like you might be over-thinking it a little bit.

I hear that Juliette is afraid of "self-defeating" and I understand that this must feel deeply threatening. I believe that such fears will be best assuaged by our exploring her feelings however, rather than pursuing this cognitive line of enquiry that has now exhausted itself.

C22 Yeah.

Juliette laughs and, as in C16, I sense that I have facilitated a release of pressure through directly naming what is going on in the space between us.

T22 And we've talked about your tendency to intellectualise and over-analyse which sometimes can make you feel like you're going a bit crazy.

I capitalise on this release of pressure by expanding on my sense that micro-analysis of cognitive processes can be counter-productive. I deliberately steer clear of using psychological jargon and employ the colloquial expression "going crazy" in a bid to counter her tendency towards intellectualisation. In doing this I am also mindful of redressing the balance of power between us- she has been looking to me to endorse her rationalisations. I have resisted doing so and I now deliberately switch to a more conversational, teenage idiom to underscore our position as equals.

C23 Yeah, I feel really crazy

T23 Mmm

C24 I do sometimes think I'm really crazy, I've kept asking myself 'Am I crazy?'

T24 What makes you think that?

Juliette is crying again and nodding her head in C23. I feel that we have finally gotten beyond her intellectualising to a contemplation of the emotion which lies beneath it. Gently and tentatively I begin to explore the shape of these fears.

C25 I don't know, It's not normal to just sort of... being obsessed with food and appearance , it's just...I dunno.

Crying, Juliette castigates herself for being abnormally "obsessed" with food and appearance. She again engages in self-criticism arising from negatively biased appraisals of her performance in therapy. This self-criticism maintains her perfectionism, fuels her mood intolerance and contributes to her low self-esteem.

T25 But I'm not sure that it is a constant obsession, is it? ... It certainly seems to have ebbed and flowed in our work together.

I move towards challenging Juliette's self-criticism and its impact on her mood directly. In doing so I am demonstrating my collaboratively empirical commitment to establishing perspective and objectivity.

C26 Yeah.

Juliette's agreement expresses relief as she tentatively moves towards adopting a less punitive, more balanced approach to evaluating progress.

T26 I haven't got the sense that it's been a constant.

I pick up on her hesitation and re-iterate my commitment to establishing a balanced appraisal of progress.

C27 No it's not constant,… so it's good. But (laughs) I still think I'm crazy! I dunno.

Juliette is calmer as she moves towards a less self-castigatory position. Her laughter as she says "I still think I'm crazy" indicates a more light-hearted flippancy than previously and her "I dunno" seems more resigned and accepting of uncertainty and ambivalence.

T27 But It feels like, it feels like things have sort of come to a climax in a way, that you're considering these questions really really intensely. Do you think that's because last week we didn't have very much time, or do you think it might be because I saw your mum this morning or because we're ending soon? Do you think those factors could be adding pressure?

I encourage Juliette to situate her feelings of therapeutic failure within the context of her perfectionist critical self-examination. I explain the timing of her internal struggle in terms of these important external factors which could well be serving to amplify her sense of negative self-evaluation. In setting her feelings of self-doubt in this context, I am at once legitimising, normalising and de-pathologising them.

C28 Yeah

T28 So it's almost like you're putting yourself and your achievements in therapy under the microscope today.

C29 Yeah

T29 and you're giving yourself quite a hard time.

In contrast to C12 Juliette has progressed to a position from which she can accept the idea that she has a tendency to put pressure on herself. She has moved from a position

of resisting any challenge to her standards to accepting the possibility that perfectionism might have a role to play in maintaining her sense of failure. This recognition was to represent an important milestone for Juliette as it heralded a turning point to a less judgemental and more compassionate approach towards herself and her difficulties.

Difficulties in the work and use of supervision

I was mindful throughout this highly sensitive session of the importance of providing a dependably warm, containing and non-judgmental therapeutic environment in which Juliette would feel safe to engage in the work. Drawing on my supervisor's expertise in working with bulimic and mood-intolerant clients I developed my understanding of the concept of "limited re-parenting" (Alexander & French, 1946) and used the therapeutic relationship as a partial antidote to counteract Juliette's early experiences of emotional inhibition and deprivation.

With this in mind I avoid being positioned as the expert in our work and constantly reaffirm our commitment to a collaboratively empirical stance. I am also careful to prioritise an exploration of emotion so as to counter Juliette's tendency towards intellectualisation and rationalisation.

End stage of therapy (16-20): conclusion and review of therapy

Changes in the formulation and the therapeutic plan

This session was instrumental in prompting us to tailor our formulation to a specific exploration of perfectionism. By the end of the session we had reached an agreement

that were Juliette's perfectionism to be corrected her mood intolerance, low self-esteem and interpersonal difficulties would also be greatly alleviated.

In sessions 16-19 we looked further at how perfectionism manifested itself in Juliette's interpersonal relationships and in her hyper-criticalness towards her weight and shape. Gradually we were able to explore these issues in the context of attachment. We looked at ways in which the family context in which Juliette had grown up had fostered in her a belief that people only accepted you, and that you were only worthy of being loved, if you appeared to be perfectly contented and beautiful. We looked at the way in which she seemed to interpret the experience of negative emotion as a form of failure and, given her fear of failure, the ways in which she repeatedly strove to avoid experiencing emotional discomfort.

These were very emotional sessions for Juliette as she became more fully aware of her tendency towards self-criticism and began to grieve for the time that she felt that she had lost to BN. They were also empowering sessions as Juliette quickly became able to relinquish self-blame and to experience righteous indignation towards the circumstances which had given rise to her difficulties. In our penultimate session we focussed on the importance of cultivating compassionate self-acceptance and of becoming more mindful of emotion so as to counter the tendency towards excessive intellectualisation. To this end we entered discussions around mindfulness and meditation as tools with which to achieve greater detachment from racing cognitions.

The therapeutic ending

By the time we reached the end of our work, Juliette's process had changed considerably and she had become adept at recognising her self-critical tendencies and at tolerating, previously difficult, experiences of negative emotion.

In our last session we constructed a therapeutic document as a form of relapse prevention (Westbrook, Kennerley, & Kirk, 2007), aimed at reminding Juliette of her newly developed skills including mindfulness practice and the cultivation of self-acceptance through compassion. We focussed on structured problem solving for situations in the future (e.g., occasional over-eating, getting a bad mark at school) with the hope of arming Juliette with skills to face difficult situations by becoming her own CBT therapist (Beck, Rush, Shaw & Emery, 1979).

Evaluation of the work

I believe that my work with Juliette was an effective piece of therapy illustrating both my competence in working within CBT and my ability to be a reflective and creative practitioner. This, alongside a strong therapeutic bond and Juliette's motivation and hard work, enabled us to meet her therapeutic goals.

On several occasions throughout my work with Juliette however, I found myself straining at what I perceived to be the limits of the model within which I was working. My incorporation of third-wave ideas notwithstanding, I came to feel increasingly uncomfortable with my rather pedagogical approach. With the value of hindsight, rather than preoccupying myself with challenging the validity of Juliette's view of the world and correcting her perfectionist "distortions", I would now adopt a systemic perspective and interpret what I might hitherto have labelled her "resistance" as a natural and healthy attempt to protect and perpetuate her systemic integrity. If I had my chance again I would work both with Juliette's internal system, from an IFS perspective, and with the systems surrounding her, in this case perhaps the scholastic system, but certainly with her family, focusing on work with Juliette's parents. An important focus of the work would be to help the family as a whole to understand the

ways in which it's inter-relationships might have initiated, as well as having served to maintain and perpetuated, Juliette's difficulties around food and her elevated perfectionism.

Arrangement for follow-up and Liaison with other professionals

Following consultation with my supervisor I wrote to Juliette's GP to explain that I would be discharging her from CAMHS. Juliette and I also had a discussion about the options that might be available to her within school should she feel the need for further support in future.

Juliette agreed to make enquiries as to the possibility of seeing her school counsellor for follow up should she deem this to be necessary.

Learning about psychotherapeutic practice and theory

My work with Juliette was instrumental in reminding me of the potential for change that can be brought about through the medium of a strong therapeutic alliance and this, in itself, helped me to reconnect to the Humanistic and Existential roots of Counselling Psychology. I strongly believe that Juliette's internalisation and modelling of our relationship considerably influenced her therapeutic progress.

I was also reminded of the considerable importance of collaborative case formulation and re-formulation at every stage of the therapeutic journey as a means of fostering a sense of hope and agency in both therapist and client (the importance of which are discussed by Snyder, Micheal, & Chearvens (1999) and Frank, (1971) respectively).

Finally I believe that my engagement and implementation of third wave ideas in the final stages of this course of therapy added flexibility and creativity to the work. In general, third wave ideas continue to inform my challenge, in line with Isabel Clarke (2009), to claims that CBT is a monolithic approach.

Learning about myself as a therapist

My work with Juliette was informed by my reading of Gilbert's (2010) *Compassionate Mind.* Throughout the work I continued to elaborate and refine my understanding of what it would mean for me to be a truly compassionate therapist. I am attending to and developing my compassion towards others and towards myself in personal therapy and through the practice of mindfulness meditation. The development of this skill offers me the space for boundless personal and professional reflection and development.

In showcasing my awareness of the epistemological tensions inherent in CBT, this piece of work encouraged me to become curious about how other therapeutic models might elucidate intra-psychic process. As such, it paved the way for my exploration of IFS in the research project.

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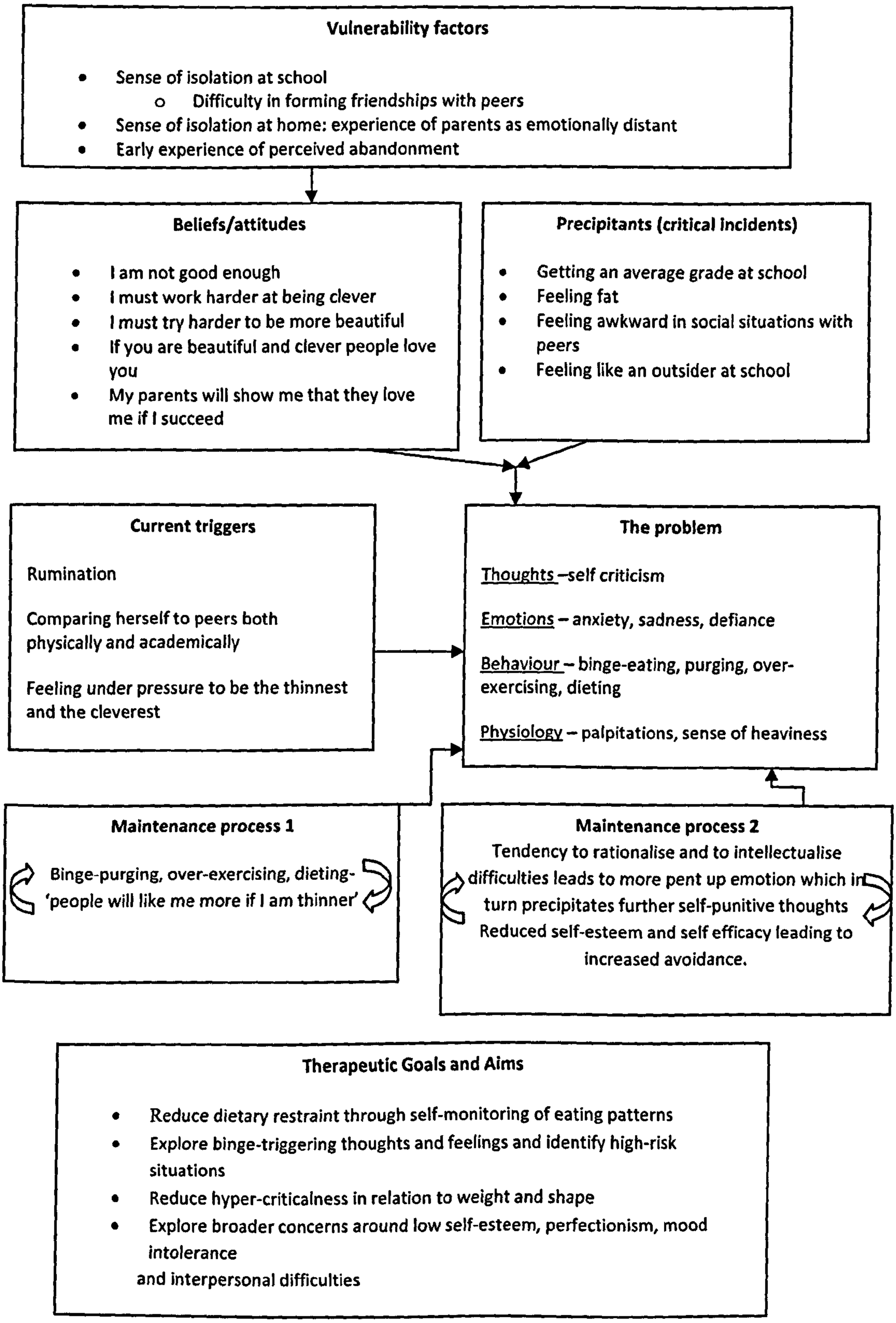
Appendices

Appendix A. Collaborative Formulation



Therapeutic Goals and Aims

- Reduce dietary restraint through self-monitoring of eating patterns
- Explore binge-triggering thoughts and feelings and identify high-risk situations
- Reduce hyper-criticalness in relation to weight and shape
- Explore broader concerns around low self-esteem, perfectionism, mood intolerance

and interpersonal difficulties

Appendix B. Situation level 'Hot Cross Bun' formulation from 2nd session

Palpitations Hot Body feels heavy Posture- stoops	I'm lonely People don't like me People don't care how I feel I'm fat and ugly Other people are more attractive than me Other people are cleverer than me I'm not good enough
Body	**Thoughts**
Behaviour	**Emotion**
Binge-eating Purging Over-exercising Dieting	Sad Angry Anxious

Appendix C. Example extract from therapeutic food diary

! denotes occurrence of bingeing or vomiting

Week 1

Time	What eaten	Binge	Vomited	Thoughts and Feelings before & after eating
8.00	muesli			B: still full from yesterday. A:must make an effort not to binge today
12.00	banana			B: hungry A: Still hungry, mustn't eat more in case it starts me off on a binge
3.00	packet of cookies		!	B: parents both working away from home, home alone. A: disgusted with myself. I am the most hopeless person in the world.
6.00 7.00	sweets and chocolates 2 ready-meal lasagnes, 2 chocolate bars	! !	! !	B: no more food at home. Had to go to supermarket and put lots of sweets and chocolates in the trolley. Ate loads on way home and couldn't stop when got home. A: very angry with myself. I feel so lonely. Totally exhausted, went to bed early.

Week 4

Time	What eaten	Binge	Vomited	Thoughts and Feelings before & after eating
8.00	muesli			Enjoyed this
11.00	apple			
12.30	baked potato, tuna fish			Eat in the canteen at school. Popular girl came up to me and made a joke, felt everyone was laughing at me, could have run away.
4.00 7.00	1 slice of toast fish and vegetables, 1 portion of ice-cream			Had not planned dessert but eat it with my parents so that I wouldn't be tempted to finish whole pot.