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The narrative reconstruction of psychotherapy

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Going to psychotherapy represents an atypical, usually unanticipated, and often emotionally significant experience in the life course. As with many such events, people construct stories about therapy experiences in order to make sense out of them and to provide their lives with a sense of unity and purpose. Yet beyond these purposes, the storying of psychotherapy is also central to the maintenance of the therapeutic gains achieved during the course of treatment (e.g., Frank, 1961; Spence, 1982). In the present study, the psychotherapy stories of 76 community adults are assessed using grounded theory methodology to determine narrative patterns that distinguish between individuals who currently show different constellations of psychological health. Two dimensions of current psychological health — ego development, or complex meaning making processes, and psychological well-being — serve as the basis for comparisons between participants. Four ways of storying psychotherapy are described, and preliminary interpretations for these types are suggested. In summary: participants high in ego development and high in well-being emphasized their personal agency throughout their stories; participants high in ego development and low in well-being prominently featured their therapists and pointed to the therapeutic alliance as the mechanism of treatment; participants low in ego development and high in well-being adopted components of dominant cultural narratives of therapy; and the stories of participants low in ego development and low in well-being presented an interpretive challenge, lacking a certain standard of narrative coherence. The themes we identified lay the groundwork for future research on the narrative construction of psychotherapy and may prove useful to clinicians as they strive to help their clients to co-construct successful stories about their therapeutic work together.

Keywords: Psychotherapy, Ego development, Well-being, Narrative, Grounded theory

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The narrative reconstruction of psychotherapy

People construct stories about their experiences in order to make sense of them. The crafting of one's personal narrative provides individuals the sense that their lives possess some degree of unity and purpose (e.g., McAdams, 1985; 2006; Singer, 2004). In analyzing stories, researchers often turn to key episodes, scenes that capture high points, low points, and turning points, for they depict those moments that the narrator deems salient and important. Bruner (1990) suggested that events are likely to get narrated to the extent to which they deviate from the canonical. The mundane contours of daily life recede when people construct their life stories, but those experiences that stand out as different in some way remain to form the raw materials for one's *narrative identity*. Very often such scenes are narrated as having been emotionally-laden and are explicitly described as having had an impact on the individual's evolving sense of self (e.g., Pals, 2006; Singer & Salovey, 1993). For some individuals, the experience of having gone to psychotherapy represents just such an event.

Certainly therapy is not like other experiences. Psychotherapy often engages a range of strong emotions, is typically kept more private than other experiences (even other health-related experiences), and is rarely to be found in people's future scripts about how they envision their lives unfolding. In one of the few studies to directly address the relation between therapy and *life* stories, Lieblich (2004) found that people regularly and spontaneously bring up their experiences in therapy when recounting their lives, and that they often refer to these experiences as key sites of their development. In addition, from a narrative perspective, therapy represents one of the few times in a person's life when he or she obtains direct assistance in the telling (or re-telling) of the life story. People seek therapy when something has occurred that resists incorporation into their existing self-story or which makes that story problematic in some way. The therapeutic experience may therefore destabilize a person's established story and challenge the person to incorporate or make new meaning out of difficult life events (Josselson, 2004; Singer, 2005; Spence, 1982; White & Epston, 1990). It has been asserted that regardless of the theoretical orientation brought to treatment or the specific set of therapeutic tools employed, narrative can serve as "a non-trivial point of convergence for the therapy field," for it offers a trans-theoretical framework for understanding the therapeutic endeavor (Angus & McLeod, 2004, p. 373).

If crafting a narrative out of personal experiences helps people to make meaning out of them, storying psychotherapy helps people to understand the ways in which they have suffered and (hopefully) transcended distress. Therapy stories help people make sense out of what it was that went wrong in their lives and how they coped with that challenge. From a theoretical perspective, therapy stories

perform a vital role for people — they serve as the foundation for maintaining the successes of treatment once it is over. In a classic book on psychotherapy, Jerome Frank wrote that weaving the “myth” of the therapeutic experience is vital to the individual’s continued well-being once treatment has ended (1961, p. 327). This sentiment was echoed by Spence (1982), when he wrote that the therapeutic narrative “may also maintain its structure over time and enable the patient to better retain what he [sic] learned during the analysis” (p. 270). Thus, psychotherapy stories share certain qualities in common with other narratives of self-defining memories (Singer & Salovey, 1993), but unlike other personal stories, therapy narratives may also function to preserve gains made in treatment. The study of therapy stories therefore provides an ideal window into the relationship between narrative identity and psychological health.

These theoretical assertions resonate strongly with a narrative conception of identity, yet they remain largely untested. In approaching the role of psychotherapy stories in individual health, a logical starting point is to survey the range of stories that get constructed about this experience. Without a doubt there is a broad spectrum of ways in which individuals might tell the story of their psychotherapy. In the current study we sought to develop a framework for interpreting these narratives that might prove useful for both researchers and clinical practitioners. Therefore, we sought to discover patterns that distinguish the psychotherapy narratives told by individuals with different constellations of current psychological health. The present study seeks to ground the emerging body of theory regarding conceptions of mental illness and healing in clients’ own voices about these experiences. As such, it is aimed at theory construction and discovery, rather than hypothesis testing.

If the goal of the present study is to explicate the range of therapy stories as they relate to psychological health, it is first essential to *define* good psychological health. An obvious candidate is subjective well-being. Indeed, positive affect and life satisfaction, as the foils to psychopathology, are privileged outcomes in the psychotherapy outcome literature (Seligman & Csikszentmihalyi, 2000), and these two qualities carry with them a host of desirable correlates and outcomes (e.g., Lyubomirsky, King, & Diener, 2005). In the narrative realm as well, several studies have sought to determine the relationships between particular narrative patterns and well-being (e.g., Adler, Kassel & McAdams, 2006; Baerger & McAdams, 1999; McAdams et al., 2001). But subjective well-being alone does not adequately capture the spectrum of desired possibilities. In their research, King and her colleagues have found that lay conceptions of “the good life” emphasize not only well-being, but also the ways in which individuals make meaning out of their experiences (e.g., King, 2001; King, Eells, & Burton, 2004; King & Napa, 1998). In assessing the good life, King and her colleagues have turned to Loevinger’s (1976) concept of ego development.

Loevinger (1976) defined the ego as a person's overall framework or lens through which meaning is made. According to the theory, people progress through a series of stages, each featuring a different interpretative lens. Individuals at earlier stages of ego development are relatively simplistic in their approach to making meaning, with a reliance on social rules and limited insight into the self. At more advanced stages of ego development, people espouse greater tolerance for ambiguity and the complexity of human interactions, as they come to understand themselves and the world around them in less egocentric, less conventional, and more differentiated terms. In sum, ego development can be understood as *the degree of complexity an individual uses in making meaning in the world*. Substantial empirical evidence supports the construct validity of ego development and suggests that it is an important element of good psychological health (e.g., Cohn & Westenberg, 2004; Westenberg & Block, 1993). Furthermore, ego development tends to be uncorrelated with subjective well-being, indicating that these two constructs make independent contributions to healthy psychological functioning (e.g., Bauer & McAdams, 2004; Bauer & McAdams, 2005; Helson & Roberts, 1994; King, 2001; King, Scollon, Ramsey & Williams, 2000; Vaillant & McCullough, 1987).

The present study will therefore follow in the tradition of empirical research that has adopted a two-dimensional conception of optimal psychological health, with high stages of ego development plus high levels of subjective well-being representing the most desired constellation. In the present investigation, then, we will focus on stories about psychotherapy, told by individuals who have been in treatment in the past, and who currently express different stages of ego development and levels of well-being. In doing so, we will not be able to speak to the larger issue of psychotherapy's causal role in shaping these alternative self-stories, nor to the evolution of these stories over the course of therapy. This is not an investigation into stories constructed *from* therapy; nor is it a study of stories told *in* therapy. Instead, we are interested in retrospectively narrated accounts *about* therapy. In the relative vacuum that currently exists concerning which narrative patterns might characterize the "best" stories generated in therapy or from therapy, understanding the different ways in which individuals who vary in ego development and well-being narrate the therapeutic experience itself is an important first step. Indeed, this focus allows us to identify a set of narrative patterns that relate to current levels of ego development and well-being in a sample of people who have worked with a therapist towards enhancing these two qualities. The patterns observed in the stories told by participants who currently espouse this desirable combination of qualities will be contrasted with those themes observed in the stories of participants with less desirable constellations of current psychological health.

Method

Participants

We collected therapy stories from 76 adults recruited from the greater Chicago area. These individuals had all been in therapy (individual or couples treatment, for at least eight sessions) in the past five years, but were not currently in any form of counseling. Demographic descriptions of the diverse sample are included in Table 1.

Table 1. Demographic Characteristics

Demographic Characteristic	Number (%)	<i>M</i> (<i>SD</i>)
Sex		
Male	26 (34%)	–
Female	50 (66%)	–
Race		
African-American	22 (29%)	
Asian-American	3 (4%)	–
Caucasian	47 (62%)	–
Hispanic	4 (5%)	
Age (years)	–	35.28 (10.37)
Education level ^a	–	3.50 (1.03)
Income ^b	–	2.12 (1.53)

a. education level was coded on a 5-point scale where 1= less than high school, 2= high school, 3= some college, 4=college (B.A. or B.S.), 5= graduate work.

b. annual income was coded on a 7-point scale where 1= <\$20,000, 2= \$20,000–40,000, 3= \$40,000–60,000, 4= \$60,000–80,000, 5= \$80,000–100,000, 6= \$ 100,000–120,000, 7= >\$120,000.

Participants reported a wide variety of problems, from significant psychopathology (anxiety disorders, major depression, eating disorders, substance abuse, etc.) to less severe relationship and occupational problems. They reported receiving an equally wide variety of treatments, from medication plus pure-form, empirically-supported therapy, to more eclectic types of therapy. This study sought to focus on the narratives of real clients' actual experiences in "treatment as usual" outpatient settings.

Description of the narratives

There is a strong tradition in the field of narrative research of providing participants with some structure for conveying their stories. For example, McAdams (1985; 2006) has developed a widely-used semi-structured interview for obtaining life stories that asks participants to break their lives into chapters and then recount a series of important scenes. In the present study, we were interested in obtaining

stories about therapy that might offer information that would be of use to psychotherapy researchers and clinicians. Several important issues from the research literature on psychotherapy seemed especially relevant to address: the experience of psychopathology, treatment-seeking decision processes, psychotherapy mechanism, and treatment termination. Grounded in our desire to address these topics, and based heavily on the format used in a previous study on voluntary life transitions (Bauer & McAdams, 2004), we developed a 5-scene structure for obtaining therapy stories.

Each participant wrote extensive narrative accounts of the following five key scenes in their therapy story: *The Problem* (a specific scene in which the presenting problem was especially clear or vivid), *The Decision* (a specific scene in which it was decided that the participant would go to therapy to address the problem), *Most Important Session* (a specific session that the participant deems the most significant), *Another Important Session* (a specific session, different from the previous one, that the participant also deems significant — obtained to gather more narrative data on the process of psychotherapy), and *Ending* (a specific scene that describes a time before, at, or after termination in which the impact of the therapy was especially clear or vivid). An optional sixth scene was also available for participants to write any other important information they felt was not captured in the rest of the narrative.

Quantitative measures

Participants also completed a series of questionnaires to assess current levels of well-being. A well-being composite was created from the sum of the standardized scores on: the *Satisfaction with Life Scale* (Diener, Emmons, Larsen, & Griffen, 1985); *Positive and Negative Affect Schedule* (Watson, Clark, & Tellegen, 1988); *Psychological Well Being* scales (Ryff & Keyes, 1995); and the reverse-scored *Hopkins Symptom Check List* (Derogatis et al., 1974).

In addition, participants completed the *Washington University Sentence Completion Test of Ego Development* (WUSCTED; Hy & Loevinger, 1996), the most widely used measure for assessing this construct. The WUSCTED protocols were scored by a trained coder whose agreement with the extensive practice protocols contained in Hy and Loevinger's (1996) manual was very high ($r > 0.85$).

Given the relatively-normal distribution of both ego development (ED) and well-being (WB), we divided the range of ED and the range of WB in two based on median splits and appropriately labeled each participant as either "high" or "low" in each of these variables. Based on these dichotomous labels, participants were assigned to one of four groups: High-ED, High-WB (N=21); High-ED, Low-WB (N=17); Low-ED, High-WB (N=16); Low-ED, Low-WB (N=22). Several other

self-reported characteristics of the therapeutic experience, including duration of therapy, type of therapy, and type of problem, were also assessed. Neither demographic characteristics nor any of these variables were significantly correlated with ED or with the composite of WB, and thus assignment to one of the four groups was not impacted by any of these factors. As a result, the identified differences in the narratives of participants in each of the four groups cannot be attributed to demographic characteristics, duration of therapy, type of therapy, or type of problem. While it may initially seem surprising that none of these factors would influence the types of narratives former clients tell, a growing body of empirical work suggests that individuals' stories about their experiences in therapy tend to emphasize elements that are common to the therapeutic experience and do not reliably differ across theoretical orientation or diagnoses (e.g., Gershefski, Arnkoff, Glass, & Elkin 1996; MacCormack et al., 2001)

Narrative analysis

In analyzing the narratives, we employed qualitative methods based in grounded theory, a system designed for approaching the analysis of data in order to facilitate the emergence of theory (e.g., Glasser & Strauss, 1967; Strauss & Corbin, 1994). Following the grounded theory approach, the entire set of narratives was first divided into four groups, based on the participants' scores on ED and WB. Given that the goal of the present investigation was to elucidate the themes that characterize therapy stories told by individuals with different constellations of psychological health, the narrative analysis proceeded separately for each of the four groups of participants. Qualitative work began with a careful initial reading of the data in each group, accompanied by an uncensored recording of all phenomena of interest. Anything distinguishing or remarkable was noted, with no attempt to provide order to the material. Following the initial reading, an effort was made to categorize, code, and sum the notes in various ways that facilitated comparison and contrast. Emergent working hypotheses or propositions, derived from the data, were developed and then a second reading was undertaken with these organizational points kept in mind. The process was iterative, requiring the repeated re-examination and revision of these propositions and their accuracy of fit to the data. A first-round reading was completed for each of the four groups before the subsequent re-examinations began. Thus, throughout the study, the emerging themes in each of the four groups informed the identification and development of the characteristic themes of the other groups.

In the present study, the qualitative methods were undertaken with a group of coders in order to minimize the inherent biases introduced by relying on only one perspective towards the data. This group was comprised of five individuals: one

senior Ph.D.-level personality psychologist (the second author of this paper), one doctoral-level student in clinical and personality psychology currently serving as a practicing therapist (the first author of this paper), one doctoral-level student in human development, and two masters-level students in counseling psychology currently serving as practicing therapists. The readers were diverse with respect to age, gender, and race, as well as in their formal training in psychotherapy and familiarity with grounded theory methodology. Over the course of several months, this group of coders used these methods to elucidate the narrative patterns which distinguish each of the four groups of participants.

Four ways of storing psychotherapy

There are both theoretical grounding and clinical significance supporting the division of the sample into four groups based on their stages of ego development and levels of well-being. Previous work suggests that ego development and well-being are independent dimensions, each with their own correlates (e.g., Bauer & McAdams, 2004; Bauer & McAdams, 2005; King, 2001; King, Eells, & Burton, 2004; King & Napa, 1998) and participants in each of these four groups can certainly be understood as espousing very different post-therapy presentations. We will now present portraits of the four groups, highlighting the themes that emerged from our qualitative investigation. A figure, summarizing the identified themes, is included (see Figure 1).

Therapy stories of the “High-High” participants (High-ego development, High-well-being, N=21)

Individuals in the High-High group (those high in both ego development and well-being) tended to begin their stories by suggesting that their experiences in psychotherapy were unique episodes in their lives, ones which stood out as depicting a time in which they weren't their normal selves or when they were uncharacteristically unable to handle the problems in their lives. For one of the few times in his or her life, the protagonist in this story is faced with a problem that is more formidable than he or she is, one which exerts its own agency and power. In this way, the High-High narrators bounded their problems in time, giving them a definitive starting point, but also paying tribute to the influence their problems had. One woman wrote, “after twenty-one years of being almost too calm, I couldn't sleep, stop crying, [or] relax at all.” Another explained, “After an adult life of frequent large moves, some of them Trans-Pacific, this seemed like nothing. So, I felt myself woefully unprepared for the inevitable transitional difficulties that did accompany

this move.” In each of these examples, the narrators describe being confronted with problems that do not fit with their previous understandings of themselves as empowered, capable individuals.

Whereas High-High narrators found themselves in an uncharacteristically weakened position at the beginning of the therapy story, they ascribed a great deal of power to their problems. Indeed, they tended to personify their problems, attributing to them physical characteristics (“a great weight,” “I had been carrying all of it”), location in space (“at the bottom of a well,” “what a paralyzing fog it was I was in”), and significant control over them. The protagonist’s struggle with the problem is marked by increasingly passive language, as the personified problem threatens to overtake them. For example, one participant explained, “there was a problem somewhere, something tying me up in knots.” She finally located this mysterious villain in her head, adding “my brain, which felt like it was imprisoning me, on to its own unfathomable agenda.” Others took this level of personification even further. One woman asserted that her anxiety “did not let me live in peace with myself and my family...my disorder did not allow me to even think right.” Indeed, a third participant described vividly how she felt controlled by her bulimia. “The sense of urgency was incredible and the urge to get sick overtook me,” she wrote. This woman even gave the character of her problem a name: “I called it the ‘Walk Of Shame’ in my head.”

As the story unfolds, it becomes clear that the process of psychotherapy is not always smooth for the High-High individuals. The protagonists in these stories frequently find it difficult to tolerate the therapist’s active stance as a helper, and often repudiate the therapist’s role once healing has begun. In the prototypical High-High story, the middle section began with the therapist sharing his or her agency with the powerless protagonist. The narrator’s voice shifts from “I” to “we” as the protagonist incorporates the therapist as a team member in the healing process. “We began by working on better alternatives to [cutting myself],” one participant wrote. “My therapist helped me with this,” a woman said of her struggles with panic disorder. However, the plots of these narratives eventually shift again — the protagonist regains agency and is able to take on his or her problem. One woman explained that the hypothesis she and her therapist derived for describing the cause of her troubles served as the launching pad for her own success in healing.

Most importantly, it gave me a way to start forgiving myself. And once I could start forgiving myself, I could start forgiving others, and the ‘stupid’ world around me. And once I could start doing that, I could actually start liking things a little bit again.

Once she and her therapist arrived at this hypothesis, the protagonist’s agency is freed and she is able to take an active stance towards her life again. It is notable

how the use of the pronoun “I” reemerges at this point, indicating the return of the protagonist’s power.

In an interesting and ironic twist, the shift back to an empowered protagonist who now feels that he or she is “getting better” often leads to the protagonist’s decision to leave, and eventually to *downplay* therapy. “A therapist can assist in [your healing], but they are unable to achieve it for the person. The person has to do it themselves,” one participant wrote. While she acknowledged the role of the therapist in facilitating change, this narrator concludes that the sole power to change lies within the client. She continues, “Although I believe [therapy] cannot fix anything for you, it can provide a supportive environment for one to process difficult feelings/situations. I tried to use my therapist as a helper to help me think differently about things, including myself.” This woman asserted that therapy cannot “fix anything for you,” it can merely provide a safe place for you to help yourself. Indeed, she made it very clear just how much her agency rebounded, indicating that she *used* her therapist. This language is remarkably different from that offered by High-High participants when first describing the problem, in which the individual is often at its mercy. Here instead, the client is almost controlling the therapist. Indeed, this type of assertion was common among the High-Highs. Another stated, “I ended counseling because, for me...I felt I could ultimately overcome my negativity on my own — and, for the most part, I have.” A third wrote, “What I achieved was I knew no one could fix me, I had to fix myself.” And a fourth, simply, “you have to help yourself, believe in yourself.” All of these statements mark a distinct return to agency by the protagonist. While not all of them are ultimately successful in their quest to heal themselves, therapy is described as primarily serving to stimulate the protagonist’s sense of agency, which often leads to its termination.

For the individuals high in both ego development and well-being, healing continues once therapy has ended, but progress is complicated by ongoing struggles which often persist right up to the moment the individual is writing the story. The indication is that things are better overall, but that life’s hardships endure and will continue to do so for the foreseeable future. One woman wrote:

By Fall 2004 [after my therapy had ended], I felt better, simply put. In fact, I felt better, more positive about life and about myself than I had in 10 years, since college...I had not solved my [work] problems — in fact, I am still struggling with focus and procrastination and meeting deadlines. But, for example, in May, 2003, I completed [a major project]...a moment of achievement for me.

Another explained:

All of the issues I came into therapy with are still issues. I’m still struggling with a lot of the same problems. But I now have better tools to work with — one of the

most important is accepting that I will *always* have problems, just like everybody else, but I can still do good work and enjoy life.

Thus, High-High individuals' stories make a significant turn when they resume their empowered role, but their endings are ambivalent, suggesting that therapy is an ongoing personal project.

Of course it is a matter of conjecture as to *why* the High-High participants might narrate their experiences in therapy in this manner. But given the dominant theme of personal agency that was observed in these stories, the particular narrative patterning makes sense. Participants in this group narrated their pre-therapy selves as largely competent, agentic individuals. In fact, many of them suggested that precisely what made the episode recounted in this story stand out for them was how unusual it was for them to feel so ineffective in fixing their problems, an issue reflected in the increasingly passive voice of the early sections of the narratives. While many of these participants indicated that therapy is an ongoing project in their lives, their stories concluded with the protagonist's returning to his or her previously empowered state. Individuals high in both ED and WB narrate this episode in their lives as an anomaly with respect to their personal agency: in their stories they were effectual prior to this episode, and they were effectual following it, but the episode itself represents an unusually disempowered period in their lives. As such, it seems likely these high functioning individuals found a way of narrating this unusual life episode in a way that does not once again make them feel disempowered. It is as though recounting this episode is akin to returning to "the scene of the crime," and it is likely important to the narrator to avoid again experiencing the powerlessness of the protagonist they are describing. In addition, client agency is widely recognized as a variable of importance in conceptualizing

<i>"High-Low"</i> High-ED, Low-WB	<i>"High-High"</i> High-ED, High-WB
<ul style="list-style-type: none"> • Enduring, internal problem • External help facilitates entry into therapy • Mechanism: therapeutic alliance • Therapist as a main character 	<ul style="list-style-type: none"> • Unique, discrete problem • Personified problem with power over protagonist • Mechanism: regaining of personal agency • Therapy as an ongoing project
<i>"Low-Low"</i> Low-ED, Low-WB	<i>"Low-High"</i> Low-ED, High-WB
<ul style="list-style-type: none"> • Enduring problem • Impoverished protagonist ("Me") • Mechanism: normalization • Lacking in narrative coherence 	<ul style="list-style-type: none"> • Decontextualized, external problem • Weakened protagonist as only main character • Mechanism: disclosure and/or insight • Self-acceptance

Figure 1. Overview of themes from four groups

successful psychotherapeutic outcome across theoretical orientations (e.g., Elliott & James, 1989; Williams & Levitt, 2007). Thus, it seems likely that high levels of agency should coincide with good psychological functioning.

Therapy Stories of “High-Low” Participants (High-ego development, Low-well-being, N=17)

The stories told by individuals showing high stages of ego development but low levels of well-being suggest that they see themselves as deep, complex people who have been emotionally down for a very long time. Their stories of therapy therefore begin by stretching far into their past, but without identifying a particular moment when their struggles began. “I have had a problem with my temper for years,” wrote one participant. “I *still* live at home with my mom,” added another, a 35-year-old man, offering that fact as emblematic of his ongoing troubles. For these individuals, life’s problems have existed for so long that they have become routine, a part of their everyday lives. The High-Low individuals clearly identify the problem that was the focus of their experience in psychotherapy, but these problems seem to be enduring issues that they claim they have faced throughout much of their lives.

One reason the High-Lows’ problems may be so durable is that they often describe them as intimately tied up in their sense of self. From these individuals’ perspectives, their problem is not some powerful separate character that they have been battling with, as it is for the High-High individuals, but a flaw in their very nature. “I have always been a private, quiet, sad person,” wrote one woman. The sadness that she feels to be inherent in her personality is compounded by her reluctance to share it with others, preferring to keep her problems to herself and suffer silently with them. Another man explained, “I’ve always felt disconnected from myself.” His problem has been consistent throughout his life, he suggests, and keeps him from being in touch with his true wishes and desires.

Against the backdrop of these enduring, troubled selves, the High-Low individuals describe a rather unique pathway into treatment: almost all of them wrote about an external source of encouragement that facilitated their entry. It is as though it did not occur to these people, who had been down for so long and who felt that their problems resided in their very nature, that help might have been available and that change was possible. Instead, they needed an external perspective to push them to try therapy. These external facilitators don’t take on the richness of fully formed characters in the stories, but their presence is an undeniable driving force behind the plot development. “At the urging of family, I sought professional help,” one participant stated quite succinctly. Another explained, “My husband, who had been more than patient for 10 years in dealing with my prob-

lem, suggested that I see the therapist.” Other individuals evidenced similar patterns, even when the external agent wasn’t another person. One man explained, “I was watching the TV and they had a commercial on about depression. And all the symptoms they were describing, I had. So I called the phone number.”

But once the High-Low individuals were in treatment, their therapists assumed the prominence of another main character in their narratives. Unlike the High-High individuals, who included their therapists in supporting roles, the High-Low individuals figured their therapists quite prominently. A man observed that for him, “Of real importance was the idea that I was dealing with a trained professional, rather than the ‘ad hoc’ advice given by friends, family, A.A., and self-help books.” A woman noted, “My Dr. was the Chief of Staff — Dr. [X]. I remember being so optimistic at the thought of ‘little old me’ having ‘the head guy’ on my case.” In addition to the status High-Low’s highlighted in their therapists, they also described their therapists, and the therapeutic relationship, as the central agent of change. “What made it work for me was because I finally found a person whom I could trust and wasn’t afraid to be open and honest with,” noted one woman. “I felt it worked because I liked my therapist and trusted her,” added another. A man in this group explained, “I know now that I would have never been able to look that deep inside or be that honest without my doctor’s help.”

Why might the High-Low participants’ stories have such a different thematic patterning than those told by the High-High’s? Again, we turn to their current constellation of functioning — relatively high stages of ego development but relatively low levels of well-being — as a lens through which to interpret the narratives. These insightful (high-ED) but relatively unhappy (low-WB) people may be familiar with long-term dissatisfaction in life. As such, it is the *healing therapeutic relationship itself*, rather than the problem that brought them into therapy in the first place, that represents the key departure from life as it usually is. In Bruner’s (1990) terms, the deviation from the canonical around which the therapy story is structured is, for the high-ED, high-WB people, the powerful problem that made therapy necessary in the first place. In contrast, for the individuals high in ED but low in WB, it is the positive therapeutic relationship itself. For the high-ED, low-WB participants, therapy may therefore be safely narrated as a time when these individuals felt cared for and it is not threatening to their sense of self to recount it warmly. Unlike the High-High participants, who seem to regard their past psychotherapy as a threat to their ongoing agentic narrative of self, the High-Low participants describe these experiences as powerfully positive and generative, a contrast that has been explored in more depth elsewhere (Adler & McAdams, 2007).

Therapy stories of “Low-High” participants (Low-ego development, High-well-being, N=16)

The problems that serve as the opening of the psychotherapy stories of individuals at low stages of ego development and high in well-being are described as discrete, decontextualized events, that often were perceived as having been brought about by external causes. These participants provided very minimal portrayal of the context in which these unfortunate incidents occurred and focused instead on the event itself. One man explained quite plainly, “I didn’t want my lady to go. She went anyway. I felt let down, like what I wanted didn’t matter. We broke up. I’ve never really gotten over it.” This break-up was incredibly difficult for him to cope with, and it stirred up other issues he had not previously focused on as well. But the problem he identifies is a distinct event that he attributes to an external cause. This pattern is evident across the Low-High individuals. In this way these beginnings clearly differ from those of the High-Low’s, who described longstanding and internal issues, and they also differed from the High-High’s who provided a largely positive backdrop against which their problems stood out.

In reading these stories, it is clear that they contain only one fully realized character — that of the protagonist — and the portrait is of a weakened hero. This main character is described as feeling powerless and out of control, but the source of these negative feelings remains vague. They read like battered heroes, but it is unclear what they have been battling. One man makes this point especially well. In describing an awful night he wrote, “It was like everyone knew everyone and I was the only stranger in there.” This statement is easy to relate to — the feeling of otherness — but it doesn’t clarify what the problem was. Were the other people being insensitive and rude or was there something wrong with him that led to his ostracism? The description conveys the protagonist’s sense of powerlessness, but it does not address its etiology the way High-High and High-Low participants did. In another example, a woman wrote, “I felt like I would never be in control or happy again and I didn’t know what to do about it. Even with the support of family/friends I couldn’t make myself feel better.” Again, it is easy to sympathize with her feeling of helplessness, but it is difficult to determine how or why she became that way.

There are two equally frequent and equally vivid mechanisms of treatment that the Low-High participants referenced in their therapy stories. While not mutually exclusive (some individuals described both), these two means of healing are quite different. For some of these individuals, *disclosure* — the mere act of voicing their problems — was cited as the key agent of change. “A turning point for me was recalling some childhood experiences,” wrote one woman; “I had never...talked about those feelings towards my parents before.” Indeed for some participants, this

confession was the primary motivation for treatment. One man stated, "I was there to talk about my life, and my anger, and my solitude, my existence." Once they had told their therapists about the problems, these individuals often felt much better. One man wrote, "I was feeling relieved that I got up the nerve to tell her about the abuse. This was a turning point, as I had never shared it before." Another woman explained how her acknowledgement of her suicidal thoughts was difficult, but beneficial. She said, "one low point, but also helpful, session was where I admitted to my therapist that I was still sleeping with razor blades next to my bed."

Yet for some of the Low-High individuals, disclosure was not where the action lay. For these individuals, *insight* was the primary mechanism of change. "One session that stands out in my mind was when I came to the realization that my parents' divorce really affected my relationship with my boyfriend," wrote one woman. "I realized I only have to live up to my own expectations...I would never have come to those realizations had I not been in therapy," added another. These realizations, which often happened quite suddenly, were cited as the chief source of therapeutic growth. One woman explained, "It was during this session that I realized that I had to take control." Another wrote, "I suddenly realized depending on myself took away so much uncertainty." In these passages the individuals conveyed a moment of acquiring a deeper level of knowledge about themselves and their problems than they possessed before they entered therapy. With this new understanding, they were able to effect important change in their lives.

The Low-High individuals' therapy stories tended to end when they came to terms with and accepted the problems they have faced. "It ended by me realizing the fact that I can't control the actions of bad people, that I need to only worry about my well-being and no one else's," wrote one man. The tone is one of resolution, acquiescence to their situation, and a shift in outlook required by the existence of their problem. This participant explained, "I had achieved coming to terms with my childhood loss/abuse and also the fact that parts of my OCD were treatment refractory and would perhaps never get better. I had started to accept OCD as a part of me and I could live with it." He recognized the pain he had suffered and acknowledged that his current struggles may be a fact of his future as well. The Low-High individuals viewed their therapy as having directed them towards this acceptance.

In interpreting the narratives of this group it is useful to remember that their current psychological presentation encompasses both a relatively simple and conventional worldview (low ED) and a relatively high level of happiness (high WB). In light of this constellation of functioning, the individuals in this group seem likely to adopt dominant cultural narratives of therapy in recounting their own experiences (e.g., Kaminer, 1992). While explicating the components of these dominant cultural narratives is an empirical task that has not been thoroughly

undertaken to our knowledge (although, see Kaminer, 1992), several facets of the Low-High's stories recall popular conceptions of psychotherapy. First, these stories are about one character — the self — and follow his or her attempts to cope with a discrete and external problem. Once in therapy, these participants point to two mechanisms of treatment: disclosure, the act of telling one's sorrows to another, and insight, the gaining of sometimes sudden and revelatory knowledge that unlocks the power of the problem allowing for its solution. Both of these pathways to healing echo popular conceptions, including the confessional component of Alcoholics Anonymous (“The first step is *admitting* you have a problem”) and the psychoanalytic moment of break-through discovery. Finally, for these individuals, their disclosures or insights result in the concluding task of self-acceptance. This too harkens to popular messages from the self-esteem movement wherein people are encouraged to acknowledge and accept their faults in the service of loving themselves. Indeed, in an effort to make sense of their experiences, the Low-High participants' stories can be understood as calling upon a range of cultural clichés about the therapeutic experience. Why this group in particular would most clearly adopt dominant themes from cultural narratives of psychotherapy is unclear. Indeed, all clients must certainly wrestle with cultural master narratives (i.e., Rosenwald & Ochberg, 1992) when constructing their personal stories. Nonetheless, it may be that the unique combination of a mostly happy, but somewhat simplistic lens on the world that characterizes this group of participants may lend itself most readily to adopting the available cultural scripts about therapy.

Therapy stories of “Low-Low” participants (Low-ego development, Low-well-being, N=22)

Therapy stories told by individuals scoring low in both ego development and well-being suggest that these narrators have always been plagued by their problems. They discuss them using essentialist, entity-based language (e.g., Dweck & Leggett, 1988) and the beginnings of their therapy stories are often vague as a result of the enduring nature of their problems. “The reason that made me want to go to therapy was not one particular moment. It was the reoccurring feelings each day,” wrote one participant. Another explained that she entered treatment “after what seemed like forever of feeling totally worthless and fatigued.” Low-Low individuals suggest that they have been dealing with their problems for many years, if not for their whole lives, and so the beginnings to their stories of therapy often seem arbitrary, like there is no logical identifiable beginning to this episode. “My problem begins so far back,” one man wrote, “it’s difficult to recall an exact moment I thought therapy was necessary. My problems were building for so long.”

It is difficult to describe the role of the protagonist in therapy stories told by narrators low in ego development and low in well-being. The narrators of these stories seem unable or unwilling to construct a clear “me.” In the most striking examples, Low-Low narrators literally omitted any reference to the subject of their sentences. “Was hooked on drugs and would do almost anything to get them,” wrote one woman. There is no actor in this sentence, no character who was hooked on drugs, no individual acting out of desperation to feed her addiction. When asked to describe his problem, another participant simply wrote, “Just not being able to say no.” Who is the individual who couldn’t say no? There is no subject that this story is about, no main character, struggling with assertiveness. Indeed, there is no agent in his description at all; the sentence is simply missing a noun or pronoun. With their lack of a main character, these narratives almost cease to be stories at all, instead reading like a listed sequence of events which happened, but to nobody in particular. It is simultaneously distancing and disturbing to read these accounts, as they feel eerily detached in their recounting of difficult experiences, for these vivid examples read like stories about no one.

Most Low-Lows are not as explicit in their missing a protagonist as these cases. But the majority of participants in this group do evidence an unclear main character. It is much more elusive and thus difficult to convey, but one lengthy excerpt is illustrative. A Low-Low woman described the problem which began her psychotherapy story like this:

We (husband & I) were fighting a lot. We had a huge fight at his parents house (we were visiting Cleveland). I don’t know what set it off. At this point all I remember was I had the kids. He left with his father & of course his father took him to a bar. His father’s solution, the worst solution. I was embarrassed since the fight was in front of family. The scene stands out since the worst fights always played out when his family was around.

The account is certainly logical; it establishes the emotional setting and then describes a particularly representative incident. But who is this scene about? To answer this question we must first eliminate those sentences which are clearly the narrator speaking, not about a character in the scene’s experience. “I don’t know what set it off” is a comment by the narrator, reflecting now on what had happened in the scene. This is clear because it is written in present tense, not the past tense of the rest of the scene. This is also true for the sentence “At this point all I remember was I had the kids.” And again, for the last sentence. So, we are left with:

We (husband & I) were fighting a lot. We had a huge fight at his parents house (we were visiting Cleveland)...He left with his father & of course his father took him to a bar. His father’s solution, the worst solution. I was embarrassed since the fight was in front of family.

Now, there are four distinct characters in the scene: “We,” “he,” “his father,” and “I.” Clearly “he” and “his father” are not relevant to the present question about the role of the participant as an agent in her own story. That leaves “We,” and “I.” If we look at each of these characters closely, we can observe the impoverished sense of *Me* that we have discussed. The use of the pronoun “we” undoubtedly includes the participant as a protagonist in her story. But the participant herself has no unique agency; no part of the plot flows directly from her, separately from her husband. Indeed, the only sentence that is solely about the participant as a character is: “I was embarrassed since the fight was in front of family.” This is the closest the narrator gets to inserting herself as a protagonist of her own story. And even here, it is a somewhat weak protagonist. Indeed, as it becomes clear later in the narrative, her embarrassment is not what led her to therapy; it was instead the intensity of her fights with her husband. The fights are a more potent agent than she is. This impoverished sense of a main character persists throughout this woman’s narrative. The same kind of impoverishment is common among the Low-Lows. In general, the therapy stories of individuals low in both ego development and well-being read as though the narrator was recounting a series of events that could have happened to anyone.

When they do get into therapy, the protagonists in these stories are no clearer. In fact, it is the process of learning that their problems are *not* unique that is narrated as providing Low-Low individuals with the therapeutic push. One woman, in summarizing her treatment history and generalizing beyond the episode she described in writing her therapy story noted, “The good [therapists I’ve had] made me feel like I was normal, like my condition was common and treatable.” Normalization is the process by which individuals in this group heal. One man who was in group therapy in addition to his individual counseling wrote, “I think the main thing that made therapy work was the fact that I wanted so badly to get better and hearing some of the horror stories of the other participants did all the good in the world.” He wanted to recover and his recognition that the other members of his group experienced similar hardships was the agent of change. Another participant explained “just knowing others went through what you did can be very therapeutic.” Indeed, normalization was the explicit goal for therapy for at least one participant. She wrote, “I just wanted to find out if my behavior was normal.”

Unlike their imprecise beginnings and downward progressions, the stories Low-Low individuals wrote do have distinct ends. The events are bounded in time, confined to the period surrounding their treatment, and without clear implications for their current functioning. One woman wrote, “After about 8–9 months of therapy I started getting appointments spaced further and further apart. I felt a tremendous amount of energy and elation...I started skipping my appointments. Finally, I just stopped totally going to therapy.” This woman overcame her

depression, began to wean out of therapy, and eventually stopped. The episode comes to a close, and the narrative ends. It is positive, optimistic, and conclusive. But it also offers no reflection on the episode she has just finished recounting. Its matter-of-fact tone does not provide insights that she may have taken from this experience; indeed, it is completely bounded in time. Another participant wrote, simply, "It ended when my counselor left." If the beginning of the Low-Low individuals' stories stretch far back into their history, the endings are delimited and do not suggest implications for how they currently operate.

The therapy stories of individuals low in both ego development and well-being pose a challenge to interpretation as personal narratives of self. Indeed these accounts read as overly-general, lacking both a definitive beginning and a true main character. Therapy is recounted as essentially a process through which people discover that their problems are not unique, a goal that, once accomplished, facilitates an abrupt and concrete end to treatment that does not have further impact. There is some empirical evidence to indicate why this group might tell stories that are largely lacking in narrative coherence. Baerger & McAdams (1999) demonstrated that individuals low in well-being exhibited lower levels of narrative coherence when recounting their life stories. They assessed four indices of narrative coherence: orientation (the story is placed in context), structure (the scenes flow smoothly and form a logical progression), affect (emotional language is used to underscore the importance of events), and integration (the story is linked to how the narrator thinks about himself/herself). Each of these indices was shown to negatively correlate with well-being. It was hypothesized that the ability to construct an integrated and coherent story of the self is vital for maintaining psychological well-being. Using the same assessment tool, recent empirical work (Adler, Wagner, & McAdams, 2007) has also demonstrated that narrative coherence is negatively correlated with level of ego development. This finding suggests that low-ED individuals, who tend to see the world in simpler terms, tend not to construct stories that adhere to established standards of coherent storytelling. In light of these two sets of findings, it is not surprising that the stories told by the Low-Low individuals in this sample were difficult to interpret.

Conclusion

Frank (1961) suggested that constructing stories about one's experience in psychotherapy, weaving "the myth" of psychotherapy, is vital to the individual's continued optimal functioning once treatment is over (p. 372). Indeed, quite a bit of theory has pointed to the idea that psychotherapy stories play a vital and unique role in supporting and maintaining the psychological health of former clients. In this

qualitative investigation we have collected stories of individuals who have recently been in therapy and identified the themes that discriminate between participants with different constellations of current psychological health. In operationalizing optimal health, we drew on the work of King (2001) and others (e.g., Bauer & McAdams, 2004; 2005) who have pointed to the combination of high levels of subjective well-being and complex meaning-making processes (as captured by high stages of ego development).

We found that those individuals who espouse both high-ED and high-WB narrated their experiences in terms of the ebb and flow of their personal agency. Their stories featured protagonists who had been weakened at the hands of a powerful and personified problem. Upon entering therapy, they found the strength to overcome these problems and reassert their own authority. Along the way, their therapists figure as mere supporting characters. In the end, these participants suggest that the work of therapy is an ongoing project that they have continued working on after termination.

In contrast, individuals in the other three groups used different thematic patterns in recounting their experiences in therapy. High-ED, Low-WB participants prominently featured their therapists and pointed to the therapeutic alliance as the mechanism of treatment. Low-ED, High-WB participants adopted components of dominant cultural narratives of therapy, pointing to the healing power of disclosure and self-insight and the press for self-acceptance. Low-ED, Low-WB individuals' stories presented an interpretive challenge, lacking a certain standard of narrative coherence that has been observed in other investigations.

Why does each group of participants narrate their experiences in psychotherapy in the ways we have outlined? This study was not designed to empirically test various explanations; nonetheless, we have offered some degree of specific interpretation with each portrait above and it is possible to draw some more general conclusions as well. Bruner (1990) suggests that "the function of the story is to find an intentional state that mitigates or at least makes comprehensible a deviation from a canonical...pattern" (p. 49–50). Without a doubt, the experience of having been in psychotherapy represents just such a deviation from the typical life course — people generally do not anticipate going to therapy in the way they predict other life events like graduations and weddings, or even like other therapeutic encounters such as annual medical check-ups or weekly confession in church. So, their attempts to narrate these encounters must be interpreted in light of how they serve as particular deviations from what is usual for them. From this perspective it is clear why High-High participants might emphasize their personal agency while High-Low participants would accentuate the therapeutic alliance (see Adler & McAdams, 2007, for a more thorough analysis of this particular difference). Yet Bruner's (1990) assertion provides somewhat less assistance for interpreting the

distinctive patterns of the other two groups. Indeed, to a large degree, the Low-High participants embrace patterns that echo cultural narratives of psychotherapy. Perhaps this group of people, who are relatively simple thinkers and also relatively happy, can best accommodate the shared discourse: something was wrong, I went to therapy to fix it, I shared my pain with another person or learned something new about myself, and now it's better. It is possible that while therapy itself was likely a deviation for them, storying the experience posed less of a narrative dilemma.

Bruner offers less guidance when it comes to the Low-Low group, whose narratives lacked a standard of coherence. It is conceivable that these participants were simply unable to rise to the challenge of successfully narrating therapy due to their poor functioning; that they have thus far failed to render these experiences meaningful and the incoherence of their stories is a reflection of this ontological chaos. Alternatively, it is possible that people who exhibit this constellation of functioning are basically bad story tellers. As described above, past research has demonstrated that low levels of narrative coherence are related both low ego development (Adler, Wagner, & McAdams, 2007) and low well-being (Baerger & McAdams, 1999). In spite of these difficulties in interpretation, Bruner (1990) underscores the importance of narrating psychotherapy in an effort to make meaning out of this unusual and sometimes transformative experience.

This qualitative investigation represents an initial attempt to systematically investigate the stories people tell about their experiences in psychotherapy. Therefore, the resulting thematic classification of therapeutic narratives should not be regarded as definitive, or necessarily exhaustive. Nonetheless, the present study lays the foundation for future narrative research into the vital storying of psychotherapy. Indeed, an empirical, hypothesis-testing replication of the themes identified in the present study in a new sample would be an invaluable next step. Nonetheless, based on this qualitative inquiry, the themes we have identified may prove useful to clinicians as they strive to help their clients to co-construct the narrative of their therapeutic work together.

Acknowledgements

This research was supported by a grant to the second author from the Foley Family Foundation to establish the Foley Center for the Study of Lives at Northwestern University. We would like to thank Katie Magrino-Failla, Katie Weisz-White, and Raelle Wilson for their participation in the coding and Jennifer L. Pals and the rest of the Foley Center for the Study of Lives for their valuable feedback and support.

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