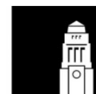

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Interactional positioning and narrative self-construction in the first session of psychodynamic-interpersonal psychotherapy

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Interactional positioning and narrative self-construction in the first session of psychodynamic-interpersonal psychotherapy

Abstract

The purpose of this study is to identify possible session one indicators of end of treatment psychotherapy outcome using the framework of three types of interactional positioning; client's self-positioning, client's positioning between narrated self and different partners, and the positioning between client and therapist. Three successful cases of 8-session psychodynamic-interpersonal (PI) therapy were selected on the basis of client Beck Depression Inventory scores. One unsuccessful case was also selected against which identified patterns could be tested. The successful clients were more descriptive about their problems and demonstrated active rapport-building, while the therapist used positionings expressed by the client in order to explore the positionings developed between them during therapy. The unsuccessful case was characterized by lack of positive self-comment, minimization of agentic self-capacity, and empathy-disrupting narrative confusions. We conclude that the theory of interactional positioning has been useful in identifying patterns worth exploring as early indicators of success in PI therapy.

Key words: psychotherapy, brief therapy, psychodynamic-interpersonal, early indicators, subject position, positioning theory, interactional positioning, narrative

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Identifying session one indicators of end of treatment outcome could be useful in matching clients to specific psychotherapeutic treatments, however, a literature search revealed only two relevant studies. First, Stiles, Shankland, Wright and Field (1997) found evidence suggesting that, in time-limited treatments, clients with well-assimilated problems (as determined by analyses of sections of their first therapy session) did better in cognitive or behavioral therapies than in psychodynamic, experiential, or interpersonal therapies. Second, Anstadt, Merten, Ullrich and Krause (1997) found that compensatory affective facial behavior between client and therapist during the first session of therapy was indicative of success. In response, the present study seeks connections between patterns of interactional positioning in four initial sessions of brief psychodynamic-interpersonal therapy, in the context of both successful and unsuccessful outcomes, with the aim of identifying markers that might have clinical use as early indicators of outcome. Patterns of interactional positioning were analyzed as it developed a research theme already initiated by two of the present authors (Madill & Barkham, 1997) and is particularly compatible with the relationship focus of the mode of therapy studied.

Positioning theory provides a framework to analyze ways in which people describe self and other (e.g., Davies & Harré, 1990). It is a constructionist perspective in that such accounts are considered oriented towards how the speaker wishes to be understood within the context in which the description is offered. By implication, autobiographical narratives are conceptualized as allowing the speaker to produce variable accounts of self and other and, hence, to provide the potential for developing new understandings. This contrasts essentialist models of personhood, dominant in psychological theories of personality and in early linguistic analyses (e.g., Labov &

Waletzky, 1967), which treat such descriptions as representing fundamental character attributes.

Wortham (2000) agrees with the constructionist perspective that "autobiographical narrative can shape the self of the narrator by *describing* him or her as a particular type of person" (italics in original, p.158) but argues that more attention should be given to the *interactional* function of narrative self-construction. Lucius-Hoene and Deppermann (2000) articulate the two ways in which narrative self-construction is interactional. First, autobiographical narratives are usually oriented towards an audience who, if immediately present, can influence the positioning of self and other within that account through asking questions and through non-verbal cues such as displaying sympathy. Second, the audience can shape autobiographical narratives through the narrator's expectations, or even fantasies, about how their account might be received and the narrator's presentational aims in relation to this.

Wortham (2000) offers a set of conceptual and methodological tools for identifying the main roles people assume within their relationships through examining the stories they produce about these relationships. One tool is the notion of a narrative identity that he defines as constituted of two parts; the narrated self and the narrating self. The narrated self is the self of the speaker as presented within his or her stories. The narrating self, on the other hand, is the self of the speaker as revealed within his or her conversation with other people. In order to locate the narrated and narrating selves within the text, the present study used three types of positioning articulated in Bamberg (1997) and Lucius-Hoene and Deppermann (2000) (For development of Bamberg's theory see Bamberg (2004)). These types are explained in the Method section of this paper but to give a general idea about them it should be mentioned here

that they answer three main questions: (1) how does the speaker (which in the present study is always the client) position him- or her-self? (2) how does the speaker position him- or herself in relation to people not party to the conversation? (3) how is the speaker positioned in relation to the person with whom they are speaking? (which in the present study is always the therapist). The first and second of these positionings constitute the narrated self (self within story) while the third constitutes the narrating self (self in conversation). As discussed above, all three positionings are interactional in that all are oriented towards, and therefore influenced implicitly or explicitly by, an audience.

The method used in this study focuses on the ways in which clients describe themselves and are, themselves, described within therapy. Such descriptions are considered important as, arguably, it is through language that we generate meaning and understand our actions in relationship to significant others (Goolishian & Anderson, 1987). However, the idea that meaning is co-constructed linguistically between self and other is not a new one and some theories that have traditionally supported intra-psychic causation are shifting their attention to relational aspects of psychopathology. A good example is psychoanalysis and Winnicott (1960) is paraphrased in recent understandings of the therapeutic relationship as stating that "there is no such thing as either the patient or the analyst – only the patient-analyst unit" (Mitchell & Aron, 1999, p.xv). Moreover, novel therapeutic approaches have been influenced by narrative and discourse theory, perhaps most notably the therapy of White and Epston (1990), which focus on transforming the client's self-narrative in a positive direction.

Psychotherapy researchers have developed a number of theories and tools to explore interaction between client and therapist and the effect of this on therapy

outcome. Like the theory of interactional positioning, alliance theories try to capture the mutual influence of client and therapist on each other. However, the focus of interest is different in that, rather than investigating the construction of self and other, alliance theories are interested in the way, for example, that the goals and tasks of therapy are negotiated and therapeutic bond established (Bordin, 1979). The structural analysis of social behavior coding system (SASB: Benjamin, 1982) is built on the theory that interpersonal communication is based on the continual negotiation of affiliation and control. Luborsky's (1977) theory of the core conflictual relationship theme (CCRT) has produced a statistical method for identifying repetitive relationship episodes from therapy transcripts representing typical maladaptive relationship patterns for individual clients. Finally, Rennie (e.g., 1990) has used brief structured recall interviews with clients in combination with grounded theory analysis to study the impact of therapist interventions from the client's post hoc perspective. However, fundamental questions remain regarding which interactions are the significant ones to study and few methods exist to explore the process of client-therapist interaction itself (Koss & Shiang, 1994).

To summarize, methodological innovations developed in relation to the theory of interactional positioning provided us with a practical guide for identifying theoretically important aspects of narrative self-construction within the transcripts of four initial sessions of brief psychodynamic-interpersonal therapy. Our aim is to identify markers that might have clinical utility as early indicators of client outcome.

Method

Data selection

Data was selected from the Second Sheffield Psychotherapy Project (SPP2; Shapiro, Barkham, Rees, Hardy, Reynolds & Startup, 1994). This is an archive consisting of

117 audio taped therapy cases of clients diagnosed with major depressive episode as defined in the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III: American Psychiatric Association, 1980). The SPP2 design compared two durations (8 or 16 weekly sessions) of two treatments (psychodynamic-interpersonal or cognitive-behavioral therapy). All SPP2 clients were professionals with managerial jobs in white-collar employment who considered their problems to be affecting their work. Screening criteria excluded individuals with continuous history of psychiatric disorder of more than two years prior to referral, who had undergone treatment similar to that provided in the study within the previous five years, and who had had significant change in psychotropic medication during the six weeks before referral. Written informed consent to use audio tapes of the therapy for research purposes was obtained from each client at post-therapy assessment.

Four clients were selected from the 30 cases of 8-session PI therapy. PI therapy was chosen as its rationale was thought to be particularly suitable for the type of analysis used in the present research in that both emphasize the relational aspects of life. PI therapy was also thought to provide greater potential for examining clients' accounts of themselves as it consists mainly of conversational strategies implemented by the therapist. The 8-session therapies were selected in preference to the 16-session therapies in order to strengthen the possibility of finding a link between patterns of interactional positioning in session one and the outcome of therapy due to the relative brevity of the treatment.

The Beck Depression Inventory (BDI: Beck, Ward, Mendelson, Mock, & Erbaugh, 1961) was administered on six occasions: three time points pre-therapy and three post-therapy, and cases chosen on the basis of client scores. Three successful cases were selected as the minimum required to provide an opportunity of identifying

consistent patterns of positioning. Success was defined by post-therapy BDI scores remaining in range the 0-9 which denotes normal mood. One unsuccessful case was also selected against which identified patterns could be tested. The BDI scores at all assessment points for the selected clients are presented in Table 1. All four clients scored in the range indicating mild to moderate levels of depression prior to therapy commencing. Of the nine successful cases available, the three most successful in terms of low post-therapy BDI scores were selected for study. For these three cases, all post-therapy BDI scores would be deemed to have met the most stringent criteria of reliable and clinically significant change (Jacobson & Truax, 1991). The unsuccessful case was selected as the most unsuccessful of the 21 available in having the highest end of treatment and most consistently high post-therapy BDI scores indicating moderately severe and severe depression. More information on each client is provided at the beginning of each case in the Analysis section where it helps contextualize the analysis that follows.

-----Insert Table 1 about here-----

Analytic procedures

The first session of each of the four selected therapies was transcribed verbatim by CS. Pseudonyms were used throughout and care taken to omit or change potentially identifying details. An agreement was signed between CS and the Psychological Therapies Research Centre, University of Leeds, UK, concerning security of data storage and confidentiality of information.

The three types of positioning articulated in Bamberg (1997) and Lucius-Hoene & Deppermann (2000) were used to analyze each of the four therapy transcripts. The first consists of the characterization of narrated self (of the client) by means of narrative devices, especially those that make “available culturally shared

constructions of identity tied to specific plots (e.g., a victim's story, a heroic account)"(Lucius-Hoene & Deppermann, 2000, p.217). This is called self-positioning (N1). The second is denoted by positioning activities between narrated self (the client's) and different partners "realized by recounting (inter)action sequences and by reanimating dialogues within stories of the past which can also draw on conventionalized plots" (Ibid, p.218). This is called positioning between narrated self and others (N2). The third is denoted by "explicit categorizations, attributions, addresses etc." (Ibid, p.217) in the interaction between narrator and interviewer. As, in the present study, the narrator is always the client and the interviewer always the therapist, for convenience we define this third positioning here as the positioning between client and therapist (N3). Following Wortham's (2000) categorization, N1 and N2 together represent the narrated self while N3 represents the narrating self.

The first stage of the analysis consisted of reading and rereading the transcripts in order to become acquainted with each session as a whole and hence provide the context for stages two and three. Stage two involved identifying the three types of positioning described above. An example of each is presented here in order to facilitate understanding of the basis on which they were identified.

The narrated self (N1 and N2): In the following extract a client offers a description of her past self in which she positions herself as the recognizable familial character of the 'good child' (N1); "*I have always said that I was a very good child*". In the next, a client positions himself in relation to his wife, who is not present, through invoking the recognizable familial character of the 'misunderstood husband' (N2); "*my wife couldn't really understand why I had this sort of resentment*".

The narrating self (N3): In this extract, a client positions himself between himself and his interviewer (therapist) as being relaxed in his interviewer's presence; "*I feel very comfortable, I don't feel any kind of anxiety being here*".

Many positionings were identified for each client in stage two, hence the aim of stage three was to select those positionings which appeared to be of particular significance within each client's narrative and within each client's interaction with their therapist. In selecting significant positionings, attention was paid to the regularity with which each positioning appeared, the emotional intensity accompanying its invocation, and its impact on the direction of the therapeutic encounter. Specific strategies were utilized as articulated by Lucius-Hoene & Depperman (2000) for identifying core aspects of identity within relationship narratives; paying special attention to (1) anecdotes, metaphors, and figures of speech that were presented in a particularly skillful manner, hence, suggesting their routine use, (2) stories accounting for critical biographical experiences, and (3) culturally recognizable plots that indicate the wider meaning structures within which the narrator is constructing their personal world. The positionings judged to be of particular significance within each session are presented with supporting quotes in the Analysis section.

Credibility check

A type of inter-coder reliability check suitable for qualitative research was conducted with a research colleague (RC) in order to test the degree of consistency with which the three types of positionings had been identified (Brown & Dowling, 1998). The RC had no previous involvement in the study, was unaware of the study's objectives, had no previous knowledge of positioning theory but had experience in conducting qualitative analysis and of coding at postgraduate level. The RC read the part of this

Method section that explains the three types of positioning and subsequently discussed any points that would support her understanding of the process of identifying them with CS. The RC then identified the positionings and the relevant quotes that supported them in each transcript and discussed her independent findings with CS. Discussions revealed that the distinction between self-positioning and positioning between self and different partners can sometimes be difficult to make but, in the research conducted here, is probably explainable by the different degree of familiarity each analyst had with positioning theory. Although each analyst identified a number of positionings in addition to those identified by the other, these differences were, in the main, due to the level of detail at which each analyst had chosen to present their analysis. That is, additional positionings were usually encompassed within a more general position that had been identified by the other. Development of this methodology would therefore benefit from being clearer in this regard. However, given this, it was concluded that the original analysis was a reasonably robust one as the differences between the two analyses were minor and there was good agreement in the overall picture each analyst present of each client.

Analysis

Successful case 1: John

John was a professional with a job at the top of the hierarchy in white-collar employment. He lived with his wife and was about to retire. He had four children, one of whom had died several years earlier. His therapist was male, in his mid-thirties, and with two years post-qualification experience.

(1) The narrated self: Self-positioning

John depicted himself as a moral character actively supporting his own principles in his professional life; "*I've preached for a long time in my, in my profession*", and as a devoted father "*enjoying bringing up four children*". However, he indicated that aspects of his professional self are inauthentic; "*I have to be an extrovert in my job really, I am a hell of an introvert*", such that he describes himself as having a "*split*" or "*dual personality*" while feeling "*inadequate*" and having "*low self regard*". He described his problems as arising from his son's death; "*that security seemed to be dissipating over the last five years. My son was killed about 8 years ago*", and his job; "*I feel impotent and anxious about my job*".

(2) The narrated self: Positioning between narrated self and different partners

John's positioning toward his colleagues was of a man burdened by their demands and seeming inability to meet their needs; "*people demanding something of me that perhaps I will not be able to provide*", and with whom he hides aspects of himself; "*I don't bring the misery to other people. I bring out the me that tends to be optimistic*". However, he presented himself as supportive of his colleagues when they are in crisis and as valuing this part of his job; "*counseling people and the staff I quite enjoy it*". John indicated that his relationship with his wife had changed in recent years in that he had "*become less dominant*" and, although their relationship was described as harmonious, he felt that his "*retirement could be a burden on her*". He positioned himself as a caring and considerate father but one who sometimes needed "*space*" from his children while his own childhood was described as harsh in having lost his mother at birth; "*does it strike you as pretty horrible?*", and he had not been in contact with his brother or sister for many years.

(3) The narrating self: Positioning between client and therapist

John tended to agree with his therapist's formulations on which he, himself, elaborates. He positioned his therapist interactionally as an empathetic listener and competent interpreter while the therapist implied that John is involved with the process of therapy; "*(T:) So there are notions of pain. You've got emotional pain. (J:) Yes, yes, and fear*". John repeatedly positioned himself as enjoying talking with the therapist; "*it feels very comfortable sharing it with you*", and invited the therapist's active participation; "*(J:) if that means anything to you if you know. (T:) I've got a flavor of that*". Together, these ways of communicating positioned John and his therapist interactively as mutual collaborators. The therapist supported this collaborative interational positioning through articulating an emotional empathy with John's situation, for example with regard to his early bereavements; (*T:) tremendous kind of history of loss. (J:)Yea. (T:) In your life. (J:)Hm. I can see it affected you really".*

Another kind of interactional positioning occurred when the therapist utilized a position that John had made between himself and different partners in order to explore the nature of the therapeutic relationship; "*(T:) you were talking about people making demands on you. I was wondering whether there is anything while you are sitting there now feeling or thinking if I am able to get this right or…(J:) No, no, I don't feel…*". The therapist also employed his understanding of John's positionings with others in order to facilitate his reflexive capacity; "*(T:)the feeling that I was getting…(J:) Yes. (T:) It was like you didn't have brothers or sisters. (J:) I don't really. (T:) You are not feeling but you know in terms of family tree you do. (J:) Yes I do and my sister brought me up she almost assumed a mother figure actually in a way but not my mother. (T:) She is not a mother she is not a sister. (J:) Yea, yes*". In this example, by characterizing John as someone who does not seem to have siblings, the

therapist enabled him to reflect more on his family relationships. In essence, the therapist's positioning towards John was an invitation for him to reconsider aspects of his earlier positionings within his narrated self.

Successful case 2: Mary

Mary was a professional in white-collar employment. When she entered therapy she was living with her husband, son, and elderly mother who suffered from an age-related disorder. She had the same male therapist as John.

(1) The narrated self: Self positioning

Mary positioned herself in diametrically opposed ways. On the one hand, she was helpless and unable to combat her problems; "*It scares me to hell the thought of it, the thought that it (the depression) might come back and the thought that I really can't do anything about it*". She mentioned her diagnosis, depression, yet portrayed herself as puzzled about the cause; "*what's the root of it? I don't understand why*". On the other hand, she was a capable person who made her own decisions concerning her problems; "*I was on tablets for about a year and I thought this is not getting me anywhere so I threw them away and I managed to go back out to work part time*", and professional life; "*I started work as just a junior clerical person, graduated to secretary, and now I run a department*". Mary's third type of self-positioning was made through a comparison of herself as a child; "*I don't think I was particularly happy*", and as a "*happily married*" woman who is "*very sensible*" and "*reasonably intelligent*".

(2) The narrated self: Positioning between narrated self and different partners

Mary described herself when she was a child as resenting "*the fact that my parents were old when I was born*" and that "*my father was always ill*". As an adult she had

developed a critical attitude toward doctors; "*I used to think that if I went to the doctors and he told me it won't come back […] I would believe him and that was all right, but I am a bit older and wiser now*". She also positioned herself as competent and agentic through resisting possible implications of psychological vulnerability in her interaction with others in her day-to-day life; "*I cover it up. I want to be well. I like being in charge if you like I suppose and being capable and lead my own life*"; and at work; "*when I feel good I have to go back to work and give reasons for being off. That means that I have to tell lies*". In relation to her family, she could feel overburdened by their demands; "*I blow my top and say that I think they should do more*", but, although she "*worr(ies) a lot about [son]*", her family was portrayed as showing some reciprocal concern; "*they are worried about me*". However, she found it difficult to express her feelings to others; "*sharing with people doesn't come easy*".

(3) The narrating self: Positioning between client and therapist

Mary's resistance to being positioned as pathological was reflected in the therapeutic encounter; "*it sounds as though I am a neurotic but really most of the family if anything goes wrong they ring me*", as was her difficulty sharing; "*(T:) Why do you feel the need to apologize here? (M:) For crying. Yes. I don't know why I should cry. Why I can't (talk about mother) without crying. I don't usually cry in front of strangers*". However, this latter interaction allowed her to express two shifts in positioning; *"(T:) Are you feeling anything now? (M:) Some release I suppose because it is the first time I have ever sort of talked about it"*. First, Mary expressed a new self-positioning as able to benefit from revealing her distress to another person. Second, by implication, she no-longer positioned her therapist as a stranger but as an empathic person warranting trust so that later she is able even to risk joking with him; "*(M:) I have to go on the bus as well (laughs). (T:) You are concerned about the bus?*

(M:) Oh, I was just joking really". At the end of the session, Mary and the therapist positioned themselves interactively as willing to work together and both expressed optimism about the outcome; *(T:) I feel that if you feel that we can work together. (M:) Yes, no I want to get better. (T:) Feel optimistic about working together? (M:) Yea. Right. Yea (laughs)*". This last quote also illustrates the pattern found throughout Mary's session of her tendency to provide affirmations of the therapist's formations.

Successful case 3: Angela

Angela was a professional in white-collar employment who lived with her elderly parents and two teenage children. At the time of entering therapy she was in the process of divorce. She had a different male therapist to the one who worked with John and Mary. This therapist was in his forties and had 18 years experience with psychodynamic-interpersonal therapy.

(1) The narrated self: Self positioning

Angela described herself as liking to do things in her own way, although this could interfere with her job; "*I'm a little bit of an individual so trying to plan for a team to work is difficult*". She also had difficulty discussing things with others as she equated this with arguing; "*it bothers me as I am getting upset. Yes I do find that happens to me quite frequently if I do start to discuss things*". However, she also portrayed herself as appearing "*confident*" and "*competent*", but described this as "*an act*". Finally, although less repeated within the session, Angela positioned herself as having been "*a good child*".

(2) The narrated self: Positioning between narrated self and different partners

Angela differentiated herself from her colleagues; "*They couldn't work with the clients but they could do all the other parts*", and the conventions of her working

environment; "*I like to work off the cuff and I find that works well for me but that doesn't work well in the system*". She described herself as uncomfortable "*asking other people to do things for me*". She also "*find(s) it difficult to sort of talk things through*" and this caused her difficulties with her family; "*not being able to discuss things, so I suppose I couldn't win with my parents. I couldn't win with my husband*", the former of whom were described as "*expecting quite a lot of me*". However, she and her daughter are portrayed as "*good pals and we can sit down and talk about things*".

(3) The narrating self: Positioning between client and therapist

Angela presented a firm belief about the nature of her problems; "*my relationships with other people and me as a person not being able to cope with part of the job".* However, in response, the therapist suggested a more open formulation that encouraged collaboration; "*Well, we don't know. I mean part of this is finding out".* As in the previous two cases, this therapist also drew parallels between the client's positioning within and outside the therapeutic encounter; "*(A:) I don't like asking other people to do things for me really. I don't know why. (T:) I wonder how it feels here because in a way by coming here you are asking, you are asking me to do things for you".* He also drew attention to Angela's passive self-positionings, for example when she construed her actions to be determined by an external force; "*(A:)I should plan programs and things far more than I do. I just find it I can't. (T:) You should. That sounds like it's someone else's talking. (A:) Oh yea. (T:) Sounds like it's the system. (A:) It's the system (laughs) yes"*, and when she attributed her problems to biological processes; "*(T:) it began as if it were your brain you know. (A:) Yes (laughs). (T:) And yet what I am picking up is something that exists between you and other people".* Both these quotes demonstrate Angela's tendency to confirm her

therapist's formulations and, by questioning her way of talking, the therapist encouraged Angela to reflect on the how she positions herself.

The unsuccessful case: Peter

Peter was a professional with a job at the top of the hierarchy in white-collar employment. He lived with his wife and three children. His female therapist was in her mid-thirties and had six years post-qualification experience.

(1) The narrated self: Self–positioning

Peter positioned himself as feeling consistently under pressure; "*I felt I can't do that. I had too much responsibility*", as "*trapped*" or "*stuck*", and incapable of coping; "*I can't cope with the work*". He entered therapy with a very definite idea about the nature of his problem, which he construed as having been out of his awareness and, hence, out of his control; "*a middle life crisis which I did not realize at the time*".

(2) The narrated self: Positioning between narrated self and different partners

Peter described himself as having made sacrifices for his family, for example through not moving house in order to get a more rewarding job; "*My eldest child is getting his decision whether to take his A-levels and we've always discussed that it may be better to stay at one place*". He portrayed himself as having supported his wife through a "*bad time*" although resenting her "*for bringing me away from [town]"* and for ignoring his needs; "*we reunited as a family unit which to [wife] this was all that mattered*". Hence, he implied that he had little control over his life and "*put(s) the emphasis on [wife] that it was her fault*". However, he also suggested that he, himself, can be un-supportive; "*I felt guilty that I wasn't as supportive as I should*", timid*; "I found I couldn't be assertive enough to actually go and knock on the door*", and

uncommunicative in difficult situations; "*when my father died. Again I suppose I did withdraw*".

(3) The narrating self: Positioning between client and therapist

In almost all instances, Peter responded in the affirmative toward his therapist's formulations. However, the empathy producing potential of this was disrupted by interactionally-constructed confusions in his narrative; "*(T:) are you going back again? (P:) Sorry. We are going back again, sort of*". On other occasions Peter, himself, highlighted the possibility that his therapist might misunderstand him; "*am I making sense? Have you muddled?*". His self-positioning as having little control over his life was also echoed in the therapy interaction. When the therapist invited him to steer the conversation; "*I'd like very much to leave it up to you to talk about what you feel is important*", Peter responded by rejecting this agentic positioning and repositioning control with the therapist; "*Fine, so, do I start? I mean, and when do I start? Sort of today or further back, or?*". These examples demonstrate how the interactional repertoire between Peter and his therapist was limited in terms of establishing a personal relationship and, despite Peter's long descriptions, his original narrated self remained intact at the end of the session.

We now make comparisons between the three successful and the one unsuccessful case.

(1) The narrated self: Self–positioning

All the clients presented themselves in very negative terms. They positioned themselves variably as feeling inadequate, helpless, inauthentic, and unable to cope. These themes express some of the phenomenological features of depression. However, in all successful cases, despite their self-degrading comments, the clients

talked about some positive aspects of themselves; John had principles and was a devoted father, Mary was capable, sensible and intelligent, and Angela was an independent individual who could work with clients. They also presented themselves as having the capacity to influence their environment. John impacted his profession, Mary reviewed her medication, and Angela did things her own way. In the unsuccessful case, though, there was an almost complete absence of positive self-comment and Peter consistently positioned himself as lacking agency. Each client had a clear idea about the nature of his or her problem. Some used diagnostic labels found within psychiatric and popular psychology literature while others were more descriptive about their condition. It is interesting to note that the client in the most successful case, Angela (recall Table 1), utilized almost wholly general descriptions of her problems while the unsuccessful case contained diagnostic labels.

(2) The narrated self: Positioning between narrated self and different partners

Each client reported problems in their relationships with other people, however, in the successful cases, the picture offered is not uniformly negative. John had a harmonious relationship with his wife, Mary's concern about her family is reciprocated, and Angela had a friendly relationship with her daughter. On the other hand, although Peter portrayed himself as having been supportive toward his wife at times, he construed this as having been un-reciprocated and described no positive relationships with others. There are also types of positioning in the successful cases in which the clients expressed agentic power in relation to other people. John enjoyed counseling his staff, Mary liked being in charge, and Angela resisted the system. In contrast, Peter's narrative was barren of positions expressing or implying influence with respect to others.

(3) The narrating self: Positioning between client and therapist

In the present analysis, the most common type of positioning between client and therapist was achieved through the formulations made by the therapist. No consistent differences were found between the unsuccessful and successful cases in terms of the clients' reception of therapist formations as, in general, clients responded in the affirmative. This is a robust feature of interaction, creating the sense of a mutual and co-operative relationship, and therefore not specific to therapy (Pomerantz, 1979). It is interesting to note, however, the extent to which John attempted to build rapport with his therapist through positioning himself as enjoying their conversation and acknowledging his therapist's empathy and Mary's attempt to produce familiarity through humor. In contrast, in the unsuccessful case, although Peter affirmed his therapist's formulations, she was positioned as potentially lacking empathy through her inability to follow aspects of his narrative. Another feature of Peter's interaction is his lack of agentic self-positioning in relation to his therapist as demonstrated in his hesitancy to act on her invitation to steer their conversation. In contrast, John could take the lead in soliciting his therapist's participation and Mary actively resisted the potential of being positioned interactively as neurotic within the therapy conversation.

In all three successful cases parallels were drawn between the way in which the client may have felt positioned within the therapy and the positions expressed in the client's narrated self in relation to different partners. John's therapist tried to establish if John felt that demands were being made on him in therapy just as he described them being made on him by his staff. Mary's therapist explored how her awkwardness showing distress in therapy mirrored her reticence to share feelings with others in her life. Angela's therapist drew attention to the irony that, in being in therapy, she may depend on him in a way she avoided doing with others. In contrast, this form of interactional positioning was absent from the unsuccessful case.

Discussion

This study applied some newly developed methodological tools for studying patterns of interactional positioning and narrative self-construction within the first session of four cases of brief psychodynamic-interpersonal psychotherapy. The study aimed to identify narrative processes that interactionally position the client and possible connections between these and end of treatment outcome. Our findings can be summarized in five points as outlined below where they are discussed in relation to the existent literature.

(1) The successful clients tended to be more descriptive and to use less diagnostic terms when they talked about their problems than did the unsuccessful client.

Although there is a growing literature on the way in which clients construct their problems within the therapy dialogue (e.g., Madill, Widdicombe & Barkham, 2001), there is little research on clients' use of diagnostic terms. Moreover, research has tended to concentrate on how the *therapist* talks during treatment in an attempt to establish the relative success of different techniques or types of therapy (e.g., Elliott, Hill, Stiles, Friedlander, Mahrer & Margison, 1987). However, one such study may throw light on our results. Barkham and Shapiro (1986) found that received empathy was associated with exploratory responses from the therapist in which attempts were made to understand the client's experience within a shared frame of reference rather than with the making of interpretations from within the therapist's theoretical model. The usefulness of such an approach is emphasized in Anderson and Goolishian's (1992) 'not-knowing' approach to therapy in which the therapist is called to abandon their theoretical preconceptions and to let the client lead the way. The making of exploratory responses and utilization of a 'not-knowing' approach could be understood as indicators of therapist openness. Client openness may have similarly

positive effects on the outcome of therapy and our finding that clients in the successful cases used more descriptive and less diagnostic terms when offering an account of their problems could be an indication of such a characteristic. In fact, research on clients' interpersonal style (Kiesler & Watkins, 1989) and self-relatedness (Orlinsky & Howard, 1986) suggest that flexibility and openness on these two dimensions were conducive to establishing a good alliance with the therapist and a good therapeutic outcome.

The following three points relate to the client's self-efficacy and, hence, are discussed together.

(2) All the clients positioned themselves in negative terms, but the unsuccessful case was characterized by a particular lack of positive comment about self, minimization of agentic self-capacity, and lack of self agency in interaction with the therapist;

(3) All the clients positioned themselves as having problems in their relationships, however the successful clients described at least one positive relationship and positioned themselves has having at least some agency in relation to others;

(4) All the clients tended to affirm their therapist's formulations, however the empathy-producing potential of this was disrupted for the unsuccessful client by interactionally-constructed confusions in his narrative while the successful clients could demonstrate active attempts at rapport-building.

Sifneos (1973, 1984) proposed a number of criteria for selecting suitable clients for short-term dynamic psychotherapy. Two that predict successful outcome in this type of therapy are particularly relevant to the present study; adequate self-esteem, and good interpersonal relations. Expanding on the latter criterion, Sifneos (1997) suggests that a potentially successful client in short-term dynamic psychotherapy

should have a history of at least one meaningful relation with another person. Moreover, an association has been observed repeatedly between interpersonal measures administered pre-therapy and alliance ratings within therapy (Gaston, 1990; Kokotovic & Tracey, 1990; Wallner, Muran, Segal & Schmann, 1992). There is also some evidence that important aspects of the alliance are established during the first session of therapy (e.g., Alvarez, 1992; Kokotovic & Tracey, 1990).

These bodies of work resonate with our findings. Our unsuccessful case was characterized by a particular lack of positive self-comment, minimization of agentic self-capacity, and lack of agency in interaction with the therapist. All these features could be considered indicators of extremely low self-esteem and, of the four cases examined, the client with the unsuccessful outcome was the only one who described no positive relationship with another person. Moreover, fundamental to all alliance theories is the idea of client-therapist collaboration, mutuality, and engagement (Horvath & Symonds, 1991). Clients in two of our successful cases demonstrated their ability to contribute these qualities through their affirmation of the therapist along with active attempts at rapport building; the latter quality absent in the unsuccessful case.

Depressive symptomatology is associated with a sense of being unable to act on or to control one's environment in both learned helplessness (Seligman, 1974) and attribution theory (Abramson, Seligman, & Teasdale, 1978). This helps make sense of our finding that only our successful clients conceived of themselves as able to influence their circumstances and the people around them in at least some areas of their lives. Hence, it could be that a modicum of perceived self-efficacy is required before a client can benefit from PI therapy. This concurs with the findings from the National Institute of Mental Health Treatment of Depression Collaborative Research

Program which suggested that therapeutic gains made by clients in specific therapies (i.e., interpersonal psychotherapy and cognitive-behavioral therapy) were achieved by building on existing skills (Sotsky et al., 1991).

(5) In the successful cases the therapist used positionings expressed by the client in their narrated self in order to explore interactional positionings developed during their face-to-face interaction.

Hobson's (1985) conversational model, on which PI therapy is based, views the therapeutic relationship as a microcosm of the client's interactions with others and, hence, the therapist seeks to make connections between interpersonal dynamics inside and outside of therapy. This is basic to Freud's (1912) theory of transference. There is some evidence that early utilization of tranference feelings in therapy is a good predictor of successful outcome (Sifneos, 1984). Furthermore, in a study of brief dynamic psychotherapy (Hoyt, Xenakis, Marmar & Horowitz, 1983), predictors of good outcome included the emphasis placed by the therapist on the patient's "expression and discussion of the patient-therapist relationship, the meaning of the patient's reactions, and the links or patterns between the patient's past and present life" (Koss & Shiang, 1994, p.689). Hence, using the therapeutic relationship to explore the client's habitual positioning narratives early in therapy may be a particularly effective strategy and pointer that the client is able to work within this form of therapy.

As the theory of interactional positioning has not before been applied within psychotherapy research the precariousness of the present results should now be put into perspective. First, one limitation of the present study is that we knew the outcome of each case before conducting the analysis. A future study utilizing a researcher blind to case outcome would avoid the possibility of analytic bias. Second, as the number of

cases considered was small, any claim for the generalizability of the current results is made with caution. Third, another possible limitation of this study is that only one session of each case was considered and, hence, we cannot be certain that the patterns found remained consistent during the course of therapy. Finally, the method used is novel and, although minor, the differences between analysts in our credibility check suggests that some clarifications are required to make it easier to operationalize.

Pragmatically, interactional positioning might be best utilized in a form in which it mimics supervision. The application of interactional positioning, applied in the early sessions of therapy, offers the potential for providing therapists with a quasi-supervisory process of clients' intra- and interpersonal discourse with the therapist. Of course, this potential is not unique to this procedure alone but is one of an increasing number of qualitative approaches which both capture the richness of the therapeutic process but also provide a separate perspective; a central axiom of supervision. The implications for clients who are characteristic of the unsuccessful client fall into the area of 'assessment as therapy' whereby trial interventions can be used in assessment in order to test a client's capacity to work therapeutically with clinically sensitive material. In situations where the characteristics of the unsuccessful case manifest in assessment, then this might be indicative of a potential mismatch between the client and a specific therapeutic approach. A clinical decision would then be required as to whether this difficulty was axiomatic to the client's presentation and whether an interpersonal or more cognitively-based intervention might be most appropriate.

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Case & pseudonym	Assessments					
	Pre-treatment		Post-treatment			
	Pre-screening	Intake assessment	Immediately prior to session 1	End of treatment	3-month follow-up	12-month follow-up
Successful 1: John	17	12	15	1	0	0
Successful 2: Mary	29	25	27	2	4	5
Successful 3: Angela	21	20	24	0	0	0
Unsuccessful : Peter	/	22	26.25	27	30.45	32

Note: Pre-screening = 7 weeks prior to therapy; Intake = 4 weeks prior to therapy

Table 1: Participant Beck Depression Inventory scores at pre- and post-treatment assessments