

**THE NARRATIVES OF PEOPLE WHO SUFFER FROM
DEPRESSION**

ALAN ROBERTSON

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DEPRESSION**

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B.A. HONS, B.D.

**Mini-dissertation (manuscript format) submitted in partial fulfillment of the
requirements for the degree of Master of Arts in Clinical Psychology at
Potchefstroom University for Christian Higher Education**

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ACKNOWLEDGEMENTS

Jesus said “ ‘Love the Lord your God with all your heart, with all your soul, and with all your mind.’ This is the greatest and most important commandment. The second most important commandment is like it: ‘Love your neighbour as you love yourself’ ” (Matthew 22:37).

I need to thank God for opening doors for me at Potchefstroom University for Christian Higher Education, thus helping me to better fulfil the above commandments. I thank Him also for the perseverance and encouragement He gave me during what was at times an exhausting journey.

I thank also the following people:

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- My wonderful wife, Denise and my beautiful children Mary, Stephen, Debbie and Paul for their patience, understanding and willingness to sacrifice on my behalf.
- Last, but not least, to the participants who shared in this study, thank you for entrusting your sacred life narratives to me. With your help I have learned so much.

SUMMARY

THE NARRATIVES OF PEOPLE WHO SUFFER FROM DEPRESSION

Keywords: narratives, depression, narrative therapy, postmodernism.

The purpose of this study was to examine and compare the narratives of depressed and non-depressed people in the light of the principles of a narrative approach to therapy which were provided by a supposition matrix. A qualitative research approach, specifically a multiple case study method was used, consisting of interviews with ten people who were suffering from depression and ten who were not.

The research discovered that depressed participants found it more difficult to find alternative meanings in their life narratives, and used more negative generalisations. Their past, present and future narratives seemed more unhelpful and they seemed less aware of their wealth of lived experience. They were more adversely affected by the limiting narratives of significant others and they did not cope as well with subjugating socio-political stories.

While both groups showed an abundance of unique outcomes, the depressed participants seemed unable to author these into helpful alternative narratives. The research suggested further that the narrative approach to therapy could be helpful in therapy with depressed people, especially helping depressed people to translate unique outcomes into alternative narratives. The narrative approach to therapy also seemed to be holistic in nature, and depression seemed to be a remarkably complex phenomenon.

OPSOMMING

DIE NARRATIEWE VAN PERSONE WAT AAN DEPRESSIE LY

Sleutelwoorde: narratiewe, depressie, narratiewe terapie, postmodernisme.

Die doel van hierdie navorsing was om die narratiewe van depressiewe en nie-depressiewe persone te ontleed en te vergelyk in die lig van die beginsels van 'n narratiewe terapeutiese benadering wat deur 'n veronderstellingmatriks daargestel is. 'n Kwalitatiewe navorsingsbenadering, spesifiek 'n meervoudige gevallestudiemetode is gebruik, wat bestaan het uit onderhoude met tien persone wat aan depressie en tien wat nie daaraan ly nie.

Die navorsing het getoon dat die depressiewe deelnemers dit moeiliker gevind het om alternatiewe betekenis in hulle lewensnarratiewe te vind, en hulle het meer negatiewe veralgemenings gebruik. Hulle narratiewe van die verlede, hede en toekoms het nie nuttig geblyk te wees nie en hulle was minder bewus van hulle rykdom van lewenservaringe (belewensisse). Hulle is meer benadeel deur die beperkte narratiewe van betekenisvolle andere en hulle het nie so goed aan onderdrukkende sosiopolitieke narratiewe voldoen nie.

Terwyl beide groepe 'n oorfloed unieke uitkomst aangedui het, het die depressiewe deelnemers dit moeilik gevind om hierdie uitkomst in alternatiewe narratiewe te omskep. Die navorsing het verder aangedui dat die narratiewe terapeutiese benadering effektief in terapie met depressiewe persone kan wees, veral om depressiewe persone te help om unieke uitkomst in ander narratiewe te

omskryf. Die narratiewe terapeutiese benadering het ook holisties van aard geblyk te wees en depressie dui op 'n opmerklieke komplekse verskynsel.

CONSENT

We, the co-authors, hereby give consent that Alan Robertson may submit the manuscript for purposes of a mini-dissertation. It may also be submitted to the South African Journal of Psychology for publication.

Prof. CA Venter.

Dr Karel Botha

INTENDED JOURNAL AND GUIDELINES FOR AUTHORS

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TITLE

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ABSTRACT

The purpose of this study was to examine and compare the narratives of depressed and non-depressed people in the light of the principles of a narrative approach to therapy which were provided by a supposition matrix. A qualitative research approach, specifically a multiple case study method was used, consisting of interviews with ten people who were suffering from depression and ten who were not. The research discovered that depressed participants found it more difficult to find alternative meanings in their life narratives, and used more negative generalisations. Their past, present and future narratives seemed more unhelpful and they seemed less aware of their wealth of lived experience. They were more adversely affected by the limiting narratives of significant others and they did not cope as well with subjugating socio-political stories. While both groups showed an abundance of unique outcomes, the depressed participants seemed unable to author these into helpful alternative narratives. The research suggested further that the narrative approach to therapy could be helpful in therapy with depressed people, especially helping depressed people to translate unique outcomes into alternative narratives. The narrative approach to therapy also seemed to be holistic in nature, and depression seemed to be a remarkably complex phenomenon.

1 INTRODUCTION

The current age in art, philosophy and the humanities is characterised by what is being described as “postmodernism” (Kvale, 1992, p. 1). Despite this trend, there is no coherent school of postmodern psychology (Parry & Doan, 1994; Venter, 2000). An important question, therefore, is to what extent the modern science of psychology can grow and benefit by interaction with postmodern ideas (Kvale, 1992).

Michael White is one of the pioneers in this process of applying postmodern thought to psychology, especially in the field of family therapy (Freedman & Combs, 1996; Parry & Doan, 1994). White is perhaps the most influential therapist in the field at present, although theorists such as Harlene Anderson and Goolishian, and De Shazer, *inter alia*, have also made a significant impact in bringing postmodern philosophy into the field of psychotherapy (Parry & Doan, 1994 ; Venter, 2000). The umbrella term for this process has come to be known as a narrative approach to therapy (Freedman & Combs, 1996; Monk, Winslade, Crocket & Epston, 1997).

In the light of the newness of these developments, it is understandable that research regarding a narrative approach to therapy and depression is still in its infancy (Etchison, 2000). For this reason, and because depression is widely believed to be the common cold of mental illness, affecting the lives of millions throughout the world (Amundson, 1998; Carson & Butcher, 1992), there would seem to be an urgent need to investigate the usefulness of narrative therapy as a method of treating depression.

Of the little research that has been completed in this field, by far the largest proportion consists of

case studies. For example, Crafford (1997) cites two case studies in which alternative stories regarding the families of origin proved successful in alleviating depression. Nyland and Ceske (1997), on the basis of two case studies, postulate that dominant cultural gender narratives promote depression. Clark and Standard (1997), referring to a family case study, suggest that caregivers can use the narrative approach to re-story their perceived reality, thus transforming feelings of depression. Laube and Trefz (1994) provide a case study in which the narrative approach was used in the context of group therapy with depressed persons and produced positive results. Johnson (1994) likewise used a group model in which the narrative framework was applied in a helpful way to uncover issues of power, culture, context and gender that underlay the depression of the participants. Carlson (1998) and Fristad, Gavazzi and Soldano (1999) show in case studies how externalising the problem initiated significant improvement in clients suffering from depression.

While these case studies are valuable and certainly suggest that the narrative approach to therapy may be useful when applied to people suffering from depression, there seems to be a lack of a critical analysis of the narratives of depressed people *per se*. The narratives in the previously mentioned case studies are in the context of therapy, with the aim of the deconstruction of the stories in order to produce therapeutic change rather than a simple, impartial critical analysis. Smith (1999, p.3) rightly points out: "... it remains an unsettling fact that there is a serious paucity of critical research that explores individuals' emotional tales of depression through narratives of the self." There is clearly a need to examine the "psychological meaning of depression" from the perspective of depressed people themselves, as expressed in their narratives (Rapmund & Moore, 2000, p.21).

A critical analysis and comparison between the narratives of depressed and non-depressed people

would go some way towards addressing this gap in the research so far. In addition this process would shed valuable light on how the narrative approach might be an effective therapeutic technique with people suffering from depression, since it is postulated that the narratives of people suffering from depression will differ considerably from the narratives of those without.

Another related aspect is the lack of consensus with regard to the main elements of the narrative approach to therapy. Crafford (1997) equates the narrative approach with a new, positive discourse regarding a person's life. Other elements which are emphasised by different researchers include: externalisation of the problem (Van Heerden, 1997), an irreverent, questioning attitude (Soal & Kottler, 1996), the re-storying of negative aspects of perceived reality (Clark & Standard, 1997) and the narrative approach as a form of social constructionism (Walsh & Keenan, 1997; Zimmerman & Dickerson, 1997). Nyland and Ceske (1997) concentrate on the usefulness of the narrative approach in challenging discourses in the cultural and socio-political context which encourage depression among young women. Johnson (1994) stresses the role of the narrative approach in confronting gender stereotypes that are associated with depression. McCleod (1997, p. 396) argues that "objectification" is central to a narrative therapeutic approach.

It seems clear that there is a need for researchers in respect of a narrative approach to therapy and depression to draw together some of the main principles of the narrative approach in order to give the research a more comprehensive focus. An attempt will therefore be made in this article to bring together some of the main elements of the narrative approach which have been emphasised by various researchers. These aspects will form a "supposition matrix" which will serve as a useful tool for comparing the stories of depressed and non-depressed people. Kvale, a respected scholar in the field of both qualitative research and postmodernism, originally used the term "hypothesis

matrix” (Kvale, 1983, p.66) to refer to a set of principles designed to give focus to qualitative research. However, the word “hypothesis” is replaced in this article by “supposition”, because of the association of “hypothesis” with quantitative research.

2 ELEMENTS OF A NARRATIVE APPROACH TO THERAPY AS A SUPPOSITION MATRIX

As indicated, various researchers have accentuated different aspects of a narrative approach to therapy. A thorough analysis of the literature regarding this approach indicated that the supposition matrix should contain at least the following eleven principles. Naturally, when one separates an approach into separate principles, there tends to be some overlapping.

Central to a narrative approach to therapy (as to postmodernism) is the principle that there is no objective reality. The meaning people confer upon events is relative, influenced by the assumptions, thinking style and life context of the individual concerned (Freedman & Combs, 1996; White & Epston, 1990). In the light of this premise, the first element of the supposition matrix could be thus stated: people suffering from depression will tend to view their narratives as objective reality, i.e., fixed and inflexible, whereas people not suffering from depression will tend to interpret their life narratives in a fluid, flexible manner, capable of many meanings.

A second principle of the narrative approach is that reality is created by language (Anderson & Goolishian, 1988; Freedman & Combs, 1996). This idea is linked to mental health in the notion that lives are “texts”, some with literary merit, some without (White & Epston, 1990, p.2). In other words, language and how it is used can contribute to healthy or unhealthy psychological

functioning. This cornerstone of the narrative approach to therapy suggests the second element of the supposition matrix: depressed people will be less sensitive to language and its nuances than those who do not suffer from depression. By “sensitivity to language and its nuances” is meant a large range of vocabulary, the ability to use words well and a capacity for imagery such as metaphors and similes. Where depressed people are sensitive to language, they will use language in a negative, limiting way.

Suppositions three, four and five are closely linked because they focus on the suggestion in the narrative approach that people arrange their experience in stories in order to give meaning and continuity to their lives. This organisation of experience into stories has a past, present and future dimension (White & Epston, 1990; Hewson, cited in Yule, 1993). With regard to the past, the narrative approach postulates that, as people arrange their stories, a great deal of experience is lost and dominant stories emerge. De Shazer (1991) suggests that three sorts of narratives appear in persons’ past stories: progressive, stability and regressive. In progressive narratives, people reach their goals, in stability narratives people’s lives remain unchanged and in regressive narratives people’s lives move away from their proposed goals. In the light of this principle, the third supposition is as follows: the past narratives of depressed people will be characterised by dominant narratives that are unhelpful, unsatisfying and regressive. The past narratives of non-depressed people, by contrast, will be characterised by more helpful, satisfying and progressive dominant narratives.

The present narrative of a person refers to the individual’s immediate context, the person’s current story. Supposition four suggests that the present narratives of depressed people will also be unhelpful, unsatisfying and regressive. With regard to future narratives, people’s dominant stories

will shape their future, and events that are anticipated to occur in the future will impact upon the developing narrative (White & Epston, 1990). In other words, if the future is envisaged with hope, the more likely it will be that the predicted future will influence the narrative in a more positive, progressive direction (De Shazer, 1991). In the light of this principle, the fifth supposition assumes that the narratives of people with depression will reveal more difficulty in visualising a hopeful future than those without depression.

The sixth principle of a narrative approach to therapy, linked with supposition three, is that people are very rich in lived experience (White & Epston, 1990). Some people, however, forget the variety and richness of their lived experience and therefore find it difficult to find alternative meanings in their life narratives. Others are more aware of their wealth of lived experience, giving them the option of reinterpreting their narratives and authoring alternative stories (Freedman & Combs, 1996). This principle of the narrative approach suggests the following supposition: the narratives of those suffering from depression will show less awareness of the wealth of their lived experience than the narratives of people without depression. Put even more simply, the narratives of the former will be shorter and less detailed than the latter.

A seventh principle of a narrative approach to therapy is that, because only a fraction of the lived experience of people can be put into their narratives, many aspects of a person's experience are not included in the dominant narrative. What distinguishes this from the previous supposition is that these aspects may well contradict the dominant story, and are therefore of crucial importance. These aspects are referred to as "unique outcomes" (White & Epston, 1990, p. 15) or "sparkling moments" (White, cited in Monk et al., 1997, p. 13). These unique outcomes are useful in the creation of alternative stories which may challenge and ultimately transform the dominant story (White &

Epston, 1990). This theoretical background leads to the seventh supposition: the narratives of people with depression will show less evidence of unique outcomes than the narratives of people without depression. Where unique outcomes are present, people with depression will find it more difficult to use these unique outcomes to author alternative stories.

In the eighth place a narrative approach to therapy postulates that our “texts” are situated among other “texts” (White & Epston, 1990, p. 18). In other words, the stories of significant others impinge upon our own stories, sometimes in a stifling, destructive way, sometimes in a life-creating way, sometimes in a mixture of both (Andrews & Clark, 1996). This suggests the supposition that the narratives of people with depression will reveal evidence of the inhibiting narratives of significant others around them. In the case of people without depression, their narratives will reflect that the stories of significant others around them tend to be supportive, contributing to growth and psychological health.

The ninth principle is closely related to the previous one in that the “texts” within which the narratives of people are situated are socio-political (Parry & Doan, 1994, p. 50). White and Epston (1990, p.20), drawing from the French philosopher Foucault, suggest that people are subject to “power” through normalising “knowledges” or “truths” which shape the lives and relationships of people. These dominant socio-political stories tend to serve as the norm by which people are valued and judged (Venter, 2000). In this sense the socio-political stories in which human beings try to perform their own unique narratives can be seen as “subjugating” (White, 1995, p. 41; White & Epston, 1990, p. 25). Arising from this, it is supposed that the narratives of depressed and non-depressed people will show evidence of subjugating narratives from the socio-political context. The narratives of depressed people, however, will reveal less ability to resist these subjugating

narratives.

The tenth principle suggests that people who seek help with psychological problems view their life narratives as “problem-saturated” (White, 1995, p. 34; White & Epston, 1990, p. 16). This problem-saturated outlook becomes the dominant story of their lives and becomes something that resides in their lives (Parry & Doan, 1994). A narrative framework encourages externalisation, an approach which suggests to people that they view problems objectively and outside of themselves (White & Epston, 1990). In this way the person feels less paralysed by the problem, seeing it as something “out there”, to be fought against, instead of an inner, crippling force (Carlson, 1998, p. 64; McCleod, 1997, p. 394). The tenth supposition therefore suggests that the narratives of depressed people will show the tendency of identification with life problems, while the narratives of people without depression will show some externalisation with regard to life problems.

The eleventh principle hinges around the suggestion by Soal and Kottler (1996, p. 123) that an “irreverent attitude” to truths taken for granted is a prominent feature of the narrative therapeutic approach. Linked to this is the assertion of Anderson and Goolishian (1992) and Monk et al. (1997), that a characteristic of a narrative approach to therapy is the encouragement of the client to become the expert and therefore to ask probing questions of her/himself and the world around her/him. It is postulated that such a questioning attitude contributes to psychological health. The foregoing suggests the final supposition: the narratives of people with depression will show a less irreverent and questioning attitude than the narratives of those without depression.

In the light of the above discussion, the research question is thus stated: how do the narratives of depressed and non-depressed people differ with regard to the “supposition matrix” and what

implications might this have for therapy?

3 THE RESEARCH

3.1 Aim

The aim of the research was to discover how the stories of people suffering from depression differed from the stories of people without depression with regard to the supposition matrix, and the implications this might have for therapy.

3.2 Design

A qualitative research approach, specifically a multiple case study method, was used in this project (Moore, 1987). A supposition matrix was used to focus the research clearly towards the field of a narrative approach to therapy (Kvale, 1983). Qualitative research was chosen because therapists who embrace the narrative approach regard themselves as part of the postmodernist philosophical movement and would therefore reject quantitative research methods since they believe that research is not performed by “experts” upon “subjects”, but derives from mutual discovery and co-research (Merchant, 1997, p. 2).

3.3 Participants

An availability sample (non-probability) consisting of twenty volunteers (ten depressed and ten non-depressed) was used (Bailey, 1987). The Beck Depression Inventory (Beck, Ward, Mendelson,

Mock & Erbaugh, 1961) was used to determine which participants suffered from depression and which did not. People who scored seven or above were deemed to be suffering from depression. A further screening with the Satisfaction with Life Scale (Diener, Emmons, Larsen & Griffin, 1985) was conducted to confirm a reasonable degree of psychological health in the non-depressed group. It was ensured that the non-depressed participants scored twenty or above, which indicates a high degree of life satisfaction (Diener et al., 1985). It was ascertained that the participants were not receiving therapy at the time of the interview.

The participants in the depressed group consisted of five women and five men, ranging in age from nineteen years to seventy-two years, with a mean age of 34.4. Three of this group were students, three were professionals, two were in the business world, one was unemployed and one was retired. Five were Afrikaans speaking, four were English speaking and one was Tswana speaking, although he spoke English during the interview. The participants in the non-depressed group consisted of eight women and two men, ranging in age from twenty years to sixty-one years, with a mean age of 36.6. Five of this group were students, three were professionals, one was in the business world and one was a housewife. Three were Afrikaans speaking, six were English speaking and one was Sotho speaking, although she spoke English during the interview.

3.4 The Researcher

The researcher has completed the academic section of the Master's degree in clinical psychology at Potchefstroom University for Christian Higher Education. During the first half of the year he worked as an Intern Psychologist at the Institute for Psychotherapy and Counselling. In the second half of the year he worked as an Intern Psychologist at Witrand Hospital. Since encountering a

narrative approach to therapy, the researcher has sensed that it might be very effective in helping depressed people.

3.5 Method of gathering information

In the process of gathering the narratives, only one question was used: would you please tell me the story of your life? In some instances some prompting was necessary, and therefore seven additional questions were held in reserve, but care was taken to ensure that they were non-therapeutic, as the researcher wanted to collect the narratives of people *per se*, without therapeutic intervention (Cohen, Kahn & Steeves, 2000). These questions were: Perhaps you would like to begin with your childhood? Would you like to tell the story of your family life? Would you like to tell me the story of your schooling? Would you like to tell me the story of your life since school? Would you like to tell me the story of your marriage? Are there any other aspects of your life story you would like to tell? How do you see your future story? Participants were informed beforehand that the researcher simply wanted the story of their lives, for research purposes. The interviews were audiotaped and notes were also taken for additional information, such as body language, and to regulate the flow of the interview (Patton, 1987). Permission was obtained to tape the interview and confidentiality was assured.

3.6 Procedures

Advertisement for volunteers, for practical reasons, was carried out among University third year and Honours students. Advertising for volunteers was also done in the churches of Sasolburg, where the researcher lives. The first ten volunteers were chosen in both depressed and non-

depressed categories. Two participants belonged to the staff of the Witrand hospital, where the researcher was doing his internship. These participants volunteered as they became aware of the researcher's topic. The tests and interviews were conducted either in the researcher's office or, in seven cases, in the participant's home.

3.7 Analysis of data

The method of analysis used in this study was adapted from the suggestions of May (1993) and Patton (1987). The taped material was transcribed by the researcher himself, thus enabling him to re-experience the interviews. The transcribed interviews of both the depressed and the non-depressed groups were then read and re-read in conjunction with the interview notes, and the data organised into major themes and sub-themes. The original transcriptions of both groups were then read again and the themes and sub-themes examined in the light of the supposition matrix, looking in particular for similarities and differences between the two groups. The researcher then drew up qualitative interpretations focusing on each principle contained in the supposition matrix.

The reliability of the study was ensured in that, firstly, in the research there was a "chain of evidence", i.e., the tape recordings were made available to others so that they could evaluate for themselves the reliability of the conclusions (Leedy, 1997, p. 12). Secondly, a supposition matrix was used as a tool by which comparisons could be made and data examined (Kvale, 1983, p. 66). Thirdly, as a kind of comparative, the narratives of ten non-depressed people were utilised. These methods should allay fears regarding the neglect of issues of reliability by qualitative researchers (Silverman, 1993).

3.8 Ethical Considerations

Participants were assured that their personal identities would be protected at all times (May, 1993). In the writing up of the data this was ensured by the use of anonymous short quotations. If the person wished to begin therapy as a result of the interview, the researcher indicated that he was prepared to see them after the research, or he referred them to other therapists.

4 RESULTS AND DISCUSSION

The data will be discussed in the light of the eleven suppositions contained in the supposition matrix. The relevant information from the Afrikaans-speaking participants will be translated for the convenience of the English readers.

Supposition one: people suffering from depression will tend to view their life narratives as objective reality, i.e., fixed and inflexible, whereas people not suffering from depression will tend to interpret their life narratives in a fluid, flexible manner, capable of many meanings.

The depressed participants were seldom able to find other meanings for the experiences recounted in their narratives. For example, there were sixteen occurrences of this tendency in the narratives of the depressed participants, compared to four in the narratives of the non-depressed participants. This characteristic of the depressed group seemed to fall into various areas of life experience. For instance, there were four instances of hurtful experiences being interpreted only negatively, without seeing possible positive aspects. One participant said: "In my third year I experienced a very, very big love disappointment. So much so that I dropped out of my second semester." There were

another four instances of tragedy being interpreted as devastating and not as an opportunity for growth. Reflecting on his father's death, one participant shared: "It was a terrible blow for me when my father died. And then my life sort of closed off there." There were three examples of rejection being treated in an inflexibly negative way. A participant complained: "... that knocked me really hard when she said I wasn't good enough for her son." Two occurrences were found of personal criticisms being accepted as true, instead of being rejected in favour of other meanings: "People were starting to despise me for my image, so I began to fit into the image." A further tendency that did not appear in the narratives of the non-depressed group was a monolithic way of interpreting the entire life narrative negatively. There were three examples of this phenomenon. For instance, one participant summed up his entire narrative thus: "I have a very sordid life, I'm afraid." The details of his narrative contradicted this inflexible view.

Non-depressed participants, on the other hand, were able to see the positive possibilities of hurtful experiences. There were nine examples of this ability. One participant, for example, reflected: "Things have gone wrong, but as I think about it, I feel satisfied that perhaps this was where the Lord wanted me." There were twelve instances of tragedy being reinterpreted more positively. One person commented: "My father died. It was a dreadful thing for me... After my father died, my sister and I became close." Eight examples of rejection appeared in the narratives of the non-depressed group. In seven of these, the participants seemed to treat the experience as a learning process. Speaking about an experience of rejection, one participant stated that the experience had forced her to move on with her life, without which she "would have missed something". There seemed to be one experience of personal criticism being re-framed in favour of a more positive interpretation, which contributed to the participant's self-esteem.

As indicated, there were exceptions in both groups. For example, one depressed person said: "I've always had someone to phone. I could pick up the phone and say, help!" This interpretation clearly found alternative meaning for a life narrative that at times seemed problem saturated. On the other hand, one non-depressed person seemed to give the story of her marriage a single, negative meaning when she admitted: "My marriage? To be honest, it's really been tough."

It is clear that the narratives of the depressed participants generally reflected a tendency of viewing life experiences as having one meaning only, usually negative, whilst the non-depressed participants were able to find alternative meanings for life experiences. This finding suggests that helping a depressed person find alternative meanings for life experiences could be helpful in therapy.

Supposition two: depressed people will be less sensitive to language and its nuances than those who do not suffer from depression. Where depressed participants are sensitive to language, they will use language in a negative, limiting way.

Sensitivity to language and its nuances was evident in the narratives of both the depressed and non-depressed participants. Five participants from each group seemed to display sensitivity to language in terms of vocabulary and use of imagery. However, the five depressed participants used this ability in a negative, limiting way. For example, one said: "They shape and mould you as they want to." Another stated: "I'll go and crawl into a shell somewhere, like a hermit crab." A third commented: "I think a lot of them were twisted weirdoes, and some of them were just purely sadists." Another instance was: "My home was a paradox. A total ambiguity."

Putting aside the issue of *sensitivity* to language in the sense of language giftedness, a striking difference between the two sets of narratives as a whole was the way depressed participants used language generally in a very negative, limiting way. Their narratives contained thirty-seven negative generalisations compared to the eighteen of the non-depressed participants. These seemed to be linked, firstly, to relationships. For example, a member of the depressed group shared: "I always make friends with difficulty." Secondly, negative school experiences were a prominent theme: "School was absolute crap." Thirdly, personal qualities were interpreted negatively: "I am a pathetic student." Fourthly, emotional experiences were generalised in a negative way: "That broke me up totally." Fifthly, unfavourable comparisons with others were made: "They always seem so happy compared to me." Finally, a recurring theme was a tendency to view life being governed by negative rules: "If you love, you are just going to lose, to get hurt."

As indicated above, there were also negative generalisations in the narratives of the non-depressed participants, but not nearly on the same scale. These grouped themselves around similar themes. For example with regard to relationships, one participant said: "I was always fighting with them." Another, reflecting on his school experience, commented: "Leaving school was the happiest day of my life." Life experiences were also generalised in a negative way by some non-depressed participants. For example, one person commented: "It was the worst experience of my life."

It can be seen that there was evidence of sensitivity to language in both groups. However, the narratives of the depressed participants revealed a much greater use of negative language than those of the non-depressed participants, particularly in the form of negative generalisations. This may suggest that a major task of a therapist working with a depressed person is to challenge the negative generalisations in the life story.

Supposition three: the past narratives of depressed people will be characterised by dominant narratives which are unhelpful, unsatisfying and regressive. The narratives of non-depressed people, by contrast, will be characterised by more helpful, satisfying and progressive dominant narratives.

The past narratives of the depressed and non-depressed participants shared similar dominant themes in terms of potentially unhelpful narratives. The major recurring themes comprised losing significant others suddenly and unexpectedly, adjustment experiences (like being sent to a different school or moving to a new town), divorce (personal or one's parents), alcoholism (either personally experienced or living with a family member with the problem), terminal illness of a family member, mental illness (either personally experienced or living with a mentally ill family member), sexual abuse, family problems, relationship problems and personal disappointments.

The major difference was that the depressed participants seemed to allow these events to turn their narratives into unhelpful, unsatisfying and regressive dominant narratives. The non-depressed participants, on the other hand, seemed to view these as growth experiences, thereby re-authoring a dominant story that was helpful, satisfying and progressive. For example, a depressed participant said: "Losing our babies was a terrible strain on our relationship, because after that we almost got divorced, because I kept on blaming myself for what happened." In other words, a negative life event led to an unhelpful dominant narrative characterised by conflict and self-blame. Another participant allowed a drinking problem to impact negatively on his academic career: "My drinking got pretty severe in my second year. That's why I failed my subjects." A third instance centred around a love disappointment leading to a dominant narrative characterised by depression: "She

broke my heart. That was a terrible, terrible experience. I became depressed again.”

By contrast, the non-depressed participants, in similar situations, transformed adverse life events into more helpful stories. One participant shared: “In standard eight I went to another school. It was a big upheaval for me. But it was my choice. It was an important learning experience.” Another participant commented: “One of my best friends died in a car crash. But it’s getting better. You learn to live with that little hole in your life... I can see the healing process.”

It can be seen that the past narratives of the depressed participants revealed an inability to turn unhelpful dominant narratives into helpful ones, whilst the non-depressed participants seemed to be able to re-author their past narratives in a more helpful way. This discovery suggests that a major task of a therapist working with a depressed person could be to co-author past narratives in a more helpful way by searching together for alternative meanings.

Supposition four: the present narratives of depressed people will show a more problem saturated character than the present narratives of those without depression.

In this regard there seemed to be a striking difference. The present narratives of depressed participants were problem saturated, while the present narratives of non-depressed participants seemed less problem saturated. For example, the narratives of the depressed participants contained sixteen present narratives, fourteen of them negative. The narratives of the non-depressed participants, by contrast, contained fifteen present narratives, with only two being negative.

The negative present stories amongst the depressed participants included the following statement: “I

enjoy absolutely nothing. As I sit here, I sit the whole day. I don't read any more. I do nothing." Another depressed participant said: "I get very paranoid. Especially now. The last two weeks I've been petrified." A third depressed person stated: "Like last week it was, I had to send my brother for treatment because he's an alcoholic and then that will catch me again and get me down." The present narratives of non-depressed participants were much more positive, for example: "I still have my boyfriend. We've been going out since standard seven, and it's still working." Another non-depressed person commented: "The most overriding factor is that I try to keep a positive outlook about everything." A third instance read as follows: "He and I get along really well. We were talking about it the other day."

As was the case in regard to the other suppositions, there were also exceptions. One depressed participant included a positive event in her description of her present story: "My friend has come back at the perfect time! It's just a godsend that she's back right now." Another depressed participant sounded this fairly positive note about her present narrative: "I'm on treatment for my thyroid, and I can feel I'm moving on." There were also exceptions in the non-depressed group, for example: "I worry that all my men – my two sons and my husband – they all suffer from depression." Another non-depressed person said: "At the moment, with the selection, everything is very uncertain."

Despite the exceptions, there seemed a clear difference between the present narratives of the depressed and non-depressed participants, in that the former showed more evidence of problem saturation. This discovery suggested that a narrative approach to therapy concentrating on viewing the present narratives in a less problem saturated way could be a fruitful method of helping depressed persons. Such a practice would obviate a possible criticism that a narrative approach to

therapy focuses too much on the past.

Supposition five: the narratives of people with depression will reveal more difficulty visualising a hopeful future than the narratives of those without depression.

The narratives of depressed people showed little hope and optimism for the future. Eight of the ten participants related pessimistic future stories. Two stated that they had no future narrative at all. The following are examples, drawn from different participants: “I feel I haven’t really got anything more to contribute to society or life.” Another said: “I don’t see any future. I don’t go forwards, but I go backwards.” A third depressed person commented: “My future story is just... my children. That’s all.”

However, there were two exceptions. For example: “I am going to start generating some income, following the Rich-Dad-Poor-Dad philosophy. I’ll probably start off in the UK, stay with my brother for a while, work there for a while and then I’d like to just start backpacking, travelling around the world.” This narrative had an optimistic future story with clearly defined goals, although perhaps a bit unrealistic. Another depressed participant admitted to no long-term goals, but had hopeful short-term goals: “I’m going to London. I’m going to get work... once I’m there I’m going to get myself into gear and find direction.”

The future narratives of eight of the non-depressed participants seemed more hopeful as evidenced by the following examples from different participants: “I am thinking of marrying this boyfriend of mine. I would like to have a career. A car and everything. A smart house.” Another participant said: “My husband and I see ourselves having a farm.” A third shared: “Whatever it is I’m going to do, I

know it's going to be good for me." Among the future narratives of the non-depressed people, there were two exceptions: "I worry a bit. I worry about trying to get these kids through studying after school. Where am I going to go. All those sort of things." Another participant said: "That's a difficult thing. I don't know what I want to do with my life, exactly."

In summary, there seemed to be, generally, a lack of hopeful, optimistic future narratives among depressed participants, suggesting that the co-authoring of a hopeful future narrative by therapist and client could be an effective method of therapy.

Supposition six: the narratives of those suffering from depression will show less awareness of the wealth of their lived experience than the narratives of people without depression. Put simply, the narratives of the former will be shorter and less detailed than the latter.

With regard to length, there was very little difference between the two groups: both groups contained lengthy as well as short narratives. The most striking difference occurred in response to the question: "Are there any other aspects of your life story you would like to share?" Six of the depressed participants volunteered no information at all in response to this question. Three responded with more information, of which the major themes were negative, comprising regrets, guilt, an unhappy childhood, pessimism regarding the future, self-blame, family problems and experiences of loss. However, one depressed participant volunteered further information that was more positive, including positive feelings regarding her mother and coping skills she had learned through therapy some years before the interview.

By contrast, only two of the non-depressed participants declined to give additional information in

response to the foregoing question. Seven of the participants volunteered a wealth of further experience, comprising mostly the following positive themes: future plans and pursuits about which they were passionate, sharing achievements and their feelings about these and happiness with regard to present lifestyles. However, there were some negative themes present in this group as well, relating to financial struggle and the ups and downs of close relationships. Only one non-depressed participant volunteered further information that was only negative, sharing her worries regarding her husband and children.

It seemed therefore that the length of the narratives of the two groups did not differ. However, the depressed participants seemed more reluctant to volunteer further information about their life narratives and when they did, it consisted mostly of negative themes, suggesting that some depressed people may be aware of an abundance of negative lived experience. Non-depressed people, on the other hand, volunteered further information more readily, which may indicate that they were more aware of their wealth of lived experience. This feature of the narratives suggested that therapy with a depressed person might focus on unlocking the person's wealth of positive lived experience.

Supposition seven: the narratives of people with depression will show less evidence of unique outcomes than the narratives of people without depression. Where unique outcomes are present, people with depression will find it more difficult to use these unique outcomes to author alternative stories.

Chadwick, Bahr and Albrecht (1984) point out that qualitative research tends to produce surprising results. The researcher found this to be true in regard to this supposition because it appeared that

with regard to the frequency and thematic character of the unique outcomes there was little difference. The narratives of the depressed participants contained seventy- three unique outcomes, compared to sixty- one in the narratives of the non-depressed participants. The unique outcomes of both groups seemed to cluster around the following themes: the ability to make friends, instances of resourcefulness, new interests, intellectual gifts and academic achievements, happy memories, experiences of job satisfaction, spirituality (not in the sense of denominationalism, but in the sense of a vital relationship with God, cf. Karasu, 1999; Peck 1978), moments of courage and congruence, experiences of independence, surviving difficult times, the ability to be empathetic, instances of assertiveness, obtaining therapy, overcoming problems in the school environment, ways of coping with unhappiness and depression, creativity and coping with grief.

However a major difference between the two groups was the inability of the depressed group to translate the unique outcomes into alternative stories. For example, one depressed participant said: "I was good at history. But then that's something that you pump into your head." Instead of seeing a sparkling moment, where he displayed an academic gift, he belittled his talent. He was therefore unable to begin an alternative story based upon a unique outcome in his narrative. By contrast, the non-depressed participants seemed able to recognise unique outcomes and respond to them. For example, one participant stated: "I started realising that the only way to do something was not to be destructive, but to be constructive; and that's when I sort of changed things around." Another non-depressed participant suffering from grief found that writing to the person she had lost helped her to cope: "When it's really bad for me, I write to him. It's good for me, because I can see the healing process."

There were exceptions in both groups. Among the depressed participants, there were eight

occurrences of unique outcomes being recognised, applied, and producing alternative narratives. For example, one depressed person recognised a unique outcome in talking to other people about her problems and began to do this regularly as a means of coping, in this way authoring a helpful alternative narrative. There were also fifteen cases of depressed participants who seemed to recognise unique outcomes, applied them for a while, but did not have the persistence necessary to turn them into alternative stories. For example, one participant seemed to gain insight from an abusive relationship and applied the lessons learnt for a while, thus temporarily authoring an alternative, more helpful story. Unfortunately the story was interrupted by a relapse into another abusive relationship. Another depressed participant expressed this tendency in this way: "It's a problem I've often had. I start something, and then just don't finish it." There were three exceptions among the non-depressed participants. For example, one person, whose narrative contained evidence of her as a good mother, was unable to apply this unique outcome to her role as a mother and continued to visualise herself as a poor mother, blaming herself for her children's problems.

Finally, another striking difference between the two groups seemed to focus on the inability of the depressed participants to discern what their unique outcomes said about them as people and the subsequent effect on their self-esteem. For example, there were forty-two occurrences of this tendency in the depressed group, compared to five in the non-depressed group. A member of the depressed group, for example, who had achieved above average academic results, described himself as a "pathetic student". Another, who had courageously survived child abuse, who had obtained wonderful academic results and whose narrative showed empathy for others, was unable to accept what this said about her as a person, saying: "I've always felt not good enough." By contrast, the non-depressed participants seemed aware of what their unique outcomes said about them as people,

as evidenced by twenty one examples. One non-depressed participant mentioning his successful, self made career, said: "There's a great sense of satisfaction having done it yourself. A sense of independence." Another, on the impact of learning to be herself, shared: "I had to say to myself, am I really going to be me? The person I am. If you are who you are, it's the best. It's really important for me."

It can be seen that, contrary to expectation, the narratives of the depressed participants contained just as many unique outcomes as the narratives of the non-depressed participants, but the depressed participants were unable to translate these into constructive alternative stories. This finding suggests that helping a depressed person to identify unique outcomes and to translate these into positive alternative narratives could be a powerful therapeutic technique with regard to depression.

Supposition eight: the narratives of people with depression will reveal evidence of the inhibiting narratives of significant others around them. In the case of people without depression, their narratives will reflect that the stories of significant others around them tend to be supportive, contributing to growth and psychological health.

Eight of the depressed participants' narratives communicated the experience of severely limiting narratives from significant others around them. The most common theme was rejection by significant others. One participant, for example, whose parents were divorced, was sent to boarding school when his father remarried. Later he was sent to his mother, who in turn sent him to his grandmother. His grandmother attempted to change him, rejecting his hairstyle, earrings, beliefs, habits and interests. Another was also sent away to his grandparents as a child, despite longing to be with his mother. Another aspect of these limiting narratives was a lack of parenting skill. For

example one depressed person suggested that his parents were too autocratic: "... I was not allowed to have friends." Another said his parents had been too strict: "If I made any mistake, I would be punished." A third stated that her mother seemed not to know the meaning of love: "My sister and I do believe that my mother loves the dog more than she loves us." Another depressed person complained of abuse: "My father treated me like a slave more than anything else." By contrast eight of the narratives of non-depressed participants revealed stories of support from significant others around them. For example, one non-depressed person shared how her parents had showed her practical compassion: "I was the only child but my parents made sure that I was never lonely by inviting other children around." Another indicated how her parents had given her time and attention: "I had a very close relationship with my father ... we were interested in intellectual things together." A third related a story of acceptance: "My father accepted the way I think."

With regard to the depressed participants, there were two exceptions. These participants described their parents as accepting, caring and supportive. There were also two exceptions among the non-depressed participants. For example, one non-depressed participant said: "I can feel rejected very easily, and perhaps it's because I still think of being rejected as a child by my parents."

It can be seen that the narratives of the depressed participants seemed to be limited by the narratives of significant others around them. The narratives of the non-depressed people showed evidence of supportive narratives of significant others. This finding suggests that in therapy with depressed people the limiting narratives of significant others may need to be explored and challenged.

Supposition nine: the narratives of depressed and non-depressed people will show evidence of subjugating narratives from the socio-political context. The narratives of depressed people

will show less ability to resist these subjugating narratives.

Subjugating narratives from the socio-political context seemed to be a common theme running through the narratives of all participants. Firstly, there were three occurrences related to political ideology in the depressed group and five in the non-depressed group. For example, one of the depressed group blamed Apartheid for his own present racism. Another's narrative reflected adverse socio-economic conditions created by political policies, making it difficult for him to grow up in a psychologically healthy manner. A member of the non-depressed group also related struggles with regard to unjust laws and racism. Another shared how he was rejected because he had friends of a different race. Secondly, there were five examples of subjugation by religion in the depressed group and two in the non-depressed group. For instance, in the former group churchgoers rejected the spirituality of a young person because it did not conform to the denomination's stereotype. In the latter group, a non-depressed Hindu participant experienced rejection by a Muslim community. Thirdly, there were ten occurrences in the depressed group of social stereotypes determining the value of persons, compared to six in the non-depressed group. For example, cleverness was equated by some parents and school teachers with worth as a person. Gender stereotypes were also a common theme. The value of females, in particular, seemed to depend upon their abilities as homemakers and mothers, not only in the view of others, but in their own estimation. The narratives also reflected social stereotypes regarding the perception of Afrikaans and English people and conditions of worth attached to these. Furthermore, the narratives revealed a social stereotype that rigidly accepts only heterosexuality as the norm.

The major difference between the two groups was that the depressed group seemed to allow the subjugating socio-political narratives to affect them psychologically, especially in blaming their

subjugating narratives for their problems. There were eight examples of this tendency. One participant, for example, blamed his own racism on government policies. Another blamed his lack of friends on the impact of Afrikaans-English stereotypes. Nine of the non-depressed participants, while being aware of subjugating narratives, seemed to view them as challenges, or obstacles to be overcome. For example the non-depressed participants from disadvantaged backgrounds did not allow racial discrimination and ideological injustice to get them down. Rather they made use of what opportunities there were, overcoming huge obstacles to achieve career success and maintain psychological health. Another participant rejected the gender stereotypes that society, through her parents, tried to impose upon her.

It can be seen that subjugating socio-political narratives were a reality in both the narratives of the depressed and non-depressed participants. The difference was that, by viewing these narratives as challenges, the non-depressed participants did not allow these narratives to adversely affect their lives psychologically. Since the depressed participants seemed not able to do this, it therefore would seem necessary in therapy to confront these subjugating socio-political narratives and to help the person to see them as challenges.

Supposition ten: the narratives of depressed people will show the tendency of identification with life problems, whilst the narratives of people without depression will show some externalisation with regard to life problems.

Identification with life problems was evident in the narratives of nine of the depressed participants. For example, one participant said: "I am divided... I am totally divided." His problems of identity seemed to be saturating his life in that he was not able to separate himself from the problem.

Another participant, speaking about a close relationship, said: "It's hugely stressful. It's just a huge mess at the moment. We have major arguments." This statement indicates that this couple was not united against the problem, a method of externalisation suggested by Moll (1997) with regard to conflict resolution.

The non-depressed participants were mostly able to put some distance between themselves and life problems. There were nine examples of externalisation. One participant said: "I look at my life. I see what's wrong with it, and I set myself goals." Perhaps the best example of externalisation was the following: "What helped me most in my fight against depression was just being able to talk about it. Um. I think that makes it more of a reality, a target to strike back at."

Once again there were some exceptions. Two of the depressed participants seemed to use spirituality as a means of externalising. For example, one participant said: "I said to God, if you want me to pull through, you do it. Do something! Because I can't." She separated herself from the problem by giving it to God. One non-depressed participant, on the other hand, recounted how he sometimes found his life saturated with problems: "There are occasions when there's nothing I can do about my unhappiness. I've felt on the verge of a nervous breakdown, with all the problems..."

It can be seen that externalisation of problems seemed to be a significant difference between the depressed and non-depressed groups. This in turn suggested that externalisation could be a very effective therapeutic technique in helping a person to cope with depression.

Supposition eleven: the narratives of people with depression will show a less irreverent and questioning attitude than those without depression.

There was evidence of irreverence and questioning in the narratives of both groups as indicated by the occurrence of ten examples in the depressed group, compared to twelve in the non-depressed group. In the depressed group, one participant, speaking of her career training, stated: "I wasn't really enjoying it there, because the set up is so academic." Such criticism suggests an irreverent, questioning attitude. Another participant, speaking about his High School days, stated: "...that was the general culture there. And I automatically rebelled." The narratives of non-depressed participants revealed a similar attitude. For example, one member of the non-depressed group said: "I don't think boarding school is a healthy situation." Another shared: "I started asking questions again, including my value system." A third non-depressed participant commented: "From day one, I was very against everything. I didn't like the traditional authority structures."

It can be seen that an irreverent, questioning attitude did not constitute a major difference between depressed and non-depressed participants. However, it seemed significant that the depressed participants seemed to cope less adequately with the rejection caused by their irreverent questioning attitude than the non-depressed participants. For example, seven of the depressed participants related how rejection provoked by their irreverent, questioning attitude led to adversity in their lives, compared to only a single similar example among the non-depressed participants. This finding suggests that therapy with depressed people might need to have a twofold thrust: encouraging an irreverent, questioning attitude as well as the resilience needed to deal with the consequences.

5 PERSONAL EXPERIENCE OF THE RESEARCHER

I found the process of gathering the narratives to be a wonderful growth experience. In particular, it enhanced my listening skill, as I was forced simply to listen patiently, asking only questions designed to elicit information. For one trained in therapy and therapeutic questioning, it was a very difficult, but rewarding exercise.

I experienced that the simple process of sharing one's life story was in itself often therapeutic for the participants. Three of the depressed participants and two of the non-depressed participants were tearful at certain moments in their narratives, indicative, I felt, of the therapeutic process at work. After the interviews I often sensed a peaceful atmosphere of hope and healing.

Examining the narratives afterwards was a fascinating exercise. There seemed to be innumerable therapeutic opportunities, so much so that my experience of the process convinced me that obtaining a client's narrative *per se* (without therapeutic questioning) could be a standard procedure in therapy.

6 CONCLUSION

The comparison between the narratives of depressed and non-depressed participants seemed to indicate that all of the suppositions were relevant to the depressed participants. For example, depressed participants found it more difficult to find alternative meanings in their life narratives; they used more negative generalisations; their dominant narratives were more unhelpful; their present narratives were more problem saturated and they found it more difficult to visualise a

helpful future story. In addition, they seemed less aware of their wealth of lived experience and were more adversely affected by the limiting narratives of significant others. They did not cope as well with subjugating socio-political narratives and found it more difficult to externalise problems. The narratives of both groups showed a similar number of unique outcomes, but the depressed participants were less able to translate these into alternative stories. Both groups showed evidence of an irreverent, questioning attitude, although the depressed participants tended to cope less adequately with the results of this behavioural style.

As the research progressed it became clear that there was considerable overlapping with regard to many suppositions of the matrix. The first six for example, showed considerable overlapping, and externalisation seemed closely linked to authoring a more helpful narrative (supposition three). This drew attention to the fact that the narrative approach to therapy seems to be holistic in nature.

The comparison also strongly suggested that a narrative approach to therapy could be a fruitful therapeutic approach with regard to depression. Specifically, helping a depressed person to find alternative meanings for life's experiences, challenging negative generalisations in the life story and co-authoring past, present and future narratives in a more constructive way seemed promising techniques. In addition, assisting depressed persons to become aware of their wealth of positive lived experience, helping them to cope with the limiting narratives of significant others, confronting and overcoming subjugating socio-political narratives together, encouraging the externalisation of problems and the development of an irreverent, questioning attitude were suggested as helpful therapeutic methods. However, the presence of an abundance of unique outcomes in the narratives of the depressed participants, contrary to expectation, indicated that the identification and re-authoring of these into positive alternative stories may be the most effective principle of the

narrative approach to therapy with regard to depression.

The presence of frequent exceptions seemed to draw attention to the immense complexity of human beings (Bryman, 1988; Chadwick et al., 1984) as well as to the complicated nature of depression. It reminded the researcher that therapy is a creative process, needing to be redesigned afresh, not only for each new client, but for each new therapy session.

7 RECOMMENDATIONS

Qualitative research, the goal of which is to find and understand patterns in the data (Maykut & Morehouse, 1994) is often influenced by the presuppositions of the researcher. The following recommendations are no exception, and are therefore offered in a spirit of deep humility, but also with the conviction that they present the researcher's "truth" derived from the study:

- Further qualitative research needs to be conducted with regard to a narrative approach to therapy and depressed people, this time with a more narrowly focussed group consisting of only men or only women, or only adolescents or a specific ethnic group.
- Further qualitative research could be conducted in connection with the use of the narrative of a depressed person, uninfluenced by therapeutic questioning (perhaps using the questions suggested in this study) as a useful therapeutic tool in regard to depression. Fruitful therapy could result as therapist and client work through this narrative together.
- Therapy should become a more "political" activity, in the sense that psychologists (perhaps

through the South African Psychological Society) challenge the subjugating narratives present in South African society, such as racism, injustice, discrimination, sexism, poverty and other dehumanising socio-political narratives which, it is suggested by the above research, have a relationship to depression.

- In the light of the evidence of the inhibiting influence of significant others as being possibly related to depression, psychologists, on a macro-level, be more aggressive in the promotion of parenting, marital and family skills among South Africans.

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