A Dissertation

Entitled

A Phase 2 Task Analysis Study of the Process-Experiential Narrative Trauma Retelling Task in a Clinical Sample

by

Emily Sara Breighner

Submitted as partial fulfillment of the requirements for
The Doctor of Philosophy Degree in Psychology

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An Abstract of

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The rising popularity of narrative techniques in psychotherapy (Advi & Georgaca, 2007; Foa, Molnar, & Cashman, 1995; Neimeyer, 2006) calls for careful research investigations of the efficacious properties and outcomes of narrative work. Narrative theory suggests that clients benefit from focusing attention on the construction of their life stories, and the sense they create from their life experiences (White & Epston, 1990). Narrative theory has been applied in the treatment of trauma, as it has been found that clients' explication of trauma narratives can aid in emotional processing of their intense emotional experiences, which can facilitate progress toward a sense of acceptance or resolution of the trauma (Elliott, Watson, Goldman, & Greenberg, 2004). The present study investigated a specific narrative intervention for trauma: the Process-Experiential (PE) Narrative Retelling Task (NTR), using a multi-stage, mixed-methods, task analytic research design.

This study identified the PE NTR task components (client actions and therapist facilitating responses) that distinguish high-resolving task performances from low-resolving task performances. This analysis was conducted via the application of the second stage of task analysis: mixed-method categorical, qualitative, and quantitative

process analysis. In this investigation, 35 Narrative Trauma Retelling (NTR) task events were analyzed: 16 high-resolving cases and 19 low-resolving cases. Task samples were drawn from archives of two process-experiential psychotherapy research data sets. Thirteen task components were found to distinguish high and low task resolvers. These results offer valuable information about the mechanisms of psychotherapeutic change in narrative trauma retelling task work, and provide information for therapists to use in optimal task facilitation. Study results, including key task components, are consistent with PE theory, which asserts that treatment for trauma requires the presence of a caring other, trauma reprocessing, re-establishment of the world as partially trustworthy, and self re-empowerment (Elliott, et al., 2004). The current investigation demonstrates the way in which the task analytic procedure can be used to hone task models and to use research to inform theory and practice.

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Chapter One

Introduction

In psychotherapy, clients often present stories of situations and events that were devastating or distressing to them (e.g. a jarring car accident, the loss of a parent, criminal victimization, a job layoff, being cruelly teased). Sometimes, these difficult experiences remain emotionally salient for months or years after they occur. Psychotherapists who practice Process-Experiential, and other narratively-oriented techniques, invite clients to tell these stories in therapy, and to re-experience and re-examine their personal narratives regarding these events. The goal of working with clients' narratives of traumatic experiences is to help them work through the experience more fully, to more cohesively integrate the story into their broader life story, and to facilitate enhanced understanding and resolution in regards to the difficult experience (Elliott, Davis, & Slatick, 1998; Fischer & Wertz, 1979; Greenberg & Pavio, 1997).

Although the effectiveness of narrative trauma retelling interventions is supported by a growing body of research (Advi & Georgaca, 2007; Foa, Molnar, & Cashman, 1995; Neimeyer, 2006), the change process that accounts for the potency of the intervention is not fully understood. Like many psychotherapeutic interventions, it is complicated to pinpoint what makes the task helpful, how clients use the task to gain resolution, and how

therapists can best facilitate the task. For the present study, a multi-stage, mixed-methods investigation was designed to address these questions.

The process of task analysis on the Process-Experiential (PE) Narrative Trauma Retelling (NTR) task began in 2006, with a preliminary qualitative study using an undergraduate, non-clinical sample (Breighner, 2006). In this first study, single-session retelling interventions were conducted using the rationally derived NTR task model developed by Elliott, Davis, and Slatick (1998). This initial qualitative investigation allowed for examination of task performances to identify factors that contributed to high task resolution, as well as honing of the task model in accordance with the analysis results relating to task stage progression and content. The next step, as described below, was to conduct a mixed-methods analysis of the NTR task using clinical samples, and to measure the relationship between productive task factors and resolution status.

This dissertation begins with a brief literature review, including an introduction to the Process-Experiential Narrative Trauma Retelling task, as well as an introduction to task analytic methodology. Following the literature review, the research questions and purpose of the present study are presented. Next, the study methods, including information about participants and selection of task performances, measures, and task analytic procedures are described. Finally, results are presented and discussed.

Chapter Two

Literature Review

Process-Experiential Therapy

Process-Experiential (PE) psychotherapy (Greenberg, Rice, & Elliott, 1993) is an empirically-supported, neo-humanistic, emotion-focused (Greenberg, 2002) therapy. The goal of PE therapy is to increase a client's ability to adaptively respond to his or her emotions instead of ignoring or avoiding them (Feldman Barrett & Salovey, 2002; Salovey & Mayer, 1990). In order for clients to develop a healthy awareness and utilization of emotion, PE theory suggests that clients must experience emotions in-session so that therapists may guide clients to heighten awareness of their emotions and practice management and response to these emotions (Elliott, Watson, Goldman, & Greenberg, 2004). Unlike cognitive-behavioral psychotherapy approaches (Beck, 1976) that aim to change the way in which clients develop and respond to dysfunctional thoughts, PE therapy targets clients' evaluation, regulation, and response to their emotions.

PE psychotherapy (Greenberg et al., 1993) was developed by incorporating person-centered, gestalt, and existential therapies. This is a neo-humanistic perspective, which assumes that all people have growth potential. A dialectical constructivist philosophy (Greenberg & Pascual-Leone, 1995; Greenberg & Van Balen, 1998; Pascual-Leone, 1991) is incorporated, such that clients are viewed as striving to create meaning

from their experiences in life. Clients are viewed as having multiple parts or "voices" that can either be in harmony or in conflict with each other (Elliot et al., 2004). The therapeutic process in PE involves supporting a client in resolving the conflict between the part of him that wants to change and grow (i.e. "Experiencer"), and the part of him that wants to perpetuate a negative pattern of emotional responses (i.e. "Critic").

The role and stance of the therapist in PE psychotherapy can be described as process-guiding and person-centered (Elliott et al., 2004). The therapist guides process by prompting the client to search for meaning in their emotional experience. However, process guiding is conducted in such a manner that the therapist does not give the client advice or try to enlighten, control, or problem-solve for the client. PE therapists believe that clients are the experts on their experiences, while therapists are experts at helping clients attend to their emotions and work through experiences to find their own meaning and direction (Elliot et al.).

The experiential therapist response style is characterized by collaborative empathic exploration via evocative questions (e.g. What are you experiencing right now?) and tentative conjectures (e.g. I wonder if you are somehow hurt by your brother's choice? Does that fit?) (Elliott, et al., 2004). Empathic explorations such as exploratory reflections, evocative reflections, exploratory questions, fit questions, process observations, and empathic conjectures function both to demonstrate empathic understanding and to stimulate clients' exploration of vague or emerging perceptions or understandings of their experience (Elliott, et al.).

PE therapy is comprised of a series of therapeutic tasks in which clients and therapists explore and resolve emotion-based problems. There are 13 specific tasks that are currently formally used in PE therapy (See Table 1). A general 6-stage structural

Table 1
13 Process-Experiential Psychotherapy Tasks

1. General Empathic Exploration for Problem-Relevant Experience
2. Empathic Affirmation of Vulnerability
3. Developing and Maintaining a Safe Working Alliance
4. Relationship Dialogue for Repair of Alliance Difficulties
5. Clearing a Space for Attentional Focus Difficulty
6. Experiential Focusing for an Unclear Feeling
7. Facilitating Expression of Feelings with Emotional Expression Difficulties
8. Retelling/Re-experiencing of a Traumatic/Painful Experience (non- Problematic Reaction Point)
9. Unfolding Problematic Reactions
10. Creation of Meaning for Meaning Protest
11. Two-Chair Work for Conflict Splits
12. Two-Chair Enactment for Self-Interruption Splits
13. Empty-Chair Work for Unfinished Business

task model was developed to summarize the task elements inherent to all PE psychotherapy tasks (Elliott, et al., 2004) (See Table 2).

For each specific task, the universal task model can be refined to specifically describe the change processes relevant to the particular task. At any point in a PE therapy session it is expected that the client and therapist are engaged in one of the 13 therapeutic tasks. Therapists listen for task markers and guide clients through the prescribed task stages.

PE psychotherapy is supported by 25 years of research on therapeutic processes and outcome (Bohart, Elliott, Greenberg, & Watson, 2002; Bratton, Ray, Rhine, & Jones, 2005;; Cornelius-White, 2007; Elliott & Greenberg, 2002; Elliott, Greenberg, & Lietaer, 2003; Greenberg, Elliott, & Lietaer, 1994; Orlinsky, Ronnestad & Willutzki, 2004; Rice & Greenberg, 1984; Stiles, Barkham, Twigg, Mellor-Clarke & Cooper, 2006, Wampold

& Levant, 1990). As of 2007, 21 outcome studies have been conducted on PE therapy including 4 controlled, 8 comparative, and 9 naturalistic studies.

Table 2

The General Structure of Therapeutic Tasks in PE Therapy

Task Resolution Stage	**Client Process**	**Therapist Responses**
0. Premarker	Marker is not clearly present, but may be implicit in client's experiencing.	•Listen for, reflect toward possible task markers.
1. Marker/ Task Initiation	Client presents indication that he/she is currently experiencing a particular kind of processing difficulty and is agreeable to work on it with therapist.	•Reflect, confirm client marker. •Elicit client collaboration for task.
2. Evocation	Client begins to explore and express difficulty, so that starts to come alive.	•Offer special procedures to address particular task, as appropriate. •Help client explore difficulty •Evoke, intensify client's arousal.
3. Exploration / Deepening	Client explores difficulty via a dialectical process, either with therapist or between different aspects of self. (Exploration process may be lengthy.) Eventually, primary underlying feelings begin to emerge, along with underlying emotion schemes and related needs and values.	•Help client access and differentiate primary and secondary feelings, emotion schemes, needs, values. •Help client stay involved with task and in contact with experiencing.
4. Partial Resolution (Emerging Shift)	Client accesses new aspects of experiencing, including previously overlooked aspects of emotion schemes; as a result, begins to feel at least a small shift in experiencing.	•Listen for, reflect emergence of new experiencing.
5. Restructuring/ Scheme Change	Client experiences a clear shift in how he/she seeing self or others, such as owning/accepting previously ignored aspects of self, coming to understand something about self or others better, or coming to see self or others in a more positive light or self as more powerful.	•Help client solidify emerging shift by exploring, appreciating, or symbolizing it.
6 Carrying Forward (Full Resolution)	Client pursues further implications of shift, including negotiation among competing needs/values, and commitments to pursue action consistent with new experiencing. Experiences greater contact with experiencing, clear symptomatic/ bodily relief	•Facilitate exploration of implications, including negotiation and appreciation of emerging experiencing.

Client groups studied include those with a diagnosis of major depression, (Greenberg, Goldman, & Angus, 2001; Greenberg & Watson, 1998; Watson, Gordon, Stermac, Steckley, & Kalogerakos, 2003) trauma and unresolved relationship issues, (Clarke, 1993; Paivio & Greenberg, 1995; Paivio & Nieuwenhuis, 2001; Souliere, 1995), decisional conflicts (Clarke &Greenberg, 1986; Greenberg & Webster, 1982), interpersonal difficulties (Lowenstein, 1985; Toukmanian & Grech, 1991), domestic violence perpetration (Goldman, Bierman, & Wolfus, 1996; Wolfus & Bierman, 1996), and psychosomatic problems (Sachse, 1995). The outcome studies that have been conducted on PE therapy to date have found it to be an effective treatment for a variety of presenting problems. Meta-analysis of overall effect sizes for these outcome studies revealed a large effect size, with a mean pre-post effect size of 1.26 (N = 18 studies; standardized difference) (Elliott et al., 2003).

PE Therapy for Trauma. PE theory on Posttraumatic Stress difficulties was developed through several studies of clients with trauma histories (Elliott, et al., 1998; Fischer & Wertz, 1979; Greenberg & Pavio, 1997). A common client problematic response to trauma is an inability to satisfactorily regulate emotion, and to either feel flooded by emotions related to the trauma (i.e. fear, shame, anger) or to feel emotionally numb, and to avoid re-experiencing these intense emotions. Avoidance of these emotions may translate to avoidance of situations that would stimulate re-experiencing, which can have a significant impact on daily life (Elliott, et al., 2004).

PE therapists view the natural response of having nightmares and flashbacks following a trauma as an adaptive process by which a person may be able to come to resolution about the event after coming to a greater understanding of why it occurred, and

how it can be prevented in the future (Horowitz, 1986) It is also theorized that the traumatic event disrupts a person's life narrative (Clarke, 1991; Wigren, 1994) and thus the trauma victim must find a way to bridge the gap between their pre-trauma and post-trauma life stories. In PE therapy, this process is supported by re-experiencing and subsequent meaning-creation work.

Four principles for the treatment of interpersonal victimization were developed by Elliott et al. (2004): 1.) providing the presence of a caring other, 2.) helping to re-empower the self, 3.) encouraging re-establishing the world as partially trustworthy, and 4.) helping to reprocess the trauma. These principles are incorporated in several PE therapy tasks, including trauma narrative retelling, chair work for unfinished business, and clearing a space tasks (Elliott, et al.). Specific research has been conducted on the use of PE therapy as a treatment for traumatic experiences such as abuse, and PE was shown to be an effective intervention. In 1995, Paivio and Greenberg conducted a study of adults who had been maltreated in childhood. They assigned 34 clients to randomly receive either 12 sessions of PE therapy or a psychoeducational group therapy. Using pre- and post-therapy outcome measures, PE therapy resulted in greater client improvement than the psychoeducational group (mean comparative effect size = 1.24), demonstrating the effectiveness of PE for clients presenting with trauma.

Another study of adults who had been victims of childhood abuse was conducted by Paivio and Nieuwenhuis in 2001. In this study, PE treatment was compared to wait-list control groups. PE therapy resulted in clinically significant reductions in posttraumatic stress disorder (PTSD) symptoms and interpersonal problems (mean comparative effect

size = 1.43), again showing PE's capacity to affect positive change in persons with trauma histories.

Additionally, Clarke (1993) conducted a small study of the effectiveness of short-term PE therapy vs. short-term cognitive therapy for sexual abuse survivors. PE therapy resulted in more successful client outcomes (mean comparative effect size = 0.76). Elliott et al. (1998) also found that PE therapy resulted in significant pre to post- therapy reductions in PTSD symptoms in crime-related PTSD. These outcome studies have begun to establish PE therapy as an empirically supported treatment for trauma; however, more research is needed.

Overview of the Process-Experiential Narrative Trauma Retelling Task

The NTR task is one of the thirteen PE tasks, specifically used when clients present in-session with a story of a difficult or painful event (Elliott, et al., 1998; Kennedy-Moore & Watson, 1999; Watson, 2002). These stories sometimes represent a client's presenting problem and the main reason that he or she is seeking treatment. At other times, trauma narratives can arise more subtly over the course of treatment when a client references an important, traumatic event from their recent or distant past. When a client presents a traumatic story in therapy, therapists facilitate emotional processing of the event in accordance with the six-stage task model that was designed for this purpose (see Table 3).

The NTR task involves the therapist guiding the client to retell the story of the difficult or painful event in detail, to explore the emotions that he or she felt at the time of the event, and to reflect on how the event affected him or her. The NTR task is especially recommended for clients who remain emotionally distant from a difficult experience,

because the retelling and re-experiencing aspect of the task provides an opportunity for clients to access warded-off emotions and to reprocess them more completely (Elliott et

Table 3
NTR Task Model (Breighner, 2006)

Client Task Resolution Stages	**Therapist Actions**
1. Introduction of Trauma Narrative ▪ Client refers to trauma or difficult experience (marker for task)	▪ Listens for and reflects marker ▪ Proposes retelling task ▪ Explains task rationale ▪ Encourages client to tell story
2. Entry into Trauma Narrative ▪ Client introduces trauma from external perspective, providing a brief overview of the nature and content	▪ Encourages client to reenter situation in imagination ▪ Asks empathic, exploratory questions regarding internal and external story details ▪ Uses empathic following ▪ Does not interrupt storytelling
3. In-depth Narration of Trauma Experience ▪ Client re-experiences important moments or aspects of trauma from a deeper, more internal perspective.	▪ Uses narrative extension devices to elicit deeper and more detailed retelling and re-experiencing ▪ Queries about memories of internal and external aspects of experience, ▪ Responds using reflection of re-experienced emotions and poignancy, evocative empathy, summarization ▪ Monitors client safety and encourages comfortable working distance (stops task if necessary) ▪ Otherwise, does not interrupt storytelling ▪ Encourages client to return to dwell on important moments/aspects of story
4. Exploration of Effects & Meanings of Trauma ▪ Client identifies and examines consequences and significance of the trauma	▪ Encourages client to explore losses experienced as result of trauma ▪ Helps client search edges of experiencing for emerging perspectives on trauma experience ▪ Listens for, asks about and reflects new meanings and perspectives about the trauma ▪ Listens for, reflects, and asks about the "point" or "moral" of the story
5. Assessment of General Core Values & Beliefs ▪ Client evaluates perspectives of self, others, the world, and life	▪ Helps client recognize, reflect on, and explore broad views about self, others, and the world ▪ Helps client define relationship between specific trauma experience and broader values and beliefs
6. Understanding or Acceptance of Trauma ▪ Client expresses enhanced or realized understanding or acceptance of trauma, self, others, the world, and life	▪ Directs client to reflect on overall experience of trauma and recovery ▪ Asks client what it was like to tell story and what new understandings emerged ▪ Reflects and summarizes client's expressions of acceptance and/ or understanding of the trauma

al., 2004). The original NTR task model was developed by Rice (1974) and described by Elliott et al. (2004) (See Appendix A). The NTR task model was further revised by Breighner (2006; Table 3).

NTR Task Stage Progression. The NTR task involves the therapist asking the client to slowly tell the detailed story of the difficult or painful experience they've had. As therapists facilitate the NTR task, clients are directed to especially focus on particularly salient moments from the traumatic event (e.g. the moment they heard the news of their father's death, the day of their trial, the day they saw the man who raped them at the grocery store).

In Stage One of the NTR task, clients present the task marker by making reference to a difficult or painful experience about which a story could be told (Breighner, 2006).

Stage Two is characterized by the presentation of a short overview of the trauma experience, including several of the most relevant features or events. The overview includes information about what happened, how the client felt at that time, and the client's current reflective stance on the experience. Clients also tend to describe how the trauma experience fits into the broader context of their life, indicating what life trajectories and projects were interrupted by the trauma. Therapists do not interrupt the trauma descriptions, but follow along, making empathic remarks when appropriate. Therapists also ask for more information about the story, facilitating the more detailed retelling characteristic of Stage Three of the Retelling Task (Breighner, 2006).

Stage Three contains the most detailed retelling, and most enlivened client re-experiencing of the trauma. Clients are directed by therapists to go through their stories,

presenting them in full sensory description as if playing a movie of their memories. During this stage, clients express deeper emotions in-session, and reflect on many aspects of the experience. Therapists, again, do not interrupt the storytelling, but ask for further clarification and elaboration when needed, and respond empathically to the clients retelling (Breighner, 2006).

Stage Four emerges as therapists sense that the retelling of a particular episode in the narrative is complete; accordingly, they ask questions about the meanings and perspectives resulting from particular aspects of the traumatic experience. In this stage, therapists ask many direct questions, which elicit client reflection and client reports regarding lessons they learned from the trauma and changes in their perspectives. Clients often report realizing that they were strong during the trauma, and that they have since approached their life and other people differently (Breighner, 2006).

Stage Five is facilitated by therapists' questions regarding reported changes in core values and cherished beliefs regarding self, others, and the world. Therapists ask questions such as "How does the theme of this story fit with the broader theme of your life," and "What does this say about who you are as a person." Clients respond reflectively to the therapist's direct questions in this stage (Breighner, 2006).

Stage Six of the Retelling Task represents a resolution of the task and of the experience. Clients are prompted by therapists to reflect on the retelling experience, as well as the overall changes in their life as a result of the trauma. Some clients have already considered these changes, while others have not. It appears that temporal distance from the traumatic event and previous processing determine the course in which Stage Six unfolds. Therapists facilitate exploration and processing in this stage. The retelling

sessions typically end with clients thanking therapists for listening, and the therapists thanking the clients for sharing their deep feelings and difficult experiences so openly (Breighner, 2006).

Confirmation of NTR Task Stage Progression. The stage progression analysis conducted in 2006 (Breighner) yielded general confirmation of the task model in that each stage appeared to act as a prerequisite for the following stage. The task stages appeared to build upon each other, paving the way for each successive stage. Although the stages are not usually reached out of this order, participants have been observed to not follow a strict one-two-three-four-five-six pattern in stage progression. Rather, stages tend to be reached and returned to throughout the retelling. Specifically, Stages Three and Four are most often repeated several times, often in a back-and-forth pattern. This seems to indicate that Stages Three and Four work together, with deeper exploration and re-experiencing of memories facilitating the emergence and development of new meanings and perspectives (Breighner).

Other Types of Narrative Interventions. The NTR task is just one specific intervention protocol, as the notion of working with client narratives, and specifically trauma narratives, is not unique to PE therapy. Narrative interventions have become widely recognized as a vehicle for addressing misunderstood, unaccepted, and unresolved aspects of experiences (Cowley & Springen, 1995; Crocket, & Epston, 1997; Crossley, 2000; Etchison & Kleist, 2000; Monk, Winslade,; Semmler & Williams, 2000; White & Denborogh, 1998; White & Epston, 1990; Zimmerman & Beaudion, 2002). Narrative techniques, in general, can be described as psychotherapy interventions that use the construction of personal narratives to facilitate change and growth (White & Epston).

These techniques have become quite popular with humanistic, experiential therapists in both clinical and counseling arenas (Cowley & Springen). The basic theory supporting narrative therapy is that people use stories to understand and explain themselves and their worlds (White & Epston). The process of telling, exploring, revising, and rewriting personal narratives can be used as a therapeutic intervention to enable clients to adopt new perspectives and actively edit their existing life scripts (Etchison & Kleist) and to draw meaning from the events in their lives (White & Denborogh).

The formal use of narrative in psychotherapy is relatively new. This approach was formalized in the late 1980s, as Michael White and David Epston began experimenting with narrative techniques in the family counseling context (White, 1988; White & Epston, 1990). White and Epston's interest in narrative therapy techniques was inspired by the family counseling work of Bateson (1972, 1979), as well as the post-structuralist theories of Foucault (1985), that stressed natural human tendencies to think in terms of *life stories* and *life paths*.

Psychotherapy interventions using narrative techniques are hypothesized to be helpful in many ways. Semmler and Williams (2000) argue that collaborative narrative exploration by clients and therapists helps clients gain broader perspectives and recognize themes within client stories. Narrative interventions may also help clients access their feelings more completely by allowing multiple internal "voices" to speak about needs and conflicts (Stiles, Honos-Webb, & Lani, 1999). Narrative exploration may allow clients to be more aware of the external (societal/cultural/political) factors at work within their lives, which may help them externalize some of the blame for their problems in an adaptive way (White & Epston, 1990).

White and Epston (1990) theorized that clients who present with predominantly negatively-toned narratives benefit from therapeutic work that emphasizes the under-recognized positive aspects of a story. This accentuation of positive aspects of a personal narrative can act to highlight and bring out the personal strengths of the client and to minimize or reframe negative events or qualities. Collaborative narrative work has been shown to lead to the development of new themes, new directions, and revised or rewritten life stories (White & Epston; Monk et al., 1997; Zimmerman & Beaudion, 2002). In general, the tone and content of the running autobiographies that people carry with them through life seem to be an important and workable therapeutic topic (White & Epston).

Narrative approaches and trauma. A narrative approach to psychotherapy may be especially suited for trauma work, since trauma, by nature, typically involves a break in the continuity of a person's life story. Trauma can be defined in many ways. The American Heritage Dictionary (Pickett, 2000) defines trauma as:

a) A serious injury or shock to the body, as from violence or an accident
b) An emotional wound or shock that creates substantial, lasting damage to the psychological development of a person, often leading to neurosis.
c) An event or situation that causes great distress or disruption.

For our purposes, *trauma* will be broadly used in the third sense given, to refer to specific life events or experiences that people identify as particularly difficult or painful, whether they occur in a single episode or in a wave of related crises.

Most people have some form of trauma experience during their lives, and of those who do, many are faced with significant subsequent life interruption due to symptoms of trauma-related disorders (Norris, Byrne, & Diaz, 2005). The National Comorbidity

Survey Report estimates that 8% of American adults meet criteria for a diagnosis of PTSD during their lifetime (Kessler, McGonagle, Zhao, Nelson & Hughes, 1994; Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995). The estimated lifetime incidence of PTSD is higher for women (10%) than for men (5%) (Kessler et al.). PTSD is linked to symptoms of depression, impaired sleep, chronic pain, and substance abuse, which result in interference of occupational and interpersonal functioning (Narrow, Regier, Goodman, Rae, Roper, Bourdon, & Hoven,1998). In addition to PTSD, many people suffer from an emergence or exacerbation of other anxiety disorders after a traumatic experience (Narrow et al.). Even those with nonclinical-level post-traumatic difficulties are prone to feeling "stuck," and unable to make forward progress in their lives due to the effects of their experiences (Elliott, et al., 1998).

Trauma experiences can interrupt important life projects and life trajectories, suddenly giving people reasons to question the previous meanings or themes in their lives, as well as their previous understandings of the world and themselves (Elliott et al., 1988; Elliott et al., 2004). Post-trauma narrative reconstruction work in psychotherapy can help people rebuild disjointed narratives and bridge the disconnect between their life before and after trauma experiences (Elliott et al.2004; Crossley, 2000).

Additionally, since trauma can be quite subjective, narrative approaches allow therapists to understand clients' experiences in the context of the clients' unique value systems and perspectives, which may be highly influenced by both personality and culture (Besley, 2002; Semmler & Williams, 2000; White & Epson, 1990;). Research suggests that people who have experienced significant trauma greatly benefit from telling about their memories of the trauma, and sharing their personal account (Pennebaker,

1997). Horowitz (1986) proposed that trauma victims tend to remain hypervigilant and emotionally unsettled if they do not process a trauma experience while in a highly aroused emotional state. Elliott et al. (2004) also suggested that neglected trauma experiences can fester subconsciously, making it difficult for a person to make forward progress in their life without first directly addressing the unresolved trauma. For these reasons, psychotherapeutic work with people who have posttraumatic difficulties is necessary because it provides opportunities for clients to tell their trauma stories and to process and resolve these events in-session.

Research on narrative approaches to trauma treatment. Although the need for narrative and retelling approaches for working with clients with posttraumatic difficulties is indicated, there is limited data supporting the use of these techniques in psychotherapy. Although narrative interventions began in the family therapy field, little research demonstrating their utility is available (Etchison & Kleist, 2000). Some research does suggest that narrative therapy is helpful in the alleviation of parent-child conflicts (Besa, 1994), in the expression of children's perspectives about family arguments (Weston, Boxer, & Heatherington, 1998), and in the reduction of self-blame for problems (Coulehan, Friedlander, & Heatherington, 1998). Research by St. James-O'Conner, Meakes, Pickering, & Schuman, (1997) examined families' responses to narrative therapy, finding that family members cited narrative techniques as helpful and effective; however only 8 families were studied. These five studies constitute the limited data identified on the effectiveness of family narrative therapy.

Support for the use of narrative techniques in individual therapy for trauma victims is also sparse (Etchison & Kleist, 2000). Amir, Stafford, Freshman, and Fos

(1998) studied the relationship between trauma narrative articulation/complexity and PTSD symptoms in people who were evaluated soon after experiencing a traumatic event. The researchers found that people who told more articulate trauma narratives had fewer anxious symptoms and were less likely to eventually develop PTSD symptoms. Crossley (2000) found that people who lived with serious physical illness were more likely to have disrupted or fragmented narratives before treatment. After narrative treatment these clients reported a greater sense of narrative unity, meaning, and coherence. Kellas and Manusov (2003) found that people who had recently suffered emotional trauma (specifically, the ending of an important relationship) were better able to accept and understand their experiences after constructing trauma narratives. In summary, applying the limited available research, it seems that individual therapy using narrative techniques has the potential to be helpful in restarting people's post-trauma lives through a process that entails the creation of more detailed, complex, and integrated trauma narratives.

The NTR Task in the Treatment of Trauma: Task Analysis

Previous research on narrative interventions has focused on the effect of interventions on outcome, with little research on the change process inherent in trauma recovery. Additionally, prior to the present series of studies, there had been no specific research evaluating the PE NTR task, and particularly for clients with trauma histories. This is not to say that the NTR task was created without a solid theoretical basis, as it was created in accordance with PTSD research (Elliott, et al., 1998), and grounded in the framework of a fundamental PE rationale. However, task analysis was needed to better

understand how this task unfolds and how it works to help people process traumatic events.

Although the research base supporting the effectiveness of narrative techniques and various other psychotherapy interventions continues to grow, the change processes that are involved in many of these interventions remain unclear. Proposed by Rice and Greenberg (1984) for studying psychotherapy, task analysis offers a powerful tool for identifying and modeling the microprocesses in particular therapeutic interventions, potentially providing valuable information for improving the practice of psychotherapy. Task analysis uses qualitative and quantitative research methods at different stages of the research process, incorporating both rational and empirical elements to generate maps and models of task resolution. Such analytic strategies are among the research techniques recommended by the American Psychological Association's 2005 Presidential Task Force on Evidence-Based Practice for the establishment of empirically derived treatments in the field of clinical psychology (APA Presidential Task Force on Evidence-Based Practice, 2006).

Qualitative task analysis is consistent with a constructivist-interpretive approach to studying human experience (see Ponterotto, 2005). Originally, task analysis was a research method developed by cognitive psychologists (e.g., Newell & Simon, 1972) that was used to identify and model the processes people go through when they attempt to accomplish a particular piece of work. Analysis of multiple task performances identifies productive and counterproductive approaches, and explains how task success is achieved (Newell & Simon). Task analysis has been used to study humans engaged in various tasks ranging from chess matches (Newell & Simon) to resolution of unfinished business

during psychotherapy sessions (Greenberg, 1996). In the field of counseling psychology, task analysis has been used to understand how two chair interventions work to facilitate the resolution of internal conflicts (Greenberg, 1984). In task analysis, key variables that are observed as crucial (or detrimental) to task success are identified, and models of task progression pathways are established. The task analytic method typically moves from qualitative to quantitative over the course of several studies, as models of a task are developed and tested.

From the point of view of task analysis, the psychotherapy process can be conceptualized as a series of affective tasks (Rice & Greenberg, 1984). These tasks address the client's presenting problems and needs, and comprise the work of therapy. Examples of psychotherapy tasks that have been studied include *empty chair work* in Emotion-Focused Therapy (Greenberg & Foerster, 1996), *resolving parent-child impasses* in family therapy (Diamond & Liddle, 1996), and *interpretation* in psychodynamic therapy (Joyce, Duncan & Piper, 1995). Although the content and objectives of different tasks varies considerably, all tasks share the following fundamental features:

(1) They are interventions that are used for particular immediate circumstances (*markers*)

(2) They are comprised of a standard set of steps or components

(3) They require clients to work toward some sort of resolution.

The *end-state* of a successful or completed task is characterized by a sense of accomplishment and resolution. Psychotherapy tasks are sometimes completed in less than a half-hour, or may span several therapy sessions. They may need to be repeated

several times in order to achieve resolution, if resolution is reached at all (Greenberg, Rice & Elliott, 1993). With each successful task resolution, a client achieves change and progresses in therapy. When a therapist identifies a frequently-used task that appears to be important to overall therapy progress, and wishes to better understand how the task works and how to best facilitate it, task analysis is called for.

Psychotherapeutic task analysis research alternates between rational, theoretical hypothesis formation, and empirical, observational testing and measurement procedures (Pascual-Leone & Goodman, 1979; Rice & Greenberg, 1984). A multi-stage approach to task analysis in psychotherapy research has been devised, described, and utilized by various researchers over the course of the last 35 years (e.g., Greenberg, 1984, 1992, 1997; Greenberg & Foerster, 1996; Elliott, Slatick, & Urman, 2001). These steps must be tailored to suit the specific task to be studied and the goals of the study (Rice & Saperia, 1984), as well as the stylistic preferences of the researchers. Nevertheless, the basic stages of task analysis, can be summarized as follows:

1) *Rational Analysis:* Creation of a working model of task pathways based on clinical experience and relevant theory.
2) *Qualitative Empirical Analysis:* Collection and qualitative analysis of task samples to identify client and therapist microprocesses that contribute to task progress. This enables comparison of high-resolving and low-resolving cases to identify key components characteristic of each task result, and to illuminate the multiple possible task pathways (first with a smaller, non-clinical, single-session sampling, and then with a larger, clinical sampling).

3) *Quantitative Process and Outcome Analysis:* Examination of the relationship between task resolution and psychotherapeutic outcome.

Each step of Task Analysis allows for revision of the task model and a deeper understanding of the task. Task Analysis can thus be used to understand the process of task resolution, in this case: trauma resolution.

Research on the NTR Task

Our past studies began the exploration of the NTR task starting from a tentative rational model that grew out of research on the use of PE therapy for PTSD (Elliott, et al., 1998). At first, trauma retelling was included within the broader PE task known as *Empathic Exploration*. However, based on clinical observations it became clear that empathic exploration of traumatic experiences was qualitatively different from empathic exploration of other kinds of experiences. Thus, Elliott et al. modified the *Empathic Exploration* task to include the specific marker, end state, and general therapeutic process for trauma retelling. Using Fischer and Wertz's (1979) research, Elliott et al. incorporated notions of narrative into trauma therapy. Subsequent to this, Elliott et al., (2004) anchored the NTR task model within a general rational framework that applies to all the PE tasks.

In the present series of studies, before beginning the first stage of empirical task analysis, the existing NTR task model was critiqued and reviewed by the researchers. The NTR task model was used in a process experiential psychotherapy training workshop, and graduate student volunteers practiced the task and provided feedback on and observations of the task stages and stage timing. Next, the task was qualitatively and intensively investigated using three high-resolution and three low-resolution examples

obtained from a sample of single-session task performances in an undergraduate, non-clinical population (Breighner, 2006). Results of the first phase of qualitative task analysis confirmed a progressive, 6-stage NTR task model, and allowed for sharpened descriptions of each stage of task work. Results also indicated that the high resolvers on the NTR task were more likely than low resolvers to demonstrate the following: more structured trauma narratives, more insight into the perspectives of significant others in reference to the traumatic experience, heightened processing of memories of bodily reactions to the traumatic experience, more insight into the positive aspects of the trauma, more exploration of the evolution of their "cherished beliefs" following the trauma, more acknowledgment of their own personal strength during the trauma, and higher levels of reflective processes throughout the retelling sessions. Therapeutic interventions that contributed positively to task progress included the following therapist actions: negotiating the parameters of the story to be retold, sharing personal reactions to hearing the client's story, prompting the client to explore losses resulting from the trauma, querying about the client's unmet needs during the trauma, and using narrative extension devices to prompt the client to tell a more complete story that included full description of internal, external, and reflective elements of their experience. Clients who were low-resolvers on the task were more likely to express confusion regarding the perspectives of significant others who were party to the traumatic experiences (Breighner, 2006). Since these results were taken from a non-clinical sample, the next step is to replicate the study in a larger, clinical sample.

Purpose of the Present Study

Task analysis of the process-experiential Narrative Trauma Retelling (NTR) task began with rational analysis of the task (Elliott, et. al., 1998; Elliott, et. al., 2004), and continued with the beginning stages of qualitative empirical analysis (Breighner, 2006). The current study will further the task analytic process by first continuing the qualitative empirical analysis process, this time using task performances from a clinical population including individuals with trauma histories, and then performing quantitative process analysis. The present study seeks to evaluate and refine the NTR task model, to allow for a richer understanding of how the task works, which will suggest how therapists can best facilitate narrative work in therapy. Specifically, the following questions will be investigated:

1. To what extent will NTR task performances found in multi-session process-experiential psychotherapy replicate the components (client actions and therapist facilitating responses) of those found within single-session non-clinical retellings?
2. What are the essential components (client actions and therapist facilitating responses) associated with high resolution of NTR task resolution in process-experiential psychotherapy?
3. How do NTR task high and low resolvers differ in session process?

Chapter Three

Method

Investigation of the above research questions entailed the application of the second and third stages of task analysis: mixed-method categorical and qualitative process analysis, and quantitative outcome analysis. For this investigation, 35 Narrative Trauma Retelling (NTR) task samples were analyzed: 16 high-resolving cases and 19 low-resolving cases. Task samples were drawn from archives of two process-experiential research data sets. These data sets are described below.

Participants

The Center for the Study of Experiential Psychotherapy- Study Two (CSEP-II). Forty-five adults (17 male, 23 female) with a mean age of 42 years old (*SD* = 11.1), the majority of whom were European-American (2 Hispanic-American, 4 African-American, 39 European-American), participated in the CSEP-II study. CSEP-II ran from 2001 to 2007 at a mid-sized, midwestern American university. Participants had an average of 14.2 sessions (range 1 to 50) of process-experiential psychotherapy. Participants responded to newspaper ads and fliers advertising free emotion-focused therapy. Inclusionary criteria for the study were broad, as no specific Axis I or Axis II disorders were required for participation. Most common primary diagnoses included Major Depressive Disorders and Anxiety Disorders. Participants were not accepted to the study

if they were actively suicidal, engaged in acute substance abuse, or receiving concurrent psychotherapy. Sixteen participants completed the research protocol in full, 14 dropped out at some point during treatment without formally terminating therapy, and 2 discontinued sessions due to psychiatric in-patient hospitalization. Informed consent was obtained from the participants regarding participation in the research study and the use of data in future research. Fifteen therapists participated: one licensed clinical psychologist, and 14 graduate doctoral student clinicians.

Post-Traumatic Stress Disorder Project (PTSD). Seven clients (6 Female, 1 Male) with a diagnosis of PTSD participated in a study of process-experiential psychotherapy (Elliott, et al., 1998). Participants were recruited through newspaper and TV ads. Thirteen therapists participated in the study: 2 who were licensed clinical psychologists, and 11 were doctoral students in clinical psychology. There were 203 total psychotherapy sessions in the PTSD study. Informed consent was obtained from the participants regarding participation in the research study and the use of data in future research.

Selection of NTR Task Performances

The CSEP-II and PTSD data sets described above were used to provide the task event sample. Sixteen high-resolving and nineteen low-resolving NTR task performances were taken from these data sets to be analyzed. Twenty-five NTR events were drawn from 13 clients who participated in the CSEP-II project, with the remaining 10 events taken from the sessions of 5 clients from the PTSD study. Samples were drawn from the two separate data sets in order to increase the sample size of the study. The NTR task was used in both research studies; however, the format of the task was slightly different in each. In the PTSD study, retelling of difficult and/or painful experiences fell under the

umbrella of the “Empathic Exploration” task, whereas in the CSEP-II data set, the retelling of difficult and/or painful experiences was categorized separately under the specific “Narrative Trauma Retelling” task category. This difference in task categorization required slightly different methods of task selection for each data set.

Within the CSEP-II archives, sessions were selected that included a narrative trauma retelling that was rated as at least “moderate in length” as indicated by the “Presence” scale rating on the *Therapist & Observer Post-Session Rating Form: Narrative Trauma Retelling Task* (Table 4). Once these task samples were identified, they were classified as low-resolvers or high-resolvers based on their level of task resolution. Task resolution was determined using the average of post-hoc observer ratings of the session transcripts. Clients who scored 1, 2, or 3 on the “Task Resolution Scale” on the *Therapist & Observer Post-Session Rating Form: Narrative Trauma Retelling Task* (Table 4) were considered “low-resolvers,” and clients who scored a 4, 5, or 6 were considered “high-resolvers.” This task performance categorization was developed in accordance with Greenberg’s (1984) task analytic methodology of comparing high and low task performances to determine active ingredients related to successful task completion.

Selection of sessions from the PTSD data set proceeded in a similar manner. However, in the PTSD data set, trauma-retellings were included within the broader task of “Empathic Exploration” on post-session rating forms. Therefore, the sessions that included empathic exploration of traumatic events were differentiated from sessions that contained empathic explorations of other types of events or emotions. The presence of trauma retellings in these sessions was noted on the *Therapist & Observer Post-Session*

Rating Form: Empathic Exploration (Table 5). To further verify that the sessions contained a trauma retelling, the author reviewed therapist process notes and session tapes for identified sessions. Sessions were selected that contained a rating of a "moderate length" or greater of empathic exploration on the *Therapist & Observer Post-Session Rating Form: Empathic Exploration* (Table 5). For these sessions, as with the sessions from the CSEP-II archive, "low-resolver" and "high resolver" ratings were assigned based on observer ratings of transcribed retelling sessions utilizing the *Therapist & Observer Post-Session Rating Form: Narrative Trauma Retelling Task* (Table 4).

Measures

Therapist & Observer Post-Session Rating Form: Narrative Trauma Retelling Task (Elliott, 2003) (Table 4). This rating scale was used to assess NTR task progress both post-session and post-hoc. Therapists in the CSEP-II study completed this measure after each therapy session, indicating the length that the task was present in the session, the quality of their task intervention, and the level of resolution that the client reached on the six-stage task model. These therapist ratings were used in the identification of NTR task samples described above. Additionally, two observer judges rated each session transcript using the rating form during post-hoc analyses. These observer ratings were used in determining resolution status of each task session sample (i.e. high-resolution status of reaching stages 4, 5, or 6 or low-resolution status of reaching stages 1, 2, or 3). Ratings of task progression were made on a 7-point, descriptively anchored scale representing the NTR task stages: 0= Marker absent; 1= Trauma Narrative Marker & Task Initiation; 2= Elaboration & Unfolding; 3= Dwelling & Deepening; 4= Emergence & Development of New Meanings & Perspectives; 5= Assessment of Core Values &

Table 4
Therapist & Observer Post-Session Rating Form: Retelling/Re-experiencing of a Traumatic/Painful Experience (Elliott, 2003).

A. Task Resolution:

0 Marker absent (abstract, superficial or prepackaged descriptions of an event/experience).
1 Marker present: Refers to a traumatic/painful experience about which a story could be told (e.g., traumatic event, disrupted life story, nightmare). Nature of experience: _____
2 Elaboration; begins detailed, concrete or factual narrative of particular event/experience; describes what happened from external or logical point of view.
3 Dwells on important moments or aspects of trauma, re-experiences parts of it in session.
4 Differentiates personal, idiosyncratic, newly emerged meanings of the experience from an internal point of view.
5 Thoughtfully weighs and tentatively evaluates alternative, differentiated views of the experience.
6 Integrates previously unconnected or inconsistent aspects of the experience; expresses broader or more integrated view of self, others or world.

B. <u>Task Intervention</u>: Facilitate client re-telling/re-experiencing through unfolding and exploration
process.

PRESENCE		QUALITY	
1	Clearly absent	1	Significant interference with task
2	Possibly present	2	Moderate interference
3	Present but brief	3	Slight interference; more needed/ missed marker
4	Present, moderate length	4	Neutral; not applicable
5	Present, extended in length	5	Slightly skillful facilitation
		6	Moderately skillful facilitation
		7	Excellent facilitation of task

Beliefs; 6 = Processing. Ratings indicate the highest task stage that the client reached during the session, with higher ratings indicating greater task resolution. *Therapist Post-Session Empathic Exploration Task Resolution Scale* (Elliott, 2002) (Table 5). Therapists in the PTSD Study rated sessions on the degree of empathic exploration task progress exhibited by clients in each session, including the stage level that the client reached in the task model. Therapists also indicated the presence of a trauma retelling within the empathic exploration. Ratings were made on a 7-point scale that was anchored with

descriptions of each stage. 0= Marker absent; 1= Marker Present: Problem-relevant experience; 2= Discusses problem in external or abstract manner;

Table 5

Therapist Experiential Session Form: General Empathic Exploration for Problem-Relevant Experience Ratings

A. Task Resolution:

0	Marker absent.
1	Marker present: Problem-relevant experience; client expresses personal interest in an experience that is (circle & describe:) powerful, troubling, incomplete, undifferentiated, global, abstract or primarily in external terms: _____
2	Discusses problem in an external or abstract manner.
3	Turns attention to internal experiencing; may re-experience previous events; searches edges of awareness; differentiates or elaborates global or missing aspects of experiencing.
4	Experiences some clarification of experience, including clear marker for another task (such as a conflict split). What got clearer: _____
5	Expresses a sense of more fully understanding, appreciating and owning the experience in its complexity or richness ("Now I know what that's all about").
6	In addition to the above, feels a marked, general sense of relief, empowerment or determination about the experience (such as knowing what to do about it).

B. <u>Task Intervention</u>: Facilitate client re-experiencing; reflect unclear, emerging experience, encourage differentiation or elaboration of experience.

PRESENCE		QUALITY	
1	Clearly absent	1	Significant interference with task
2	Possibly present	2	Moderate interference
3	Present but brief	3	Slight interference; more needed/missed marker
4	Present, moderate length	4	Neutral; not applicable
5	Present, extended in length	5	Slightly skillful facilitation
		6	Moderately skillful facilitation
		7	Excellent facilitation of task

3=Turns attention to internal experience; 4= Experiences some clarification of experience; 5= Expresses a sense of more fully understanding, appreciating, and owning the experience; 6= Feels a marked, general sense of relief, empowerment, or determination about the experience.

Narrative Trauma Retelling Stagewise Productive Actions Checklist (Breighner,

2006) (Appendix B). The NTR task model resulting from the Study 1 Cross Analysis, an earlier stage of the NTR task analysis, was used to rate task performance segments on the presence or absence of each element of the model. Each task stage in the model is characterized by a list of distinguishing features of client and therapist activity indicated by initial task research. Confirmation or disconfirmation of the presence of these task stage characteristics allowed for honing of the task stage model and comparison of high-resolvers and low-resolvers. Ratings were made on a 2 point scale (0= absent, 1= present). Coding guidelines were also explicated for the use of the checklist, and are included in Appendix B.

Process Analysis of Individual Task Performances.

The following procedures were employed for the analysis of each trauma retelling sample:

1. NTR task performances from the CSEP-II and the PTSD datasets were collected using the task selection criteria described above.
2. For the selected NTR task samples, audiotapes of the therapy sessions that contained these retellings were collected. Undergraduate psychology students participating in a research practicum transcribed the psychotherapy audio tapes.
3. Graduate student judges analyzed transcripts from the selected NTR task samples. The first phase of judging included dividing the trauma narrative retellings into NTR task stages 1-6. Judges were provided with coding guidelines for each task stage to facilitate analysis (See Appendix B). Two judges rated each task sample. The highest stage reached by each judge was compared using intraclass correlation to determine interrater reliability.

4. Task samples were classified as “high-resolvers” or “low-resolvers” according to the task categorization criteria described above.
5. Two judges analyzed each transcribed performance stage segment and rated whether each client and therapist process in the model for that stage was present or absent. The ratings were completed using a 2-point scale (0=absent, 1=present) on the *Narrative Trauma Retelling Stagewise Productive Actions Checklist* (Appendix B).
6. After each stage segment was rated, the judge evaluated whether there were any additional productive client or therapist actions present in the segment that were missed by the existing categories. If so, the judge wrote a description of a new category, which was added to the end of the existing category list on the *Narrative Trauma Retelling Stagewise Productive Actions Checklist* (Appendix B). After coding all of the samples, the judges went back and recoded earlier segments including newly added categories.

Cross Analysis of Task Performance

After the individual case analyses were completed for each NTR task performance of the 16 high-resolvers and 19 low-resolvers, an analysis was performed to compare high and low resolvers statistically using chi-squared analyses. Statistically significant differences between high and low resolvers aided in identification of key ingredients of the NTR task as well as distinctive aspects of cases that did not resolve.

Chapter Four

Results

Interrater Reliability

An intraclass correlation coefficient was used to assess interrater reliability between the judges' ratings of the highest task stage (i.e. stages 1 through 6) reached in each NTR event. Two judges were used for each of the 35 task events. Reliability between the ratings of the highest stage reached in NTR task events was very high between judges (ICC = .938, $p < .001$).

Next, the percent agreement was computed between judges on the ratings of the presence or absence of each of the 69 productive action variables (i.e. the client and therapist actions proposed to contribute to task resolution). These ratings were computed using the judges' ratings on the *Narrative Retelling Stagewise Productive Actions Checklist* (See Appendix B). Two judges were used for each NTR event. A total of 210 disagreements were found out of a possible 2415 productive action ratings across the 35 events, yielding 91.30% agreement between judges.

Possible Confounding Variable Analysis

Before examining the relationships between resolution status and client and therapist action components, the 19 high-resolving and 16 low-resolving trauma events were tested on therapist expertise level, session number, data source, and gender

variables to determine if these factors related to resolution status. Events facilitated by expert therapists were compared with events facilitated by graduate-level therapists using Chi-Square analysis to determine if therapist expertise level distinguished high and low resolving NTR events. There was not a statistically significant difference found between high and low resolving groups with respect to therapist expertise (X^2 (1, N = 35) = .010, p =.92). A Pearson Correlation was performed to examine the relationship between how many psychotherapy sessions a client had participated in at the time of the NTR event and the highest task stage reached by the client. There was no statistically significant difference observed between number of sessions and resolution progress (r = -.22, p = .210).

Chi-square analysis was also conducted to determine if high and low resolution events groups differed in relation to whether the events were drawn from the CSEP-II data set or the PTSD data set. Chi-Square results did not indicate a significant difference between resolver groups on the basis of the study that was used (X^2 (1, N = 35) = 0.565, p > .75). Finally, high and low resolving groups were analyzed using Chi-Square analysis to determine if client gender distinguished high from low resolution events. No significantly significant differences were noted between high and low resolving events in relation to gender (X^2 (1, N = 35) = 0.71, p > .70).

Task Analysis

Once adequate interrater reliability was established, the 16 high-resolving and 19 low-resolving trauma events were tested on the 69 components of event activity (44 client actions, 25 therapist actions) that were rated by the judges. Summaries of ratings of

the components in the events are displayed in Appendix C (*NTR Client component analysis*) and Appendix D (*NTR Therapist Component Analysis*).

Possible difference between the two groups (high-resolvers and low-resolvers) were tested using Chi-Square analyses. A Bonferroni correction was used to account for expected error in performing 44 Chi-Squares for the client variables and 25 Chi-Squares for the therapist variables. A p value of .001 was established for the client variables, and a p value of .002 was established for the therapist variables. High and low resolving groups were found to be significantly different with regard to the presence of 4 client components ($p < .001$) and 5 therapist components ($p < .002$).

Client Component Analysis. Five out of the possible 44 client actions were found to relate to resolution status ($p < .001$). Thirty-nine client actions were not found to be statistically significant in their relation to trauma event resolution ($p > .001$). Appendix C displays the Pearson Chi Square values and Presence and Absence frequencies for low-resolving and high-resolving trauma events.

The Chi-Square analyses displayed in Appendix C show the components of client task activity that distinguish high resolving task performances from low resolving performances.

T*rauma meaning exploration* was present in 11 of the high-resolving events, and absent in 5 high-resolving events. The component was present in only 3 of the low-resolving events, and absent in 16. These results indicate that there is a statistically significant relationship between the resolution status and trauma meaning exploration X^2 $(1, N = 35) = 10.151$, $p = 0.001$.

Reflection on current attitudes toward the trauma was present in 9 high resolving events, and absent in 7, but present in just1 low resolving event, and absent in 18. *Reflection on current attitudes toward the trauma* related to task resolution to a statistically significant degree X^2 (1, N = 35) = 11.064, p = 0.001.

The client's *inability to understand others' actions, motives, and/or perspectives during the trauma* was found to significantly relate to resolution X^2 (1, N = 35) = 13.203, p = 0.000. *Inability to understand others' actions, motives, and/or perspectives during the trauma* was more common in high resolving events, with 10 presences and 6 absences. This component was not as common in low-resolving events, with 1 occurrence and 18 non-occurrences.

The *identification of losses from the trauma* was present in 13 high resolving cases and absent in 3. *Identification of losses from the trauma* was present in only 3 low resolving cases and absent in 16. Loss identification was found to relate to resolution X^2 (1, N = 35) = 14.998, p = 0.000.

Finally, *Open, cooperative, and thoughtful responses to the therapist's questions, prompts, and cues* were found to relate to resolution X^2 (1, N = 35) = 10.101, p = 0.001. *Open, cooperative, and thoughtful responses to the therapist's questions, prompts, and cues* was observed in 11 of the high resolving cases; absent in 5. This component was only found in 3 of the low resolving cases and absent in 16.

Therapist Component Analysis. Two out of the 25 therapist actions were found to relate to trauma event resolution status (p < .002). The Pearson Chi-Square values and frequencies of component presence and absence in high and low resolving events are displayed in Appendix D.

The Chi-Square analyses displayed in Appendix D show the components of therapist task activity that distinguish high resolving task performances from low resolving performances.

In particular, *Asking of direct questions regarding meanings and perspectives of the trauma experience* was not observed in low resolving cases, but was present in 7 high resolving cases; absent in 9. *Asking of direct questions regarding meanings and perspectives of the trauma experience* was found to relate to trauma resolution status X^2 (1, N = 35) = 10.391, p = 0.001.

Secondly, *Prompting of the client to elaborate on reflections and explore "edges of experiencing"* was present in 12 high resolving events, and absent in 4. This component was less common in low-resolving events, within 3 occurrences and 16 non-occurrences. *Prompting of the client to elaborate on reflections and explore "edges of experiencing"* was found to relate to resolution (X^2 (1, N = 35) = 12.434, p = 0.000).

In summary, results of the present study identified 7 task components; 5 client variables and 2 therapist variables that related to NTR task resolution at a statistically significant level. Low Resolving events and high resolving events were compared on the basis of the number of statistically significant task components they displayed out of a possible 7. A Chi-Square was performed to examine if High and Low Resolvers were distinguished by the quantity of significant task components. Each of the Low Resolving events was found to lack all of the significant task components. None of the High Resolving events had zero significant task components; one event had one component; five events had three components present; three events had four components present, three events had five components present; and two events had six components present.

These differences were found to be statistically significant X^2 (1, N = 29) = 29.00, p = 0.000.

Chapter Five

Discussion

The purpose of the present research was to further the task analytic process of the PE NTR task. Consistent with expectation, NTR Task performances found in multi-session process-experiential psychotherapy were found to be similar to the non-clinical, single-session task performance collected in Study One (Breighner, 2006). The client and therapist task components were found to correspond between studies, with the exception that there was less formality in task initiation and task closing in the clinical sample. Additionally, two client components were observed in Study Two that were not recognized in Study One: clients identifying losses that occurred as a result of the trauma and describing the impact of these losses in their lives; and clients reflecting on cherished beliefs (i.e. global views and values regarding self, others, life, and the world) that were developed as a result of the trauma. These new observations were incorporated into the working model of potential task activities.

Those clients who reached high task resolution on the NTR task displayed several key characteristics in comparison to low-resolving clients. Specifically, high NTR task resolvers were more likely to have a positive attitude toward the task and therapist, to retrospectively identify their unmet needs during the trauma, to reflect on the actions and feelings of significant others during the trauma, to explore the personal significance of

the trauma, and to reflect on the changes in their lifestyle and personal character that resulted from the trauma experience. Therapists were also found to perform several key actions that related to task resolution. These included guiding the client in exploration of their unmet needs and the meaning of the trauma, directing the client to develop new perspectives on the trauma, and demonstrating their understanding of the client's experience. The identification of these important task elements aids in understanding of the change process in the NTR tasks and PE psychotherapy, and suggests directions for future research.

Task Analytic Process

Task analysis is a research method that allows for the evaluation of the change process (Greenberg, 1984; Greenberg & Foerster, 1996). Instead of simply comparing those who receive intervention with those who do not, as would be typical clinical trial methodology, task analysis allows for comparison of those who go through the intervention in a specified manner with those who do not. Since it is believed that aspects of task performance can affect resolution, task analysis is a well-suited research method to explore microlevels of the change process (Rice & Greenberg, 1984).

Clients who achieve high task resolution and who have successful therapy outcomes can provide clues to the key dimensions of psychotherapeutic change. This task analytic methodological process has been constructively applied in studies of the PE unfinished business task (Greenberg, 1997; Rice & Greenberg, 1984); client resolution of self-critical conflict splits (Greenberg, 1984); couple conflict resolution (Greenberg & Johnson, 1988); client-therapist alliance rupture repair (Safran & Muran, 2003); client response to therapist interpretations (Joyce, et al., 1995); client resolution from

hopelessness (Sicoli, 2005); and client resolution of global distress (Pascual-Leone & Greenberg, 2007).

Greenberg and Foerster (1996), used Chi-Square tests to compare high and low task resolvers on the PE "Unfinished Business Task," and found that expression of need and shift in view of the other distinguished high and low resolving groups. In the present research, the analyses of the productive client and therapist actions that relate to high task resolution were also studied, this time examining the PE NTR task.

Qualitative Empirical Analysis

Phase Two task analysis of the Process Experiential Narrative Trauma Retelling (NTR) task began with the collection and qualitative analysis of 35 task events. This was the first qualitative task analyses of the NTR task using a clinical sample. The qualitative analysis utilized the *Narrative Retelling Stagewise Productive Actions Checklist* (See Appendix B) that was developed in Phase One research (Breighner, 2006), to rate the presence or absence of client and therapist microprocesses that contribute to task progress. These ratings were used to edit the existing task model, as well as to categorize the 35 events as "low-resolution" or "high-resolution" to allow quantitative analyses of the relationship between productive actions and task resolution.

During the coding of the client and therapist components of the NTR task events, two additional client action components were observed, which allowed for improvement of the task model. New categories were thus created to incorporate these observed task processes, and were termed *identification of losses and description of impact of losses resulting from trauma* and *reflection on cherished belief development (global views and values regarding self, others, life, and the world) as a result of trauma*. These

components were rated in the current analyses, and will be used in future task research utilizing the *NTR Stagewise Productive Actions Checklist* (Appendix B).

It was not unexpected that cherished belief development would be observed during trauma retelling sessions. In fact, Clarke (1989) found that clients with trauma histories often experience shifts in their world views, specifically the idea of the self as vulnerable, the idea of the world as unsafe, the idea of others as harmful, and the idea of others as unhelpful. Fischer and Wertz (1979) indicated that negatively altered worldviews that result from trauma can lead to action tendencies of flight and avoidance, and thus it may be important for these newly adjusted cherished beliefs to be identified and processed within psychotherapy. The addition of this client activity to the listing of productive actions enhances the ability of the *NTR Stagewise Productive Actions Checklist* (Appendix B) to capture this client microprocess and better understand its role, if any, in the change process.

Another revision that resulted from the qualitative analyses was revision of the *NTR Task Model*. Specifically, the client and therapist component titles and descriptions were reworded to provide more precise descriptions of event activity. For example, Stage names were reworded to reflect observed Stage activity. Stage Six was changed from "Processing" to "Understanding or Acceptance of the Trauma," to more clearly reflect the nature of the Stage. Additionally, the particular client and therapist actions that were found to relate to task resolution in the quantitative analyses were more explicitly stated in the task model descriptors. For example, in the Fourth Stage, since it was found in the present study that exploration of loss and unmet needs are factors that distinguish high and low task resolvers, these elements were added to the Stage Four task description,

which now reads, “Client identifies and examines consequences, losses, alternate endings, unmet needs, and personal significance of the trauma.” The revised *NTR Task Model* can be found in Appendix E. This version of the NTR Task Model (Appendix E) can be compared to the *Original NTR Task model* circa 1998 (See Appendix A). Since its inception in 1998, the NTR task model has now been twice revised as informed by phases one (Breighner, 2006) and two of task analysis.

Quantitative Process Analysis

The relationship between task resolution and event components was examined using Pearson Chi-Square analyses. Nine client actions and four therapist actions were found to relate to NTR task resolution. Each of these variables was found to be present more often in high-resolving cases. It was noted that each of these statistically significant factors were absent in the low resolving events, whereas high resolving events tended to contain 3-5 of significant components.

Client Components. The client variables that were identified to relate to high NTR task resolution included aspects of:

1. Attitude toward the task and therapist
2. Reflection on the actions and feelings of significant others
3. Exploration of the meaning and significance of the trauma

The clients who *responded openly, cooperatively, and thoughtfully to therapist's questions, prompts, and cues,* were more likely to succeed in task resolution. This component represents a client’s readiness to engage in trauma narrative work, openness to the therapeutic process, and alliance strength. This component is relevant throughout the task, as the therapist asks questions and prompts task direction in each task stage.

This component corresponds with some central PE treatment principles, specifically the relationship principles of the therapeutic bond and task collaboration (Briere, 1989; Courtois, 1988; Elliott, et al, 1998; Elliott et al, 2004; Fischer & Wertz, 1979; McCann & Pearlman, 1990; Winn, 1994). This component's significance corresponds with the theory that providing the presence of a caring other is a key ingredient in the treatment of trauma (Elliott, et al., 2004).

Another group of clients who had higher task resolution based on aspects of their trauma narratives were clients who *reflected on significant other(s)' actions, motives, and/or perspectives during/after trauma.* This component involves the questioning of others, including those who may have behaved in a hurtful manner toward the client, and those who responded desirably or undesirably in the situation. In the Phase One study, it was found that unfinished business typically accompanies traumatic experiences (Breighner, 2006). The phase one study also found that high NTR task resolvers had higher levels of insight into the perspectives of significant others in reference to the traumatic experience, while low NTR task resolvers were more likely to express confusion regarding the perspectives of significant others who were involved in the traumatic experience (Breighner). Present results suggest that processing of this unfinished business relates to higher task resolution. This variable is present primarily in Stages Three and Four of the task model. Applying a reflective stance to significant others in the trauma experience fits into the task-specific PE treatment principle of experiential processing (Elliott, et al., 2004). PE theory suggests that trauma victims benefit from interventions that encourage them to begin to rebuild trust, at least partially, in the world. (Elliott, et al.), and this component is relevant to that pursuit.

Two variables that were found to relate to high task resolution address the question "What does this experience mean to me?" These aspects were *reflection about the trauma's meaning, significance, and purpose,* and *description of current attitude toward the trauma.* These components fit into the Fourth, Fifth, and Sixth task Stages. In the Study One conducted by Breighner in 2006, it was also found that high NTR task resolvers displayed higher levels of reflective processes throughout the retelling sessions.

Client's *reflection about the trauma's meaning, significance, and purpose* also related to high task resolution. With this component, the client assesses what it means that the trauma happened to them. They are making psychological or moral sense of the trauma by constructing meaning. This is the main goal of task Stage Four. Meaning reflection aligns with the treatment principle of the task principle of task completion and focus, as well as self-development (fostering client responsibility and client empowerment) (Elliot, et al., 2004). This aspect is hypothesized to be especially helpful in trauma treatment by helping to reprocess the trauma (Elliott, et al.). *Description of current attitude toward the trauma* represents the here-and-now general feeling and opinion, and also fits into the last three task stages. These three components align with the task-related treatment principles of task completion and focus and self-development (Elliot, et al., 2004). These aspects are theorized to be especially helpful in trauma treatment by aiding in trauma reprocessing (Briere, 1989; Courtois, 1988; Elliott, et al.; Elliott et al, 1998; McCann & Pearlman, 1990; Winn, 1994).

One component that addressed the question "How am I different now?" was found to relate to high task resolution: *identification of losses and description of impact of losses resulting from trauma*. This finding is consistent with Epston's (1997) and

Zimmerman and Beaudion's (2000) findings that collaborative narrative work contributes to the development of new life directions. *Identification of losses and description of impact of losses resulting from trauma* connects to feelings of sadness, loneliness, or emptiness at the absence of someone or something that is gone or less prevalent due to the trauma. This component is especially important since loss is a central theme in trauma narratives (Breighner, 2006). Loss exploration is a part of stages Three and Four of the NTR task model.

Therapist Components. The therapist activities that were identified to relate to high NTR task resolution were guiding the client in meaning creation, and guiding the client in development of new perspectives on the trauma to enhance and elaborate on the narrative. These therapist actions fit in NTR task Stages Three, Four, and Five.

Therapists who *asked direct questions regarding meaning/significance of trauma experience* were engaged in sessions with higher resolution rates. Questions such as "What does it mean to you that . . .", and "So the main thing about all of this is . . ." were used. Therapists who asked these types of questions pulled for the client to explore meaning in a way they may not have without prompting. This is relevant especially to NTR task Stage Three. This action can be categorized within the PE task treatment principle of experiential processing and task completion and focus. This action aligns with the theory that helping a person to reprocess trauma can help them make progress in trauma resolution (Briere, 1989; Courtois, 1988; Elliott et al., 2004; Elliott et al, 1998; Fischer and Wertz, 1979; McCann & Pearlman, 1990; Winn, 1994*).*

Therapists who *prompted the client to explore the "edges of experiencing;" expanding reflections* had higher resolving sessions. Questions such as "What kind of

anger?" "Where in your body did you feel it?" help the client to expand the narrative beyond the material they initially present. This action stimulates new ideas for clients, and is relevant in all stages. This action falls within the PE task-specific treatment principles of experiential processing, task completion and focus, and self-development. This component's significance supports the theory that reprocessing is a key element of trauma-focused PE therapy (Briere, 1989; Courtois, 1988; Elliott et al., 2004; Elliott et al, 1998; Fischer and Wertz, 1979; McCann & Pearlman, 1990; Winn, 1994).

Previous studies have shown that individuals who articulate trauma narratives have lower levels of anxiety, and decreased likelihood of developing PTSD (Amir, Stafford, Freshman, & Fos, 1998). Kellas and Manusov (2003) found that people who had recently suffered emotional trauma were better able to accept and understand their experiences after constructing trauma narratives. These studies indicate the potential for the helpfulness of narrative techniques for people who work with trauma narratives in therapy, but the specific components of the change process have remained largely unclear. The present study was one of the first to look at key ingredients to change in the narrative trauma work. Results indicated that the PE treatment principles are found to be active components in relation to trauma resolution, especially the relationship principle of empathic attunement, bond, and task collaboration, and the task principles of experiential processing, task completion and focus, and self-development. The specific PE trauma – focused therapy theories were supported in that key components to trauma resolution were found to fall within the theorized treatment component categories of providing the presence of a caring other, re-empowering the self, encouraging re-establishing the world as partially trustworthy, and helping to reprocess the trauma (Elliott, et al., 2004).

Limitations of the Study

This study has several limitations. The sample size of 35 was enough to be able to conduct preliminary analyses, but a larger collection of NTR events would allow for predictive analyses that would indicate variables that are predictive of task resolution. The NTR events were taken from sessions in which earlier versions of the task model were used. The *Empathic Exploration Task Model* version (See Appendix G) was used in the PTSD study data, and an early version of the NTR Task Model (See Appendix A) with the CSEP-II study data. Assessment of psychotherapy sessions using the newly revised NTR Task Model with Phase One and Phase Two task analyses (See Appendix E) are needed to further evaluate the current model.

Additionally, the use of two separate data sets in this project resulted in different levels of information being known about each data set. Less information is known about client attrition in the PTSD data set, and less information is known about exact diagnosis in the CSEP-II data set. With more information about client dropout rates and diagnosis, analyses could have been conducted to determine any possible relationship of these factors to event resolution.

Also, it may be useful to further condense the number of factors on the *Observer NTR Stage Assessment* (See Appendix B) to simplify the task assessment process. It could also be useful to include PE treatment principles or to emphasize treatment components that are hypothesized within PE theory to enact change. For example, emotional re-experiencing is seen as a key process in PE therapy, so aspects of emotional re-experiencing could be evaluated more specifically in the task analysis to examine the role of re-experiencing in task resolution. Another concern regarding the use of the

Observer NTR Stage Assessment is that this measure organizes client components by stage, which allows for the repetition of factors that occur in multiple task stages. An NTR measure that was not categorized by stage would be ideal.

Finally, the statistical methods used in the study included running 69 Chi-Square analyses to determine if each task component distinguished high task resolvers from low task resolvers. Greenberg and Foerster conducted chi-Square analyses in their 1996 task analysis of the PE Unfinished Business Task, indicating that this procedure is common for the particular research method; however, there could be disadvantages to running so many statistics and raising the chance of error due to finding significant task components due to chance. In future studies, it would be advisable to investigate other statistical methodology options to address this limitation.

Future Directions.

The next stage of the task analysis of the NTR task will go beyond the session-level analysis of the task, requiring outcome studies of high vs. low resolvers to determine if the refined model and the scale devised from it truly capture the actual change process in trauma resolution. In order to conduct these analyses, it will be necessary to collect a large number of NTR task events using the current task model, and to also collect pre-therapy and post-therapy outcome data in order to compare high and low task resolvers with respect to successful or unsuccessful therapy outcomes. It is hypothesized that high task resolution on the NTR task would lead to improvement in pre- to post-therapy outcome measure scores, since gaining trauma resolution would likely aid in symptom reduction and result in increased life satisfaction.

Implications of Task Analysis for PE Therapy

In order to empirically support the rationally derived PE task models, each of the 13 PE tasks (See Table 1) should be analyzed using a task analytic approach to establish an empirical basis for the rationally derived task models. Once that is complete, a comparison can be made of key ingredients of the change process. If there are universal elements that contribute to client change in each of the 13 tasks, these will be established as key components of effective Process Experiential psychotherapy. Another broad recommendation is to perform task analyses with the NTR task as well as the other 12 Process Experiential (PE) therapy tasks to assess the role of emotional re-experiencing in task resolution and psychotherapy outcome. In-session emotional re-experiencing is proposed to be the central key ingredient of PE therapy, and task analyses could investigate this theoretical claim. These analyses would allow for revision and verification of the core Process Experiential model of change. This is the ideal manner by which practice can inform theory (Greenberg, 1984).

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Appendix A

Original NTR Task Model (Elliott et al., 2004; cf Rice, 1974)

Client Task Resolution Stages	**Therapist Actions**
1. Trauma Narrative Marker ▪ Client refers to trauma	▪ Listens for and reflects marker ▪ Propose and negotiate task (including task rationale)
2. Elaboration ▪ Client provides detailed, concrete narrative of trauma; from external/factual point of view	▪ Asks questions about situation and what led up to it ▪ Encourages client to re-enter situation in imagination
3. Dwelling ▪ Client re-experiences important moments or aspects of trauma while maintaining sense of safety	• Evocative responses ▪ Listens for and reflects poignancy ▪ Attends to immediate client experiencing ▪ Helps client keep safe working distance ▪ Stops task if necessary
4. New Meanings Emerge ▪ Client remembers or differentiates idiosyncratic meanings of trauma from internal point of view	▪ Listens for, reflects, and supports new meanings, especially decreased self-blame
5. Alternative Views ▪ Client reflects on and tentatively evaluates alternative views of trauma; integrates previously unconnected or inconsistent aspects of the experience	▪ Helps client reflect on and explore alternative views
6. Re-integration ▪ Client expresses broader or more integrated view of self, others, or world; considers new ways of acting while still maintaining personal safety	• Reflects and underscores newly integrated story ▪ Facilitates exploration of new ways of acting

Appendix B

NTR Stagewise Productive Actions Checklist

Stage	Client Actions	Therapist Actions
Stage 1: Introduction of Trauma Narrative *The client reveals that something traumatic happened to them.*	❑ Identified relevant trauma narrative	❑ Proposed retelling task ❑ Encouraged client to tell story
Stage 2: Entry into Trauma Narrative *The client tells the therapist what happened to them, in a nutshell.*	❑ Introduced story of trauma, providing brief summary (about 2-5 speaking turns in length) ❑ Began to describe external and internal memories of trauma ❑ Reflected briefly on overall trauma experience ❑ Reported current level of resolution/acceptance of trauma ❑ Situated trauma narrative within the context of larger life narrative ❑ Responded openly, cooperatively, and thoughtfully to the therapist's questions, prompts, and cues ❑ Presented story subplots out of order (common) ❑ Other:	❑ Did not interrupt storytelling; listened attentively ❑ Used empathic following devices, indicating understanding and interest ❑ Requested further elaboration and clarification of story subplots ❑ Negotiated task parameters to keep work focused on narrative retelling ❑ Clarified scope of trauma (what time frame and content is included in narrative) ❑ Shared personal reactions to hearing an overview of the client's story ❑ Other:
Stage 3: In-depth Narration of Trauma Experience *The client tells the therapist about what happened in detail, and how they felt during*	❑ Retold key segments of trauma narrative in rich detail ❑ Emotionally re-experienced trauma memories by mentally re-entering traumatic scenes ❑ Described the role and	❑ Used narrative extension devices (frequently requested elaboration, clarification, and continuation of story telling of external,

the most difficult and painful moments of the trauma.	❑ Marker for Unfinished Business Task was present ❑ Described how it felt to be in the difficult/ painful situation ❑ Focused especially on especially salient segments of the trauma ❑ Identified and described the most difficult part or aspect of traumatic experience ❑ Described memories of physiological/bodily reactions to the trauma ❑ Responded openly, cooperatively, and thoughtfully to the therapist's questions, prompts, and cues ❑ Presented story segments out of order (common) ❑ Other:	❑ Employed empathic following devices, indicating interest and understanding ❑ Summarized or reflected main ideas and themes of story segments ❑ Responded empathically to the client's in-session reliving of traumatic experiences, expressing acceptance of the expression of deep emotion ❑ Did not interrupt storytelling ❑ Prompted reflection by highlighting emerging realizations ❑ Other:
Stage 4: Emergence & Development of New Meanings & Perspectives *The client reflects on how they think and feel about what happened to them.*	❑ Explored meanings of trauma ❑ Identified positive aspects/ learning that resulted from traumatic experience ❑ Identified losses as result of trauma ❑ Speculated about alternative outcomes to trauma, or what might have been if things had happened differently somehow ❑ Explored and identified unmet needs during particular moments of	❑ Asked direct questions regarding meaning and perspective of trauma experience ❑ Prompted the client to explore losses resulting from trauma ❑ Prompted client to elaborate on reflections and to explore edges of experiencing ❑ Used empathic following devices to track the client's

	❑ Reflected on decisions or behaviors during the trauma ❑ Reflected on current opinion, attitude, and/or perspective on trauma experience ❑ Considered how perspective of trauma has changed over time ❑ Reflected on role of significant others in trauma ❑ Was unable to make sense of others' actions, motives, and perspectives during the traumatic experience ❑ Gave self credit for personal strength during trauma ❑ Responded openly, cooperatively, and thoughtfully to the therapist's questions, prompts, and cues ❑ Other:	❑ Queried directly about the client's unmet needs during the trauma ❑ Other:
Stage 5: Assessment of Core Values & Beliefs *The client reflects on how the experience changed them, and changed their life.*	❑ Explored how beliefs about themselves were changed/strengthened by trauma experience. ❑ Explored how personal values had changed as result of trauma ❑ Reflected on development (expansions/changes) of beliefs about other people in general ❑ Reflected on how trauma changed approach to life/ beliefs about the world ❑ Other:	❑ Prompted the client to explore and identify changes in cherished beliefs (global views and values regarding self, others, life, and the world) as a result of the trauma experience ❑ Other:

Stage Six: Processing *The client reflects on how they are doing considering that they have been through the trauma, where they are at in the resolution process, and where they will go from here.*	❑ Examined changes in behavior/future directions of life as a result of trauma experience ❑ Identified what was lost/ gained as result of trauma experience ❑ Expressed enhanced self-view and increased perception of personal strength and/or coping ability as result of trauma ❑ Expressed acceptance of trauma ❑ Expressed gratitude for having the experience despite the difficult and painful nature of it ❑ Expressed newfound conviction/opinion about significant other(s) resulting from trauma ❑ Identified current unmet needs resulting from trauma experience ❑ Reflected on experience of retelling in-session ❑ Reflected on the value of the retelling ❑ Compared current retelling experience to previous experiences ❑ Expressed sense of safety/comfort felt during retelling ❑ Described how trauma retelling could make a positive contribution to society and benefit other people in similar situations ❑ Collaborated with the therapist in ending the task ❑ Other:	❑ Responded empathically to the client's reflections, demonstrating interest and desire to understand ❑ Prompted the client to explore edges of experiencing ❑ Guided the client to explore positive and negative aspects of changes that occurred in their life as a result of the trauma ❑ Used metaphor or rich descriptive language when empathically reflecting the client's current status in trauma recovery ❑ Asked direct questions regarding what it was like for the client to tell the story in-session ❑ Thanked the client for sharing story ❑ Collaborated with the client in ending the task ❑ Other:

Coding Guidelines

Description of material to be coded:

- Transcriptions of psychotherapy session segments (ranging from approximately 15-45 minutes in length) in which a version of the process experiential narrative retelling task is used

Purpose of coding:

- To rate the presence or absence of client and therapist processes

Tools:

- Narrative Retelling Stagewise Productive Actions Checklist

Task for Raters:

Check off the actions that were taken by the client and therapist during the segment that you coded. If there were additional actions taken during a particular stage that you feel may have contributed to task progress or lack of task progress, please check "other," and describe the action.

Appendix C

NTR Client Component Analysis

Client Production Actions	Pearson's Chi-Square	df	Asymp. Sig. (2-sided)	LR Absent	LR Present	HR Absent	HR Present
Made reference to difficult painful event about which a story could be told (S1)	na	na	na	0	19	0	16
Briefly summarized trauma (S2)	0.867	1	0.352	1	18	0	16
Presented brief narrative (S2)	1.786	1	0.181	2	17	0	16
Reflected briefly on overall emotional experience of trauma (S2)	0.867	1	0.352	1	18	0	15
Identified current level of resolution/acceptance of trauma (S2)	1.393	1	0.238	7	12	3	13
Described larger life context of trauma episode (S2)	0.801	1	0.371	10	9	6	10
Responded openly, cooperatively, & thoughtfully to the therapist's questions, prompts, & cues (S2)	1.793	1	0.181	6	13	2	14
Presented story subplots out of order (S2)	1.446	1	0.229	8	11	10	6
Re-experienced emotions that were alive during trauma, describing them in greater detail than in stage 1 (S3)	0.184	1	0.668	6	13	4	12
Reflected on significant others' views/reactions during trauma (S3)	1.861	1	0.172	9	10	4	12
Presented first-person narrative in greater detail than in stage 2 (S3)	0.184	1	0.668	6	13	4	12
Focused on specific segments of trauma narrative; salient moments (S3)	0.696	1	0.404	8	11	9	7
Identified & described the most difficult aspect or moment of trauma (S3)	0.121	1	0.728	12	7	11	5
Described memories of bodily reactions (S3)	0.218	1	0.64	8	11	8	8
Described unfinished business with a significant other pertaining to trauma (S3)	0.024	1	0.877	9	10	8	8

Client Production Actions	Pearson's Chi-Square	df	Asymp. Sig. (2-sided)	LR Absent	LR Present	HR Absent	HR Present
Responded openly, cooperatively, & thoughtfully to therapist's questions, prompts, & cues (S3)	2.763	1	0.096	10	9	4	12
Continued to tell story out of order (S3)	1.281	1	0.258	17	2	12	4
Reflected about the trauma's meaning, significance, & purpose (S4)	10.151	1	0.001*	16	3	5	11
Identified positive aspects or lessons learned from trauma (S4)	0.077	1	0.782	16	3	14	2
Reflected on how life would be different if the trauma had never occurred (S4)	8.117	1	0.004	16	3	6	10
Identified unmet needs during trauma (S4)	7.296	1	0.007	18	1	9	7
Described current attitude toward trauma (S4)	11.064	1	0.001*	18	1	7	9
Reflected on significant other(s)' actions, motives, &/or perspectives during/after trauma (S4)	13.203	1	0.000*	18	1	6	10
Identified losses & described impact of losses resulting from trauma (S4)	14.998	1	0.000*	16	3	3	13
Responded openly, cooperatively, & thoughtfully to therapist's questions, prompts, & cues (S4)	10.151	1	0.001*	16	3	5	11
Identified how the meaning/significance of the trauma has changed over time (S4)	3.896	1	0.048	19	0	13	3
Reflected on decisions & behaviors during trauma (S4)	1.177	1	0.278	16	3	11	5
Identified aspects of personal strength during the trauma (S4)	0.077	1	0.782	16	3	14	2
Reflected on reactions & response to trauma (S4)	1.281	1	0.258	17	2	12	4
Described developments (expansions/changes) of perspectives of significant other(s) resulting from trauma (S5)	2.143	1	0.143	16	3	10	6

Client Production Actions	Pearson's Chi-Square	df	Asymp. Sig. (2-sided)	LR Absent	LR Present	HR Absent	HR Present
Reflected on cherished belief (global views & values regarding self, others, life, & the world) development as a result of trauma (S5)	1.177	1	0.278	16	3	11	5
Reflected on how trauma experience changed approach to life (S5)	4.717	1	0.03*	16	3	8	8
Reflected on how trauma experience changed self (S5)	0.054	1	0.817	16	3	13	3
Examined changes in behavior & future goals in life as a result of the trauma (S5)	0.077	1	0.782	16	3	14	2
Reflected on role of loss in new life trajectory (S5)	0.58	1	0.446	18	1	14	2
Expressed enhanced self-view & increased perception of personal strength/ coping ability resulting from trauma (S5)	2.763	1	0.096	16	3	16	0
Expressed acceptance of trauma & gratitude for having the experience despite the difficult & painful nature of trauma (S6)	0.077	1	0.782	16	3	14	2
Expressed newfound conviction/opinions about significant other resulting from trauma (S5)	0.016	1	0.9	18	1	15	1
Identified current unmet needs still resulting from experience (S5)	2.519	1	0.112	19	0	14	2
Reflected on the experience of retelling (S6)	0.203	1	0.653	17	2	15	1
Compared current retelling experience to previous experiences (S6)	0.203	1	0.653	17	2	15	1
Expressed sense of safety/comfort felt during retelling (S6)	1.786	1	0.181	17	2	16	0
Described how trauma retelling could make a positive contribution to society & benefit other people in similar situations (S6)	1.22	1	0.269	19	0	15	1
Collaboratively decided to end session (S6)	0.104	1	0.748	5	14	5	11

S= Stage

Appendix D

NTR Therapist Component Analysis

Therapist Production Actions	Pearson's Chi-Square Value	df	Asymp. Sig. (2-sided)	LR Absent	LR Present	HR Absent	HR Present
Proposed task and encouraged client to tell story (S1)	0.867	1	0.352	1	18	0	16
Did not interrupt storytelling; Listened attentively (S2)	0.867	1	0.352	1	18	0	16
Employed empathic following devices indicating interest and understanding (S2)	0.203	1	0.653	2	17	1	15
Requested further elaboration of story subplots and clarification of unclear internal and external story elements (S2)	1.036	1	0.309	14	5	14	2
Negotiated task parameters by collaborating with the client to identify scope of experience to be retold (S2)	0.867	1	0.352	18	1	16	0
Shared personal reactions to hearing overview of the client's story (S2)	0.121	1	0.728	7	12	5	11
Used narrative extension devices (frequently requested elaboration, clarification, and continuation of story telling of external, internal, and reflective elements) (S3)	1.793	1	0.181	6	13	2	14
Employed empathic following devices indicating interest and understanding (S3)	0.274	1	0.6	10	9	7	9
Summarized the main ideas and themes of story segments (S3)	0.002	1	0.968	7	12	6	10
Responded empathically to the client's in-session reliving of traumatic experiences, expressing acceptance of the expression of deep emotion (S3)	0.748	1	0.387	6	13	3	13
Did not interrupt storytelling; Listened attentively (S3)	0.046	1	0.83	10	9	9	7
Prompted reflection by identifying emerging realizations (S4)	0.473	1	0.492	15	4	11	5
Prompted the client to focus on and retell most difficult/central/poignant aspects and pieces of trauma story (S4)	3.327	1	0.068	16	3	9	7

Therapist Production Actions	Pearson's Chi-Square Value	df	Asymp. Sig. (2-sided)	LR Absent	LR Present	HR Absent	HR Present
Asked direct questions regarding meaning/significance of trauma experience (S4)	10.391	1	0.001*	19	0	9	7
Prompted the client to explore losses resulting from trauma (S4)	1.177	1	0.278	16	3	11	5
Prompted of the client to explore the "edges of experiencing;" expanding reflections (S4)	12.434	1	0.000*	16	3	4	12
Employed empathic following devices indicating interest and understanding (S4)	6.927	1	0.008	19	0	11	5
Queried directly about the client's unmet needs during the trauma (S4)	6.311	1	0.012	16	3	7	9
Prompted the client to explore and identify changes in cherished beliefs (global views and values regarding self, others, life, and the world) as a result of the trauma experience (S5)	0.054	1	0.817	16	3	13	3
Responded empathically to the client's reflections, demonstrating interest and desire to understand (S5)	0.781	1	0.377	16	3	15	1
Prompted of the client to explore the "edges of experiencing;" expanding reflections (S5)	1.22	1	0.269	19	0	15	1
Directed the client to explore positive and negative aspects of changes in life as result of trauma (S5)	0.781	1	0.377	16	3	15	1
Used metaphor, rich description, and/or tentative conjectures to summarize the client's trauma experience (S6)	1.786	1	0.181	17	2	16	0
Asked general questions regarding the client's in-session retelling experience (S6)	na	na	na	19	0	16	0

S = Stage

Appendix E
Revised NTR Task Model

1. Introduction to Trauma Narrative:
    a. The client refers to trauma or difficult experience.
    b. Brief allusion that there is a story to be told
    c. Example: *When I was in seventh grade, I got run over by a school bus.*
2. Entry Into Trauma Narrative
    a. Client begins to tell story
    b. Retelling is from primarily external perspective
    c. Client begins to provide brief overview of nature and content of story (without yet going into great detail or internal perspective)
    d. Example: *It was in September of 2004. At the time I was living in Minneapolis. My brother was 6 that year.*
3. In-depth Narration of Trauma Experience
    a. Client goes into greater detail while retelling specific story segments that were particularly meaningful
    b. Client re-experiences important moments or aspects of trauma from deeper, more internal perspective
    c. Example: *I am shivering, and looking around, confused. I am so afraid that I am dying. The ambulance siren is going off, but I can't even really hear it because I am just trying to breathe.*
4. Exploration of Effects & Meanings of Trauma
    a. Client reflects of trauma experience
    b. Client identifies and examines consequences, losses, alternate endings, unmet needs, and personal significance of the trauma
    c. Example: *Part of the reason the school bus accident was so difficulty was because all the kids on the school bus saw what happened to me, which was embarrassing on one hand, but on the other hand they were all so supportive during my recovery process, so it showed me that I was cared for by people in my community. But I've had flashbacks and nightmares about that day ever since.*
5. Assessment of General Core Values & Beliefs
    a. Client reflects on self, others, the world, and life
    b. Client evaluates perspectives and how they have changed or strengthened
    c. Example: *After I got run over by the school bus, I realized how precious life was, and I stopped taking many things for granted. I also realized that unpredictable things can happen at any moment to any of us. I also learned that I do have people that I can count on that will help me if I need it, and that is comforting to know.*
6. Understanding or Acceptance of Trauma
    a. Client expresses enhanced understanding or acceptance of trauma, self, others, the world, and/or life
    b. Client may express reaching of resolution state (characterized by relief, peace, feeling less stuck, and/or feeling that unfinished business is resolved)

c. Example: *For a long time, I wished I could go back in time and erase what had happened. I was so mad at myself for getting run over, and I just wanted to erase it from history. But now I believe that experience helped me become stronger, and I am okay with having it in my life story. I'm going to think about it sometimes, and maybe I'll still get a little nervous when I see yellow vehicles, but I'm not going to look back every day anymore. I'm glad that I don't take things for granted anymore, and I hope that I can make a difference by lobbying for bus safety in my community. It was one of the hardest experiences in my life, but I'm okay now, and I feel like I can be myself again.*