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The Co-Construction of Self-Talk and Illness Narratives: An HIV Intervention Case Study

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UNIVERSITY OF MIAMI

THE CO-CONSTRUCTION OF SELF-TALK AND ILLNESS NARRATIVES: AN HIV
INTERVENTION CASE STUDY

By

Yvette Bueno

A DISSERTATION

Submitted to the Faculty
of the University of Miami
in partial fulfillment of the requirements for
the degree of Doctor of Philosophy

Coral Gables, Florida

May 2009

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INTERVENTION CASE STUDY

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The Co-Construction of Self-Talk and Illness Narratives:
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This case study investigates the co-construction communication patterns that emerged during an Human Immunodeficiency Virus (HIV) intervention designed to reduce negative and critical self-talk. The transcripts of eight sequential acupressure and behavioral (SAB) counseling intervention sessions between a therapist and two medically nonadherent HIV-infected women were analyzed using Giorgi's (1989, 1994, 1997, 2006) phenomenological method of inquiry. The analysis revealed three major themes: "assessing the present," "reviewing the past," and "forging the future," and eight subthemes: "safe atmosphere," "disclosure," "negotiating meaning," "releasing the past," "breaking the past-to-present pattern," "reducing uncertainty," "generating options," and "projecting images." Prior to the intervention sessions, the women reported experiencing negative and critical self-talk and inconsistent medication adherence. Self-talk and illness narrative modifications were evident within and across sessions as the therapist used sequential acupressure and behavioral counseling techniques. During the one month follow-up, the participants reported no experience of negative and critical self-talk and described actions taken toward goals discussed and imagined during the intervention such as medication adherence, exercise, and reenrollment in school. The co-construction themes that emerged in the intervention were consistent with findings in the comforting

message literature with specific parallels to the factor analysis findings of Bippus (2001).

This work lends support to comforting message research and suggests that distinctions between everyday comforting messages and chronic illness support strategies may be more similar than anticipated. Other study conclusions include clinical and practical implications for people working with HIV-infected individuals.

DEDICATION

To my daughter, who was my inspiration to go back to school and get this doctorate: Ava, my desire to show you that we need to follow our dreams was the extra nudge I needed to make it happen. Your love and hugs made me smile through even the toughest days and your ability to push me to reach deeper, grow stronger, and become a more caring and compassionate person made me feel alive even on the most ordinary of days. To my husband, Blake, who I met just days before I started life as a doc student, you are my rock! I could not have done this without your relentless encouragement, love, and support. Thank you for marrying me before my comprehensive exams and the dissertation work despite knowing what life would be like until it was all over. To my son, Zaiah, my one-year-old blessing, you have filled this past year with wonder, laughter, and happiness. My heart smiles at your sweetness and joy for life. To my parents, Milady and Danilo, *un millon de gracias por todo!* To my best friend, Vicky, please come to all my conferences; I love you, girl!! To my very first mentor, Heino Meyer-Bahlburg, who introduced me to the world of research and the life of the mind, my endless gratitude.

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CHAPTER 1. OVERVIEW

Self-talk, the statements that we say to ourselves either silently or aloud, typically contain a positive or negative value. These statements affect illness narratives which are central to identity and provide insight into the decision-making mechanisms of an individual. For the chronic illness sufferer, the ability to adapt to an altered sense of self (Bury, 1982; Charmaz, 1983; Klienman, 1988) and the capacity to cope with uncertainty (Atkinson, 1995; Babrow, Hines, & Katsch, 2000; Babrow, Kasch, & Ford, 1998; Brashers & Babrow, 1996; Katz, 1984) poses pressing challenges that are manifest in self-talk statements and illness narratives.

Mishler et al. (1981) were among the first to distinguish the voice of the “lifeworld,” a patient’s social and emotional meanings of illness, as separate from the definitions of disease derived from the medical establishment. The subsequent rise in research investigations into patients’ illness narratives has positively impacted our understanding of illness and the clinical encounter. Healing and agent-empowering effects for persons living with a chronic illness have been attributed to the use of illness narratives in clinical practice (Charon, 2006; Kleinman, 1988). However, the elicitation of narrative may only be part of the healing process. Some classification schemes for narratives suggest that a positive narrative may not originate for all or even a large percentage of illness sufferers (Frank, 1998; Mosack, Abbott, Singer, Weeks, & Rohena, 2005). This research suggests that some people do not reach optimal narratives and may stay in narratives that are chaotic or of loss orientation.

The act of sharing and co-constructing the illness narrative interpersonally has the potential to address issues of uncertainty and negative illness narratives. Eggly’s (2002)

work examined the physician's contributing role in the construction of the patient narrative during patient-physician interaction. The interplay between interpersonal communication and intrapersonal communication directed toward health outcomes forms the framework and focus for the current study involving nonadherent HIV-infected individuals.

Communication researchers have found self-talk to be a proximate condition of self-esteem in populations experiencing challenges such as sexism and racism (DeFrancisco & Chatham-Carpenter, 2000) and adaptation to college life (Orbe, 2003). Witte and Meyer's (1995) description of the Extended Parallel Process model states that the nature of self-talk may either propel or hinder health behavior.

Although self-talk research in the area of communication has been limited, multiple studies in the fields of psychology, education, and sports performance link self-talk to mental health states and performance. Previous studies demonstrate that the reduction of negative and critical self-talk increases self-esteem, decreases depression, (Peden, Rayens, Hall, & Beebe, 2001; Philpot & Bamburg, 1996), and reduces anxiety while enhancing locus of control (Duncan, Konefal, & Spechler, 1990; Konefal & Duncan, 1998; Konefal, Duncan, & Reese, 1992). The reduction of negative and critical self-talk and the presence of positive self-talk has been found to be a proximate condition of self-esteem and enhanced self concept (Birkimer, Druen, Holland, & Zingman, 1996; DeFrancisco & Chatham-Carpenter, 2000).

The current case study investigates how self-talk and illness narratives are co-constructed between a therapist and two nonadherent HIV-infected participants during a

sequential acupressure and behavioral (SAB) counseling intervention. SAB was designed to reduce negative and critical self-talk.

This case study is the first known inquiry in the field of communication to explore the self-talk of HIV-infected persons as a health communication intervention tool. Self-talk intervention studies have not been conducted with HIV-infected individuals, nor have behavioral coping studies with HIV-infected individuals used sequential acupressure techniques in addition to behavioral counseling techniques. The findings potentially will advance knowledge within the area of intrapersonal, interpersonal, and health communication. The research builds upon the social constructionist literature in health communication by describing the process of co-constructed reality and exploring its impact on language and behavior. A case study design allows for an in-depth exploration into the process of self-talk and illness narrative co-construction.

CHAPTER 2. LITERATURE REVIEW

Many times, HIV-infected individuals, such as individuals with other chronic illnesses, struggle with an altered sense of self. This struggle is compounded with the hardship of adhering to a highly active antiretroviral therapy (HAART) medication regimen and a host of other issues, which include disclosure, stigma, and uncertainty, affecting HIV-infected individuals. Self-talk interventions may be beneficial for nonadherent HIV-infected individuals. Research studies indicate that nonadherent HIV-infected individuals tend to exhibit depressive symptoms (Catz, Kelly, Bogart, Benotsch, & McAuliffe, 2000; Safren et al., 2001) while HIV-infected individuals with positive states of mind (Horowitz, Adler, & Kegeles, 1988) and a sense of self-efficacy show greater adherence to HAART (Simoni, Frick, & Huang, 2006).

This section begins with a brief description of self-talk development and is followed by a multidisciplinary literature review about self-talk. Research and literature from the fields of psychology, sports, and education describe the broad range of definitions and functions of the self-talk concept. A description of intrapersonal communication, the level of communication in which self-talk manifests itself, and its relevance to health will be presented. Additional work linking self-talk to improved well-being and health behavior outcomes is discussed.

Pertinent literature regarding illness narratives, in particular, HIV illness narratives that describe the co-construction of narratives are described in detail. Research findings regarding HIV, adherence, and coping interventions are presented to gain a better appreciation for the specific circumstances of HIV-infected individuals. Lastly, the objectives of the sequential acupuncture and behavioral intervention are presented.

Self-Talk Development

The early egocentric language used by children frequently models, in words and expression, that of the adults who are closest. It is within this framework of adult influence on the child that Dance and Larson's (1976) conceptualization makes sense. Inner speech or internal dialogue is one's perception of self and the language one uses in interpersonal communication situations. Johnson's (1984) model of inner speech supports this contention. He proposed that inner speech takes its origin in external speech; inner speech represents its psychological transformation. The conceptualization that a child's development of self-talk is based on interpersonal data from parents and teachers serves as the premise from which to explore the material within this field. The studies that consider the interactionist nature of a child's development of self-talk have linked the positive or negative nature of self-talk directed toward children to performance outcomes by teachers, such as reading and mathematics (Burnett, 2003; Burnett & McCrindle, 1999). Burnett considers the role of teacher and significant other's positive or negative statements as mediating variables that influence a child's internalization of other's attitudes that are adopted and generated as self-talk within the child. Results from Burnett & McCrindle's study found that positive statements from parents and teachers had a mediating effect on positive self-talk, however, this was not true of peers' positive statements; instead, it was the negative statements that had an indirect effect on adolescent self-esteem and negative self-talk.

The cognitive, emotional, and behavioral aspects of self-talk have been primarily explored in psychology, education, and sports. The importance and relevance of self-talk

within the field of communication has been minimal despite earlier conceptualizations that endorsed its essential function in communication (Johnson, 1984).

Self-Talk Across the Disciplines

There appears to be very little consensus about the precise definition or even label of self-talk. A variety of terms across psychology, sports, education, and communication studies seem to describe the same phenomenon with subtle variations. Several of the definitions found within the psychological literature describe self-talk as a cognitive function that is practically equivalent to thinking or thoughts (Ayres, 1988; Gabel, Colcord & Petrosino, 2001; Prins & Hanewald, 1999). Other labels for self-talk under the “talk as cognition” umbrella include terms such as positive/negative thinking, positive/negative thoughts and positive/negative talk. Other similar terms, (i.e., inner speech, self-referent speech, and internal dialogue), refer to an act that takes place within the person (Johnson, 1984; Kendall, Howard, & Hays, 1989; Ronan, Kendall, & Rowe, 1994). Within these studies, self-talk is conceived of as an intrapersonal phenomena that can be of positive or negative valence and where an optimal balance between positive and negative talk is deemed favorable.

A majority of sport sciences studies define self-talk as a performance-enhancing tool and a motivational technique (Hardy, Hall, & Alexander, 2001; Papaioannou, Ballon, Theodorakis, & Auwelle, 2004; Van Raalte, Brewer, Rivera, & Petitpas, 1994). Van Raalte et al.’s field study observed the self-talk and gestures in junior tennis matches and found positive talk was not related to better performances, yet negative self-talk was related to worse performances. The researchers in this study were unique in their measurement of personal belief in the effects of self-talk on performance. They split the

population into believers and nonbelievers of self-talk; those who believed self-talk to be truly useful and effective versus those who did not. Although there was no difference in the self-talk of either group, the nonbelievers scored fewer points than the believers.

Self-talk has also been described as a strategy or self-instructional skill used to predict and produce positive outcomes (Alkhteb & Taha, 2002; Burnett, 2003; Hardy et al., 2001; Papaioannou et al., 2004; Van Raalte et al., 1994). The interpretation of self-talk as a strategy or skill was often evaluated with regard to a performance in sports or an educational task. Fewer studies, particularly those in communication, conceptualized self-talk as an internal state linked to beliefs, behaviors, and self-esteem. These studies connoted self-talk as interchangeable with or a mediator of self-esteem and self-concept (Birkimer et al., 1996; DeFrancisco & Chatham-Carpenter, 2000; Orbe, 2003).

A majority of the findings in the area of self-talk stem from the self-talk analyses of differences in special populations. Kendall et al. (1989) used the “automatic thoughts questionnaire” that classified an analogue population and an inpatient psychiatric population as overly optimistic, depressive, or normal. One of the questions posed in Prins and Hanewald’s (1999) work with children considered the child’s focus. These questions addressed self-talk differences between problem-focused or emotion-focused children. The child-oriented classification sheds light on the previous classification systems. Prins and Hanewald’s work asked whether the presence of coping self-talk, defined as distraction and anxiety controlling cognitions, contributed to decreased performance for anxious children. Their findings suggest no direct link between the two, however their findings do support the idea that high-anxiety children experience both coping cognition and decreased performance.

Studies that described self-talk intervention techniques also focused on the function of self-talk as a cognitive mechanism to work through negative emotional states such as anger and depression (Philpot & Bamburg, 1996; Seay, Fee, Holloway, & Giesen, 2003). Some of the techniques in the field involved the implementation and use of positive self-statements and the restructuring of negative statements to increase self-esteem (Philpot & Bamburg). As an intervention technique, self-talk was commonly modeled and prescribed by a therapist.

Researchers appear divided about their evaluation of self-talk as affecting cognition and/or emotion. Hardy et al. (2001) explained that self-talk has the ability to guide actions and influence affect. They found that negative and positive self-talk was positively correlated with unpleasant and pleasant affect in a group of high school athletes. Birkimer et al. (1996) suggested that particularly healthy or unhealthy behaviors are related to rules that reinforce or reprimand a particular behavior. The link between the participation in a healthy or unhealthy behavior correlates to subsequent internal states, such as self-talk and emotional reactions. Both affect and cognition in this instance represent an internal state. Hence, within this frame, self-talk was defined as thinking and cognition that directly related to feeling and emotion. Nonetheless, other researchers find the merit of exclusively evaluating the cognitive content functions of self-talk as either instructional or motivational. Papaioannou et al. (2004) conducted an experimental study on the use of self-talk within a professional soccer shooting task and found that self-talk cues were effective in increasing attention. Due to the disparate notions regarding the association among self-talk, emotion, and cognition, certain researchers have sought to refine self-talk measurements in order to clarify the links. Ronan et al. (1994) sought to

refine this distinction. They acknowledged that the relationship among self-statements, affect, and cognition was not clear. They investigated the negative and positive (e.g., happy, anxious, and depressed) affect moments of children by asking them to report the “thought that popped into your head” [at the time] (p. 512). The researchers concluded that, although the instructions specifically asked for “thoughts,” some of the items generated were highly emotional in content (e.g., “I feel good”) (p. 527).

Self-talk has been actively investigated within a variety of fields, often with the understanding that it serves a self-help and self-improvement function. The communication literature on self-talk characterizes the phenomenon as occurring within the intrapersonal level of communication. A review of that literature demonstrates that intrapersonal communication holds the potential for change and improvement.

Self-Talk as Intrapersonal Communication

Intrapersonal communication, as defined by Roberts, Edwards, and Barker (1987), is a process that includes messages that are physiological and psychological and that occur within individuals at conscious and unconscious levels as individuals attempt to understand themselves and their environment. Intrapersonal communication has similarly been defined as a “mental process, a physical state and a biological psychological system” (Stacks & Sellers, 1989, p. 244). Communication scholars recognize the physiological underpinnings of intrapersonal communication as cerebral (Sellers & Stacks, 1990; Stacks & Andersen, 1989) and cellular transmission of information (Vocate, 1994), or more broadly as the “beginning of the mind-body connection that involves other parts of the body including the nervous system, organs, muscles, hormones, and neurotransmitters” (Fletcher, 1989, p. 190). Intrapersonal

communication that occurs within the human system is proposed as a process that an individual uses to make meaning and relay messages. These messages affect the body via cognitive processes, emotional states, and physiological responses that overlap and influence each other.

Intrapersonal communication refers to both the physiological message system in the body as well as the construction of meaning that occurs within the process of encoding and decoding information (Kreps, 1988). Hence, it is both the processing of information and construction of meaning that aid the individual in understanding the self and his or her environment. The following excerpt pointedly describes what occurs within the intrapersonal system: “Whether or not what is decoded originates inside or outside the body of the intrapersonal communicator, and whether or not what is encoded is actually expressed leaked or given off, intrapersonal communication has occurred” (Shedlatsky, 1989, p. 94). The therapeutic value of intervening at this level is promising because of the bridge between the mind and the body that is established with intrapersonal communication. Through the promotion of inner harmony, the health and stability of the human system may be improved (Apple, 1989). From this perspective, the ability to impact the intrapersonal communication system may yield significant results at the cognitive and emotional level.

Intrapersonal Communication and Health

The communication scholar’s interest and impact in the ever-growing field of health has developed rapidly over the past 25 years. The expanding field of health communication emerged from the recognition that communication activities are embedded in health information and patient participation. In the early stages of health

communication's development, it was an achievement just to include communication as a key variable in the health care and delivery process (Kreps, 1988). Much of the work to date in the area of health communication has focused on the interpersonal aspects of physician and patient interactions and the dissemination of health information. Kreps, Kreps, O'Hair, and Clowers (1994) emphasized the need to directly link communication to health outcomes in research, thereby describing how communication affects health status. Kreps (1988) asserted that the meaning individuals assign to health and illness impacts the level of confidence and commitment individuals have in their treatment and care. He added that the interpretation of illness created through intrapersonal communication serves as a psychological and biological tool that influences the human regulatory process.

The intrapersonal communication site of meaning making and symbol composition has the capacity to impact health care choices, self-efficacy and commitment (Kreps, 1988). The modification of negative and critical self-talk, an intrapersonal health communication phenomenon, may have the capacity to impact self-efficacy and commitment, yet remains largely unexplored in the health communication literature. Unlike the concept of self-efficacy (Bandura, 1994), which has been embraced by health communication scholars and adopted from the psychologically driven health behavior models such as the Theory of Planned Behavior and the Theory of Reasoned Action (Ajzen, 1991; Ajzen & Fishbein, 1980), little work has been done in the area of self-talk. Self-talk differs from self-efficacy, a "can do" attitude construct, because it refers specifically to the content and nonverbal qualities of an individual's inner dialogue. The elicitation of self-talk is a phenomenological act that rejects preconceived understandings

in favor of a patient's own discourse. Self-talk refers to "talk" where the self is both the source and the object of interaction (Vocate, 1994).

Self-Talk Linked to Health States and Health Outcomes

Support for the link among self-talk, mental health states, and performance positions self-talk as an intrapersonal communication phenomena that connects the mind and body. Additional support for this contention is offered by Weikle-Blackwood (1995), who proposed a direct link between self-talk and health. She described self-talk as a system within the body.

The connection between self-talk and health stems from the belief that inner speech is another control system of the body. These systems include electrical, chemical and mechanical functioning that are linked to behavior. The language of intrapersonal communication is seen as a control system. Self-talk bridges the cognitive, emotional and physiological systems. Self-talk may be intentional or unintentional, silent or vocalized. Neither intentionality nor audibility affect its distinguishing self-awareness nor that the self is eliciting a response from itself as it would from another person on the other levels of human communication. (p. 103).

Berger and Luckman (1976) considered the "internal conversation between different segments of the self", a socially constructed process by which the available typifications in the world are internalized (pg. 73). As such, the internalized dialogue results from the interpersonal communication, which is alternately affected by societal, contextual, and cultural meanings. These interpersonal interactions within context produce what is used for personal dialogue. Berger and Luckman described how these interactions and the resulting influence constitute the "individualist" (p. 171). The individualist refers to the person who emerges from this communication interplay by selecting an identity among several that were made available. The availability of different world types to any given person may vary depending upon circumstance and the

dominance of one world view over another throughout a person's development.

Carving out a negative set of material, in essence, constitutes critical and negative self-talk. Perhaps the most well-documented aspect of self-talk within the psychology and performance literature is negative self-talk. Negative self-talk has been linked to negative mental health states, such as anxiety and depression (Kendall et al., 1989; Peden et al., 2001; Ronan et al., 1994), and has been found to correlate positively with poor sports (Van Raalte et al., 1994) and academic performance (Burnett, 2003; Burnett & McCrindle, 1999). Treadwell and Kendall (1996) have proposed that it is the absence of negative self-talk, not the presence of positive self-talk, that contributes to healthy psychological adjustment. Other scholars have concluded that it is not the frequency of either negative or positive self-talk but rather the ratio of positive and negative self-talk that may prove to be detrimental. Schwartz and Caramoni (1989) concluded that the optimal balance of positive and negative talk is .62 to .38, respectively.

Negative thinking has been considered a predictor for later development of depression (Peden et al., 2001). In addition, a patient population with comorbidity for anxiety and depression demonstrated the highest levels of negative self-talk (Ronan & Kendall, 1997). Negative and critical self-talk, including negative thinking, has been consistently related to increasing levels of affective distress.

An exhaustive investigation of self-talk studies in the field of communication revealed only a couple of studies associating self-talk and well-being. Interestingly, the only two studies establishing a link between self-talk and well-being were qualitative in nature and were conducted with African American populations (DeFrancisco & Chatham-Carpenter, 2000; Orbe, 2003). Orbe's study investigated the communication

experiences of first-generation African American college students. Scholars have likened the experience of African American first-generation college students to one of entering unchartered territory in which the student is a marginal member and, as a result, is in an ongoing process of negotiating identity (Orbe). Twenty-nine students participated as coresearchers in this phenomenological study consisting of focus group sessions. The theme of self-talk was one of four that emerged as central to the communicative experiences of African American first-generation students. Within the study, the concept of self-talk was akin to consciousness and portrayed as the deliberation and decision management processes of first-generation college students. Self-talk in this investigation was presented more as a site where insight, negotiation, and motivation took place. For example, self-talk was undertaken by the students to negotiate the pressures of being the first in their families to go college and to aid in sifting out an identity in that role. This description of self-talk is closely aligned with identity, yet remains unlike a proximate condition of self-esteem despite the fact that some deliberation outcomes may result in an enhanced sense of self.

The following study in communication draws a direct association between self-talk and self-esteem. DeFrancisco and Chatham-Carpenter (2000) conducted in-depth interviews with 21 African American women about the construction and maintenance of high self-esteem. The researchers juxtaposed the findings that negative media images, racism, and sexism pose unique challenges for African American woman. The researchers set out to understand how a sample of African American women viewed self-esteem and sought to qualitatively investigate what influenced the women's self-esteem. The researchers found that women in the study used self-talk to encourage a positive

outlook, pride, and respect. The women in the study shared what they said to themselves to cope with bad experiences and described how this talk allowed them to manage their life experiences. Additionally, self-talk practice was found to be transferred from one generation to the next as a part of the oral culture. DeFrancisco and Chatham-Carpenter concluded that the women's utilization of self-talk and the way in which it is intertwined with their relationships supports the perspective "that individuals can create and maintain self-identity and self-esteem through interaction" (p. 86). The conceptualization of self-talk as a builder of confidence and self-esteem in this study appears most similar to the studies within education while also symbolizing the potential of self-talk to embrace a positive disposition and affect similar to the work in the field of psychology. From a methodological standpoint, the discovery of self-talk through emergent themes in qualitative interviews is emblematic of its role as a phenomenological concept in communication, unlike its more typical usage as an assessment tool in psychology and the sport sciences.

The development and modification of self-talk demonstrates potential for behavior change, as described in the Extended Parallel Process model. Witte and Meyer (1995) claimed that many of the questions asked in the realm of health communication concern intrapersonal communication but are not recognized as such. They noted that self-persuasion or self-talk are involved in health adoption and behavior change. In Witte and Meyer's Extended Parallel Process model, they remarked that "the evaluation of a health threat initiates two self-talk processes, which result in either danger control (i.e., cognitive processes) or fear control processes (i.e., emotional processes)" (p. 372). According to the model, people will either talk themselves into taking action and protect

themselves or become overly stimulated by fear with accompanying self-talk and inertia. The effects of self-talk can either facilitate or hinder health behavior adoption. It is the only health communication model to date that specifically recognizes self-talk in the health decision-making process. Although the specific characteristics of self-talk, such as tone, volume, content, and emotional effect have only recently begun to be investigated (Konefal & Duncan, 2008), many support the notion that self-talk is an essential building block for meaning resulting from interactions that form the core for subsequent levels of communication (Burnett, 2003; Burnett & McCrindle, 1999; Johnson, 1984; Van Raalte et al., 1994).

Given the detrimental impact of excessive negative and critical self-talk, psychological interventions have targeted self-talk specifically as an area of intervention. Intervention studies of this type primarily have sought to increase positive self-talk and restructure negative self-talk which resulted in increased self-esteem and reduced depression and anger outbursts (Philpot & Bamburg, 1996; Seay et al., 2003). Studies examining the efficacy of cognitive behavioral interventions on the reduction of negative self-talk have found an increase in self-esteem and decrease in depression in treatment groups when compared to controls (Peden et al., 2001; Philpot & Bamburg). Other studies point to indicators such as locus of control, social phobia, anxiety, and self-actualization that have been enhanced through a reduction in the volume, tone, and location of critical self-talk or negative self-talk (Duncan et al., 1990; Konefal & Duncan, 1998; Konefal et al., 1992).

Illness Narratives

Within the context of an ill person's life, the concepts of self may be influenced by health care providers, other ill people, family, and friends. If the context and associations are positive, it is possible that the self-talk may reflect the same. Charmaz (1999) explained that, although it is difficult to change an internalized negative definition of the self, transformation is possible through repeated positive exposures. Through the shared stories and accounts of illness, identity and facets of the self are disclosed. These stories may include self-talk statements or references in language about past and present experiences that reveal the nature of the self.

The distinction between self-talk and narrative is primarily one of structure, since their common phenomenological orientation makes them similar in revealing the words that describe the experience of the individual. However, narrative methodology is open-ended, with ample room to build in the elements of storytelling by which people make sense of the events and actions in their lives (Reissman, 1993). Much of the work in the area of illness narratives has served to give voice to the patients' experience of illness and offset the dominant interpretation of illness by medical providers (Mishler, 1984). Several illness narrative investigations reveal that illness disrupts the biographical account of the self, whereby the person experiences a loss of the former self and negotiates new identities in the face of chronic illness (Bury, 1982; Charmaz, 1983; Kleinman, 1988). Illness is viewed as a threat to identity and the use of language through narrative is an attempt to restore the self (Bury, 2001). Charon (2006) studied how physicians actively participate as engaged audience for the goals of gaining valuable

information and honoring the patient. This type of work has led to a wealth of information regarding subjective illness experiences and transformations of identity for the chronically ill.

The study of illness narratives within health communication emerged in the 1970s. These narrative texts consist of stories and accounts of individual lives affected by chronic illness. Patient narratives in particular have dominated the literature as the chronically ill layperson has found a voice through narrative in a health care climate that Bury (2001) described as more democratic, where citizens are armed with increasing knowledge gained through technology. The surge of personal narratives is, in part, due to a backlash to the overwhelming influence of medical narratives produced by experts. These expert narratives once dominated the discourse of health and disease and, in the process, neglected the ill person's concept of illness. Increased attention to patient narratives occurred as the result of empirical work that provided analysis and data that detailed the interviews and exchanges between patients and physicians (Frankel & Beckman, 1989; Mishler, 1984; Reissman, 1990).

Stories of the sick serve a purpose for the teller and listener of the story. For the teller, it is a way of creating order and cohesion. "Storytelling makes possible a review and reevaluation of the person's life. By piecing the past together, a storyteller makes sense of the present and future" (Charmaz, 1999, p. 371). Mishler (1992) explained that, through personal narrative, one can analyze the process of identity formation. It is through the process of putting the story together that the representation of lived experience creates elements of what is knowable as identity.

How individuals recount their histories—what they emphasize and omit, their stance as protagonists or victims, the relationship the story

establishes between teller and audience—all shape what individuals can claim of their own lives. Personal stories are not merely a way of telling someone (or oneself) about one's life; they are the means by which identities may be fashioned. (Rosenwald & Ochberg, 1992, p. 1)

For the chronically ill person, the sense of cohesion and order is often threatened by symptoms, treatment, and general uncertainty. Mathieson and Stam (1995) explored the identity-altering self-narratives of 27 cancer survivors. The identity of the cancer survivors was assaulted through changes in interpersonal relationships, their sense of autonomy, and visions of the future. Using a grounded theory methodology, the researchers developed the following categories of self narratives: (a) signals of identity threat, (b) identity threat, (c) biographical work, and (d) renegotiating identity. The researchers asserted that with illness, self-narratives must be transformed. The transformation of narrative and the telling and sharing of narrative has multiple effects for the teller and the audience.

The narrative of a life interrupted by illness is more than a production for the teller; it also allows the listener to enter into the lived experience of being ill and generates alternative meanings of health and illness. Charon (2006) described two main functions that narrative has for the listener or reader: (a) the ability to understand deeply and (b) the task of honoring the patient by bearing witness to the suffering of the ill person. Charon admitted that listening closely helps her and other health care providers understand and treat their patients more effectively. Others contend that the most important thing one can do for the ill is to pay close attention to the meaning that the person attaches to the illness as an end within itself (Kleinman, 1988; Remen, 1994, 1996). This notion places an emphasis on the need that the deeply ill have for genuine empathy.

Investigations of illness narratives in the field of health communication and sociology have often resulted in categorization of narratives akin to archetype stories and journeys (Bury, 2001; Frank, 1998; Mosack et al., 2005). At times, the classifications align themselves with a progression through different chronic illness states, while others deny a sequential process composed of stages. Bury's exploration of chronically ill persons resulted in three narratives: contingent (those narratives which describe beliefs about the disease and effects on everyday life), moral (those narratives which serve to negotiate identity and change between the individual and society), and core (those narratives which reveal the meaning of suffering and illness at a deeper level).

Frank (1998) described three common illness narrative types of the deeply ill. He explained that illness narrative cores can typically be classified as restitution, chaos, or quest stories. It is noteworthy to mention that the stories are recognizable not only by the narrator's account but also by the emotions and reactions they generate in the listener. Restitution stories reflect the triumph over disease through treatment or medication. The ill person describes what occurred and how their illness was cured. The narrator plays a small role in this story, as the physicians and medication emerge as heroes and the illness is nothing to dwell on once it has been cured. Chaos stories are characterized by their inability to be told coherently due to lack of structure and incomplete sentences. A withdrawal response is elicited in the listener who soon feels as helpless and ineffective as the narrator. The quest story emerges when the teller embraces new aspects of the self that are present as a result of the illness. At its core, a quest story is about acceptance and reclaiming the self.

HIV Illness Narratives

Mosack et al. (2005) analyzed the illness narratives of 60 HIV-positive drug abusers. They established a categorization scheme composed of loss, benefit, and status quo orientation narrative description. They blended the three narratives detailed by Frank (1998) and explained the loss orientation as a narrative that included the description of symptoms and psychological distress associated with the HIV diagnosis. Focus and concerns about physical deterioration, haunting imagery about the virus, and body image preoccupation were evident in narratives of this type. The benefit orientation narrative described spiritual and physical gains made or received after the HIV diagnosis. These stories were filled with references to God and personal spirit because HIV made them straighten out their lives (i.e., quit drugs, rely on God, receive benefits such as housing and medical services). The status quo orientation narrative describes an acceptance of disease and eventual death.

Another narrative look at HIV was undertaken by Stevens and Doerr (1997). Thirty-eight HIV-positive low-income women were interviewed about their HIV diagnosis discovery stories. Three categories emerged that described the women's HIV discovery experiences: discovery as epiphany, confirmation, or calamity based on the multistage narrative analysis technique (Stevens & Doerr). Ten percent of the sample experienced HIV discovery as epiphany, which entailed seeing life with renewed meaning and significance. This categorization is similar to Frank's (1998) quest classification and the benefit orientation detailed by Mosack et al. (2005). Women's stories that belonged to this category described a shift as a result of the HIV diagnosis. Changes in their life included quitting drugs and reestablishing relationships. Thirty-

seven percent of the sample had a sense or a feeling that they would eventually find out that they were HIV-positive. A tone of resignation and expectation was common in these narratives of confirmation and seemed to often be just another hit along a long line of traumas and setbacks (e.g., abuse, homelessness, drugs, and incarceration). This classification most closely resembles the status quo orientation in Mosack et al.'s typology. Narratives of calamity upon learning of an HIV-positive diagnosis were the most frequent type of narrative to emerge in the Stevens & Doerr study. Fifty-three percent of study participants experienced HIV discovery as calamity. Emotional responses ranging from shock to fear and distress are emblematic of this narrative classification. Frank's chaos narrative and Mosack et al.'s loss orientation are similar.

Co-Construction of Illness Narratives

Often, there is intention on behalf of the provider/therapist/teacher who wishes to move the story towards the goal of clarity, coherence, brevity, and healing (Mattingly, 1994; Ricoeur, 1984; Sharf, 1990; Stevens & Doerr, 1997). The recognition that the co-construction of narrative has the power to change the practice of medicine is dawning. Eggle (2002) argued that an expansion of the nature of narrative within the medical interview should be broadened to include "the constructivist notion that the illness narrative is created by both participants in the interview rather than by the patient or by an objective truth" (p. 341). Fisher's (1987) narrative theory maintained that humans achieve knowledge and understanding through stories and storytelling. With its basis in social construction, narrative theory emphasizes that people tell stories to make sense of themselves and represent that self to others. The selection in language and structure is what differentiates each story and, through analysis, one can track identity and self-

perception. This paradigm of communication is well suited to studies of illness, which, by definition, is a patient's experience of disease, which can only be learned through personal disclosure of a story and not quantitatively measured and assessed.

Of particular interest to the present investigation are the few studies in which investigators have begun to map the co-construction of illness identities in varied contexts: physician-patient relationship (Eggly, 2002), therapist-patient relationship (Tilden, Charman, Sharples, & Fosbury, 2005), individuals in social support groups (Brashers, Neidig, & Goldsmith, 2004), and intrafamilial communication (Anderson & Martin, 2003). The analyses in the aforementioned studies described the identity transformation process through the analysis of the co-construction of narratives of the chronically ill.

Aside from providing a personal chronology and framework for identity, the telling of personal narrative can be therapeutic. The act of sharing the story with another can promote a means of catharsis and healing (Brody, 1987; Frank, 1991; Pennebaker, Kiecolt-Glaser, & Glaser, 1988). Anderson and Martin (2003) studied a husband and wife's narratives about cancer. Separate interviews with the wife (the cancer patient) and the husband revealed their roles, feelings, and assumptions about the impact of the illness on the family. The narratives themselves revealed their increased ease with communicating their personal narratives with each other and the extended family. The authors concluded that, through sharing of stories, the ill person and affected family members were able to participate more actively in the health care process. The level of activity was evident in the co-constructed shaping of the survivor identity for the wife. The husband and others with whom she shared her story influenced that identity.

The idea that others have the ability to aid in the construction of illness narratives for the ill person is exercised in narrative therapy. Muntigl (2004) noted that the function of narrative therapy is for the therapist to elicit raw experiences and then help the client reframe and reconcile these experiences in a way that is easier to manage and understand. The result, when successful, is an expansion of a person's worldview and a shift in behavior and attitude through narrative modification. Petraglia (2007) explained that narrative therapy can influence past experience and future expectations. However, this type of alteration is not exclusive to narrative therapy. Narrative reconstruction also occurs as a function of psychotherapeutic sessions through the retelling and reconstruction of more useful and fulfilling narratives (Schafer, 1992; White & Epston, 1990).

Some researchers have investigated the co-construction of illness narratives between patient and health care provider, physician and patient (Eggly, 2002; Sharf, 1990), and psychotherapist and client (Tilden et al., 2005). More recently, the medical establishment has used a patient-centered approach whereby the patient discloses information without constant interruption and freedom to describe his or her illness.

The most efficient approach [to eliciting the necessary information about the present illness] is to allow the patient to tell the story in his or her own words, while gently and behaviorally shaping the storytelling toward the necessary clarity, completeness, and brevity. (Lipkin, 1995, p. 71)

Lipkin explained that the patient's story is essential and that skill is required to elicit it with appropriate probes and questions to ensure a complete and clear picture that will be optimal for the physician and the client. It is an explicit statement that the

physician is an active participant in the narrative of the patient through gradual shaping of the story. This apparent medical model reflects a molding by the physician toward effective narration.

Eggly's (2002) qualitative study discovered co-constructions that expand on this simple framework. She used conversational analysis to analyze 21 narratives of physician-patient interviews. Using a narrative identification format derived from Labov (1972) and Polanyi (1985), Eggly discovered two general narrative categories within the interviews. In the first discourse strategy, the physician asked questions that clarify connections between events, even though no chronology of events was initially present in the patient's story. In the second strategy, the physicians used repetition to obtain a more detailed report of the patient's description therefore changing the length and quality of the account. The last discourse strategy is evidenced when the physician and the patient seem to disagree over the meaning of a particular event and the exchange proceeds until there is an agreed upon story. These stories and accounts did not contain the required elements described by Labov and Polanyi initially, as told by the patient, but through the question and answer session, developed into a narrative that contained the elements for narrative criteria. Based on these findings, the researcher emphasizes that the narrative definition should be expanded to include all interaction and stresses that narrative is co-created through the interaction of both participants in the interview. This expanded definition is applicable to self-talk statements and their co-construction.

Sharf (1990) applied a rhetorical narrative approach to the study of physician-patient communication. She evaluated the communication exchange as rhetoric, a persuasive intent by the clinician to make the patient take an action, such as follow a

medication regimen or quit smoking. She noted that the patient often has his or her own agenda. Thus, the encounter may demonstrate attempts to influence by both parties. She underscored the importance of evaluating the patient's, physician's, and final narrative, suggesting that the absence of influence on each other's narrative is not likely to lead to a favorable health outcome. The co-construction by patient and physician of a health narrative is prescribed as the rhetorical goal.

Tilden et al. (2005) presented a case study illustrating the co-construction of identity of a person with diabetes who was not adherent to medication. The case study tracks the diabetes patient across seven psychotherapy sessions. Giorgi's (1989, 1994, 1997, 2006) phenomenological method was used to guide the analysis of the study. The findings revealed two themes: (a) the rejection of a diabetic identity and (b) the integration of a diabetic identity. The self-expression of the young adult with diabetes was tracked through language and experienced a transformation from "I don't matter" to "I do matter" in therapy. The language and communication exchanges presented in the findings reflect the revised sense of importance, which was accompanied by adherence to medication. This qualitative study contributes to the literature on illness narrative and identity in the following ways: (a) it tracks the process of change that led to the co-construction of a revised identity and (b) links co-construction of identity to medication adherence in a diabetic patient. This investigation into the role of identity co-construction and adherence to medication represents a limited area of research with the chronically ill. HIV-infected individuals face similar demands for medication adherence, yet no study to date has examined the impact of self-talk and illness narrative co-construction on HIV-infected individuals' coping and adherence.

Living With HIV

The diagnosis trajectory of HIV has been altered from fatal prognosis to chronic illness in the past decade. The development of antiretroviral medication in 1996 led to reductions in mortality and associated morbidity for individuals infected with HIV. The protease inhibitor drug combinations commonly referred to as HAART demonstrated decreases in HIV viral load and led to immune reconstitution through increases in CD4 cell counts in HIV-positive individuals. The relationship between the use of antiretroviral therapies and the decreased risk towards the progression of Acquired Immunodeficiency Syndrome (AIDS) has been well documented (Bangsberg et al., 2001; Cook et al., 2004).

Despite the advances in treatment, the challenges associated with living with HIV persist and do not appear to be any less distressing than in the past (Kennedy, Rogers, & Crossley, 2007; Siegal & Lekas, 2002). Depression, anxiety, and negative self-esteem issues often accompany an HIV-positive diagnosis. These issues are often compounded with the rigors of medication adherence. Even minute variations in adherence play a critical role in determining the success or failure of antiretroviral therapy (Chesney, Morin, & Sherr, 2000; Perno et al., 2002; Van Vaerenbergh et al., 2002). There is the additional risk that those adhering at suboptimal levels will develop mutant strains of the virus (Bangsberg et al.). The development of mutant strains would prevent adequate treatment at the individual level and the possibility of transmission of a drug-resistant virus at the societal level.

Much of the recent HIV-related literature has focused on identifying predictors and variables associated with adherence. Nonadherent individuals are more likely to be depressed (Catz, Kelly, Bogart, Benotsch, & McAuliffe, 2000; Murphy et al., 2001;

Safren et al., 2001). Alternately, positive state of mind (PSOM) (Horowitz et al., 1988), a measure that assesses individual's capacities to enter positive cognitive and interpersonal states over the previous week, and self-efficacy, defined in a specific study as, "How sure are you that you will take your medication over the next 4 weeks?" have been positively correlated with adherence (Simoni et al., 2006).

A review of intervention studies targeting HAART adherence among HIV-positive individuals indicates moderate success (Wagner et al., 2006). In the studies that do demonstrate increased adherence, very little is known about the mechanisms of action that increase self-efficacy and encourage different states of mind. The most commonly investigated intervention approach is cognitive behavioral therapy. Cognitive behavioral approaches emphasize rational thinking, the consideration of pros and cons, and negative and positive behavioral consequences. This therapeutic approach stems from a conceptualization of humans as primarily cognitive beings, responding and behaving based on their thoughts. These rational-world paradigm interventions endorse the use of educational materials and skills building, which reinforce the notion that increased knowledge and rational decision making will beget behavior change. However, it is probable that the omission of the emotional aspects of a condition result in only moderate change because the condition has not been addressed holistically. The human mind as an integrative unit, inclusive of the cognitive, emotional, and volitional processes suggested by Bateson (1972), may advance interventions that are responsive to the various components of the integrative unit that is a human within the healthcare system. According to Bateson, to break up the processes is wrong and unhealthy. Thus, to focus

on the cognitive processes without considering its interdependence with emotions and the needs or goals of the individual are likely to result in limited influences, at best.

SAB Intervention

Dr. Janet Konefal, director of the University of Miami Center of Complementary and Alternative Medicine, developed the SAB intervention, based on her interest and experience with mental health counseling and acupuncture, to treat mental as well as physical health conditions. SAB interventions have targeted the relief of negative emotional states and the enhancement of listening, seeing, and defensive internal patterns. The SAB clinical interventions have addressed the improved clarity, enhanced sensory reception, and emotional relief with an adult population experiencing moderate psychological problems. The development of Dr. Konefal's SAB therapy results from over 20 years of experience working with diverse populations, including HIV-positive individuals. Konefal (2005) is concerned with intrapersonal and interpersonal communication patterns and how they influence how information is stored and received. Konefal assumed that language patterns can enhance or hinder a person's behavior, thinking, relationships, or emotions. Language and images are those symbols used to construct models of the world, which we store in our brain and nervous system. Through the manipulation of stored symbols, physiology and physical sensations associated with remembered or constructed experiences can enable individuals to change their emotional and intellectual reactions of an experience.

Konefal and Duncan(2008) combined the use of behavioral counseling and acupuncture to create SAB. As a result of her experience, she transitioned modalities from acupuncture to acupuncture to enhance patient comfort by eliminating the small

possibility of HIV transmission by acupuncture to reduce pain and the induction of pain in this patient population known to have frequently untreated or under-treated pain states (Briebart et al., 1996). Acupressure uses the basic acupuncture points and is based on the same theoretical foundations as acupuncture (i.e. the manipulation of meridians and acupoints). It may be categorized with acupuncture, with the exception that acupressure does not involve the use of needles. Acupressure is based on the practices and theory of traditional Chinese medicine, which involves the stimulation of acupuncture points through finger manipulation, which may include pressure, tapping, or holding a meridian point. The pressure may be gentle or rigorous, depending upon the purpose for stimulating the meridian point. Meridian points act as doors to the body's pathways (e.g., internal organs, tissues). The meridian points are stimulated to allow for balance and health in the body through the smooth travel of life energy, Qi (Hsieh, Kuo, Yen, & Chen, 2004).

Although the mechanisms of action for acupressure are not fully understood, evidence suggests that the stimulation of acu-points can generate a release of opioid peptides and affect the secretion of neurotransmitters and neurohormones (Takeshige & Sato, 1996; Wu, Zhu, & Cao, 1995).

Acupressure has been used clinically to reduce negative mental health states and has also been associated with positive health effects. The therapeutic use of acupressure or application of finger pressure to meridian points has gained support as an intervention for mental (Diepold, 2000) and physical symptoms (Collins & Thomas, 2004; Hsieh et al., 2004; Tsay, 2004). Separate studies have found acupressure effects to lower anxiety in prehospital emergency settings (Kober et al., 2003), improve sleep quality and life

quality with elderly institutionalized residents (Chen, Lin, Wu, & Lin, 1999) and patients with end-stage renal disease (Tsay & Chen, 2003; Tsay, Rong, & Lin, 2003).

Physiological effects after acupuncture demonstrated altered EEG patterns and decreased stress in a sample of healthy volunteers (Fassoulaki, Paraskeva, Patris, Pourgiezi, & Kostopanagiotou, 2003); changes in heart rate and skin conductivity were also evident after employing acupuncture for cancer survivors. These results were parallel with improved scores of impact of event scales and substance use disorders (Monti, 2003).

Research Questions

As HAART enables longevity for people living with HIV, illness identities continue to reform. The exploration and analysis of the co-construction of self-talk and illness narratives has the potential to improve the lives of people living with HIV. The analysis of therapist interactions with people living with HIV will shed light on the co-construction transformation process, as evidenced through changes in critical and negative self-talk and illness narratives.

Tilden et al. (2005) used a longitudinal and sequential analysis of multiple therapy sessions. The SAB case study consists of multiple sessions as well, with eight intervention sessions in total. Two participants, both HIV-positive, nonadherent to medication, and endorsing negative and critical self-talk completed the SAB intervention. The data collected and analyzed consisted of transcriptions of videotaped intervention sessions. The overarching research question for the current study asks how self-talk and illness narratives are co-constructed between the therapist and participants.

The purpose of this case study was to understand how the self-talk and illness narratives of two HIV-positive women were co-constructed during a SAB intervention.

The SAB intervention emerged in response to a request by local health care professionals who wanted a complementary therapy approach to reduce the negative and critical self-talk present in HIV-positive young adults.

To guide the inquiry, two specific research questions were set forth that promote the advancement of the co-construction of self-talk and illness narratives between patient and health provider (Eggly, 2002):

RQ₁: What co-construction communication patterns emerge during the SAB intervention?

RQ₂: What narratives and co-constructed narratives emerge in the SAB intervention?

CHAPTER 3. METHOD

Design

According to Yin (1994), a case study has intrinsic worth when the subject matter has been previously inaccessible to scientific observation. In these cases, “the descriptive information alone would be revelatory” (Yin, p. 41). Case studies may be used to explore in depth a program, a process, or one or more individuals bounded by time and activity (Stake, 1995). In this case study, the main unit of analysis includes the complete transcriptions of eight intervention sessions involving the verbalizations of two participants and one therapist. Each participant’s intervention is an embedded case study within the larger intervention unit of analysis.

Recruitment

Upon receiving Institutional Review Board approval, HIV-infected participants over age 18 were recruited through an outpatient services center in the southeastern United States. Prior to beginning recruitment, I met with the staff to describe the research objectives. Eligible adults at the clinic were informed about the study by the nurse practitioners, a peer counselor, and a case worker at the outpatient services center. I met with interested adults at the clinic to describe the study and determine eligibility. The study had five inclusion criteria: (a) adults age 18-25, (b) English-speaking, (c) HIV-positive diagnosis received 6 or more months ago, (d) adult self-reports that he or she is not adherent to medication regimen, and (e) adult recognizes and reports critical/negative self-talk.

Four criteria excluded an individual from participation: (a) incarcerated individual or under court order, (b) HIV-positive diagnosis and in 100% compliance with medication regimen, (c) under age 18, (d) Non-English speaking.

Participants

Two females, ages 24 and 25, completed the SAB intervention. Both women were diagnosed with HIV during their teenage years. Both were victims of sexual abuse as children and believe they were infected as children. The women were single, one had a child, and both were employed full-time at the time of the study.

Therapist

Dr. Janet Konefal is a psychologist and developer of the SAB intervention. She conducted the SAB intervention for both women. Konefal has conducted individual and group therapy for over 25 years. She is employed at the University of Miami and is the assistant dean of Complementary and Integrative Medicine.

Procedures

As the sole researcher in the study, I provided all adults that met the inclusion criteria and expressed interest in the study with an informed consent form, a videotape consent form, and a HIPAA form to read. I read and explained all of the forms and answered all questions. The adults were then informed that they could sign the consent for participation in the study if they understood and agreed with the information in the consent form. All adults that agreed to participate signed the consent form. I assigned an ID code to the participant at that time. The participant was then scheduled for four individual intervention sessions with the intervention therapist to take place during consecutive weeks. Each intervention session lasted approximately 1 hour. I sat quietly

during the session and videotaped the interaction. The first follow-up interview was scheduled 2 weeks after the fourth intervention session. That session lasted approximately 1 hour. A second follow-up interview was scheduled four weeks after the fourth intervention session. That session also lasted approximately 1 hour. All participants received movie coupons for each intervention session and follow-up interview they attended.

Confidentiality

The consent forms and screening forms (which contained name and other identifiers) were filed in a cabinet that was separate from the study data cabinet. The data files did not contain names or other identifying information. A study ID number was used to ensure confidentiality. The videotapes collected throughout the study were kept for the study investigation and analyses. All materials associated with the study were stored under double lock within file cabinets.

Sequential Acupressure and Behavioral Intervention

The SAB four-session intervention developed by Dr. Konefal targets the enhancement of sensory reception and clarity through behavioral counseling and acupressure techniques. The intervention addressed four topic areas that were deemed critical based on the feedback from the nurse practitioner at the adolescent medicine clinic that indicated that HIV-infected young adults reported negative and critical self-talk about their HIV/health status, self, medication, and the future. Each topic was addressed twice during the four-week intervention. Open-ended questions, such as, “How do you feel about your health status?” “How do you feel about yourself?” “How do you see yourself in 20 years?” and “What do you say to yourself about medication?” were

designed to elicit the patient's self-talk, personal narratives, and internal images. Upon eliciting the participant's self-talk and narratives, the therapist intervened with behavioral counseling and/or acupuncture techniques to aid the participant in explaining past experiences succinctly and clear any negative emotional charges. The techniques were also used to generate images of the future. During the first session, the therapist explained that she would use acupuncture on the participants head and shoulders to assist the participant in hearing or seeing things more clearly and to help the participant overcome negative emotional states.

Specific behavioral counseling techniques consisted of visualizations, metaphors, and the identification of "yes, but" patterns in language and shifts to the use of "and." Visualizations are imagery techniques used to frame and reframe the past and the future. The participant was asked to create mental images of a past or future situation or experience in order to view it in a way that aids the individual in staying resourceful and free of negative charge. Konefal (2005) defined metaphors as "a way of verbally communicating a concept by expressing it in terms of another word, phrase or story" (p. 75). Konefal did this by sharing sayings and stories of herself or a friend in an effort to broaden the participant's perspective. Visualizations and metaphors are techniques designed to develop new ways of representing past, present, and future experience. The therapist also identified yes, but patterns in language and urged the participants to replace "but" with the word "and," since the yes, but pattern effectively shut out alternative viewpoints.

The acupuncture component of the intervention consists of the following six corrections: (a) listening (ears); (b) seeing (eyes); (c) defensive (mouth); (d) yes, but

correction; (e) self-sabotage/self-destruct; and (f) emotion. Prior to the application of any acupressure sequence, an internal congruency response (ICR) test is conducted to determine the particular acupressure technique that is warranted. All acupressure techniques in the intervention address the nervous system, the endocrine system, and the left/right side of the brain. The ICR is conducted as follows:

1. The therapist repeats the statement uttered from the participant or verbalizes a statement relevant to the nature of the negative or critical self-talk as the participant extends one arm.

2. The therapist then applies pressure on the arm above the wrist, while asking the participant to resist. If the muscle goes weak in conjunction with a particular statement, the participant is in need of acupressure correction that corresponds to the body location and corresponding pattern.

3. The therapist proceeds to ask the participant to place his/her finger(s) on one of the following location(s): (a) on each ear, (b) on the eyebrow, (c) mouth, or (d) tip of the participant's tongue. An ICR was conducted for each location. If the arm goes weak while the participant is touching his/her ear, that indicates the need for a listening correction. ICR that is incongruent while the participant touches his/her eyebrows indicates the need for a seeing correction. Incongruence while a participant touches his/her mouth indicates the need for a defensiveness correction. Incongruence while the participant touches the tip of his/her tongue indicates a yes, but correction.

4. The sequence is stopped when the ICR is incongruent with one of the symbolic locations.

For each body location, the therapist will ask the participant to extend one arm. The ICR is again conducted at the end of the correction to test congruity with the same statement, emotion, and/or issue. The ICR is not a test of strength, but rather measures the agreement between the participant's physical and internal state.

The listening, seeing, and defensive and yes, but corrections have similar sequences and will be described. The listening correction is used when the participant has difficulty listening to him/herself or others. For example, a person who is unable to incorporate the suggestions of a doctor may be experiencing internal dialogue interference, a loud and harsh voice that says, "Be wary of doctors." The goal is to identify the talk that keeps the participant stuck and unable to achieve his/her goal. However, instead of talking the participant through the explanation, the therapist employs an acupuncture technique that enhances the sensory mode. Throughout the entire correction, the participant is asked to place one finger loosely on his/her left or right ear. The left ear correction helps integrate the information heard, while the right ear correction helps the participant hear the information. The therapist places a finger on the nervous system point between the eyebrows (glabella) and gently presses both sides of the participant's head above the ear three times, on the participant's inhalations. Next, the therapist touches the endocrine points (using a finger on each side of the bridge of the participant's nose) and places the palm of the hand on the participant's occipital lobe. The therapist gently pulls upward three times on the participant's inhalations. Next, the therapist touches both the left and right sides of the participant's forehead. Finally, the therapist gently taps the C4-T4-T8 vertebrae while the participant breathes gently.

The seeing correction is used when a person has difficulty looking at something—real or imagined. The image may be remembered or constructed or appear in language with a strong visual component. As in the listening correction, the visual interference may keep the participant in a nonproductive emotional state. For example, a participant may say, “It is like a brick wall.” Feelings of helplessness and exhaustion associated with this image may prevent a person from achieving his/her goals. There are three parts to this correction that are administered while the participant pushes gently upwards on the midpoint of each eyebrow. The therapist places a finger on the glabella and gently presses both sides of the head above the ears three times on the participant’s inhalations. Then, the therapist places a finger on the endocrine points (one finger on each side of the bridge of the participant’s nose) and gently pulls upward on the participant’s occipital lobe three times on the participant’s inhalations. Lastly, the therapist touches both the left and right sides of the forehead and gently taps the C4-T4-T8 vertebrae while the participant breathes gently.

The defensiveness correction is used when a person is defensive in action or word. Defensiveness often serves as a visual or verbal block, which disrupts the participant’s ability to hear and see things clearly. First, the participant is asked to place one or more fingers loosely over his/her mouth throughout the duration of the correction. The therapist places a finger on the nervous system point (glabella) and gently presses both sides of the participant’s head above his/her ears three times on the participant’s inhalations. Next, the therapist places a finger on the endocrine points (one finger on each side of the bridge of the participant’s nose) and gently pulls upward on the participant’s occipital lobe three times on the participant’s inhalations. During the last part of the

correction, the therapist touches both the left and right sides of the forehead and gently taps the C4-T4-T8 vertebrae while the participant breathes gently.

The yes, but correction is used when a person interrupts or cannot listen to what is being said or is using “yes, but” in their language. A yes, but may block the clarity of verbal messages. Throughout the correction, the participant maintains one finger on the tip of his/her tongue. The therapist first places a finger on the nervous system point (glabella) and gently presses both sides of the participant’s head above his/her ears three times on the participant’s inhalations. Then, the therapist places a finger on the endocrine points (one finger on each side of the bridge of the participant’s nose) and gently pulls upward on the participant’s occipital lobe three times on the participant’s inhalations. Lastly, the therapist touches both the left and right sides of the participant’s forehead and gently taps the C4-T4-T8 vertebrae while the participant breathes gently.

The self-sabotage/self-destruct and emotion corrections involve different acupuncture sequences. The self-sabotage and self-destruct correction is used when a participant has self-destructive tendencies or self-sabotage patterns. The self-sabotage and self-destruct correction requires the therapist to conduct an ICR. If the arm goes weak for the ICR, the therapist can proceed with the correction. The therapist touches the tip of the base of the sternum (xiphoid), liver point, and spleen point and upwardly flicks the mid-brow point in this sequence. An ICR is conducted again. If weak, the therapist very gently rubs his/her fingers back and forth over the full forehead for 15-20 seconds. The ICR is conducted again. If the response is weak, the correction is repeated, but this time the touch point locations are touched twice. The therapist keeps repeating the process, increasing the touch by one each time until the ICR test is congruent.

The emotion correction is used when the participant is in an emotionally charged state. The pulses can be used to identify the emotions involved in the situation. The pulses are used in conjunction with ICR. First, the therapist tests using the ICR and then lists the negative states or factors associated with the negative state. An extended arm with negative state should go weak during ICR. The therapist gently touches one of the six pulse points and tests ICR. The ICR test in relation to that pulse point (organ and emotion) will make the muscle go strong. The therapist will go through all six pulse points listed until the charged pulse point is located. The therapist will refer to a chart corresponding to the pulse point that countered the weak muscle. This is also referred to as an emotion check. The muscle will go weak on the emotion involved in the negative state. The therapist will clear the emotion, elicit the negative state, have the person hold the identified pulse point, and then place the same hand across the forehead. The participant remains in this position and breathes. The participant stays in this position until the negative state has cleared or has reduced significantly.

The therapist may also use a consistency check that checks head-to-heart consistency or discrepancy before or after the application of acupressure corrections or behavioral counseling techniques.

Data Collection

The intervention sessions were conducted at a university in the southeastern United States. All intervention sessions were videotaped and I was a silent observer and note recorder during the intervention sessions.

Data Analysis

Two research strategies guided the interpretation of the transcribed intervention sessions. A phenomenological thematic analysis (Giorgi, 1989, 1994, 1997, 2006) and a narrative inquiry guided by Eggly's (2002) format for identifying narratives were conducted. Giorgi's (1989) phenomenological method for thematic analyses seemed fitting for a study of co-construction that observed the negotiated reality between the therapist and participants. The essence of phenomenology seeks to uncover the meaning and structure of a human phenomenon through the identification of essential themes. The lived experience of the participant, his/her reality, and the essence of his/her experience is paramount within this framework (Van Manen, 1990). Husserl (1964) founded the philosophical method of phenomenology. Its application in the social sciences includes the adoption of the phenomenological attitude, an encounter with the phenomenon, and a description of the essence of said phenomenon. Giorgi (2006) added that a disciplinary attitude be used when observing the phenomenon so that field-specific language and perspective would evolve. According to Giorgi's method, the first step includes a reading and subsequent rereading of the transcripts. A second step involves the intuitive identification of meaningful units in the data. The last step involves a synthesis of the transformed units of meaning to reveal the structure of the phenomenon of co-construction. In order to adhere to the phenomenological method, one must bracket one's personal experience and concentrate solely on what is being observed as the phenomenon.

The two types of narratives modeled by Eggly (2002) in her investigation of physician-patient co-construction of illness narrative were used. One set of narratives

sought were those that follow the adapted structural model of Labov (1972) and Polanyi (1985) criteria for defining narrative. The first set of narratives were easily identified as narrative due to their adherence to the narrative format. These narratives were tagged when the story included a temporal juncture, the story was coherent and relevant to the medical encounter, it had an introduction that related it to the conversation, a clear chronology of events was present, and the point was made effectively. On the part of the physician, certain guidelines were also required to meet narrative criteria. The physician had to listen to the story, refrain from interrupting in a way that detracted from the story, and had to demonstrate understanding of the objective of the story (Eggle). The other set of narratives were identified as co-constructions. These excerpts displayed negotiation of meanings between the physician and patient around the chronology of events, the elaboration of key events, and the meaning of key events.

Validity and Accuracy of the Findings

Aside from the explicit descriptions of the operations of a case study to ensure replication, little else can be attributed to the reliability of the results, as is common in quantitative research endeavors. Instead, the strength of this case study and qualitative methods may be gained from its ability to generalize to theory, what has been termed by Yin (1989) as “analytic generalization” (p. 32). Another strategy implemented in this study included the researcher bias disclosure or “bracketing,” a standing back and taking stock of one’s own personal experience to discover one’s own “taken-for-granted assumptions” (Giorgi, 1994, p. 214).

CHAPTER 4. FINDINGS

Three separate findings sections will be presented. First, the co-construction phenomenon themes of the SAB intervention will be discussed. These findings will be followed by Roberta and Nancy's (pseudonyms) illness narratives obtained by using both an adapted Labov (1972) and Polanyi (1985) narrative format and a nonconforming narrative criteria. Lastly, the number of acupuncture and standard behavioral counseling techniques used by the therapist per session and topic are presented.

Co-Construction Themes

Giorgi's (1989, 1994, 1997, 2006) phenomenological method revealed three major themes that appeared central to the process of critical and negative self-talk reduction and narrative co-construction during the SAB intervention: assessing the present, reviewing the past, and forging the future. The first theme, assessing the present, focused on the establishment of a safe atmosphere, participant and therapist disclosure, and the negotiation of meaning. The second theme was characterized by the participants' sharing of past experiences. Self-talk and narratives that linked present self-talk and patterns of behavior to old attitudes and behavior patterns were reviewed and reframed into more useful self-talk and illness narratives. These modified texts and images allowed the participant to have greater mental flexibility and access to positive mental resources. The third theme, forging the future, was the part of the process in which the therapist encouraged the practice of positive self-talk and visualizations of future images.

Assessing the Present State

Several essential components collectively served to assess the present state of the participant. The present state referred to the participant's current self-talk, narrative, and

corresponding emotions, attitudes, and behavior towards a particular situation or topic. The subthemes of creation of a safe atmosphere, frequent disclosure, and the understanding of and subsequent negotiation of meanings enabled this assessment.

Atmosphere

At the beginning of each session, the therapist asked the women how they were doing, if they had noticed any changes since the previous session, and what were the issues they wanted to work on in addition to the planned topics. During this time, the therapist and participants engaged in question and answer and the therapist seemed intent on creating an atmosphere of safety and comfort. Early on in the first session and scattered randomly throughout the other sessions, it is noted that the therapist's (T) interactions with Roberta (R) and Nancy (N) were empathic, supportive, and replete with praise. An example of this is evident in Session 1 with Roberta:

T:1-1: And I am just touching some acupuncture points and you'll notice that some points stay strong and some points, it goes weak. If you said, "My name is Roberta..." arm stays strong. Now, if you say, "My name is Janet," the arm won't stay strong because you're not congruent. It is not your name. Okay, give your arm a rest. It is not about whether you are telling the truth or not because if you believe something that's inaccurate, the arm will stay strong because you are congruent with it.

R:1-2: Like self-truths....

T:1-3: Yes! I like that. I am going to say that. May I use that in class?

The therapist introduces a technique to be used throughout the intervention. The explanation is explicit. Roberta's response indicates that she understands the process and the therapist replies enthusiastically with a compliment. In addition to the use of compliments as ice-breakers, the therapist responded with praise and admiration as the participants shared details about their lives. In the following excerpt, Nancy discloses that

her stepfather sexually abused her as a child and that her mother, unaware of the abuse, refused to believe her. Nancy tells the therapist that she was infected with HIV by her stepfather. In the following excerpt, the therapist listened closely and responded with praise as Nancy shared details about her current relationship with her mother.

T:1-90: That's angry, resentful. Good. So I want you to go there, that angry vulnerable, resentful... (Emotion correction) Angry. Breathe through it. How can she continue denying it? Let's check the arm.(ICR muscle test) Let's think about Mom, how even though she was unable to protect and take care of you, you are now protecting and taking care, despite whatever angry, resentful, hurt feelings you had. (ICR muscle test—arm goes weak) (Visualization correction) What do you think that says about you that you can do that?

N:1-92: I am a good person, 'cause if I can overlook that, the fact that she did that and that happened to me, because now I have something that I have to live with my whole life, that is not going to go away, and I overlook that and care for her. I'm a very good person.

T:1-93: I think you are a remarkably good person. (ICR muscle test) There is anguish, anguish comes up. (Emotion check) (ICR muscle test—goes weak) Anguish that you have the virus and it is going to stay with you. (Emotion correction—anguish) Because having the virus 20 years ago, it's certainly different today. Today, most people go about their business. When they need to, they have medication they can take. Have new research coming up all the time (ICR muscle test) with less and less side effects. So go back one more time and think about the fact you are now taking care of your mother who couldn't take care of you and you can get strength from that....My way is a pat on the back for doing that.

N:1-94: (Pats self on back)

T:1-95: It is quite an accomplishment....

The therapist asks the participant to view herself and uses an acupressure visualization correction to enhance this sense. The therapist prompts a process of participant-generated self-praise. As a result, the participant generates positive statements about herself. The therapist offers a nonverbal option for feeling good about oneself. It serves as a model behavior that offers the participant an alternative symbol for feeling

good. It is important to mention that, during this exchange the therapist uses emotion corrections to clear the anger and anguish generated by the relationship with the participant's mother. Once cleared, the positive emotions and self-talk can take root.

Disclosure

The therapist and the participants each engaged in active disclosure in the form of prompted and unprompted instances of self-talk and personal narratives about career, health, and self. The participant disclosures were surface-level at times and, as a result of verbal probing and the application of standard behavioral counseling and acupressure techniques, the disclosures subsequently became more detailed and were intrinsically linked to other topics and emotions. Disclosure served the function of providing information about a particular thing or event in addition to providing insight into the participant's perspective and view of the world. The participant's disclosure described the participant's current state, while the therapist's use of disclosure facilitated rapport and provided the participants with examples of alternative perspectives. In the following excerpt, Roberta responds to questions about her health status:

T:1-32: Oh, you got a sweet tooth. (ICR muscle test—strong) So you have clarity now about what the issue is. So this sweet tooth, what is that?

R:1-33: I like sweets. Anything sweet.

T:1-34: How often do you eat sweets? Do you eat sweets for breakfast? (ICR muscle test—weak) Notice what sweets do, eating sweets. (Emotion test) Sadness, grief, anguish, hmmm.... So the concept that you are defensive about eating sweets. Well, you know they are not good for you...

R:1-35: No, I don't think I am defensive. I know I eat sweets as a way, I started eating sweets when I got molested, and that is how I used to feel comfortable. That used to be my thing. I would eat sweets and feel okay. That used to always be my thing. Sweets have always been my comfort food.

Note that in this interaction, although occurring during Session 1, Roberta discloses being molested as a child. There appears to be enough safety in the interaction for Roberta to challenge the therapist's assessment of her defensiveness, an assessment that was conducted through acupuncture testing for emotions. Roberta disagrees with the assessment only to reveal a deeper connection to the impact of sweets in her life.

During the intervention, the therapist also disclosed personal narratives and other metaphor stories to assist the participant in the framing of topics that seemed to be beyond the participant's current understanding. These instances were particularly relevant to the participant's present feelings about the future. For Roberta, her desire to go to the Navy was impeded by her HIV status. The therapist encouraged Roberta to think of other options. The task proved somewhat difficult at first, but Roberta did generate alternatives. The following excerpt demonstrates the therapist's use of a personal narrative to aid Roberta in achieving a modified conceptualization.

R:1-126: I don't know. I still don't know what I want to be.

T:1-127: Well, you want to be careful with what you want to be because that sounds like once you pick it, you can't change it. You might think about who you are and what you want to do next because what you want to do next might be good for a year a couple of years or maybe your whole lifetime or maybe that will be something else you want to do next. So we want you to look for something, but not necessarily be looking like that is the only thing. That will be the next thing you are going to do. Does that make sense?

R:1-128: Okay.

T:1-129: Well, does it make sense? What you are going to do rather than what you are going to be?

R:1-130: It doesn't sound like a career.

T:1-131: Well, so is what I do a career? I work here at the university.

R:1-132: Depends on how you feel about it.

T:1-133: For me, it is what I do. It is a career, it is what I do. My next career is I'm going to be an artist. I am going to go paint or sculpt. I am still going to be Janet. What I am going to do is different. I am going to have another career and what I did before I came to the university was I was a school teacher in the public school system. That was what I did, but who I was still Janet.

R:1-134: Don't know....

T:1-135: Different way to think about it. Kind of expands your possibility. (ICR muscle test)

The therapist's personal career narrative offers Roberta a frame for understanding that what she does for work does not have to be who she is. This understanding provides Roberta with a broader perspective on career choices and potentially less emotional charge regarding the career choice.

Negotiating Meaning

During the intervention, several key definitions were subject to negotiation between the therapist and the participants. It was precisely during the negotiation of meanings of the topics of sickness/health, medication, and the self that the next therapeutic goal of either investigating the past or generating visions of future experiences was determined. However, prior to any negotiation, several conditions were established in the interaction. A safe and welcoming atmosphere where compliments, praise, and empathy was commonplace preceded both Roberta and Nancy's disclosures and subsequent negotiations of meaning. In the following excerpt, Roberta and the therapist negotiate the meaning of red marks and corrections on written work.

R:2-88: I don't know why I end up writing her papers. I don't think I am good, but I always end writing her papers. But I still don't think I am that good.

T:2-89: What is that good?

R:2-90: Good enough to make an A. I can pull off a C, but I can't make an A.

T:2-91: Okay and what would it take?

R:2-92: I guess I would get tutoring, be willing to have someone else edit my work without feeling bad about it.

T:2-93: So, not feeling bad. (Emotion check) Lost, vulnerable, somebody else sees your mistakes, you are vulnerable, you are at risk. What would they do? Put red all over the paper?

R:2-94: I hate that I freak out over that, you know. If I put all that effort into writing it, and they have reds all over it. That's....

T:2-95: (Visualization correction) Well, I want you to look at the red on the paper, all of that red, breathe through that red. Because every red mark on that paper is something for you to see. Every red mark is something for you to learn. It is an opportunity that someone who is good in English is giving you. When I first started here at the med school, writing very differently from the way the rest of the world writes.... It is very scientific, it is very, um, detailed. It has a lot of structure and form and I wasn't aware... not how I wrote before I got here. So my proposals and papers would come back with more red than what I wrote. But it was something I appreciated, gave me direction, and told me what to do. Just something for you to think about.

R:2-96: I don't have a problem with the writing, it is the editing. (Listening correction—Left) I freak out when they do the whole thing, paper, in red. I feel that nothing I did was good enough if they had to edit the whole thing. That means that not even one paragraph was good.

T:2-97: So what is your opportunity?

R:2-98: I learn from it, but....

T:2-99: There goes that yes, but again.... (Yes, but correction) I learn from it and.... Do that one again. So there is red all over the paper and....

R:2-100: I learn from it and I rewrite it but they still put more red on it.

T:2-101: Still but, still but. Hear that but.... Okay, so change that to and. And I rewrite it again and....

R:2-102: I get a better grade.

T:2-103: Oh, you get a better grade. Did you learn something else?

R:2-104: Actually, I learned a lot of rules. If they explained why they changed something. Sometimes, they don't explain why they changed it, but if they change and they explain to me, then I get it. It can be incorporated into what I know.

T:2-105: Yeah, so therefore, the more red, the better. Since they have to explain it, they have to write more.

R:2-106: They don't have to write it in red pen, though.

T:2-107: Oh, it is just the color red. Okay I want you to... (Visualization correction) well, look at that color red and make it really bright. Look at it 'cause it is only red. An opportunity. So this generalization here is, any mistake is an opportunity.

R: (Nods)

T:2-108: An opportunity to learn, an opportunity to clean up a mess, to do something different. Otherwise, you just make the same mistake over again. If you get so mad at the mistake, you can't look at it and learn from it. You're at risk of making the same mistake over again and then you call yourself names. (ICR muscle test) What else do you say to your self out loud or inside your head that is negative?

R:2-109: Mostly that. Can't think of anything else right now.

Roberta expressed her feelings about not being good enough with regard to her writing. "Being good enough" was symbolic for Roberta's feelings of inadequacy and low self-esteem. The meaning exchange between therapist and participant identifies the participant's negative self-talk of "not good enough." The therapist attempts to combat the logic of the negative self-talk through the clearing of emotion, the presentation of her own narrative, the identification of yes, but patterns and. by using visualization corrections. to reenact the experience of seeing the red and being able to draw the more positive association of editing feedback as an opportunity. The therapist draws Roberta into a more productive response to editing by changing the word and image associations mapped to it. In the following example, Roberta and the therapist engage in a meaning exchange about the definition of dying.

T:3-100: (Yes, but correction) Why can't you be happy for long?

R:3-101: Because eventually, I am going to die.

T:3-102: Well, me too. Eventually, we are all going to die.

R:3-103: Yeah, everybody knows they are going to die, but I already have my sentence. I am just waiting for the day.

T:3-104: Woo. I want you to hear what you said, listen to that. (Listening correction—Right) In a way, we all have our sentence. We all know we are going to die. I mean, as soon as we are born, we have that sentence. Yes or no?

R:3-105: I guess.

T:3-106: I am going to die at some point, you are going to die at some point. But you don't know when, do you?

The therapist challenges the participant's "death sentence" conceptualization as exclusive to her. The therapist clears the yes, but defensiveness and enhances listening so that Roberta can hear her own words. Roberta and the therapist continue to negotiate the meaning of life and death in the session.

R:3-107: But I have a choice of how....

T:3-108: Oh, do you? What is your choice? (ICR muscle test)

R:3-109: Just living my life as fully as I can.

T:3-110: And are you doing that?

R:3-111: Yeah.

T:3-112: Well, can you do that to all the way out to 50, 60, 70, as full as you can, as rich as you can, as healthy as you can?

R:3-113: Not really, because as full as I can is not taking meds, not waking every day and having to worry what happens when I take the medicine or anything like that...making sure I eat so I don't get the side effects of the medicine. So that is the difference. If I live as full as I want to live, that means that the medicine is not there to help me survive longer, so I am not going to live so long.

Roberta discloses her definition of living as full as you can, which does not include taking medication. She has associated meanings with medication that make it difficult for her to feel good about taking it. Nancy displays similar sentiments. In the following, excerpt one can track how the definitions and associated meaning about medication and sickness are linked with distinct feelings and emotions.

T:2-91: So how do you feel when you take your medication?

N:2-92: I have no problem taking it.

T:2-93: So you don't have thoughts about it, one way or the other, like, "this helps me," or "God, I hate taking this"?

N:2-94: Yeah I hate taking it, yeah that feeling....

T:2-95: I want you to go into that feeling, I hate taking it. (ICR muscle test) (Emotion check) Low self-esteem, yours. According to this system, it actually says you feel bad about yourself when you take the medication.

N:2-96: (Nods) Yeah. (ICR muscle test—weak)

T:2-97: So what do you say to yourself about when you have to take this medication?

N:2-98: I'll be glad when they find a cure.

T:2-99: Well, that is a good thing to say. how come that makes you feel bad though? What is the tone?

N:2-100: I don't like it. It is very hard. I don't, I hate taking the pills.

T:2-101: Okay, touch here (Listening correction—Right) and what do you say....

N:2-102: I'll be glad when they find a cure.

T:2-103: And what tone is that in?

N:2-104: Very high tone.

T:2-105: A very high tone. (Listening correction—Right) Listen to it again, (ICR muscle test) (Self-destruct correction) because that is counter to taking the medication, which is supposed to help you. (ICR muscle

test) Okay, there is something for you to see. (Visualization correction) So how does the medication help you?

N:2-106: It make my T cells go up and my viral load go down, stay down, actually.

T:2-107: Well, that is good. So when you think about that, does that make you feel good?

N:2-108: (Shakes head) No.

T:2-109: No, I can tell it doesn't. See if we can find out why. (Emotion check) Lost, vulnerable, profound, deep and unrequited love. Deserted, you feel deserted. Hmm, deserted from somebody else, deserted from yourself. So how.... (Second emotion check) Sadness, grief. Anguish. Yours. Your anguish over having to take medication. It is kind of an emotionally painful experience when you have to take medication. Where do you feel that in your body?

N:2-110: In my gut.

T:2-111: Okay, so what I want you to do is hold that place in your gut where you feel it and put your hand across your forehead. (Emotion correction) Anguish. Think about the medication that you take and that pain feeling you have got, you take this medication to get T cells up and you wish you didn't have to but right now this medication helps you maintain and it will keep you healthy until they come up with something better because they are searching.

N:2-112: I hope they find it.

T:2-113: Ones with less side effects to be more effective and more targeted, that is what they are looking for. So that you take medication to keep your viral load low and your T cells high. (ICR muscle test) What happens in your gut when you think about that? Worse? Better?

N:2-114: Better.

T:2-115: Muscle, head, and heart. So your head says, "Yes, this is a good thing." And your heart.... (Arm goes weak) And what does your heart say?

N:2-116: I don't like taking it, but I have to take it.

T:2-117: So it comes up here as muddled instability, emotional instability, can't figure it out, paranoia, your paranoia. So do you think something bad is going to happen to you in the future from taking the medication?
No.(Second emotion check) Paranoia about taking the medication. Feeling bad. Feeling bad about yourself. Feeling bad about having to take the

medication? Can you say some more because I can't clear this yet and I don't quite understand this.

N:2-118: Taking medicine. I don't like taking it.

T:2-119: What do you think it says about you having to take this medication?

N:2-120: That I am a sick person. That I am not healthy.

T:2-121: (Listening correction—Right) This, "I am a sick person. I am not healthy." I have a slightly different theory about medication, so I am going to ask you a question. Can a healthy person still have to take medication?

N:2-122: If they want to take it, they can take it. They don't have to. If you are sick, you have to take it.

T:2-123: And how do you define sick?

N:2-124: You got a medical condition that you have to take pills.

T:2-125: Do you have symptoms every day? Do you, what makes you, by definition of having the virus, are you sick?

The therapist explores Nancy's self-talk related to medication. The associated negative emotions are discovered, as well as the additional self-talk that tells Nancy that she is a sick person. The therapist uses a couple of listening corrections to enhance her listening in order to clearly grasp the logic of the sick versus health debate. The interaction continues with a personal narrative from the therapist about health and sickness.

N:2-126: (Laughter)

T:2-127: I just want to get this out there. So a decade ago, I had lunch here at the university and I got hepatitis, called hepatitis A, and I had symptoms for several weeks and I got over the symptoms, but this virus, hepatitis, a virus is still in my system so there are certain things I need to be careful about, like my liver, because hepatitis affects your liver, so I don't drink too much alcohol, make sure that I take extra vitamins, careful what I eat, and I don't think I am sick. I guess it is a medical condition. I do have this virus. If you went and checked it under a microscope, you would find that hepatitis A virus. I still have it, but I, if you ask me, "Are you sick?" I

would say I am healthy. As a matter of fact, I would say I am very healthy because, on a daily basis, what I do for it takes care of it and therefore I am a healthy person. Just want to offer you that example because are you healthy on a daily basis.

N:2-128: Yes, but your disease.... People die every day from mine.

T:2-129: (Yes, but correction) Breathe. See, I think there is a difference if somebody gets ill from the condition than if they have the condition and they are healthy on a daily basis. So, if you are healthy today, you are healthy today, rather than thinking you are a healthy person with this condition, rather than, "I am a sick person," and feel bad about it. One boosts up your immune system. "I am a healthy person with this condition, so I take care of myself." That'll boost your immune system and the idea that you are a sick person, that is a stress on your immune system, based on research that has shown that. So this concept that you are a healthy person even though you have this virus, this medical condition, when what happens, when you think about it? Do you get into an argument in your head? (ICR muscle test) Do you say that is a possibility?

N:2-130: Yeah, that is a possibility.

T:2-131: Yeah, because if you feel good, it seems strange to me, if you feel good that day, to call yourself sick. Now, if I get a cold, I am a healthy person that has a cold that day. (ICR muscle test) Head, heart. We got it both places, head.... (stays strong) We will come back and check that again.

At first, Nancy verbally rejects the therapist's proposed definitions of sickness and health, but the therapist offers a personal story, asserts the new definition, and clears the defensive yes, but pattern. Nancy replies with the possibility that it may be so.

Reframing and Releasing the Past

This theme refers to the part of the co-construction process whereby the therapist and the participant discuss past experiences and their emotional components. The therapist assists the participant with negative emotional charge release associated with the past through acupressure and recreates the participant's perspective of the past to aid the participant in his/her present state and future planning. Two subthemes emerged under this theme: reframe and release the past, and breaking the past-to-present pattern.

Reframing the Past

Reframing the past involves examining the self-talk, definitions, and past experience narratives that are no longer useful to the participant. Typically, when the participant is unable to work out positive or productive self-talk in the present, the therapist and participant revisit the experiences of the past together to seek the origins of the emotions and/or self-talk that may prevent a positive replacement. This occurs through participant visualizations. The negative emotional charges that are connected to those experiences are reduced or eliminated through acupressure. The following excerpt describes how the therapist and Nancy resolve the past residual anger about being a victim of sexual abuse and being HIV-infected, thus laying the foundation for more positive self-talk. The discussion refers to Nancy's desire to be a police officer and how the residual anger might affect her career choice.

T:1-142: Uh huh....

N:1-143: The anger that I have right now that does not go away.

T:1-144: And where do you feel that anger? Because your face got tight.

N:1-145: In my chest.

T:1-146: (Emotion correction) So that it is okay for you to be angry and you could stay resourceful. You don't want to jeopardize, you know, that he gets away on a technicality because you got too angry. So I just want you to think over for a minute, because we have covered a lot of different subjects. So when you think about yourself now, what do you say to yourself? What is your self-talk?

N:1-147: I have accomplished a lot. I am a bigger person. I used to hate my life. I thought I would never be somebody. I would never try. I thought that getting HIV was the end of my life.

T:1-148: (Clears self-destruct) Even though you are not there anymore, we will clear the residual. (ICR muscle test) And if you had a phrase that you would say to yourself about being okay, "I'm good." What would it be so that, when you are in a tense moment and you wanted to say something to

yourself that would get you resourceful or calm you down or get you focused....

N:1-149: I'm a good person.

T:1-150: So I want you to listen to how you would say that to yourself. Would you hear that in one ear or both? Is it your own voice?

N:1-151: Both.

T:1-152: I think you keep getting better....

The therapist clears a self-destruct pattern from Nancy's past personal history that potentially could drive Nancy to get a job where her personal anger could jeopardize her career and her future. Like Nancy, Roberta also reviews the emotions residing from her childhood sexual abuse. The specific discussion below refers to not telling anyone of the abuse at the time it occurred. In this instance, the therapist uses visualization to replay the past experience and add resources to the past so that positive cognitions and emotions may be generated in the present.

T:1-58: Yeah.... (Listening correction—Left) Yeah, that younger you, she did not know it was okay to tell her.

R:1-59: No, or at least my kindergarten teacher, I see her as a mom, too. I could have told her.

T:1-60: Yeah, hindsight. But I think it is good for that younger you. So now, what I want you to do is put an image of you up there with that younger you and let her know that it is okay for her to tell her mom or her kindergarten teacher. It is okay for her to talk about this to an adult so she could get some help, even though she liked this man, even though he had done some nice things for her. (Roberta crying) Yeah, because...

R:1-61: (Nods head)

T:1-62: No, so we are not blaming her, we just want to make her more resourceful. (ICR muscle test) Let's check head to heart. Sadness, grief, anguish. Anguish over what happened. Anguish over being tricked or fooled. Yeah, that kind of anguish. (Emotion correction) So put this hand across your forehead, look at that younger you, at that anguish and the pain she felt about being tricked by someone who was nice to her. So she

was confused. And what did she need then, what were eating all those sweets about, what did she need that she couldn't get because she couldn't tell her mom or her teacher? What did she need?

R:1-63: Strength.

T:1-64: Uh huh. How could she get that?

R:1-65: I didn't.

T:1-66: So, if the adult you could have gone back then, could have been around, what could you have given her?

R:1-67: I don't know.

T:1-68: Could you have given her a hug?

R:1-69: I didn't like hugs back then.

T:1-70: Did you learn to like hugs?

R:1-71: Not really.

T:1-72: Not even today?

R:1-73: I accept them.

T:1-74: (ICR muscle test) From the right person, in the right way, hugs can be very nice. (Self-sabotage/self-destruct correction) From the wrong person, in the wrong way, hugs are not so nice. Maybe you could teach her that. Maybe you could teach her about good hugs and inappropriate hugs. Good hugs from a friend that could make her feel good. A hug from someone who is abusing her and taking advantage of her? That is an inappropriate hug. Let her know it is okay to fight back, even, even if the person was nice to her. Being nice is not an excuse. So do you have the strength today?

R:1-75: Yes.

T:1-76: Good. So would you let her know that? Would you let her know that you are from her future and that today you have the strength because you are older and wiser and she was just a little girl? She truly was a victim and today, as a grown-up, she wouldn't be a victim. You let her know it is important to protect herself. Does she know that she is okay, that it isn't her fault?

R:1-77: Yes.

In Roberta's account, one notices how the past feelings and reservations about not wanting hugs have carried over into her present. The therapist clears a self-destruct pattern that would prevent Roberta from experiencing support and affection from others. The therapist assists the participant in setting up a visualization exercise in which the past events are reviewed and positive resources are introduced to repair and reinforce the image of the younger self.

Breaking the Past-to-Present Pattern

This particular theme refers to the part of the co-construction process whereby the therapist first identifies and then attempts to break the participant's past-to-present pattern. The therapist points out to the participants that they are carrying over the past expectations and outcomes into their present and even future endeavors. The following example describes Roberta's childhood visualization experience surrounding her childhood sexual abuse and its connection to eating sweets in the past and in the present. Roberta's account continues in the following excerpt:

T:1-80: (Emotion correction) Anything else you can give to let her know that she is okay, she really doesn't need all those sweets, she can reach out to people like her kindergarten teacher and she could find comfort in taking care of herself and have more energy eating her greens and her vegetables and her fruits? I want you to teach her that she should have seven fruits and greens and vegetables a day and that when she eats those, if she has any room for a sweet, she can have one. Can you teach her that?

R:1-81: I don't know.

T:1-82: (ICR muscle test) Touch this ear. (Listening correction—Right) Seems to me, maybe there wasn't anybody back then teaching her to take care of herself. Mom was working, this friend turned to a very unkind indeed. But you know how to eat healthy today. You may not do it but you know how, right? So I want you to teach her how. I want you to teach her about greens and vegetables and fruit and sweet mangoes, how they taste just like the sweets she likes.

R:1-83: Yeah I liked that, even then.

T:1-84: And carrots, they can be pretty sweet with a little orange juice. (Still conducting emotion correction) So I want you to pretend that you and her are sitting down together to eat and you have all these greens and vegetables and fruits and it is fun. Yeah, and she feels good about herself. Telling jokes and stories. There is some fun to this good way of eating. (ICR muscle test) It is important. Does she know how important she is to you?

R:1-85: No.

T:1-86: Would you tell her? It seems to me that this younger you is quite important to you. It is important to feel connected to her. That's right. She can know that she is okay despite what happened. She's okay. She is a good person. She deserves some fun and happiness and success and she deserves to be alive and well. (ICR muscle test) Yeah, she got some cloudy thinking about... (Emotion correction) about whether she deserves to be alive and well. I don't know about the man that molested her, I just know about it through her and she deserves to be alive and well. This is her time and sometimes terrible things happen and we learn a great deal about how important we are to ourselves and how important it is to take good care of ourselves so we can have a full, rich, and happy life. As happy as we can be. One or two giggles (Roberta wipes tears) a day, something nice to do, and (ICR muscle test) so I want you to think about this statement. "I am okay." Have you ever said that to yourself?

R:1-87: Yes.

T:1-88: Good. Do know if you say it on this side or this side or from the front? Where do you hear it if there was a speaker? Where would the speaker be that says, "I am okay"?

R:1-89: Me.

T:1-90: Uh huh....

R:1-91: I would just say it.

T:1-92: Yeah, but when you say it inside, to yourself?

R:1-93: I don't say it inside to myself.

T:1-94: Oh, I want you to practice saying that to yourself. You know, that self-talk that other people can't hear unless we say it out loud. (ICR muscle tests) Yeah, there. That silent thought, "I'm okay." (Visualization correction) (ICR muscle tests) Okay, now. I want you to put it over here (Listening correction—Right), sort of like a little speaker whispering in

your ear, "I'm okay." (ICR muscle tests) Yeah, that is a good spot. Now, I want you to put another speaker over here. "I am okay." (ICR muscle tests) (Visualization correction) Yeah. Now have that thought again. "I am okay, despite anything that has happened to me, I'm okay." (ICR muscle tests) "I'm a good person, I deserve a good life. This is my time." (ICR muscle test) That is kind of my philosophy. "This is my time." I figure if you're here, this is your time. (ICR muscle test) (Roberta smiles) I like that one, too.

R:1-95: I don't think I take that in a positive connotation.

T:1-96: No? Well, think that again. (ICR muscle tests) You don't. Let's find out. Lost, vulnerable, profound, deep and unrequited love. Somebody not returning your love. Mom, kindergarten teacher, this man. (arm drops) You really loved this man (Emotion correction) that did you wrong. I want you to breathe because you loved him, because you're a good person and you were a good kid and he is a little, he had some serious problems. Some people do. And the problem is that some people's problem spill over onto others. Someone who loved you did you very wrong. What happens when you think about him now, today?

R:1-97: I can't see his face anymore.

T:1-98: Don't need to. (ICR muscle tests)

R:1-99: Sometimes I'm happy, sometimes I go sad. Most of the time, I'm sad.

T:1-100: (Emotion check) One of the things that comes up is trust, disgust. Your disgust of him. Disgust at what he did, not so much him. So I want you to go there for a minute. (Emotion correction) Sense of disgust. I don't know where you hold it in your body or even if you need to hold it. You have the skills to say, "No," and are able to protect yourself. You don't have to hold on to all those intense negative feelings, because sometimes they bother us and, despite anything that happened, I deserve a good life, have some fun, some giggles, some success, and to be good to myself. Okay. Think of him again. Do you still see him? Is he out of your life?

R:1-101: No, he will always be there... until they find a cure for HIV.

This instance demonstrates the past irrevocable link to the participant's present state, one in which she cannot believe herself to be a good person due to conflicting emotions tied to the man who sexually abused her. The therapist prompts a letting go of

the past and realizes that the participant has linked the man, the HIV, and her sense of worth together. Although the therapist has identified the root of emotional resistance and supported the letting go of the emotion, the past's link to the present has become intertwined with many aspects of Roberta's life. In Session 2, Roberta discusses her negative self-talk about her abilities in kung fu and, upon further probing, the therapist discovers an underlying pattern of past-to-present in this context as well.

R:2-10: Actually, I was just thinking about when I do kung fu. Even if people tell me that I'm okay, I do good, I always feel that I don't do as good as everybody else.

T:2-11: Okay, so it's a comparison.

R:2-12: Yes, I always compare myself to other people and I always come up short.

T:2-13: (Laughter) Okay, touch this ear (Listening correction—Right) and run this comparison. You're not as, how would you say it? "Not as good." Do you say that out loud, on a scale of 1-10?

R:2-14: Loud. Loud. I say it out loud.

T:2-15: Oh you say it out loud. So you say it to yourself and out loud. Right now, I just need you to listen to how you say it to yourself and breathe on it. (Two Listening corrections—Right & Left) Running this comparison. Okay. Oh, a yes, but. You've got that big yes, but.

R:2-16: Sense of humor in my personality.

T:2-17: Well, what if you shifted that to and? What would, do you think would happen? Instead of yes, but, it was simply this and this and then you had to figure it out.

R:2-18: I don't know.

T:2-19: So how do you yes, but yourself? You get better at kung fu. Is that what you practice?

R:2-20: Yeah. I don't think I am that bad, but....

T:2-21: But, I'm not that bad, but.... How would you finish?

R:2-22: But I would have been better doing it if...I were doing it forever. If I studied when I was younger.

T:2-23: Then you would be doing it better now.

R:2-24: Yeah. I would be flexible at it.

T:2-25: So that is like past to present. The fact that you didn't do it in your past makes you not where you want to be now. And what happens to the fact that you are doing it now?

The therapist points out the past-to-present pattern. In essence, failure to practice kung fu in the past makes the present appreciated less. Within the same session, the therapist and Roberta recognize that this is a habitual pattern.

T:2-33: (ICR muscle tests) Are there any ways that you are kind of stuck in the past? Any, "I didn't do that in the past, so I'm not good today," or "That happened to me in the past and that's why I'm not happy today"?

R:2-34: Ohh.... My whole life is based on the past or what I couldn't do in the past. But it doesn't bother, I don't think it bothers me that much. It is subconscious. Not really.

We learn that Roberta has a pattern of making what has happened to her in the past effect her present. The therapist has identified and now Roberta is aware of her unconscious pattern. Nancy demonstrates a similar pattern. The acupuncture techniques uncover that a sense of deserting herself repeatedly emerges when confronted with the task of passing a test.

N:3-21: I always think to pass. I hope to pass, but when I take the test, it seems like I pass, but then, when I get my scores, I didn't pass.

T:3-22: This is funny because at the level of head is okay, level of heart, there is something going on. Lost, vulnerable. Vulnerable. We can check it this way. (ICR muscle tests and emotion check) Lost, vulnerable, profound, deep, abandoned, deserted. You feel deserted. You're doing the deserting. You're deserting someone besides yourself. You are deserting yourself. I don't quite get that. Let's see if there is any original. Yes, conception to birth, 5, 10... 5, 6, 7... age 7, deserting self, family.... No, friends.... No, school. At age 7, did you feel like giving up on yourself at school? Did you ever do that?

N:3-23: Giving up on that test, yeah, because I am almost done with my bachelor's and I don't even have my associate's, my AA. I took it three times and it's the fourth time I am going to take it. I am wondering if I can take a class over.

T:3-24: (ICR muscle tests) So, deserting yourself. Yes. Is there an unconscious emotion? Yes, there is an unconscious emotion.... Sadness, grief, anguish, cloudy thinking, dogmatic position. Yours.... No, someone else's. Hmm.... Dogmatic position. Somebody else is telling you what you should and should not do, who you are, who you aren't.... Back to age 7, teacher. Do you remember who your teacher was at age 7? That would be 2nd grade.

N:3-25: Yes, Ms. Tyler.

T:3-26: You do remember. What was she like?

N:3-27: I liked her.

T:3-28: Did you have any other teachers? (ICR muscle test)

N:3-29: In 2nd grade? No.

T:3-30: After school teachers, or....

N:3-31: I had a summer school teacher, Ms. Ray, I didn't like her.

T:3-32: Tell me about her. What happened with her?

N:3-33: I don't know, I just remember bad things in that lady's class. She stuck gum in my hair.

T:3-34: She stuck gum in your hair?

N:3-35: (Nods in agreement) I was chewing gum and she told me throw it away and I didn't throw it away. I pretended to throw it away, so she took it and stuck it on my head.

T:3-36: So I want you to think about her for a minute (Emotion correction) and that dogmatic position of hers, that she is right and you are wrong. Maybe even that implication that there is something wrong with you, that you are not smart enough. Breathe. Okay, let's go on this side, too, because we have two and this one is giving up on yourself, back then, with her, and today, with this exit exam. Breathe. So what do you think it is going to take to pass this exam?

The therapist seeks and clears up Nancy's emotions related to past experience. The therapist seeks an origin to the emotion and conducts an emotion correction to release the negative charge. Nancy has linked the emotion of deserting herself in elementary school that was associated with a negative event to the emotion of deserting herself when taking the college exam.

Forging the Future

Much of the past and present self-talk and personal narratives were elicited by the therapist to examine the negative or positive value and understand the emotional associations with the events and self-talk. The process of forging the future involved three subthemes: reducing uncertainty, generating options, and projecting images.

Reducing Uncertainty

Upon eliciting the negative self-talk and or illness narrative, the therapist urged the participants to consider new ways of thinking; however, this prompt was often met with uncertainty by the participant. Both cognitive and emotional requirements were needed to visualize and practice the changes suggested by the therapist. The following excerpt revolves around the therapist's proposal of a new image for the virus. The participant responds with apprehension and uncertainty.

T:3-49: Would you be willing to give it that information? Because maybe this virus could just float around in a way that doesn't harm you and you don't harm it. You know, like countries... like Canada and the United States. We have peaceful borders. Peaceful between you and your body and the virus.

R:3-50: I think they already do.

T:3-51: Could you set it up in such a way that your immune system is okay? So that you can handle whatever in the environment that you need to handle? You can do that. So that this virus, in your words, could not kill you, it's just there?

R:3-52: I don't know.

T:3-53: Okay, so this sense, what came up? (Emotion correction)
Profound, deep, and unrequited love. You can love yourself even though this virus is in your system. Set it up in a way that supports your immune system. Okay, so I want you to look at that image of the virus again and just let me know if it changes in any shape or color or voice quality. Just let me know. So let's put that imaginary screen up there, but this time, I want you to see the virus up there, just floating around inside in a way that lets you be healthy and strong. (ICR muscle tests)

R:3-54: Can't do it.

T:3-55: What happens? What do you see?

R:3-56: It is like a storm cloud.

T:3-57: Good. Thank you very much. I want you to look at the storm cloud....(Visualization correction) (ICR muscle test)— Head to heart. (Emotion check) Dogmatic positioning—yours. So do you have some rule that, if the virus is there, there has to be a storm cloud? There has to be...

R:3-58: No. Not that I know of.

T:3-59: Okay. So would it be possible, if you have the virus, to be healthy and strong and live to be...

R:3-60: Oh, yeah.

T:3-61: Good. So I want you to see, look at that for a minute. Breathe. (Visualization correction) Yes. There is the possibility that, even though there's the virus, you could be healthy, strong, and live to be 80, 90. No?

R:3-62: I don't want to live that long.

T:3-63: Well, how long you want to live?

R:3-64: I always wanted to live to 30. That way, I won't have no wrinkles and I won't be old. I'll still be, I really don't want to live that long.

T:3-65: And how old are you now?

R:3-66: 25.

T:3-67: You've got 5 years. You are going to self-destruct on that thought. (Self-destruct correction) And what is wrong with a few wrinkles?

R:3-68: Nothing, I guess. I just don't want them on me.

T:3-69: What would that mean, if you had a wrinkle on you, and I don't think you get wrinkles until you are 40 or more? That's when I got mine, when I was over 40. What does that mean to have wrinkles and get old?

R:3-70: Means that I can no longer do what I want to do.

T:3-71: (Listening correction—Left) Oh, that's what I thought.

R:3-72: Time ran out.

T:3-73: When you get old, you can't do what you want to do. So what is it that you would like to be able to do if you got to, say, 50 or 60 and you don't think that you would be able to do it?

R:3-74: I don't know. I never picture being old. I never even dream about being old.

T:3-75: Well, what if you were going to picture a healthy, vibrant, fun-to-be-around older you?

R:3-76: I don't know.

T:3-77: What would that look like?

R:3-78: Guess I would like my mom.

T:3-79: Is she healthy, vibrant?

R:3-80: Not any more, but I would still look like her, maybe.

T:3-81: You might still look like her, but this image I am asking you to conjure up or imagine is a healthy, vibrant, energetic, for instance...

R:3-82: I guess I would still be traveling.

T:3-83: Someone who would still be doing kung fu in their 50s. Are you going to give that up when you are 29?

R:3-84: I don't know. I guess if I am 50, I want to see my nephew still around.

T:3-85: Good.

Uncertainty about implementing the new image of the virus meshed into the inability to see herself at 50 and 60 years old. Both images would propel the participant into an extended view of the future that the participant was not immediately ready to

embrace but, through continued support of the therapist, seemed to begin the process. By Session 4, there is evidence that Roberta has begun to embrace a vision of the future.

T:4-5: Some nice action? So, when you think about your future now, what happens?

R:4-6: Still the same, but I am making promises and I don't normally do promises. I always tell my cousin, well, he wants to be a singer and I called him up and said he came down here to get known, but he is going about it the wrong way. I told him. if I finish school, when I finish school, I'll do the demo tapes for him on the computer so it can be digital and stuff, so he don't have to worry about it, but all he has to make sure for me is that he goes to school, continues to go to school. I make promises and I don't normally make promises.

T:4-7: What do you think that means about you and your attitude towards the future?

R:4-8: I guess it is getting better.

Generating Options

In order to forge new self-talk and images of the future, the therapists requests that Nancy and Roberta seek specific alternatives for accomplishing their goals. This was particularly evident when discussing work and careers. For both women, career decisions played an important role.

T:1-110: Uh huh.... (Self-sabotage/self-destruct correction) So you like being out on the ocean?

R:1-111: Yes.

T:1-112: Is the Navy the only way to do that?

R:1-113: It is the easier way.

T:1-114: Well, yeah.

R:1-115: I wanted to leave home. I wanted to travel. I didn't want to be home at 18. That was the only way out.

T:1-116: (ICR muscle test) Cloudy thinking. You know why? (Emotion correction) Because it is not the only way out. Maybe with some clarity,

you could find other ways to travel beyond the ocean. Full and rich life. (ICR muscle test) What about that thought? (Visualization correction) Let's see if we can see more ways. Because one of the things this work does is to get your mind working together. That is why we go like this (hands across forehead), left, right side of the brain. So you can figure out more solutions of what you want. One of the primary things I do when I work with people is have them think about what they want and make pictures of that. They start making pictures of what they want. Now, at least they know where to go and they can figure out how to get there. So I don't know, exactly know to get to travel, lots of opportunities for that piece. (ICR muscle test) So let's think of at least three different types of work that might get you open to travel.... (Pause) Even if it is something that you do, that's a possibility. I don't want to do it, we just want your brain to start churning out ideas.

R:1-117: Pilot.

T:1-118: Anything to do with airplanes and travel 'cause any one of those jobs in those industries will open up. Military....

R: (Eyes fluttering)

T:1-119: Now we got that brain working! I see those eyes going everywhere...

R:1-120: Those are my contacts.

T:1-121: (Laughs) One more thing that you could....

R:1-122: Bus driver.

The therapist uses a self-sabotage/self-destruct acupressure correction to eliminate Roberta's fixation on feeling that there is only one way out. The emotional charge on that thought is also addressed with an emotion correction. Nancy also generates alternatives for career choices.

T:1-125: (Emotion correction) Very old anger. Breathe through that experience where you felt helpless and hopeless, so that you can move forward in a direction that is good for you and others. Not this residual kind of anger, so you can stay resourceful. That's it. Let's check. (ICR muscle test) So one of the things you like to do is contribute and prevent that happening to somebody else, as well as capture. So that is a pretty big contribution to a community. So let's go back to that question. If you

didn't get accepted into the Academy, how is life going to go on beyond that for you?

N:1-126: I don't know it is going to be....

T:1-127: I don't either, but I think it is important (Visualization correction) that you have some options. Call them Plan B, Plan C. Sometimes, we even need a Plan D when Plan A doesn't quite go how we want. So how else could you make a contribution, how could you help kids that maybe had a similar devastating experience? Help moms to recognize what is going on?

N:1-128: A psychologist.

T:1-129: Yeah, you would probably make a good one.

N:1-130: I don't want to sit in the office.

T:1-131: You know what? Not all psychologists sit in the office. Not all social workers sit in the office. Some of them are right out there, on the go, right in their community. Even some of the people that work on research projects right here at the University are in the field, on the go, with people in those kinds of situations, looking for ways to stop it and help. And again, that is not to say for you to go and do that, but for you to recognize that there might be other ways that you could use this energy you have and this focus to contribute to make things better. So what is another way? What else could you do that would be right, active in the community? That is what I hear you say. You don't want to sit behind a computer or sit in a chair, blah, blah, blah... people, right? (ICR muscle test)

N: (Nods)

T:132: I think that is a very good thing to recognize.

N:1-133: Maybe a probation officer.

T:1-134: Okay, so there is another option.

N:1-135: A juvenile probation officer.

In this example, the therapist clears the associated emotion in order for Nancy to continue to evaluate options for her career.

Projecting Images

The projecting images part of the process typically began to emerge in the first couple of sessions and became more solidified in the final session. An example of Nancy's projections in Session 2 follows.

T:2-150: Okay, so what kind of 80-year-old do you want to be? If you could be the best, healthiest 80-year-old in your imagination, what would that be? What would you be doing?

N:2-151: Exercising.

T:2-152: Okay, so I want to see that 80-year-old you exercising.

N:2-153: She's retired, she would be traveling, if I can.

T:2-154: So she would be traveling.

N:2-155: Still be able to walk.

T:2-156: Well, if she is exercising, she should be able to walk. What kind of exercising is she doing?

N:2-157: Walking, not running, and light exercising.

Note the difference in Nancy's projected image during Session 4.

T: 4-136: Good! What about your life? How far out do you see yourself successfully, healthy? How far out do you see yourself?

N:4-137: I can see the 80-year-old.

T: 4-138: Alright. How is she doing?

N:4-139: Still exercising.

T:4-140: Is she trim, fit?

N:4-141: Yes.

T:4-142: And is she facing you, or is she facing out towards her future?

N:4-143: She is facing me.

T:4-144: And if she had something to say to you and you were open to listen, what would she say to you?

N:4-145: Don't let nothing get in your way.

Roberta also produces a stronger future image (see T:3-73 through R:3-84 under *Generating Options*) from Session 3 to Session 4.

T:4-105: So what are you going to be like at 70? A healthy 70 you?

R:4-106: I am still be outspoken, so I always be smiling. I don't want to be a mean, grumpy old woman.

T:4-107: You are going to be smiling, outspoken.

R:4-108: My family would be around, too.

T:4-109: Uh huh. (ICR muscle tests)

R:4-110: The kids, the younger generation. I am probably going to be one of those old people that sit there and tell you how it used to be, but I am okay with that. I want to be able to tell the stories, if any of my family just forget. I want to be the one to tell them, "No, no, no, no. She never used to be like that." Make sure the truth gets out and they don't change the stories and act like they were perfect. I am going to make sure that everybody knows they were still human beings no matter how high they go up. Make sure the next generation knows.

T:4-111: And how active are you going to be?

R:4-112: Pretty active because my back isn't going to slope. I am going to keep it straight.

Narrative Inquiry

Two models of illness narrative were used in this investigation. Both models were used by Eggly (2002). One is an adapted version of the Labov (1972) and Polanyi (1985) criteria for narrative and the other is Eggly's (2002) discourse strategy for co-constructed narratives. In this finding section, Roberta and Nancy's narratives will be presented separately in order to better understand the storytelling process of each participant.

Roberta's Illness Narratives

Roberta learned of her HIV diagnosis during her teenage years. During the intervention, she disclosed that she was a victim of childhood sexual abuse. Her mother's boyfriend, the perpetrator, was HIV-positive. Ten years after her diagnosis, Roberta discusses the impact of HIV on her career plans. Throughout the intervention, it becomes evident that the HIV diagnosis has influenced Roberta's low self-esteem and uncertainty about the future. She discusses her doubts about knowing what she wants to be and do with her career. During the baseline interview, Roberta reported that she took her antiretroviral medication 2 out of the past 3 days; however, during the intervention, she explained that having to go out and get her medication instead of having it delivered, as it once was when she was under 21, "was not worth it."

Two narratives that fit the modified Labov (1972) and Polanyi (1985) narrative model were found in the therapeutic sessions with Roberta. One of the narratives concerns her inability to see the future, which is attached to her HIV diagnosis. She states that her inability to visualize herself in the future is not due to HIV, but rather what the illness has stopped her from doing.

R:1-105: That is not why I don't see a future.

T:1-106: Okay, go ahead. Why don't you see your future? (ICR muscle test)

R:1-107: I don't know. I know it is not because of the virus because, when I got diagnosed, all these opportunities opened for me. It is because what I want in the future.

T:1-108: What do you want?

R:1-109: I wanted to go to the Navy.

The modified Labov (1972) and Polanyi (1985) narrative follows:

R:1-115: I wanted to leave home. I wanted to travel. I didn't want to be home at 18. That was the only way out.

HIV-infected individuals are unable to join the military. Roberta's one dream, her only way out, was blocked due to her illness. The other illness narrative discovered in Roberta's text occurred during Session 3 regarding medication.

T:3-17: One the topics that we need to cover is what happens to you when you think about taking your medication. What kind of thoughts do you have? How do you view taking your medication?

R:3-18: Hmmmm....

T:3-19: That was a good question.

R:3-20: How do I view it? Most of the time, I don't pay attention to it. At first, when I first got diagnosed, I knew that when I took the medication I would get better with it. I knew that there was not a cure but I kind of looked at it as I would get better, but as the years went by, then they started saying that my liver enzymes were so high and I started to see the medicine as, you know, maybe I am looking at it wrong. If the disease doesn't kill me, the medicine is still going to kill me, too, and that is how, pretty much, I have stayed.

Two co-constructed narratives (Eggly, 2002) were found in Roberta's text. The first is a co-constructed narrative that elaborates upon the medication narrative described above by Roberta:

T:3-132: Good. (ICR muscle tests) Head to heart, heart to body, body to head. (ICR muscle tests) So this connection between your head and your body. In kung fu, that is similar to this connection between your head and your body and the virus, so that you could let your head and your body be in sync. So yeah, okay, the virus is there and there are things you do to take care of yourself. There are also things and you still go on with your life. It is like you... peaceful coexistence.

R:3-133: But being on medicine is just not living. It almost like waking up on meds and sleeping on meds. It is like my life revolves around medicine, not that....

T:3-134: It is not just something you do. Your life revolves around it. Good. So I want you to look at that. (Visualization correction) 'Cause the way you have it set up now, it is like your life revolves around it and there

is a possibility that meds are secondary, just something you do, like taking a vitamin.

R:3-135: Don't do it.

T:3-136: Oh.

R:3-137: Don't take any other medicine than what I have to take.

T:3-138: Because....

R:3-139: I am already taking medicine.

T:3-140: Well, taking supplements and eating well is not the same thing as taking medicine.

R:3-141: For me, it is.

T:3-142: Oh, yeah? How come?

R:3-143: It is another pill to add to the list of pills I have.

T:3-144: So this is just about pills?

R:3-145: Yeah.

T:3-146: Oh, okay. (Visualization correction) Okay, I want you to look at all those pills. So I have clients who are very healthy and they take lots of pills. they take pills, capsules, drinks, all of which they take to keep themselves healthy. They take vitamins C, B, herbal concoctions to clean their liver. So what happens to you when I say that? (ICR muscle test) Yes, but....

R:3-147: They are wasting their time.

T:3-148: And why are they are wasting their time? (Yes, but correction) Why would they be wasting their time?

R:3-149: 'Cause they are already healthy. What are they taking all those medicines for?

T:3-150: Well, one, they don't see it as medicine. They see it as a way to avoid medicine or they see it as a way to keep themselves healthy, even though they have to take medicine. Because, say that someone had to take pain medicine because they had a knee injury, osteoarthritis or something, because their knees were painful. So they had to take pain medication sometimes, but that puts their liver at risk. So these people would take the pain medication so they could go to work that day and then they would

take something to support their liver so that the pain medication doesn't do damage to their liver. They see it as this is the pills they're taking. They don't see it as their life revolves around the pills. Here is their life and pills is just something they do to take care of their life. But here is their life. Right now, you have these pills as a center focus.

R:3-151: Yeah, because I have to get up and think about taking the medicine. It is not a habit.

T:3-152: Ah. And how long you have you been doing this?

R:3-153: Since I was 16.

T:3-154: And it is not a habit?

T:3-155: No.

T:3-156: And when do you think you are going to make it a habit?

R:3-157: I don't know.

T:3-158: Could you make it a habit? (ICR muscle test)

R:3-159: Probably could.

T:3-160: (Self-sabotage correction) So what if this taking the medication is this something you did in the morning, like brushing your teeth or taking a shower or whatever your routine is in the morning? What if taking your medication was like taking a shower?

R:3-161: It's not.

T:3-162: What if it was? I am clear it isn't. (Laughter) Breathe. (Listening correction—Left) (ICR muscle test) So just for a minute, ponder that possibility. That taking your meds is routine and something you do in the morning and it is done.

R:3-163: But....

T:3-164: (ICR muscle test) (Yes, but correction) And, and, and...

R:3-165: The thing about the medicine... I can't just drink it with anything and sometimes we don't have, like, juice or milk or something like that. Because with water, I can taste the flavor so I can't drink it with water. So it is just something that if we don't have something in my house, it is just not part of the routine.

T:3-166: And what could you do to make it easier for yourself?

R:3-167: I would like for it to be just one time a day, but that is not possible.

T:3-168: Yet. That could eventually happen.

R:3-169: No, they tested it for people, like the medicine that I take twice a day. It can be taken on a once-a-day basis, but you can't be medicine experienced.

T:3-170: Okay.

R:3-171: So, um....

T:3-172: Well, and some day, if you are going to live to be 60 and 70 years old, they are going to simplify these meds even more.

R:3-173: If I live that long and I'm still on medicine, it's no.

T:3-174: No.

R:3-175: I don't want to be on medicine that long. If they don't find a cure by then, there is no point in living that long.

T:3-176: So let me understand this. It takes you how long to take your meds?

R:3-177: A second.

T:3-178: Oh, and if you take them twice, that is 2 seconds. So for something that costs you, timewise, 2 seconds a day, you are going to give up a couple of decades of your full life?

R:3-179: I never intended to live that long.

T:3-180: Oh, you just might, though. What if you did? There is a possibility that you do.... And if you are going to do that, then you might as well make it the best that you can. If you don't die, what are you going to do, kill yourself?

R:3-181: No, I am not going to live that long.

The co-constructed narrative provides greater elaboration over the key issue of taking medication and reveals its underlying relationship with the issue of living or dying. It is evident in this excerpt how much influence in the way of challenges and alternative perspective the therapist offers during this co-construction. During this session, Roberta

and the therapist begin to negotiate the meaning of living and dying. Roberta's second nonconforming narrative expands on the topic of life and HIV.

R:3-187: No, I had a better appreciation of life before I found out I was HIV-positive. (ICR muscle test)

T:3-188: So why did you give it up? Did it help you out?

R:3-189: I didn't consciously give it up.

T:3-190: Can you consciously get it back? (ICR muscle test) (Self-sabotage correction) 'Cause it seems to me there are places in your life, areas where you just live it full out. Personally, if I saw one of my coworkers do a cartwheel in the hall, I would simply applaud. That is just me personally. So if you do cartwheels in the hallway—I am not telling you to—but if you do, I want you to hear me applauding in the background. Because that is a pretty full, outrageous way to live your life.

R:3-191: Yeah I am teaching my nephew to be like me.

T:3-192: And you can do that despite the fact that you have this virus.

R:3-193: I guess.

T:3-193: And I am suggesting that you take that fullness and that love of life that you have in your kung fu class and you just open it up a little bit more so that you could last a little bit longer.

R:3-195: I used to be so happy and then there was a moment that I got kind of sad and that was when I told my mom [about] the virus and she didn't believe me and it kinda took more out of....

T:3-196: Mom didn't believe you. Sadness, anguish. (Emotion check) Sadness, anguish when Mom didn't believe you. (Emotion correction) Where do you feel that? In your head? In your chest? Mom didn't believe you....

R:3-197: In my heart.

T:3-198: Put your hand on your heart. 'Cause that was then and this is now and maybe there is something to learn from it. Mom has her own special set of problems.

R:3-199: Yeah. I told her if I die, it is going to be her fault. I guess that is when it started.

T:3-200: Uh huh. And if you live? (ICR muscle test) And if you live, could that be because... (Listening correction—Left) because you said so? Because it is what you wanted? (ICR muscle test) So this thing about Mom's fault that you got the virus. (ICR muscle test) (Emotion check) Anguish. This, "It's Mom's fault," because that may be true; it just may not be helpful because that is in the past. Breathe through that. And because more important is how you choose to live your life from here on forward, full and rich and doing cartwheels. I was just sitting here thinking how many adults I know can do cartwheels, that's impressive.

R:3-201: Not that much.

T:3-202: That's right. (ICR muscle test)

R:3-203: You have got to be in dance to be able to do that or full of life and spirit.

T:3-204: Well, let it show! (ICR muscle test) Well, it is not for me to say when to let it show, (Self-sabotage correction) but I can help you access it more often so you experience that spirit for life you have. That is wonderful. Okay, think about you being happy despite anything that has happened in the past, despite Mom or the virus, any of those obstacles, roadblocks, whatever you want, difficulties, whatever you want to call them. Just right now, you being happy, full, rich, happy life, where you get to do some traveling, being around kids, doing cartwheels in the hallway when nobody is looking. (ICR muscle test) So I've got to tell you, I don't know if you are going to live to be 50, 60, 70, 80, 90, or 100. If you do, you might want to choose it to be full and rich.

R:3-205: I think I live my life just in the moment, so I guess if I get there, I'll still be in the moment, but...

T:3-206: Well, alright.

R:3-207: But....

T:3-208: But. I heard that. But...you don't know. So my goal is I am going to live to be 100 and run a mile and if you want, you can come to my birthday party.

R:3-209: You are going to run a mile when you are 100? Why?

T:3-210: Because think of how healthy I have to keep myself to run a mile. In order to run a mile when I am 100 and I don't want to be a little old lady that can't do anything when I am 100. I want to be smart as a whip and I still want to be able to exercise and run a mile. Now if you come, you have to agree to let me come in first because I will probably not

be very fast. I was never really interested in how fast I could run, just that I could run.

R:3-211: I don't like to run. Okay, I get bored halfway through running.

T:3-212: You could do a kung fu demonstration if you want.

R:3-213: Yeah, if you are going to be 100, wouldn't I be in my 40s to get there?

T:3-214: How old are you, 25? You would be 25, 35, 45, 55, 65. You would be 65 at my party.

R:3-215: That is too old. That is too far in the future to make a promise like that.

T:3-216: Well, just leave it as a possibility, just a possibility that you could be 65 at my 100th birthday.

R:3-217: It would be cool to be 65, prove to the world that I could do something.

T:3-218: Wouldn't that be cool?

R:3-219: Yeah, but still too old.

T:3-220: Well, I want you to think about how cool that would be for a minute. Head to heart, heart to head, because that would definitely be cool.

R:3-221: That would be.

The therapist probes for additional information regarding Roberta's lack of appreciation toward life after the HIV diagnosis. The therapist challenges the notion and moves forward with invitations for Roberta to view the future in a favorable and enjoyable way.

At follow-up, Roberta reported having taken active steps to obtain her medication, such as going to the pharmacy and requesting a new prescription from her physician. Although she had not begun taking her medication at follow-up, she had reenrolled in college after a 3-year break and she reported no negative and critical self-talk.

Nancy's Illness Narratives

Nancy is a single mother of an 8-year-old boy who is HIV-negative. She learned about her HIV status when she was 15 years old. Nancy is employed and trying to finish her bachelor's degree. She is also searching for employment opportunities in the police force. She reports becoming HIV-positive from her experience of childhood sexual abuse and states that she experiences residual anger from it. During baseline, she reported taking medication 2 out of the past 3 days. However, during the intervention, she learned that she did not get accepted into the police department, stated that she became depressed, and stopped taking her medication. Subsequent discussions in sessions also revealed her misgivings about medication, primarily due to the medication side-effects.

Three of Nancy's modified Labov (1972) and Polanyi (1985) narratives refer to career limitations and HIV. These narratives are found in sessions 1, 2, and 3. The first narrative occurs during Session 1. It relates to her HIV health status and stalled career development. The same, yet more elaborated, narrative occurs in Session 2 (N:2-74 through N:2-86) and Session 3 (N:3-204 through N:3-206).

N:1-5: (Pause) I'd say probably dealing with my health and my career, what I am trying to be, and it limits me. And I think about that a lot because what I really want to be is a U.S. Health Marshall and I really can't be that because of my health status. I try to lower it down to being a police [officer] but they're telling me, I am not sure. For a fact, everybody has their, "and if," "and buts" about it, that maybe I can't go into it and maybe I could, but I just I am doing the process until they tell me no. (ICR muscle test)

Another modified Labov (1972) and Polanyi (1985) narrative tells of her HIV diagnosis discovery:

N:1-19: When I got pregnant with my son. Then I went for medical attention and they tested me and they told me I was positive.

T:1-20: And how old were you?

N:1-21: I was 15.

The excerpt continues with narrative:

N:1-27: I was being molested at the age of 6 and I guess he was positive. He died. He finally died of HIV.

Three of Nancy's modified Labov (1972) and Polanyi (1985) narratives are about medication. The first is in Session 1:

N:2-181: No, not really. There was this one that I was concerned about because that is what made me gain a lot of weight. It had cholesterol inside. Cholesterol, Norvir, and it made me gain so much weight and I had to exercise real hard to try at least some of it. It blew me up when I started taking it, it blew me up. I was 130 and I had jumped to 170.

T:2-182: And then what happened? How did you get back down?

N:2-183: I had to exercise. I was not exercising. I was exercising but not extremely hard. I had joined this study, an exercising study (ICR muscle test) and that is what really helped me lose some of the weight, because it had a lot of cholesterol in it.

T:2-184: And then did your system balance out again?

N:2-185: Yeah, but it is like I can't stop it. If I ever try to stop when I start back taking it again, I gain more weight.

T:2-186: So to balance, that you have to keep exercising. Well, good. It is a good thing you have that 80-year-old exercising.

The second medication narrative occurs during Session 3:

N:3-216: I just don't care because they told me I can't be a cop no more. They disapproved. I stopped taking my medicine because I was depressed. I can't do Marshalls, I can't be a cop.... What can I do?

The third medication narrative occurs during Session 4:

T:4-9: So let's start with the meds. What happens to you now when you think about taking the meds?

N:4-10: I just take them. (Shaking head) I really don't think about nothing. I take them like I am supposed to take them 'cause I take vitamins every

day. I have no problem with vitamins. Just take them along with my vitamins as if they vitamins.

One nonconforming co-constructed narrative is encountered in Session 2 about medication, which weaves into definitions of sickness and health:

T:2-91: So how do you feel when you take your medication?

N:2-92: I have no problem taking it.

T:2-93: So you don't have thoughts about it one way or the other, like, "This helps me," or "God, I hate taking this"?

N:2-94: Yeah, I hate taking it. Yeah, that feeling.

T:2-95: I want you to go into that feeling, I hate taking it. (ICR muscle test) (Emotion check) Low self-esteem. Yours. According to this system, it actually says you feel bad about yourself when you take the medication.

N:2-96: (Nods) Yeah. (ICR muscle test)

T:2-97: So what do you say to yourself about when you have to take this medication?

N:2-98: I'll be glad when they find a cure.

T:2-99: Well, that is a good thing to say. How come that makes you feel bad though? What is the tone?

N:2-100: I don't like it. It is very hard. I don't, I hate taking the pills.

T:2-101: Okay, touch here (Listening correction—Right) and what do you say?

N:2-102: I'll be glad when they find a cure.

T:2-103: And what tone is that in?

N:2-104: Very high tone.

T:2-105: A very high tone. (Listening correction—Right) Listen to it again, (ICR muscle test) (Self-destruct correction) because that is counter to taking the medication, which is supposed to help you. (ICR muscle test) Okay, there is something for you to see. (Visualization correction) So how does the medication help you?

N:2-106: It make my T cells go up and my viral load go down, stay down, actually.

T:2-107: Well, that is good. So when you think about that, does that make you feel good?

N:2-108: (Shakes head) No.

T:2-109: No, I can tell it doesn't. See if we can find out why. (Emotion check) Lost, vulnerable, profound, deep and unrequited love. Deserted. You feel deserted. Hmm... Deserted from somebody else. Deserted from yourself. So how...? (Second emotion check) Sadness, grief, anguish. Yours. Your anguish over having to take medication. It is kind of an emotionally painful experience when you have to take medication. Where do you feel that in your body?

N:2-110: In my gut.

T:2-111: Okay, so what I want you to do is hold that place in your gut where you feel it and put your hand across your forehead (Emotion correction). Think about the medication that you take and that pain feeling. You have got, you take this medication to get your T cells up and you wish you didn't have to, but right now, this medication helps you maintain and it will keep you healthy until they come up with something better because they are searching.

N:2-112: I hope they find it.

T:2-113: Ones with less side effects, to be more effective and more targeted. That is what they are looking for. So that you take medication to keep your viral load low and your T cells high. (ICR muscle test) What happens in your gut when you think about that? Worse? Better?

N:2-114: Better.

T:2-115: Muscle, head, and heart. So your head says, "Yes, this is a good thing," and your heart.... (ICR muscle test) And what does your heart say?

N:2-116: I don't like taking it, but I have to take it.

T:2-117: So it comes up here as muddled instability, emotional instability. Can't figure it out, paranoia, your paranoia. So do you think something bad is going to happen to you in the future from taking the medication? No. (Second emotion check) Paranoia about taking the medication, feeling bad, feeling bad about yourself, feeling bad about having to take the medication. Can you say some more because I can't clear this yet and I don't quite understand this.

N:2-118: Taking medicine. I don't like taking it.

T:2-119: What do you think it says about you having to take this medication?

N:2-120: That I am a sick person. That I am not healthy.

T:2-121: (Listening correction—Right) This, "I am a sick person. I am not healthy." I have a slightly different theory about medication, so I am going to ask you a question. Can a healthy person still have to take medication?

N:2-122: If they want to take it, they can take it. They don't have to. If you are sick, you have to take it.

T:2-123: And how do you define sick?

N:2-124: You got a medical condition that you have to take pills.

T:2-125: Do you have symptoms every day? Do, what makes you, by definition of having the virus, are you sick?

Upon the exploration of Nancy's self-talk regarding medication, an associated negative feeling is discovered. The negative feelings and self-talk are cleared and challenged by the therapist. The co-constructed narrative allows for the negotiation of meaning and the elaboration of key terms.

At Follow-Up 1 and Follow-Up 2, Nancy reported taking her medication with increased adherence. She registered for the exam and had begun exercising three times a week.

Participant's Reported Medication Adherence

Nancy and Roberta reported taking their medication on 2 of the past 3 days. However, during the intervention, they each reported differences in their medication adherence. During the intervention, Nancy stated that she stopped taking her medication after the police department rejected her application. Nancy's narratives about medication also revealed that she held doubts and negative emotions towards the medication as a

result of the side-effect of gaining weight. Roberta disclosed her doubts about the medication side effects having a detrimental impact on her liver and the difficulties of making her medication consumption routine.

At Follow-Up 1, Nancy reported having taken her medication 2 out of the past 3 days. This adherence increased to 3 out of 3 days on Follow-Up 2 for Nancy. Roberta did not report any adherence in Follow-Up 1 or Follow-Up 2. However, she did report taking action steps to obtain her medication. She began the process of requesting a new prescription for the medication.

Roberta's Negative and Critical Self-Talk

“I am so boring,” was Roberta’s initial example of negative and critical self-talk. She reported that she heard the statement in a loud, nagging, and truthful voice that was moderately stressful. Roberta’s self-talk during the sessions included the following:

R:2-10: Actually, I was just thinking, when I do kung fu, even if people tell me that I’m okay, I do good, I always feel that I don’t do good as everybody else.

R:2-54: ...but my poems aren’t good.

R:2:64: But I try to fix them. I can’t, ’cause I don’t have good grammar skills.

R:2:90: I can pull off a C, but I can’t make an A.

R:2-210: I guess others can give credit to me, but I am not ready to give it to myself yet.

R:3-175: I don’t want to be on medicine that long if they don’t find a cure by then. There is no point in living that long.

R:4-46: I am a flaky person.

R:4-122: I am just supposed to get sicker because I am not taking my meds.

At the first follow-up interview, Roberta reported no negative and critical self-talk. She did report having doubts and she stated that the doubts were not as bad as before. At the second follow-up, Roberta stated she had no negative or critical self-talk to report. She reported doing better by thinking, “I know I can do better and I never used to do that...when I start to think badly, I tell myself that is not true anymore.”

Nancy’s Negative and Critical Self-Talk

Her initial example of negative and/or critical self-talk was, “My stupid self, I should have listened to my first thought.” This loud, angry voice was moderately stressful for Nancy at the time. Other self-talk reported by Nancy during the intervention included the following:

N:2-120: (Response to, “What do you think it says about you to have to take medication?”) That I am a sick person. That I am not healthy.

N:2-143: I would say I am going to die before then because I have a disease that kills people.

N:3-11: ...I passed the math part. I passed with a B so I don’t have to take the math part, but English part... I have to take and I can’t pass it.

N:3-19: The thing is they showing me how to do it. I guess I am not a good test taker. That’s the thing, cause.

N:3-143: I hope I pass this time because I don’t want to be back here.

N:3-57: I may not understand it and I can’t go to nobody and ask.

N: 3-168: But I can’t apply them right (writing rules).

N:4-50: I get some magazines and I look at nutrition but I can’t follow it.

At Follow-Up 1, Nancy reported that she only continued to experience negative and critical self-talk about the English exam. “I am not going to make it if I don’t get the associate[‘s].” She reported that the self-talk was moderately stressful and loud. At

Follow-Up 2, Nancy reported no critical and negative self-talk and stated that she had been feeling very positive.

Sequential Acupressure and Standard Behavioral Counseling Techniques

A variety of techniques were used during the intervention to address the negative and critical self-talk and accompanying negative emotional states that emerged. A frequency count of technique per session and topic was conducted. The results are presented in tables 4.1, 4.2, 4.3, and 4.4. Table 4.1 presents the number of acupressure corrections used during the intervention with Nancy. A greater number (23) of acupressure techniques were used during Session 3 concerning issues about self-esteem and self-efficacy related to performance on a college exam. Table 4.2 presents the number of acupressure techniques used during the intervention with Roberta. A greater number of acupressure techniques (30) were used during Session 2 concerning issues of self-esteem and self-efficacy related to writing and kung fu performance.

Table 4.1.

Number and Type of Acupressure Corrections Used During Nancy's Sessions

Session	Topic	Acupressure Correction Type and Frequency					
		L	S	Y,B	D	SS/SD	E
1	HIV / career	1					
	Trauma / HIV / mom	3					
	Career			1			
2	Career stopped	1	3	1		3	1
	Medication	3	2	1		1	2
	Future					1	
3	Exam / self	6	5	5		1	6
	Future	3	1				
4	Health / eating / exercise	4	2	2		1	5
	Exam / self		4			1	3

Note. L refers to a listening correction. S refers to a seeing correction. Y, B refers to a yes, but correction. D refers to a defensiveness correction. E refers to an emotion correction.

Table 4.2.

Number and Type of Acupressure Corrections Used During Roberta's Sessions

Session	Topic	Acupressure Correction Type and Frequency					
		L	S	Y,B	D	SS/SD	E
1	Health / sweets / trauma	6	5	1	2	5	3
	HIV / career		1			1	1
2	Kung fu / self / writing	16	2	4		3	5
3	Medication	1	2	3		2	2
	Future	3		1		1	
	Self	1	2			2	3
	HIV		3				1
4	Future	2	2				
	Self / family	5	5		1	2	1
	HIV / health /eating	7	5		2	3	2

Note. L refers to a listening correction. S refers to a seeing correction. Y, B refers to a yes, but correction. D refers to a defensiveness correction. E refers to an emotion correction.

Standard behavioral counseling techniques were employed during the intervention with Roberta and Nancy. Table 4.3 presents the number of behavioral techniques used during the intervention with Nancy. A total of five visualizations and four metaphors were used. Table 4.4 presents the number of behavioral techniques used during the intervention with Roberta. A total of eight visualizations, seven metaphors, and three yes, but identifications in language patterns were used.

Table 4.3.

Number and Type of Behavioral Techniques Used During Nancy's Sessions

Session	Topic	Technique	Frequency
1	Trauma	Visualization	0
	Career	Metaphor	1
2	Future self	Visualization	1
	Career & illness	Metaphor	2
3	Skill & perseverance	Metaphor	2
4	Obstacles & future self	Visualization	4

Table 4.4.

Number and Type of Behavioral Techniques Used During Roberta's Sessions

Session	Topic	Technique	Frequency
1	Trauma	Visualization	1
	Life & career	Metaphor	3
2	Younger self	Visualization	1
	Life lesson	Metaphor	1
	Skill	Yes, but	3
3	Future self	Visualization	1
	Medication & illness	Metaphor	2
4	Future self	Visualization	2
	Virus	Visualization	2
	Eating healthy	Visualization	1
	Life	Metaphor	1

CHAPTER 5. DISCUSSION

The aim of this case study was to describe the co-construction communication patterns involved in the reduction of negative and critical self-talk during an HIV behavioral intervention. The self-talk and illness narratives of the participants were co-constructed with the aid and influence of a therapist during the intervention. The absence of negative and critical self-talk was endorsed by the participants one month after the intervention sessions ceased. Both participants had taken active steps in achieving goals that were imagined and generated during the sessions, such as adhering to medication, exercising, reenrolling in school, and registering to take qualifying exams. The communication themes shed light on theoretical as well as clinical issues of importance for the areas of intrapersonal and interpersonal communication, health communication, and HIV.

Six specific implications resulted from this investigation: (a) support for established definitions of self-talk, (b) novel descriptions of the functions of self-talk, (c) negative and critical self-talk reduction as a mechanism of action for self-efficacy, (d) a phenomenological model for the reduction of critical and negative self-talk, (e) convergence between the co-construction process and social support functions, and (f) practical and clinical implications for HIV-infected individuals' uncertainty management.

Self-Talk

The findings in the present study support a notion of self-talk that is created in interaction with others (Burnett, 2003; Burnett & McCrindle, 1999). The presence of childhood trauma and the absence of positive social support during development reduced the likelihood of positive self-talk for the participants. As the participants narrated their

stories about the past, their internalized self-talk with corresponding tone and emotional response was revealed. It became apparent through participant self-disclosure that some of the negative and critical self-talk had been adopted from the participant's primary caretakers, such as parents and teachers. The interpersonal communication data from the close adult figures had been adopted and internalized. In addition to the adoption of the negative and critical self-talk, corresponding negative emotions were also experienced. The narratives and expressions of emotion by Nancy and Roberta support Weikle-Blackwood's (1995) notion that self-talk has accompanying emotional states that may or may not be conscious. The therapist frequently used the ICR muscle tests and emotion checks to seek emotional states that the body was indicating were present but the participant did not verbalize. The therapist repeatedly conducted sequential acupressure emotion corrections while the participants revisited their past experiences.

This study supports and expands upon the notion that self-talk connects the mind and the body through emotional and physical components (Fletcher, 1989). Repeatedly during the intervention, the verbalized emotions corresponded to locations in the body where tightness and heaviness were felt by the participants. The combined sequential acupressure and behavioral counseling interventions resulted in positive outcomes for the participants. Insights into the mind-body connection may serve to inform health care practitioners that verbal communication in addition to specifically applied acupressure may relieve participants of their negative emotional state in a short timeframe.

To my knowledge, this is the first study to document the modification of negative and critical self-talk within the field of communication. The potential for intrapersonal communication to create change and influence behavior through interaction is possible

and warrants further investigation within communication. An expansion of the self-talk dimension in Witte and Meyer's (1995) model presents a plausible starting point. Both Roberta and Nancy engaged in paralyzing self-talk with regard to their medication regimen. According to the extended parallel process model, fearful self-talk has the ability to paralyze an individual from taking action when deciding whether to engage in or refrain from particular health behavior. The presence of negative and critical self-talk may prevent individuals from engaging in certain behaviors such as adhering to medication or exercising. This case study suggests that the function of self-talk in Witte and Meyer's model is fertile ground to pursue intervention approaches capable of modifying the pathways of self-talk toward a more positive and productive direction.

The role of self-talk in the adoption of health behaviors may hinge on the relationship between self-talk and self-efficacy. The prospect that the reduction of negative and critical self-talk works as a mechanism of action in achieving self-efficacy may have far-reaching consequences in the area of health communication. The current investigation demonstrates that the intrapersonal communication phenomenon, self-talk, is recognizable and adjustable within an intervention designed to reduce negative and critical self-talk. Based on the study participants' shifts from negative self-talk statements to positive self-talk statements within and across sessions and taking into consideration the action steps of the participants at follow-up, it is plausible to conclude that the reduction of negative and critical self-talk increased self-efficacy. A frequency count of applied acupressure corrections during the intervention demonstrated that the majority of corrections occurred during the participants' reports of negative and critical self-talk about their perceived inadequacies and doubts. For Nancy, the ability to persevere in

taking a test after failing it three times was a significant issue that was closely tied to her self-esteem and the ability to be successful. For Roberta, the inability to accept critique without feeling bad and her uneasiness with compliments placed her in a bind that did not allow her to feel good about herself. For both of the women, the low self-esteem and lack of self-efficacy was mapped to HIV, childhood sexual abuse, trauma, and relationships with others, namely parents and teachers.

The reduction of negative and critical self-talk may also have an effect on enhanced self-efficacy through the co-construction of positive self-talk, thus permitting the participants to enter positive states of mind. Positive states of mind have been found to be a correlate of HIV medication adherence rates (Horowitz et al., 1988). The participants showed differing levels of ability in accessing and developing positive self-talk, with Nancy appearing to use more positive self-talk than Roberta. However, both experienced a reduction of negative and critical self-talk at follow-up. This may be due, in part, to the phenomenological orientation of the intervention that used the words of the participant. The participants' own words were used as a starting point instead of a predetermined set of self-talk items or points. Furthermore, the positive self-statement modeling of the therapist reinforced positive self-talk. The therapist's calm, reassuring tone and positive words offered a model for positive self-talk that was gradually adopted.

In addition, the reduction of critical and negative self-talk and subsequent development of positive self-talk may have served to maintain self-esteem, as described by Chatham-Carpenter's (2000) investigation. An analysis of the case study text revealed that positive self-talk was created in the intervention. However, the extent to which the new self-talk was used after the intervention was not assessed. Future studies may

consider assessing the frequency and type of self-talk statements that were routinely used after the intervention, in addition to assessing the reduction of negative and critical self-talk.

Co-Construction Process and Social Support

The study findings present a phenomenological model of the co-construction process that led to the reduction of negative and critical self-talk. Three themes, “assessing the present,” “reviewing the past,” and “forging the future,” and eight subthemes, “safe atmosphere,” “disclosure,” “negotiating meaning,” “releasing the past,” “breaking the past-to-present pattern,” “reducing uncertainty,” “generating options,” and “projecting images” describe the co-construction process that led the participants to reduced negative and critical self-talk. The in-depth investigation of this phenomenon suggests that a purposeful method of past, present, and future analysis and projection enabled the co-construction to occur. The primary change portions of the process occurred in the re-creation of past stories and in the framing of the future. The “reviewing the past” part of the process involved visualizations of past events in which the participant was encouraged to add resources to the old images so that they would become stronger and more resourceful. The negative self-talk and accompanying emotions were, in a sense, laid to rest during these exercises and the mental slate was cleared for the production of positive self-talk. During intervention discussions about the future, the therapist encouraged the participants to engage in future visualizations and generate new images and new self-talk to accompany those images. Some descriptions of present accounts exposed old patterns that had been carried over into the present (i.e., Roberta’s use of sweets as comfort food); the therapist made a point to note how the changes were

experienced by the participant from that time to the present. The exercise in itself proved to the participant, “I was that way before and I changed,” and it is possible to change again. Furthermore, the importance of clearing the accompanying emotion when reframing the past events can not be understated. The therapist led the movement across temporal states as needed, first identifying negative self-talk and negative emotional states and then working on certain topics until the negative cognitions and negative emotional charges were cleared through behavioral counseling and acupressure techniques. The purpose of revisiting and reconstructing the past accounts enabled the participant to detach the accompanying emotion and clear any self-talk from the past event.

The underlying structure of the co-construction process that emerged during the reduction of negative and critical self-talk intervention is consistent with a variety of findings across the social support functions literature. First, from a denotative standpoint, social support effectively refers to the “verbal and nonverbal communication between recipients and providers that reduces the uncertainty about situation, the self, the other, or the relationship and functions to enhance a perception of personal control in one’s life experiences” (Albrecht & Adelman, 1987, p. 19). From this perspective, social support, has the capacity to impact a person’s affective, cognitive and behavioral states.(Albrecht & Adelman).

The messages of the therapist in the present study are comparable, in part, to the emotional support and informational support messages described by House (1981). The provision of emotional support includes the elicitation of disclosure, listening, showing concern, and offering encouragement and acceptance. Several co-construction themes

resemble this definition of emotional support: creation of a safe atmosphere, therapist and participant disclosure, and reduction of uncertainty. Informational support refers to the examination of the source of stress and the consideration of alternative options (Albrecht & Adelman, 1987). This support function parallels the co-construction themes: releasing the past, generating options, and projecting images.

The structure of the co-construction process discovered in the present study lends support to Bippus's (2001) factors of comforting messages. Comforting messages refer to verbal messages that alleviate a distressed person's emotional state during everyday events (Burlson). Bippus conducted a factor analysis based on two studies that evaluated the skill and outcome of comforting behaviors by individuals who had experienced a comforting interaction. There were five evaluative factors: (a) other orientation, (b) problem-solving, (c) relating, (d) refraining from general negativity, and (e) different perspective. Four of the five factors are conceptually similar to the co-construction themes revealed in this study. The other orientation refers to the ability of the comfort provider to create a therapeutic atmosphere (Burlson). The co-construction theme, creating a safe atmosphere, is the first subtheme listed under assessing the present and is the first step of the negative and critical self-talk reduction co-construction process. The second factor, problem-solving, which refers to the comfort provider's offering of solutions to the distressed person's problems, does not fit into the co-construction theme structure. According to Bippus, problem-solving includes suggesting and advising a course of action during the comforting interaction. This strategy is unlike the intervention in which the participant is encouraged to arrive at his/her own solutions. The relating factor, which refers to the comfort provider's use of disclosure as a form of distracting

the distressed person while offering a story about a similar experience, is similar to the present study's second subtheme, disclosure. Although not listed as a theme of the co-construction process, the core of the intervention was to reduce negative feelings and behaviors through the reduction of negative and critical self-talk. The undercurrent of the intervention is similar to the refraining from general negativity factor that refers to the absence of negative responses and behaviors on the part of the comfort provider. The different perspective factor expresses the comfort provider's effort to provide alternative views to the distressed person's problem. The co-construction process theme, reviewing the past, includes reviewing and releasing the past, while the forging the future themes, generating options and projecting images, enable the participants to view their problem in a different light.

Bippus's (2001) second study focused on finding outcome factors resulting from the experience of comforting interactions. There were three outcome factors found: (a) positive mood (e.g., smiling, laughing, and feeling more positive following the comforting interaction), (b) empowerment (the feeling of being better able to handle problems), and (c) stopped rumination (being able to stop focusing on the problem). Evidence of these outcome factors appear in the follow-up reports of the participants in the case study. The participants reported no negative and critical self-talk and instances of specifically telling themselves to not think negatively any more; feeling more positive; and movement towards medication adherence, exercising, and advanced education. The great similarity between the case study co-construction themes and comforting interaction evaluative and outcome factors in this study not only offers support for comforting research strategies, but also advances the notion of supportive interactions that are

capable of altering self-talk toward specific health behavior outcomes. Additionally, the distinction between chronic illness support and everyday support may not be significant, given the similarity in messages and structure. The influence of nonverbal messages in the present interaction in the context of support messages warrants further investigation.

Uncertainty and Struggles with HIV

The co-construction theme, forging the future, identified in the present study includes the co-constructed process of uncertainty reduction that occurs prior to the elicitation of alternative options and the generation of future images. Uncertainty reduction, a well-documented area of health communication, is vital to the illness experience (Babrow et al., 2000; Brashers & Babrow, 1996). During the intervention, the participants' negative and critical self-talk was often accompanied by an emotional state. The acupuncture techniques worked to clear the negative emotional states and to reduce the emotional charge in the past and prevent the emotional states from carrying over into the present and future. These instances, however, were not accomplished without some clinging to the past or resistance to move forward by the participants. The uncertainty evident in the interaction was countered by the supportive functions of the therapist. The study by Brashers et al. (2004) describes the supportive role of others in managing uncertainty about HIV. The researchers investigated how social support potentially aids and interferes with uncertainty management in the areas of health, identity, and relationship concerns. The researchers analyzed the data derived from six adult focus groups using a constant comparative technique to discover themes. Social support members provided identity acceptance and validation and helped the ill person focus on important decisions about care, thereby reinforcing the concept of co-constructedness in

illness. Brashers et al. notes the importance of a social support team, stating “Supportive others participate in uncertainty management by assisting with information seeking and avoiding, providing instrumental support, facilitating skill development, giving acceptance or validation, allowing ventilation, and encouraging perspective shifts” (p. 323).

The therapist in the present study manifested four out of the six guidelines for providing such support: (a) facilitating skill development, (b) giving acceptance or validation, (c) allowing ventilation, and (d) encouraging perspective shifts. According to Brashers et al. (2004), the illness experience includes personal, social, and medical forms of uncertainty. Areas of uncertainty for the study participants revolved around career, skill mastery, and long-term health. The supportive role of the therapist in the SAB intervention has clinical implications for HIV interventions through the modeling of questions, prompts, self-talk, and illness narrative co-construction.

The issues and doubts that surfaced about career, the future, and medication were, in many ways, similar to the issues that surfaced in Westerfelt’s (2004) qualitative study of 21 HIV-positive men. In the study, three themes regarding adherence to medication emerged: (a) desire for information, (b) struggle to adhere, (c) and struggle to control. All of the themes but the desire for information was shared by the participants in the present study. Struggle to adhere often referred to the participants’ management of side-effects. Roberta and Nancy expressed concerns about weight gain and liver toxicity. Both women, at different points in time, doubted the efficacy of the medication and became keenly aware of the side-effects. Although not an insurmountable problem, the side-effects of HAART posed challenges in establishing a medication routine. According to

Westerfelt's findings the adherence struggle often led to a variety of opinions and feelings within the same person to adhere and to not adhere, suggesting that the decision to adhere fluctuates over time, even over a day within the same person. These fluctuations in adherence were evident in the current study participants' lives as well. Another noted struggle found in Westerfelt's work was the struggle to control. Struggle to control referred to the task of incorporating the medication regimens into the daily routine as either another part of life or an all-consuming task. Roberta and Nancy expressed both sides of the medication incorporation struggle. Roberta stated that medication became a focal point of her life that limited her, while Nancy, although dissatisfied with having to take medication, stated it was just like taking a vitamin. The struggle to adhere and struggle to control were addressed in the context of the intervention to reduce negative and critical self-talk. The phenomenological structure of co-construction described in this study provides a roadmap for health care practitioners and providers to follow when addressing medication adherence struggles.

Illness Narratives

The verbal exchanges between the therapist and the participant displayed modified Labov (1972) and Polanyi (1985) conforming narratives and nonconforming co-constructed narratives. The intervention demonstrated how the therapist challenged and skillfully confronted the participants in the search for deeper narrative structures. The nonconforming narratives were richer and were characteristically similar to the nonconforming co-constructed narratives found by Eggly's (2002) investigation into patient and physician interactions. Eggly's statement summarizes the social constructionist nature of illness narratives within the health care context: "Illness is not

an objective phenomenon over which physicians have unique ownership or expertise; instead, illness is demonstrated to be an interpretive phenomenon constructed through the active participation of both doctor and patient during their interactions” (p. 358).

This study confirms the narrative types described by Eggly (2002), defined as those co-constructed by health provider and patient toward the elaboration of key events through repetition and negotiation of the meaning of key events. However, it differs from Eggly’s account because the narratives encountered in this study advance the notion that co-construction can be guided by the therapist’s intent toward participant well-being. In the SAB intervention, the therapist demonstrates an active agenda of collaborative repairing and restoring self-talk and narratives towards more positive text while increasing the likelihood of positive health outcomes.

The evaluation of cancer narratives conducted by Mathieson and Stam (1995) analyzed 37 interviews with cancer patients to learn how “narrative was revised and constructed in illness” (p. 286). The biographical work theme from the Mathieson and Stam study matched the renegotiations experienced in the SAB intervention. Particularly, the renegotiations concerning the long-term work over the lifespan as a stable requirement of identity. This ongoing work is distinct from the work involved in signals of identity threat and negotiated identity, which tend to occur after initial diagnosis. During biographical work, “the cancer patient must ultimately decide how the events of illness fit in among the other events of her life. This inevitably entails uncertainty, doubt, and revisions for the future plans” (p. 299). Biographical work aptly describes the work undertaken by the participants in the intervention.

Roberta and Nancy's personal narratives reveal that their conscious concerns revolve around their careers. Their HIV diagnoses severely impacted their perspectives on the future, despite the hopes and successes of HAART. Neither could see themselves out into the future beyond 20 years. This lack of future orientation was closely tied to medication issues and the meaning of living as a sick or healthy person. It repeatedly arose in the intervention and related to the participant's visualizations of the future and their ability to take action steps in the present. Once the participants began narrating their identity as healthier, they were able to generate future healthy images of themselves. The co-construction of illness narratives that emerged during the reduction of critical and negative self-talk intervention has practical relevance for the chronically ill in communication contexts.

Limitations and Future Directions

Several limitations of the study should be considered when evaluating the findings. As a qualitative case study, the findings are not generalizable to an HIV-positive population or a chronically ill population. One of the purposes of the case study methodology purports to explore contexts that have not been previously observed. The findings in this study revealed a series of communication patterns that reduced negative and critical self-talk during an HIV behavioral intervention. In addition to providing a model for practitioner use, it adds to the literature by replicating research in the area of comforting message research. Of particular interest is the overlap between the co-construction themes identified in the case studies and comforting message strategies. The similarity in message strategies suggests that comforting messages may have longer term implications than anticipated and that the strategies used for individuals with chronic

illness do not differ dramatically from the strategies present in everyday comforting interactions. Future comparisons of strategies between acute stressors and long-term stressors are indicated.

Another limitation was the use of self-reporting for adherence to medication data. There is the possibility that, at follow-up, the participants responded in a socially desirable manner. It seems that, during the intervention, the participants thoroughly described doubts about taking their medication in addition to reporting shifts in medication adherence within the 4-week timeframe. Subsequent studies need to involve the use of testing to achieve greater precision in medication reporting.

The absence of nonverbal behavior coding presents another limitation of this study. Except for acupressure, no other nonverbal behaviors were noted. Coding for nonverbal immediacy, such as smiles and forward leaning, would provide further data for comparing and advancing comforting message research and the social support literature.

Future directions for practical and theoretical inquiry indicate that the use of conversational analysis techniques may provide microstrategies for health communication interventions. The more detailed-level analysis may yield specific strategy composition for use in health communication interventions.

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