The development of theory in narrative family therapy: A reflective account

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Abstract
In this paper I will discuss the position of narrative family therapy within the history and context of the broader church of family therapy and systemic practice. I will then consider, critically, the implications for the development of my own practice as a children’s community learning disability nurse using narrative therapy ideas.

“Experience is not what happens to a man; it is what a man does with what happens to him” — Aldous Huxley (193, p. 5)

Keywords
narrative therapy; family therapy; systemic practice; reflection

What narrative therapy?
Stories and narratives have existed for as long as humans have had language. They have brought meaning to the world, and have allowed for history and tradition to be related through generations. How we respond to stories, or narratives, is the concern of narrative therapy; both the ones we create ourselves but also those that are ascribed to us by others, culture, and wider society. Through narrative therapy, in collaboration with a therapist, it is suggested a person can discover and re-author their own problem-saturated stories (White & Epston, 1990).

I was initially overwhelmed by the variety and breadth of models and theories to choose from, but during the last two days of my family therapy and systemic practice training many things started to make sense. I was able to consolidate my understanding of the history and context of family therapy; this in turn allowed me to consider more fully my own epistemological position and current practice in relation to a number of family therapy developments and models. I realised that many of the ideas in narrative therapy not only felt very coherent with my philosophical stance, but also mirrored aspects of how I currently work. I have also considered how I could better incorporate these ideas in a more ontologically secure way into my practice that recognises the origins of some of my thinking regarding work with children and their families. It has allowed me to see the nuanced differences that there are with some other aspects of how I work with families that at first sight may appear to be narrative in nature but are actually based within a different theoretical frame.

Narrative therapy resonated very much with the philosophy of working with people with learning disabilities, and reacquainted me with Goffman (1961) which is a key text when considering the effect of ‘total institutions’ and that disability is a construct created by society rather than an objective truth. The other aspect that drew me to this model was its collaborative nature, which is how I currently work. It also fits with the use of person-centred planning: a predominant philosophy in learning disabilities practice (Department of Health, 2009) whereby clinicians support people with learning disabilities to make their own decisions about their lives no matter how disabled they may be judged by society.

The development of narrative therapy
Narrative therapy was co-developed in the 1980s by Michael White, based in Adelaide, Australia, along with David Epston, based in Auckland, New Zealand (Carr, 2000). White and Epston were very influenced by the post-modernist and social constructionist movements.

The first development of family therapy was Minuchin’s structural family therapy followed by the second phase of constructivist family therapy that included both the strategic and Milan models. Narrative therapy was in sharp contrast to these two perspectives particularly in its stance against individual diagnosis and systems theory (Carr, 2000), and yet aspects of these models still inform parts of narrative therapy and are acknowledged in individual therapists’ personal development journeys (Hayward, 2003). Narrative therapy was also informed by wider sources such as post-structuralist philosophy, anthropology, and...
feminist writings (e.g., Carr, 2000). Narrative therapy is grounded in many of Foucault’s ideas around power/knowledge and also ‘truths’ that become such because they have been ascribed as such by society or political mores (Besley, 2002).

Etchison and Kliest (2000) ask why there is such a small evidence base with narrative therapy despite it being an established family therapy approach for more than a decade. Larner (2004) suggests that the way research is considered is so skewed towards empirical evidence bases that social constructionist approaches do not fit, or even strive to fit. As he says, narrative therapists tend to evaluate their efficacy through dialogue with individual clients rather than research studies.

There is an emphasis on language and communication in narrative therapy. Familiar words may be used with new or specific meanings and there may be very deliberate use of non-stigmatising terms that avoid traditional expert terminology (Besley, 2002). It is suggested that the problems that people present with come from a conflict between what they themselves believe about their own experience and dominant oppressive narratives imposed by others. Narrative therapy challenges the biomedical model that locates the problem within the person. Problems are viewed as separate from the person and there is an assumption that the person will have the strengths and capacity to change their relationship with their problem (Morgan, 2000).

Narrative therapy “centres people as the experts in their own lives” (Morgan, 2000, p. 4). Therefore the positioning of the therapist is important; rather than an expert they become a collaborator who acts as a consultant guided by the direction the individual wants to go. Therapy should not be concerned with beginnings and endings but with “creating space for a specific kind of conversation between participants” (Boston, 2000, p. 451) where the therapist is curious and comfortable ‘not knowing’.

In narrative therapy it is believed there can be many stories happening at the same time for a person both positive and negative. They will be to do with the past, the present, or the future and there will also be stories from wider contexts such as the family, community, and society. Narrative therapy aims to allow a person or family to re-author their stories so that they feel cogent with the way they live and so perceive things in a better frame (Carr, 2000). I find this a very useful lens to have when I am working with families where a disability is not going to be ‘cured’ or go away and where the family will continue to have difficulties. If they are able to consider an alternative story to the dominant one, they may find it less difficult to bear.

**Narrative therapy and my own practice**

When considering my own practice and narrative therapy I was very influenced by an article by Alice Morgan (2002). She discussed how she had been intimidated by the thought of a ‘pure’ model that she did not feel competent enough to adopt. She then started to notice what she was already doing that was within the narrative model and incrementally built on this. I liked this idea and started noticing what within my current practice I do and could develop.

**Positioning of the therapist**

There is much literature describing narrative therapy and its philosophical position (Carr, 2000; Morgan, 2000); however, there are still challenges to both its epistemology and its applicability. Carr (1998) suggests that it is important to be aware of the tension between the power that will be inherent for some clinicians working with a family and the need to take a collaborative position with the family that does not strengthen the oppressive dominant narrative. Due to the nature of my role it is difficult for parents not to come with a view of me as an expert in learning disability, autism, or behaviour, and sometimes they are actively seeking this. When I first meet with them I try to engender a collaborative approach that positions them as the expert with their child, or, with older children, them as the expert of their lives. I am there to ask questions and provide guidance directed by their needs.

I am mindful of the danger of a label or biomedical description defining an individual and their perception of themselves. Where I differ from the strict interpretation of a social constructionist, narrative therapy philosophy is in my belief that labels can sometimes be helpful to both the individual and the people around them in understanding the behaviour of that person and offering them appropriate support. This has been based on my experience working with parents and individuals with different conditions, and those with uncertain aetiology, and what they have said from both sides of the argument. In trying to show a different perspective to the ‘problem-saturated descriptions’ of the child with a disability I do, however, often offer a parent the chance to look at their problem with a different lens than the
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one that may be the dominant narrative.

Larner (2004, p. 19) describes narrative therapy "As a collaborative and reflective form of therapy, the person’s language and agency is given priority rather than a particular model or technique”. I currently write my notes on carbonated sheets whilst I am with the family and am explicit that the copy I keep is what constitutes their notes. This allows for openness and for them to be able to hold a record of what we have discussed. I try to use their words and terms as I write; I also offer suggestions or ask questions. Particularly after reading some of the ways Epston (2008) writes to individuals and families, I feel this is something I could develop more fully.

Mapping the influence of the problem

Although narrative therapy is not focused on the problem, it does acknowledge its influence. This helps with identifying a person’s strengths, resources, and exceptions to the problem (Lambie & Milsom, 2010). This creates the context for externalisation. I have found that I am currently often "mapping the influence of the problem" (Guterman & Rudes, 2005, p. 4) with families, but was not aware it was part of this model as I was more familiar with exceptions within a solution-focused brief therapy model (De Shazer, 1985).

Externalisation

I was surprised at how much externalisation I already do in my practice. Sometimes it is closer to the externalisation as described by narrative therapy practitioners (Epston, 2008; Morgan, 2002) but I note now that some other similar techniques which I may initially have taken for part of narrative therapy are subtly different and therefore work slightly differently, such as Social Stories (Gray, 2010), Comic Strip Conversations (Gray, 1994), or social scripts (Byng-Hall, 1995). I find for a lot of people I work with analogy, metaphor, and descriptions, supported with pictures or objects, can really help them to understand complex or abstract topics.

Where I have not used externalisation so much is with young people regarding their view of themselves as learning disabled (Lambie & Milsom, 2010) and I feel this is an area I could usefully develop for some of the young people I work with.

Unique outcomes and thickening the plot

Whilst mapping the influence, and subsequently externalising the problem, the therapist needs to be attuned to the person’s accounts of their strengths, resources, and when the problem is not occurring. They need to identify these points as ‘unique outcomes’ (Goffman, 1961) and provide ways to re-author new stories.

There are often many reasons for someone to have held on to a particular story of a problem for themselves and these problem-saturated stories will often have been developed over a number of years. The new story needs to be potent enough to replace the old one and this can only happen through developing detail or thickening new plots (Carr, 1998). This can be done using landscapes of action questions around the events, sequences, time, and plot, and landscapes of consciousness questions that relate to meaning, effects, evaluation, and justification. These two domains and their distinctions were first described by Bruner (in Carr, 1998). From this thickening of the plot, links need to be made with past events and then into the future and how things could be without the problem. In practice, I find this to be the most difficult to do. Indeed Harper and Spellman (2006) warn of assumptions being made in narrative therapy that a person can ‘magically’ replace old stories with new and believe them. Although I have often looked with families at exceptions to their problems, and I will also try to look to the future to help them plan their steps to new alternative outcomes, I have not followed this particular process explicitly.

Conclusions

I am interested to see how possible it is to integrate forms of family and systemic therapy further into my practice, but I am unlikely to solely use one approach. Larner (2004) cites the work of Miller and Duncan which suggests that the actual method or type of therapy used only accounts for 15% of its success. Larner (2004) also suggests that we need to be aware if using an integrative model of family therapy that different approaches seem to have success in different presenting difficulties. It talks of narrative therapy being more successful than behavioural approaches for psychosomatic conditions such as soiling.

Hayward (2003), in his response to critiques of narrative therapy, postulates that narrative therapists have often come to that point through a journey of beliefs in how to practice ethically and they may be clear that they want to work strictly within that model. These therapists can subsequently be criticised for not embracing the wider schools of family therapy. Yet Bowen in his introduction to Epston (2008) talks of how narrative therapy practice in Britain has managed, he feels, to encompass both a whole
model approach as well as practitioners using aspects of narrative therapy to enhance an integrated approach to therapy. I feel that using narrative therapy practices as part of an eclectic model will enrich what I can provide for families (Guterman & Rudes, 2005).

**Reflection**

This paper has allowed me to gain much greater insight into the general historical context of family therapy models and approaches, and where all the different ideas fit into that context. It is not linear, it is not easily defined. In fact it can be downright messy with overlaps, tensions, and dilemmas of epistemology. Many, if understood well, may offer the therapist the chance to creatively look at how to best support a family. This exercise has allowed me to be clear that I would not use a purist or singular narrative therapy approach. I feel this is also how it has essentially developed over time in that narrative approaches are very much incorporated into a more integrative model these days rather than used in isolation (Larner, 2004; Carr, 2000). What it has given me is a greater understanding of the development of narrative therapy's history and its place in the wider context family therapy and systemic practice. I have been able to consider the issue critically through a variety of literature. On a philosophical basis, I would agree with Carr (1998) and Hayward (2003) that narrative therapy can be an ethical way of working and drives one to continually question that global truths are more valuable than local knowledge. This has allowed me to work towards creatively incorporating ideas, such as working with children and families to be ‘experts in their own lives’ or externalising, into my own practice.

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**References**


