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Narrative Therapy: Similarities Among Clinicians and Practice Implications

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by

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Abstract

Narrative therapy is a philosophy-based approach to therapy that emerged in the 1980's, and has been incorporated into various practice settings. The purpose of this study was to identify if there are there commonalities among those who practice narrative therapy. In addition, this study inquired whether there are there commonalities in the application of narrative therapy. Eleven mental health clinicians in the Twin Cities filled out an online mixed quantitative and qualitative survey, via Qualtrics. Survey responses indicated similarities among those who practice narrative therapy with the following identified themes: formation of clinical identity, power of words, belief in the possibility of multiple stories, and positioning of the therapist. Survey responses indicated differences in the application of narrative therapy with the following identified themes: training and range of practice incorporation. Further research would be beneficial to explore the settings in which narrative therapy is being utilized and how clinicians incorporate narrative therapy with other therapeutic modalities.

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Narrative Therapy: Similarities Among Clinicians and Practice Implications

Narrative therapy is a relatively new approach to therapy, with the spread of literature and practice around the world beginning in the 1980's (Besley, 2001).   Narrative therapy is rooted in post-structuralism and was developed by Michael White in collaboration with David Epston (Carr, 1998). In describing narrative work, White said, "Is this work better defined as a world-view? Perhaps, but even that is not enough. Perhaps it's an epistemology, a philosophy, a personal commitment, a politics, an ethics, a practice, a life, and so on" (White, as cited in Freedman & Combs, 1996, p. 1).

 White's quote suggests the complexity of the narrative model, even in defining the practice. Through the focus on experience, narrative therapists facilitate the development of a person's narrative, positioning themselves as a co-investigator in the development, telling, and re-authoring of stories to determine what other possibilities there may be from the stories that the client views as problematic. Narrative therapy is more than a modality of conducting therapy. When a clinician decides to draw primarily from narrative therapy, they have decided that they align with a philosophical perspective, and they are open to this difficult to define, complex, and empowering work (Combs & Freedman, 2012).

 Narrative therapy relates to social work in many ways, particularly through its emphasis on social justice. This is exemplified by a narrative process which involves the clinician linking their client to others who have struggled with similar issues, as they grow in the ability to live out their preferred story. Through this linking of resources, individuals are able to come together and join others to collaborate and have their voices heard through mezzo or macro levels in society. Clinicians also bring power differences in society to light, through the questions they ask. This invites clients to look at how societal influences impact their life, and how they want to consider those factors as they re-author their narrative (Combs & Freedman, 2012).

With narrative therapy as a newer practice that is defined as broader than a clinical modality, this leads to curiosity of the research that has been conducted surrounding the practice. There is not a large amount of generalizable, quantitative research on narrative therapy. This is in the spirit that narrative therapy, which puts value on experience and meaning making which is offered by qualitative research (Etchinson & Kleist, 2000). Literature on narrative therapy continues to emerge, though the therapists who choose to work in a narrative way have not been studied. Research has been conducted related to the development of clinical orientation, and has indicated that factors such as training, source of knowledge development, and personality are factors that influence the development of a therapist's clinical orientation (Arthur, 2001). This research, along with the philosophical foundation and the associated practice concepts may lead to curiosity about the clinicians who choose to incorporate narrative practice. This also may lead to further curiosity surrounding how clinicians actually use or apply narrative therapy into their practice.

The focus of this project is to gain perspective on what commonalities exist among therapists who practice in a narrative way. This project also seeks to explore whether the application of narrative practice is similar among clinicians. A mixed qualitative and quantitative survey was sent to therapists who identified as practicing in a narrative way in an urban setting in the Midwest. The following is the conceptual framework which guided this project, followed by a review of the literature surrounding narrative therapy and clinical orientation, the methodology used, the findings, and a discussion.

Conceptual Framework

There are certain theories that have guided this study. One theory that guided this

study is poststructuralism, which is what principles behind the formation and practice of narrative therapy are based upon. Poststructuralist philosophy incorporates the belief that there is no absolute truth, and that there are exceptions to rules (Freedman & Combs, 1996). Poststructuralism also focuses on power dynamics, as models of therapy that stem out of poststructuralism focus on the clinician as a non-power figure (Kogan & Gale, 1997). Held (1995) described why therapists may align with poststructuralist ideas expressing, "Despite almost 50 years of scientific study of psychotherapy, there is still surprisingly little consensus about what causes problems and what causes solutions" (p. 14). The influence of one's philosophical perspective is central to their development as a person and clinician, particularly when aligning with a model of therapy that is heavily based on philosophy.

Another theory this study draws upon is the person-in-environment perspective that is central to the social work profession. The person-in-environment perspective looks at the many aspects that influence an individual's life, considering the biopsychosocial factors that may impact a person (Hutchison, 2008). The person-in-environment perspective can be helpful in understanding the influences behind the clinical development of a therapist, including variables such as gender, age, and history with narrative therapy. The influence behind an individual's belief system may guide clinical development and identity as a therapist who practices in a narrative way, which has specific philosophical and political tones.

Combining poststructuralist philosophy with person-in-environment theory is helpful in understanding what driving forces are behind of a clinician's desire to work in a narrative way. This study explores several different factors of narrative therapy and a

clinician's life to see what, if anything, therapists who practice in a narrative may have in common and if application of narrative therapy is similar among clinicians.

Literature Review

Poststructuralism

Poststructuralism stems from structuralism, which is society's dominant viewpoint and still remains the dominant culture in counseling (Combs & Freedman, 2012). Poststructuralism incorporates the belief that there is no absolute truth, and that there are exceptions to rules. This is different from structuralism, which incorporates the belief that there is a worldview and basic truth that all individuals share (Freedman & Combs, 1996). Poststructuralist models are more interested in individual knowledge rather than generalization, whereas structuralist models involve analysis and the formation of experts categorizing disorders and generalizations. (Combs & Freedman, 2012). Models of therapy that stem out of poststructuralism focus on the clinician as a non-power figure (Kogan & Gale, 1997). The practice of narrative therapy aligns with these key aspects of poststructuralism (Freedman & Combs, 2012).

Narrative Therapy

Emergence. The collaborative work of Michael White from Australia along with David Epston from New Zealand led to the emergence of narrative therapy (Lock, Epston, & Maisel, 2004). Narrative therapy literature and practice spread in the late 1980's in the United States and Europe, among other countries (Besley, 2001). The practice of narrative therapy continues to spread around the world, and is considered to be a mainstream therapeutic modality. Training and narrative therapy centers have spread to places such as: Canada, the United States (including Minneapolis, MN), the United

Kingdom, Greece, and Australia. David Epston continues to speak and provide training

around the world, while Michael White died in 2008 (Narrative Therapy Centre of

Toronto, n.d.).

White and Epston were influenced by the concepts of knowledge and power

brought forth by Michel Foccault, a French philosopher. Foccault philosophized about

knowledge and power, arguing that one cannot occur without the other. He was

interested in looking at the complicated relationship between knowledge and power

(White & Epston, 1990). White and Epston were very intrigued by this, which can be

seen in practice concepts associated with narrative therapy. One concept of narrative

therapy involves externalization of the problem. Making the problem external from the

person separates the knowledge and belief that the problem is their truth, dismissing what

they had believed was concrete truth and empowering them with new and more preferred

options (White & Epston, 1990). This is one example of how Foccault's influence can be

seen in the practice of narrative therapy.

The therapeutic relationship. Narrative therapy rejects the idea that clients are

to be pathologized by the expert, who has historically been the therapist. Instead, the

client and therapist work together to investigate what the client has come to feel is

problematic, exploring different possibilities of a more preferred life (Angus & McLeod,

2004). The position of the therapist is decentered, both in the client's story and while

investigating larger societal messages and norms (Kogan & Gale, 1997). A narrative

therapist and their client unite together against what has become problematic, through the

use of narrative concepts such as externalization, which is seen as considering the

problem as separate from the person. Once that is established, the client and the therapist

can discuss the problem as its own separate entity and unite together against the problem

(Monk et al, 1997). A narrative therapist asks questions in a skilled and curious manner

to invite the client to bring forth what they know and have experienced (Freedman &

Combs, 1996).

      Concepts. Narrative therapy incorporates the use of metaphor, which is a tool to

help make meanings of life events (Combs & Freedman, 2012). The use of metaphor in

narrative work strongly influences the work (Freedman & Combs, 1996). A common

example of how metaphor is used is that, "The main character in the plot is frequently

positioned in the therapeutic conversation as the courageous victor rather than the

pathologized victim…" The "main character" is the client, who is a "courageous victor"

as they explore and discover preferred ways of working with their problem (Monk, 1997,

p. 4).   This exploration is done in a non-pathologizing manner, as narrative therapy has a

lack of emphasis on diagnosis (Hill, 2012). Therefore, in the early stages of narrative

therapy, the therapist and client find a name for a problem that they both find acceptable

(Lock, Epston, & Maisel, 2004). In the end, the client's language is privileged rather than

the therapist's interpretation or own wording (Carr, 1998).

      Narrative therapy is a practice that not only puts value in the importance of words

and language, but also in the importance of experience and a person's external

environment. Narrative therapy emphasizes the influence of social construction, which is

defined by the ways in which interactions with both other people and institutions has led

to the creation of a person's social reality (Freedman & Combs, 2012). Another way to

view social construction is by what has come to be seen as real through society's

acceptance of things that are considered social norms. The influence of others is an area

of exploration in narrative therapy. People influence, and are influenced by others' beliefs

and actions; therefore, any sort of social group plays a part is a person's story (Combs &

Freedman, 2012). Other orientations of therapy may look at how a person's social

network has been problematic to their situation. Instead, narrative therapy looks at how

the social network can be seen as a positive resource to help the person stand up against

their problem (Carr, 1998).

   The process. A key aspect of narrative therapy involves externalizing the person

from a problem they are experiencing (Monk et al, 1997, p. 13). Externalizing means that

the person gives voice to, or personifies, the problem they are up against; therefore giving

the problem a separate identity from the person (White & Epston, 1990). The ability to

see the problem as not a part of the person is a way to give distance from the problem-

saturated story that a person may be experiencing, and allow people to develop a greater

understanding of the problem and of themselves outside of the problem (Combs &

Freedman, 2012). An example how language can incorporate externalization would be

calling a person who struggles with anorexia "A person experiencing anorexia" instead of

"An anorexic person" (Lock, Epston, & Maisel, 2004).

   Deconstruction is an important concept and process that occurs in narrative

therapy. The deconstruction that occurs has to do with what has been an individual's

dominant story, much of which has been largely influenced by society. First, the

dominant story is brought to awareness, or to the conscious mind. The therapist and

client work together to deconstruct what has come to be problematic through the therapist

asking questions to look further into how this story has become a dominant story, though

not necessarily the correct story or only option (Angus & McLeod, 2004). A large part of

this may include investigating how cultural norms may have been an influence in how the problem was constructed (Monk, 1997). As a perceived problem becomes deconstructed and the hold of it on a client's life has become distant, an alternative way of working with the problem is developed (Angus & McLeod, 2004). This alternative way is seen as the construction of a preferred reality (Monk et al, 1997).

The creation of a preferred reality can also be seen as re-authoring, a narrative term that implies the creation of a preferred reality through previously unseen possibilities (Lee, 1997). Once a problem is deconstructed and distanced from the client, the client and clinician work together to discover a different story. Through curiosity of the therapist and skilled questioning, the therapist can assert if there has been any sort of shift of the client in position with the problem. Any slight shift can be seen as an area to explore and work with. The therapist can work to help a client identify where there has been a shift, or to help bring it to the conscious mind for the client. At this point, the therapist can advocate for the client through being persistent in helping to continue the shift in narrative and remaining curious and observant. The process of re-authoring can be quick for some clients, and long and complicated for others. It is essential that therapists remain intuitive and creative when looking at the smallest of shifts, and at the history of how it came to be in a person's life (Monk et al, 1997). Re-authoring can bring forth personal growth, an increase in self-knowledge, and self-reliance (Lee, 1997).

Development of Therapists' Sense of Clinical Orientation

   Research behind clinical orientation. Clinicians tend to define or advertise how they practice in terms of what clinical orientation(s) they utilize (Buckman & Barker, 2010). There are not copious amounts of published literature on therapists' choice of

clinical orientation (Arthur, 2001). Research that has been conducted on therapists' view

of the development of clinical orientation suggests that epistemology, training, and

personality are important influences, as cited in Arthur (2001). Philosophic worldview is

another factor that has been identified as an important influence, along with the

theoretical framework of training courses and supervisors' clinical orientation (Buckman

& Barker, 2010).

In a study done by Skovholt & Ronnestad (1992), semi-structured interviews of

100 clinicians were conducted to look at therapist development. Themes were then

identified. One theme identified that clinicians who were early in their career relied on

external experiences, while clinicians further along in their career relied more on their

internal judgment or knowledge. Another theme identified that a clinician's style of

working becomes more in line with their personality and thought processes as they go

further along in their career. Some therapists reported straying away from certain

approaches as their career developed, because they felt the approach was not harmonious

with them as a person. While research suggests various reasons behind clinical

orientation, other researchers believe that clinical orientation is a result of factors that are

inadvertent (Arthur, 2001).

Narrative Therapists' Choice of Theoretical Orientation

Distinction. Combs & Freedman (2012) wrote that narrative therapy is more than

an orientation of conducting therapy, but can even be distinguished as a way of living. A

few reasons for this include the social justice practices that are incorporated into narrative

therapy, along with the interest of the therapist in the possibility of multiple ideas when

re-authoring an individual's story. For example, therapists who practice in a narrative

way collaborate with their clients to work toward the client's preferred way of living, and ultimately support what the client prefers, rather than the therapist. Narrative therapy also recognizes societal norms and dominant stories that suggest what an individual "should" do. Clients' recognition of this can be empowering (Combs & Freedman, 2012). A narrative therapist ideally serves as both a consultant at the personal level, and at the political level in regards to the mental health discourse in our society along with societal norms which are culturally prevalent (Carr, 1998).

There are practices associated with narrative therapy to assist clients in feeling less marginalized and isolated. A practice of narrative therapy, called taking-it-back involves the client sharing what they have received in therapy with others. For example, the individual may be asked to allow the therapist to share a document they created with others who are attempting to stand up to the same issue. Another example may involve the therapist sharing with their client positive impact that their client's narrative had on them, following the belief that therapy changes both clients and the therapists (Carr, 1998). Another process involves inviting other therapists or people in a client's life to take witness. An outsider witness group is a client's support team, identified by the client, who are invited to come to a therapy session and take part in what the client has created as their new narrative (Carr, 1998).

Overall, when an individual decides to work in a narrative way, they have decided that they align with the overarching philosophical perspective (Hill, 2012). As previously mentioned, this philosophical alignment is one identified way that research suggests that therapists choose a clinical orientation (Buckman & Barker, 2010). A personal belief in the concepts associated with narrative therapy along with the social justice and political

aspects of narrative therapy are essential to a clinician's decision to engage with narrative concepts and practice.

Research Question

With the unique and complex aspects of narrative therapy, one might wonder how individuals end up practicing in a narrative way. With research suggesting that there are many personal aspects that are influential to therapists when looking at what clinical orientation(s) to incorporate, the first question this study aims to look at is: Are there commonalities among those who practice narrative therapy? As a result of narrative therapy being a relatively new and hard to define modality of therapy, the second research question is: Are there commonalities in the application of narrative therapy?

Methodology

The purpose of this study was to explore what those who practice narrative therapy have in common in their clinical identity formation as therapists and if there are commonalities in the application of narrative practice. This study focused specifically on clinicians who identified as practicing in a narrative way.

Research Design

The research design for this study was a written questionnaire utilizing both quantitative and qualitative questions. The written questionnaire was distributed via email to participants utilizing Qualtrics.com, an online survey tool, with access provided by the University of St. Thomas. Survey questions included demographic questions of the participants, the history of narrative therapy in a participant's life, and questions that attempted to gather why the participant chose to practice in a narrative way.

Because the basis of narrative therapy involves looking at an individual's experience and constructed life story, the research design and methodology for this study

was chosen to collect data in a way that gives participants a way to tell the story of what drew them to this specific approach to therapy. In order to gather information about the clinicians, demographic questions were added as well. The majority of the questions were qualitative, which was appropriate for the premise of narrative therapy along with the exploratory nature of this study. The open-ended questions allowed participants to put their experiences in their own words, and personalize the data (Monette et al., 2008).

Sampling

The population for this study was therapists who identify that they practice in a narrative way across the Twin Cities area. The proposed sample size was 20 clinicians.

In order to obtain the target participants for this study, the researcher used a few different methods. The researcher looked-up clinicians on psychologytoday.com, and used their email given as public data to send the survey via email to those who identified "narrative" as a treatment orientation. The researcher utilized a nonprobability snowball sample, through asking all therapists via the email with the survey link to forward the survey on to other narrative therapists. The researcher also sent the Qualtrics survey to professional contacts via email, and asked each contact to forward the survey on to other professionals they know who work in a narrative way. Because the email contained language requesting each participant to pass on the survey to others who utilize narrative therapy, the hope was that the sample would continue to build as the survey was forwarded. This type of snowball sampling strategy was chosen because the narrative therapy community in the Minneapolis-St. Paul area is seemingly small, and narrative therapists may know others in the area from trainings or professional events.

Protection of Human Subjects

Before beginning data collection, this study was reviewed and approved by both a research committee and the Institutional Review Board (IRB) at St. Catherine University to ensure the protection of human subjects. Participants were social workers and other clinicians with varying degrees; therefore, participants were not from vulnerable populations. The questions asked of participants contained minimal risk for harm. There was not potential for coerced consent, as the researcher was not be surveying current or previous co-workers, supervisees, or clients. The researcher also ensured that all potential participants were aware of the voluntary nature of this study through an informed consent process.

Potential participants were be invited to participate in this study via email, which included a link to the survey. Upon clicking on the link, potential participants were directed to a cover letter informing their consent. This cover letter included information about the purpose of the study, why the potential participant was selected to participate, the possible risks and benefits associated with the study, how a participant's confidentiality was protected, and explained the voluntary nature of the study. The cover letter informed each potential participant that completion of the survey indicated consent. Then, an option to press "Continue" was provided to proceed with the study if they decided to participate.

The researcher ensured the confidentiality of participants' data. Once she received the anonymous data from Qualtrics, it was kept and maintained in a password-protected document on her personal computer. All data was destroyed by June 1, 2014 following completion of this study. The researcher's access to Qualtrics was also deactivated after the end of the school year on May 23, 2014.

There were no identified risks to participate in this study. Questions that were included asked professionals about their history with narrative therapy, why they enjoy practicing narrative therapy, and what they feel makes it a distinctive way of practice. Possible benefits included increased consciousness for the practitioner on his or her method of practice, and reflection on professional development.

Data collection

Instrument design. The instrument for this study was an online questionnaire that included both quantitative and qualitative questions (Appendix B). The majority of the questionnaire was open-ended qualitative questions, which includes questions about how the participant was introduced to narrative therapy, why they chose to practice in a narrative way, if they had received narrative therapy before and if that influenced their decision to practice in a narrative way, their favorite part about practicing in a narrative way, and what they feels makes narrative therapy distinctive. The quantitative portion of the survey included questions to obtain demographic information on participants' gender, age, and licensure. Another quantitative question asked if the participant had ever received narrative therapy before.

Participants received the survey link via email and were then directed to the online program, Qualtrics, to complete the survey. Because many people in the social service industry have limited time, an online survey was chosen to not take up a lot of the participants' time. An online survey is also easy to forward on to others, making the snowball sampling strategy more effective.

Reliability and validity. The researcher created the survey utilized for this study. To attempt to establish reliability for the measure, the researcher developed the questions

for the survey by looking at research in the narrative field. The researcher also had her

research committee and research chair review the survey to make certain that all

questions made sense and did not require additional clarification. The research

committee and research chair offered suggestions to enhance or expand upon the

questions.

Because the survey was previewed by a research chair and committee members,

the measure appeared to have face validity which looks at whether the concepts in the

survey cover what they are meant to measure. Because the measure was created with

research on narrative therapy having been conducted, the survey had content validity

(Monette et al., 2008). The committee members and research chair have expertise in

clinical practice, so their expert opinion was valuable in determining the reliability and

validity of the study.

Data Analysis

Qualtrics produced descriptive statistics automatically for all quantitative

questions of the survey, which provided summary information on age, gender, licensure,

and whether a participant had received narrative therapy.

To analyze the nominal data in this study, the researcher looked for trends through

bar graphs and tables. Content analysis was used to discover common themes of the

qualitative questions of the study in the participants' responses.

Strengths and limitations

This study has both strengths and limitations. The use of an online questionnaire

has obvious strengths. With its distribution via email, each participant could easily

access the survey from any computer and did not require any assistance from the

researcher (Monette et al., 2008). This was especially beneficial, as the survey did not take a lot of time for participants to complete. This was an exploratory study, and therefore the researcher had no hypotheses to potentially influence the study in any direction. By participating in this study, the benefits were potentially an increased consciousness of a clinician's method of practice, and room to reflect on how they have progressed as a professional. This study also contributes to research in the narrative field, which is newer and lacks research on narrative clinicians and application of practice.

There were also limitations to this study. First, utilizing a non-probability snowball sample did not allow the researcher to generalize the findings of this study to the general population (Monette et al., 2008). Also, as this is an exploratory study that was conducted via an online survey, the study lacks depth. More depth could have been added to this study if participants engaged in qualitative interviews rather than filling out an online survey (Monette et al., 2008). Also, the study had time limitations and therefore does not include longitudinal data. Another potential limitation is that the researcher did not use a standardized tool. This study lacks the reliability and validity that is offered with standardized measures.

Findings

Respondents

A mixed qualitative and quantitative survey was sent via email to clinicians in the Twin Cities who identified that they used narrative therapy in their practice. The researcher created a list of clinicians as a result of professional contacts and psychologytoday.com, selecting clinicians that identified "Narrative" under the therapeutic modalities they use. The researcher then sent out the Qualtrics survey link

via email. Eleven total surveys were completed. Ten respondents completed the full

survey, and one respondent completed part of the survey. Out of the ten respondents, six

identified as female, and four identified as male. The range of years in practice identified

was 1 year- 8 years, with a mean of 4.2 years. Figure 1 demonstrates the breakdown of

the number of years respondents have been in practice. Two respondents clarified their

answer about how many years they have been in practice. One said, "Something like 5

years I think, depends how you measure," while the other said, "3 including grad school."
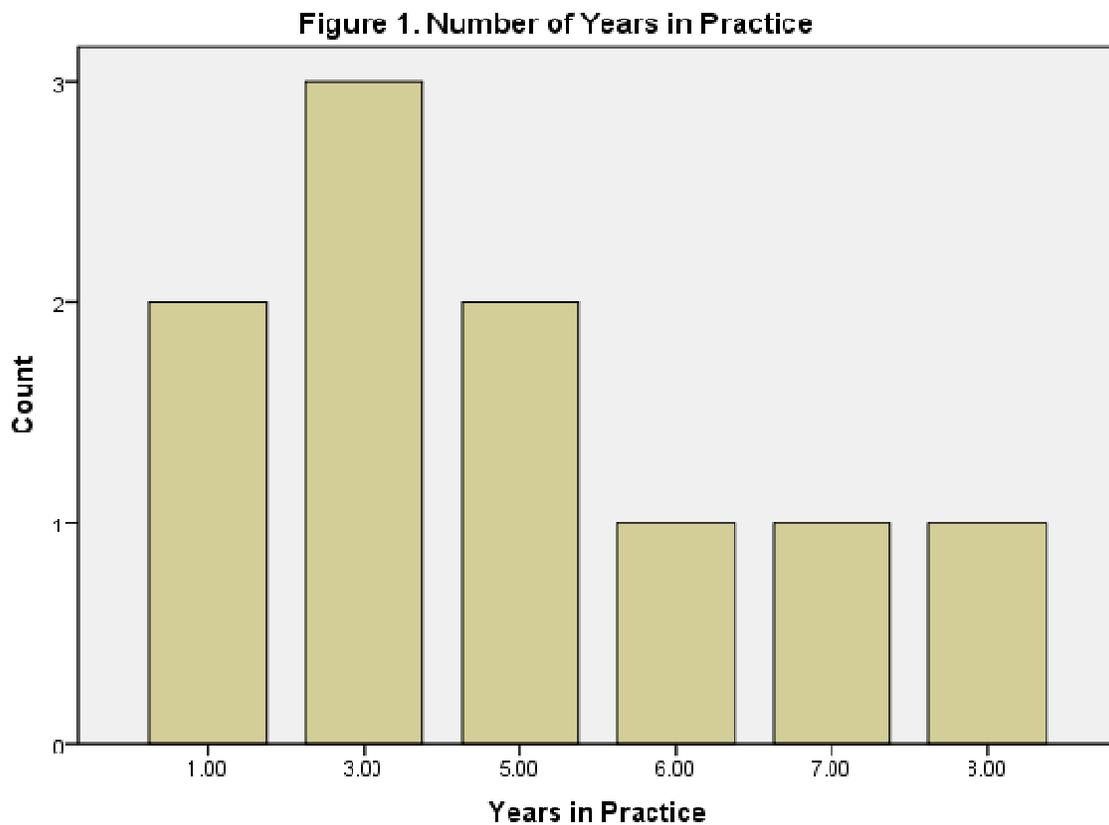

Figure 1. Number of Years in Practice

Four respondents identified as having their LICSW's, one identified as having

their LPC, one identified as having their LPCC, one identified as having their LMFT, one

identified as having their LAMFT, one identified as having their pre-LAMFT and LSC,

and one identified as pre-licensed. The age range identified by the respondents was 29-
40 years, with a mean age of 33.1. Respondents were asked, "Have you ever received
narrative therapy before?" Figure 2 demonstrates the breakdown of responses.
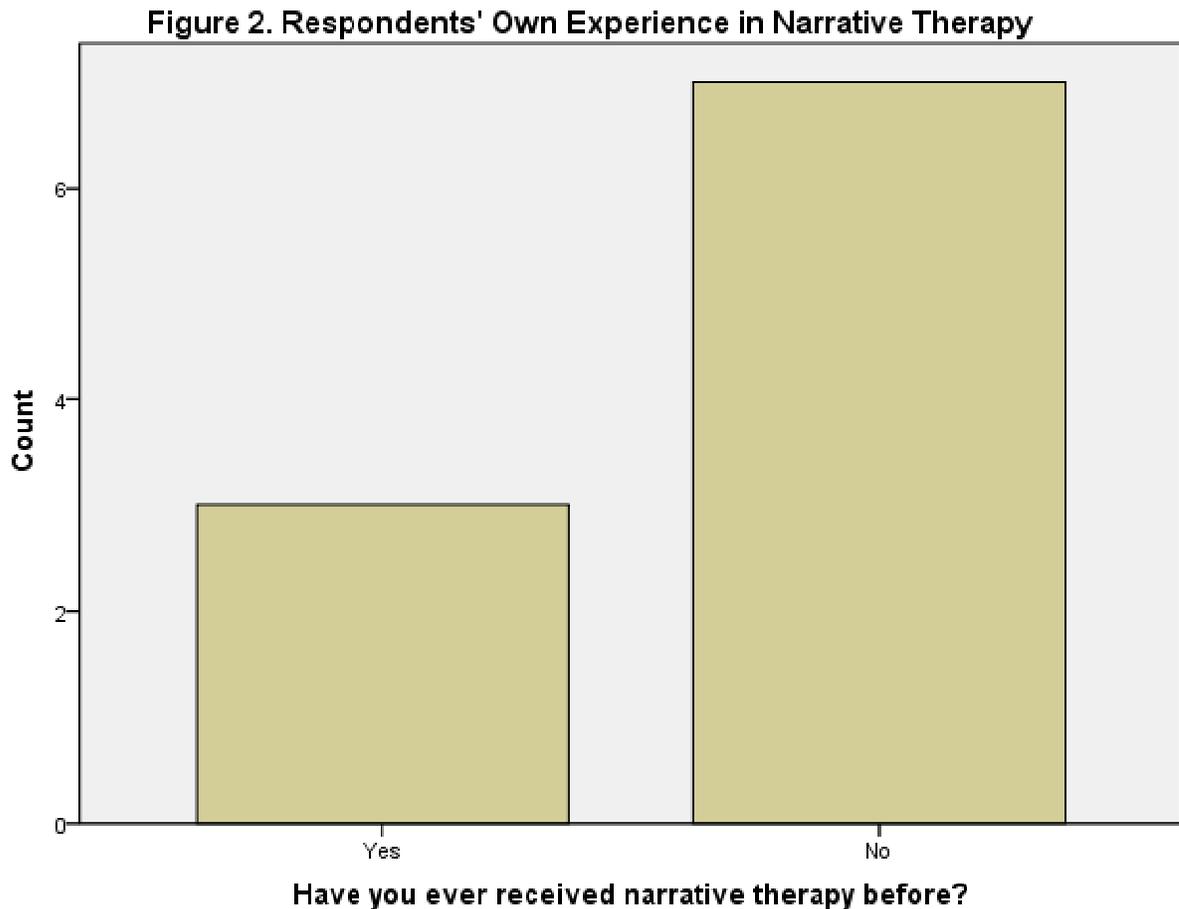
Figure 2. Respondents' Own Experience in Narrative Therapy

Three respondents said they had received narrative therapy before, while seven
said they had not. A follow-up question for those who said they had received narrative
therapy before was, "If you responded "Yes" to the previous question, how did that
experience influence your decision to practice in a narrative way?" The three
respondents indicated that it influenced their decision to practice Narrative Therapy in a
positive way. The three respondents said:

"It supported it and helped me realize aspects I wanted to include in my practice and some that I would do differently."

"Remarkably well!"

"I experienced it as a client after learning it as a therapist, so it thickened my understanding and provided me a view from the other chair of what it's like to be on the receiving end of the questions"

Research Question 1

The first research question asked**:** Are there commonalities among those who practice narrative therapy? When responding to, "How do you believe that therapists form their clinical identity" seven out of eleven respondents wrote "education," or "graduate school," as contributing factors. Four respondents wrote that they believe "experiences," both past and general were influential. Three respondents wrote that "philosophy" is influential. One respondent wrote, "More specifically I believe that [a therapist's] "clinical" identity, as it is acted upon by their personal identity, is greatly impacted by their education, personal philosophies and general predispositions."

When responding to the question, "How would you define Narrative Therapy?" one respondent wrote, "Narrative is a deep and rich practice that is difficult to sum up." Another participant responded, "…do not see it as a "form" of therapy. I see it as a set of principles applied to practice, which help people live more fully as themselves." Seven respondents used the word "Story" in their definition of narrative therapy. For example: *"The healing application of a more true story…"*

"Using a client's story to facilitate awareness and change."

"Each patient has a unique story that they can write and rewrite…"

See Table 1 for the full list of participants' responses.

Table 1.

Survey Question 3

How would you define narrative therapy?
I do not see narrative therapy as have one singular definition. It do not see it as a "form" of therapy. I see it as a set of principles applied to practice, which help people live more fully as themselves. I see my own ascription to narrative ideas, and how that plays out in the therapy room. What are the key forces or contributions that assist in my narrative practice? The therapist as decentered in position yet influential, externalization of problems in language and therapeutic conversations (which is is fundamentally very challenging in comparison to other medical or mental health models wherein problems are inherently located in people).
Narrative therapy for me is an expressive function of the dynamic between therapist and client. The narration of the client's thoughts, feelings and emotions is enlarged, supplemented, and emboldened by the process of talk therapy and the "narratirization" of their past problems and hidden unconscious motives/desires.
Unweaving a person's story; seeing the person as part of the solution, not the problem; externalizing the problem; talk talk talking, being curious
The healing application of a more true story of one's life, identity and empowerment
A respectful, nonjudgmental way to support people in telling their narrative/story in order to make meaning of their lives, which allows them to recreate their preferred identities, define goals and dreams, and work toward them.
Using a client's story to facilitate awareness and change.
It's a different approach with the client, by allowing them to reauthorize their experiences. A truly open and nonjudgmental approach that invites people to construct their preferred identity and way of life.
Each patient has a unique story that they can write and rewrite. Narrative therapy is identifying the patient's values and helping them move toward these.
While Narrative is a deep and rich practice that is difficult to sum up, the best way I've found is in the statement, "Take care how you tell the story, for that will influence how you live it."
Life is a story and we all have a roll in how our story goes. We are not victims of our story but rather have the ability to effect the direction of our story.

When asked, "Why did you decide to practice in a narrative way?" seven respondents wrote about how it personally worked for them. "It moved me," one respondent wrote after she witnessed a talk by one of the founders of narrative therapy, Michael White. Others said:

 "Because I resonate with the key concepts…"

"It resonated with my view on working with people…"

 "I was instantly drawn to the ability to deconstruct cultural narratives and "norms."'

Another similarity the researcher identified was seen in how respondents wrote about the concepts that they liked about narrative therapy. Respondents wrote about "creativity" and "non-judgment" when replying to the question, "What is your favorite part about practicing in a narrative way?"

"The latitude for creativity"

"It's fun and gives me a chance to be creative with kids."

"Genuinely seeing the problem as the problem, and people as people."

"I like that it is respectful of each person's uniqueness."

"People are effected by their problems and can effect their problems - they are not defined by their problems."

Overall, the data suggests certain similarities among respondents. Respondents had a variety of licensures in the human services field, yet were generally newer clinicians, with the most experienced clinician having been in practice for eight years. This is not surprising, as narrative therapy is new in terms of therapeutic modalities. Respondents also seemed to have difficulty giving a definition to narrative therapy, which co-founder Michael White even had difficulty with giving a brief definition of narrative therapy when he said, "Is this work better defined as a world-view? Perhaps, but even that is not enough…." (White, as cited in Freedman & Combs, 1996, p. 1)." Respondents also wrote about the freedom and creativity that as favorable aspects of narrative therapy, and the importance of a person's life story, a process so definitive to narrative practice.

Research Question 2

The second research question asked: Are there commonalities in the application of narrative therapy? A survey question asked, "What concepts of narrative therapy do you use in your practice?" One similarity identified was about externalization, a key narrative concept. Six out of ten respondents wrote about the use of externalization. One respondent wrote about several ideas, "Decentered positioning yet influential, narrative questions, outsider witness, deconstruction, externalization of the problem, counter story to the problem, problem saturation story, narragrams," while another wrote only about one concept used, "Finding exceptions in their story…"

When asked, "What population is narrative therapy helpful for?" differences in responses emerged. The first was identified by how four out of ten respondents said "Any" or "All". The other six were more selective in their responses. For example, one respondent said, "I use it for clients who I feel are a good fit," and another said, "More

introspective and/or symbolic clients." Another respondent said, "The client needs to be able to form insight."

When asked, "What presenting issue is narrative therapy helpful for?" differences emerged as in the previous question. Eight out of ten respondents wrote that they believe "Any" or "All" or that they have not found a presenting issue the model has not worked for. The other two responses were more selective to the presenting issue they believe narrative therapy works for. One said, "Depression," and one said, "It varies on the individual…"

When asked, "Do you see yourself as practicing exclusively in a narrative way?" ten out of ten respondents answered, "No." As a follow-up question, respondents were asked, "If you answered "No" to the previous question, what other clinical orientations or ways of working do you incorporate into your practice?" Six out of ten respondents said, "CBT." Four out of ten respondents said, "Solution-focused." See Table 2 for respondents' replies to survey question 14.

Table 2.

Survey Question 14

If you answered "No" to the previous question, what other clinical orientations or ways of working do you incorporate into your practice?
I am a structural family therapist, who integrates contextual family therapy and narrative practices.
Lacanian Psychoanalysis, NLP, CBT
EFCT, Experiental, CBT, Behavioral, Solution Focused, Imago, Adlerian
Play therapy, sand tray therapy, attachment theory, strengths perspective, restoring worth/value, etc.
Adlerian (Individual psychology), solution-focused, and positive psychology
CBT, Gestalt, Strengths based, etc.
CBT, DBT, Mindfulness, Buddhist Psychology
CBT, Solution-Focused, DBT
Narrative, Motivational Interviewing, Solution Focused, and mind/body work influence my practice.
Nouthetic/Biblical, CBT, Strategic

Overall, there appear to be differences in the application of narrative therapy. This is not surprising given different aspects of diversity among respondents. Some identified respondents had gone through an 8-9 month official certification program, while others appeared to have baseline knowledge of narrative practice. This is also demonstrated by how there are clinicians who believe that narrative therapy is helpful to all populations and presenting issues. However, there also are clinicians who see limitations in narrative practice.

Discussion

Responses pertaining to therapist similarities largely supported literature relating to concepts and practices of narrative therapy. Themes identified in the similarities of therapist included: the formation of clinical identity, power of words, the belief of the possibility of multiple stories, and positioning of the therapist. Responses pertaining to the application of practice were not in areas that literature has addressed. Themes identified in the application of practice included training and a range of practice incorporation.

Similarities of Therapists

      Clinical identity. Survey responses indicated similarities among those who practice in a narrative way. First, in identifying how they believe that clinical identity is formed, seven respondents said mentioned graduate school or education, while three respondents said mentioned philosophy as aspects that contribute to formation of clinical identity. Respondents agreed to many aspects of what research suggests are influential in the development of clinical identity, such as philosophy and education (Buckman & Barker, 2010). This is congruent with narrative practice, as narrative therapy is based off of post-structuralist philosophy.

      Power of words. Also congruent with narrative practice is the power of words. In narrative practice, a client's own language and interpretation is privileged over the therapist's (Carr, 1988).   Respondents brought the belief of importance of wording to life through clarifying the researcher's open-ended questions, framing it for their own understanding, or for the words that fit for them. For example, when asked, "How do you believe that therapists form their clinical identity?" one respondent said, "I believe clinical identity-or lens…" This clarified that this respondent preferred to look at the question as a "clinical lens" rather than a "clinical identity." Another respondent expressed ambivalence to the question all-together:

"Through practice, theoretical implementation, and experience. Do therapists form their clinical identity? This infers that the individual shapes an outside source, but I don't see it in this way. My clinical identity is so much a part of me, my ways of knowing and being in the world. I cannot separate the knower and what is known. My identity is shaped by numerous forces - which have occurred along a developmental process. My clients have

taught me how to be a therapist. My socially constructed relationships and practice, as

well as my larger field as a family therapist, contribute to defining my identity."

Stories/Multi-stories. Narrative therapy holds central the idea that everything has

the possibility to be multi-storied, recognizing that dominant stories and societal norms

are not the only options to consider when re-authoring an individual's story (Freedman &

Combs, 2012). The way in which certain survey questions were phrased may have been

perceived that the researcher was looking for a specific answer, or one storied, as

evidenced by when the respondent said, "Do therapists form their clinical identity? This

infers that the individual shapes an outside source, but I don't see it in this way."

When asked, "How would you define narrative therapy?" one respondent said, "I

do not see narrative therapy as have one singular definition. It do not see it as a "form" of

therapy." When asked, "What population is narrative therapy helpful for," the same

respondent said, "In the spirit of narrative, I'm not sure I can answer this question…"

These responses seemingly indicate that the respondent felt the question asking for a

"definition" of narrative therapy is not a multi-faceted question, or that asking what

population narrative therapy might be helpful for is too specific and does not leave room

for interpretation.

These responses, along with other clarifications of questions could also be

representative of the narrative concept of "not knowing" or not assuming. In terms of

narrative therapy, that indicates asking questions with an open mind, and without

assumptions (Combs & Freedman, 2012, p. 44). As words and the idea that multiple

stories can exist are so central to narrative therapy, in hindsight the researcher finds these

clarifications made freely by the respondents to be valuable information about the perspective of clinicians practicing from a narrative way.

Positioning of therapist. Narrative therapy rejects the idea that the therapist is an expert, instead putting the therapist in the role of co-investigator (Angus & McLeod, 2004). Responses validated this aspect of narrative practice. Respondents wrote in regards to why they decided to practice in a narrative way:

"I had seen many modalities purporting to value client's expertise in their own lives, but then in practice or behind closed doors center the therapist as the expert analyst in the room. I wanted no part of that…"

"It resonates with my view on working with people. I like that it separates a problem from the person, and empowers them to live the lives they want to live."

"It is a good way to get the client to see their strengths, courageous times in their life and all they have accomplished so far."

These responses all spoke to the privilege of the client's voice over the therapists, or the focus on the client's view of their story, something central to narrative practice.

Application of Practice

Training. Differences in how clinicians apply narrative therapy in their practice emerged in different survey questions. This is not surprising, as the researcher discovered a variety of therapists who identify as using narrative in their practice in the Twin Cities. First, there are at least two centers in the Twin Cities that identify as narrative therapy centers. The centers identify narrative therapy as their way of working, and both of these

centers offer eight to nine-month certificate programs to become formally trained in

narrative therapy. Three respondents identified that they had completed or were in

process of completing a narrative therapy certificate program.

When answering, "My training in narrative therapy includes (ex. completion of

certificate program, workshops, self-research)," four respondents identified that their

training in narrative therapy came from their education. Two respondents identified that

their training included grad school and self-research.   One respondent said, "None

officially- reading a book in supervision and my supervisor teaching us from her clinical

experience. also have attended some workshops at conferences."

Practice incorporation. Overall, the respondents seemed to range in those who

primarily practice in a narrative way, and those who have more basic knowledge of

narrative practice. Available literature generally looks at the use of specifically narrative

concepts in practice. The respondents, as indicated in Table 2 (page 29), are using

narrative therapy along with several different modalities in practice. There also seemed

to be a range of clinicians who believe that narrative therapy is helpful to all, which is

congruent with narrative literature, and those who see limitations in narrative practice.

Implications for Narrative Work

Narrative therapy is spreading throughout the world, and will continue to

become incorporated into various settings and even more mainstreamed. Responses

indicated that narrative work is being used across a wide spectrum. For some, it appears

to be a way of framing a conversation with a client, while for others it is the basis of their

clinical practice. Some clinicians use narrative therapy with other poststructuralist forms

of therapy, such as Solution Focused Brief Therapy. Others incorporate narrative therapy

with modalities of therapy that are behavioral based, such as Cognitive Behavioral

Therapy (CBT) and Dialectical Behavioral Therapy (DBT). Overall, with the spread of narrative therapy throughout societies all over the world, the implications of how of narrative work will look in practice in the future is both unknown and exciting.

Implications for Social Work Practice

Many concepts of narrative therapy support the very core of what social work identifies as its values as a profession. An ethical principle, outlined in the National Association of Social Worker's (NASW) *Code of Ethics is,* "Social workers respect the inherent dignity and worth of the person (National Association of Social Workers, 2008). Narrative therapy supports this ethical principle, through putting valuing in a client's wording, story, and preference over the therapist's. Narrative therapy does not assume dominant societal narratives, such as Western cultural norms. This is a truly empowering approach to therapy.

Narrative therapy takes a more political and social justice tone than identified modalities of therapy.   Also outlined in this ethical principle is, "They seek to resolve conflicts between clients' interests and the broader society's interests in a socially responsible manner consistent with the values, ethical principles, and ethical standards of the profession" (National Association of Social Workers, 2008). This fits with the social justice aspects of narrative therapy, one example being the practice of taking-it-back in narrative therapy. This is a way to stand up against isolation through the sharing of documents and stories from others who have experienced similar issues (Carr, 1998).

Strengths and Limitations

The strengths of this study included adding to a body of research that is limited on this subject, and having a diverse group of respondents (years in practice, gender, age,

licensure). The study also included mostly open-ended question, so was able to go in-depth to find out more about the respondents' relationship to narrative practice.

There were also limitations to this study. The qualitative survey with basic quantitative questions make this research not generalizable. The researcher worked in a nine-month time frame to complete this research, which lead to time constraints. The sample size of this research was small, with eleven total respondents. Another limitation was the researcher's basic knowledge of narrative therapy practice. Therefore, the wording of the questioning on the survey, something so core to narrative practice could have influenced if clinicians chose to take this survey. While this was a limitation, the researcher was able to gain valuable data through the way in which respondents worded their answers the survey questions.

Replication of study, including further exploration of what settings in which narrative therapy is being utilized and how clinicians incorporate narrative concepts with other therapeutic modalities is highly recommended.

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Appendix A. Participant Consent Form

Consent Form

-

Narrative Therapy: Similarities Among Clinicians and Practice Implications

I am conducting a study about narrative therapists and choice of clinical orientation. I invite you to participate in this research. You were selected as a possible participant because of your experience of working as a therapist in a narrative way. Please read this form and ask any questions you may have before agreeing to be in the study.

This study is being conducted by: Mikaela Dunn, MSW student at University of St.

Thomas/St. Catherine University under guidance of Sarah Ferguson, MA, MSW, Ph.D., Associate Professor and BSW Program Director at the University of St. Thomas/St. Catherine University.

Background Information:
The purpose of this study is to see what commonalities there are among therapists who practice in a narrative way and what commonalities exist in the carryout of narrative practice.

Procedures:
If you agree to be in this study, you will be directed to complete a 21-question, online questionnaire that will take approximately 10-15 minutes of your time.

Risks and Benefits of Being in the Study:
The study has minimal risk. The questionnaire data will only be used for the purpose of this study and will be destroyed immediately upon completion of the research. You will only be answering questions related to your perceptions and do not have to answer any questions that make you feel uncomfortable.

The direct benefits you will receive for participating are: helping the researcher gain knowledge and insight about narrative therapists and development of clinical orientation, contributing to the growing body of research on narrative therapy, and developing self-awareness on your own development as a clinician.

Confidentiality:
The records of this study will be kept confidential. In any sort of report I publish, I will not include information that will make it possible to identify you in any way.   The types of records I will create include questionnaire data that will be stored in a protected place on my personal computer that will not be able to be accessible by anyone else. The analysis of this data will be inserted into a paper I turn into my professor and present to a committee but will not contain information that could identify you in any way. All data will be destroyed upon completion of the research, by June 1, 2014 at the latest.

Voluntary Nature of the Study:
Your participation in this study is entirely voluntary. Your decision whether or not to participate will not affect your current or future relations with the University of St. Thomas or St. Catherine University. If you decide to participate, you are free to withdraw at any time. Should you decide to withdraw, data collected about you will not be used. You are free to skip any questions you do not wish to answer.

Contacts and Questions:
My name is Mikaela Dunn. If you have questions, you may contact me at 651-295-7360 or email me at mrdunn@stthomas.edu. You may also contact my professor, Dr. Sarah Ferguson, at 651-690-6296 or email her at smferguson@stkate.edu. You may also contact John Schmitt, Institutional Review Board (IRB) Chair at St. Catherine University at 651-690-7739 or email him at jsschmitt@sktate.edu with any questions or concerns.

Completion of the survey implies your consent. If you agree to participate in this study, please click "Continue."

Appendix B. Survey Questions

1. Completion of the survey implies your consent. If you agree to participate in this study, please click "Continue."

2. How do you believe that therapists form their clinical identity?

3. How would you define narrative therapy?

4. How were you introduced to narrative therapy?

5. Why did you decide to practice in a narrative way?

6. What concepts of narrative therapy do you use in your practice?

7. Do you see yourself as practicing exclusively in a narrative way?

8. If you answered "No" to the previous question, what other clinical orientations or ways of working do you incorporate into your practice?

9. What population is narrative therapy helpful for?

10. What presenting issues is narrative therapy helpful for?

11. Have you ever received narrative therapy before?

12. If you responded "Yes" to the previous question, how did that experience influence your decision to practice in a narrative way?

13. What is your favorite part about practicing in a narrative way?

14. What makes narrative therapy distinctive?

15. My training in narrative therapy includes (ex. completion of certificate program, workshops, self-research)

16. What is your age? (in years)

17. I identify my gender as

18. My licensure includes (ex. LICSW, LMFT, LAMFT)

19. The number of years I have been in practice is

20. 3 adjectives to describe my personality are