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NARRATIVE THERAPY: ONE PERSPECTIVE ON THE WORK OF MICHAEL WHITE

Alan Carr

INTRODUCTION

Narrative approaches to therapy have come to occupy a central position within the field of family therapy in recent years and this is due in large part to the influence of Michael White. Alone and in collaboration with David Epston, Michael has pioneered the development of this approach to practice. (Epston & White, 1989; White & Epston, 1992; White, 1989, 1995; Epston, 1989). Inspired by this seminal work, other practitioners have begun to write about narrative therapy in clinical practice (e.g., Freedman & Combs, 1996; Parry & Doane's, 1994; Zimmerman & Dickerson, 1996; McLeod's, 1997; Jenkins, 1990) to debate its place within the wider field of family therapy (Gilligan & Price, 1993) and to incorporate ideas from narrative therapy into mainstream mental health practices (March & Mullen, 1994; 1996). Narrative therapists work with a wide range of client groups with difficulties which are recognized within mainstream mental-health circles as being among the most difficult to treat including childhood conduct problems; delinquency; bullying; anorexia nervosa; child abuse; marital conflict; grief reactions; adjustment to AIDS; and schizophrenia.

Within narrative therapy, however, none of these difficulties are viewed as intrinsic or essential attributes of people or relationships. Rather, these labels are seen as being part of a wider mental health pathologizing discourse or narrative which maintain rather than resolve problems of living. The power

practices entailed by these labels, add to rather than lighten the burden on people dealing with such difficulties. Drawing on the work of Foucault (1965; 1975; 1979; 1980;1984), White refers to the process of applying psychiatric diagnoses to clients and construing people exclusively in terms of these diagnostic labels as *totalizing techniques*. Within a narrative frame, human problems are viewed as arising from and being maintained by oppressive stories which dominate the person's life. Human problems occur when the way in which peoples lives are storied by themselves and others does not significantly fit with their lived experience. Indeed, significant aspects of their lived experience may contradict the dominant narrative in their lives. Developing therapeutic solutions to problems, within the narrative frame, involves opening space for the authoring of alternative stories, the possibility of which have previously been marginalized by the dominant oppressive narrative which maintains the problem. These alternative stories typically are preferred by clients, fit with, and do not contradict significant aspects of lived experience and open up more possibilities for clients controlling their own lives. The narrative approach rests on the assumption that narratives are not representations of reflections of identities, lives and problems. Rather narratives constitute identities, lives and problems (Bruner, 1986; 1987;1991). According to this position, the process of therapeutic re-authoring personal narratives changes lives, problems and identities because personal narratives are constitutive of identity.

RE-AUTHORING LIVES

The process of re-authoring, a term drawn from the work of the anthropologist Myerhoff (1982;1986), is essentially collaborative and requires therapists to engage in particular practices. For White (1995), the following are among the more important practices central to narrative therapy:

- Adopt a collaborative co-authoring consultative position
- Help clients view themselves as separate from their problems by externalizing the problem
- Help clients pinpoint times in their lives when they were not oppressed by their problems by finding unique outcomes
- Thicken clients descriptions of these unique outcomes by using landscape of action and landscape of consciousness questions
- Link unique outcomes to other events in the past and extend the story into the future to form an alternative and preferred self-narrative in which the self is viewed as more powerful than the problem
- Invite significant members of the persons social network to witness this new self-narrative
- Document new knowledges and practices which support the new self-narrative using literary means
- Let others who are trapped by similar oppressive narratives benefit from their new knowledge through bringing-it-back practices.

A summary of these key features and other practices central to narrative therapy are presented in Figure 2.1.

Figure 2.1. Practices in narrative therapy.

<p>Practice 1.</p>	<p>Position collaboratively</p>	<ul style="list-style-type: none"> • Adopt a collaborative co-authoring consultative position. • Be open about therapeutic context, intentions and values • Privilege clients' language • Question about multiple viewpoints, rather than the objective facts • Privilege listening over questioning • Be vigilant for opportunities to open up space for new liberating stories
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Practice 2.	Externalize the problem	<ul style="list-style-type: none"> • Help clients see themselves as separate from their problems through externalizing the problem • Join with clients in fighting the externalized problem
Practice 3.	Excavate unique outcomes	<ul style="list-style-type: none"> • Help clients pinpoint times in their lives when they were not oppressed by their problems by finding unique outcomes. • Help clients describe these preferred valued experiences.
Practice 4.	Thicken the new plot	<p>Ask landscape of action and identity questions to thicken the description of the unique outcome.</p> <p>Landscape of action questions focus on</p> <ul style="list-style-type: none"> • Events • Sequences • Time • Plot <p>Landscape of consciousness focus on</p> <ul style="list-style-type: none"> • Meaning • Effects • Evaluation • Justification
Practice 5.	Link to the past and extend to the future	<ul style="list-style-type: none"> • Link the unique outcome to other past events • Extend the story into the future • Form an alternative and preferred self-narrative in which the self is viewed as more powerful than the problem.
Practice 6.	Invite outsider witness groups	<ul style="list-style-type: none"> • Invite significant members of the persons social network to witness this new self-narrative. This is the outsider witness group
Practice 7.	Use re-membering practices and incorporation	<ul style="list-style-type: none"> • Re-connect clients with internal representations of supportive and significant members of their families and networks
Practice 8.	Use literary means	<p>Use literary means to document and celebrate new knowledges and practices.</p> <ul style="list-style-type: none"> • Certificates and awards • News releases • Personal declarations and letters of reference
Practice 9.	Facilitate bringing-it-back practices	<ul style="list-style-type: none"> • Invite clients to make a written account of new knowledges and practices for future clients with similar problems • Arrange for new clients to meet with clients who have solved similar problems in therapy

THE POSITION OF THE THERAPIST

Within White's narrative therapy, the therapist adopts a position of consultant to those experiencing oppression at a personal level from their problems and at a political level from a mental-health discourse and set of practices which permeates western culture. Thus, people with problems of living are viewed as requiring help in fighting back against these problems and practices which have invaded their lives. This positioning is described by White, drawing on ideas from the French philosopher Derrida (1981), as both deconstructionist and constitutionalist. A deconstructionist position entails empowering clients to subvert taken-for-granted mental-health definitions and practices. A constitutionalist position entails working from the premise that lives and identities are constituted and shaped by three sets of factors:

- The meaning people give to their experiences or the stories they tell themselves about themselves
- The language practices that people are recruited into along with the type of words these use to story their lives and
- The situation people occupy in social structures in which they participate and the power relations entailed by these.

The positioning of the clinician within narrative therapy involves addressing these three sets of factors by deconstructing the sense people make of their lives; the language practices they use; and the power relationships in which they find themselves. In deconstructing practices of power, White draws on the work of the French Philosopher Foucault (1965; 1975; 1979; 1980; 1984). People are unconsciously recruited into the subjugation of their own lives by power practices that involve continual isolation, evaluation and comparison. Eventually our clients internalize ludicrous societal standards, yet believe that in doing so they are justifiably aspiring to valued ideals of fulfillment and excellence. This leads for example to self-starvation and anorexia; extreme self-criticism in depression; or a sense of powerlessness in the face of threat and anxiety. In turn, mental health professions have compounded this problem by developing global

unitary accounts of these states that purport to be objective truths, such as the diagnostic categories contained in DSM IV (APA, 1980) and ICD 10 (WHO, 1992). Furthermore, these professions support practices that prevent clients from questioning the socio-political contexts within which these so-called objective diagnostic truths emerged.

The collaborative co-authoring position central to narrative practice is neither a one-up expert position nor a one-down strategic position. At a recent workshop White (1997) showed a clip of videotape in which he used turntaking at questioning to help a young girl with a diagnosis of Attention Deficit Hyperactivity Disorder to participate in an interview. Other professionals involved in the case had been unable to help the girl to do this and had labelled her as unco-operative. Michael, made an agreement with her early in the meeting that for every question she answered, she could ask him a question. The girl stuck to this bargain because she was very curious about Michael's perception of the world, since he told her at the outset of the meeting that he was colour blind. This collaborative approach was highly effective in helping the girl tell her story about her difficulties in managing friendships and school work.

Within White's narrative therapy there is an openness about the therapist's working context, intentions, values and biases. There is a privileging of the client's language rather than the therapist's language. There is a respect for working at the clients pace that finds expression in regularly summarizing and checking that the client is comfortable with the pace. The therapist assumes that since social realities are constituted through language and organised through narratives, all therapeutic conversations aim to explore multiple constructions of reality rather than tracking down the facts which constitute a single truth. There is no room for questions like

- *From an objective viewpoint, what happened?*

All inquires are about individual viewpoints.

- *How did you see the situation?*
- *How did your view differ from that of your mother/father/brother/sister/etc?*

There is a constant vigilance for marginalized stories that might offer an opening for the person to engage in, what White (1989,1995) refers to as an "insurrection of subjugated knowledges". That is, an opening that will allow the person to select to construct the story of their lives in terms other than those dictated by the dominant narrative which feeds their problem. This requires the therapist to privilege listening over questioning, and to question in a way that helps clients to see that the stories of their lives are actively constructed, rather than passively recounted and given.

EXTERNALIZING THE PROBLEM

Externalizing the problem is the central therapeutic technique used by Michael White to help clients begin to define their problems as separate from their identities. A particular style of questioning is used to help clients begin to view their problems as separate from themselves. Central to this style of questioning is inquiring about how the problem has been affecting the person's life and relationships. Of a young boy with persistent soiling problems Michael White asked the boy and his parents a series of questions about Mr Mischief, an externalized personification of the soiling problem:

- *Are you happy what Mr Mischief is doing to your relationship?*
- *How is Mr Mischief interfering with your friendships?*

Of a girl with a diagnosis of anorexia nervosa he asked:

- *How far has anorexia nervosa encroached on your life?*
- *How did anorexia nervosa come to oppress you in this way?*

With people diagnosed as psychotic and experiencing auditory hallucinations he asked

- *What are the voices trying to talk you into?*
- *How will their wishes effect your life?*

In a health education project which aimed to prevent the spread of aids, AIDS was personified and participants in the project were asked

- *Where will AIDS be found?*
- *How will AIDS be recognized ?*

This procedure of asking questions in a way that assumes the problem and the person are quite separate helps clients to begin to externalize the problem and to internalize personal agency (Carr, 1997). It may also interrupt the habitual enactment of the dominant problem-saturated story of the persons identity.

In *relative influence questioning* the client is invited to first map out the influence of the problem on their lives and relationships, and second to map out the influence that they exert on the problem. Relative influence questioning allows clients to think of themselves not as problem-people but as individuals who have a relationship with a problem. Here are some examples of relative influence questions:

- *In that situation were you stronger than the problem or was the problem stronger than you?*
- *Who was in charge of your relationships then. Were you in charge or was the problem in charge?*
- *To what extent were you controlling your life at that point and to what extent was the problem controlling your life?*

This type of questioning also opens up the possibility that clients may report that on some occasions the problem influences them to the point of oppression, whereas on others, they can resist the problem. Thus relative influence questions allow clients to construct unique outcomes which are the seeds from which lives may be re-authored.

When it is clear that in some situations, problems have a greater influence than people, whereas in other instances people win out, questions may be asked about clients' views of contextual influences on this. Here are some examples of such questions

- *What feeds the problem*
- *What starves the problem*
- *Who is for the problem*

- *Who is against the problem*

EXCAVATING UNIQUE OUTCOMES

To help clients internalize personal agency and develop a self-narrative in which they view themselves as powerful, White has developed an interviewing technique which involves inquiring about unique outcomes. Unique outcomes, a term coined by Goffman (1961; 1986), are experiences or events that would not be predicted by the problem-saturated plot or narrative that has governed the client's life and identity. Unique outcomes include exceptions to the routine pattern within which some aspect of the problem normally occurs. The therapist asks clients about particular instances in which the client avoided being oppressed by the problem or prevented the problem from having a major negative influence on their lives.

- *Can you tell me about a time when you prevented this problem from oppressing you?*

Clients are then invited to account for these unique outcomes and to redescribe themselves and their relationships with others in light of these exceptional events.

- *How did you manage to resist the influence of the problem on that occasion?*
- *What does this success in resisting the influence of the problem tell us about you as a person?*
- *What effect does this success in resisting the influence of the problem have on your relationship with your mother/father/brother/sister?*

THICKENING NEW PLOTS

Once unique outcomes have been identified, these events may be incorporated into a story and the plot thickened by mapping them with *landscape of action* and *landscape of consciousness* questions. The distinction between these two

domains was originally drawn by Jerome Bruner (1986). Landscape of action questions aim to plot the sequence of events as they were seen by the client and others. Landscape of consciousness questions aim to develop the meaning of the story described in the landscape of action. They tell us about motives, purposes, intentions, hopes, beliefs and values.

One micromap that may be useful in thickening descriptions in the landscape of action contains the following four elements

- Events
- Sequences
- Time
- Plot

Within this micro-map, events are significant things that clients remember happening in their lives.

- *Can you tell me your memory of that?*

Sequences are elaborated by asking clients about the antecedents and consequences of the significant events.

- *What was happening before this event and what happened afterwards?*
- *Was there a turning point where you knew things were turning out for the best?*

Time refers the stage of their lifecycle in which these sequences of events occurred.

- *At what point in your life did this occur?*

Finally the plot refers to the meaning the person gives to the sequence of events which occurred at a particular time. In defining the plot Michael White proposed the question:

- *If your problem was a project what would you call it?*

A second micro-map used to help clients story their experience in the landscape of consciousness contains the following four elements:

- Meaning
- Effects

- Evaluation
- Justification

For both situations in which the main problem occurred or exceptional circumstances in which it was expected to occur and did not, the therapist may first inquire about the meaning of the event for the client.

- *What sense did you make of that?*
- *What does this story say about you as a person?*
- *What does this story say about your relationship with your mother/father/brother/ sister etc?*

This may be followed by inquiries about the effects of the event of the clients life.

- *How did that effect you?*
- *How did that effect your relationships with your mother/father/brother/ sister etc?*

To help clients evaluate the event they may asked

- *Was that a good thing for you, or a bad thing?*
- *Was that a good thing for your relationship or a bad thing?*

Finally they may be invited to justify this evaluation by exploring their reasons for viewing the event as having positive or negative implications for their lives.

- *Why was that a good (or bad) thing for you?*
- *Why was that a good (or bad) thing for your relationship?*

LINKING THE NEW STORY TO THE PAST AND EXTENDING IT INTO THE FUTURE

In linking new stories to the past experience of experience questions may be used. These are questions that invite clients to excavate forgotten or marginalized aspects of their experience or to imagine alternative ways of being that are consistent with their preferred self-story.

- *If I were watching you earlier in your life, what do you think I would have seen that would have helped me to understand how you were able recently to achieve X?*
- *What does this tell you and I about what you have wanted for your life?*
- *If you were to keep these ideas in mind over the next while, how might they have an effect on your life?*
- *Of all those people who know you, who might be best placed to throw light on how you developed these ideas and practices?*
- *If you found yourself taking new steps towards your preferred view of yourself as a person, what would we see*
- *How would these actions confirm your preferred view of yourself*
- *What difference would this confirmation make to how you lived your life.*

In the co-authoring position, clients are the senior partners. All explorations of the future are tentative rather than prescriptive. In practice, this positioning require the therapist to explore new possibilities tentatively using what Jerome Bruner (1986) calls subjunctivizing language:

- *What if....*
- *Could if be.....*
- *Suppose you were to....*
- *What would you.....*

This is a language of possibilities rather than predefined certainties.

OUTSIDER WITNESS GROUPS

When clients discover that there are alternatives to their problem saturated identities and when they have excavated a number of unique outcomes and begun to link these together into a new self-narrative, the probability that such a new plot can be thickened and take root in the client's life is enhanced if there are witnesses to this process. White, drawing on the work of Myerhoff (1986), refers

to these people as the client's *outsider witness group*. This group may contain members of the client's social network who understand their problem and who may be able to advise or coach the client with relevant knowledge or skills in how to manage the problem.

Outsider witnesses let clients know what they are up against and what to expect in overcoming problems and taking charge of their lives.

THERAPEUTIC DOCUMENTS

White and Epston (1990) have shown how letters of invitation, redundancy letters, letters of prediction, counter-referral letters, letters of reference, letters of special occasions, self-stories, certificates, declarations and self-declarations may be used in the practice of narrative therapy. The practice of introducing therapeutic documents is clearly a complex process. Guidelines for introducing such documents into the consultation process include the following;

- Discussing the usefulness of the documents to other people
- Discussing the issues that such documents might address
- Discussing the form that such documents might take
- Deciding with clients how best to collaboratively prepare such documents
- Deciding in collaboration with clients how to circulate therapeutic documents within the client's network
- Deciding with clients to whom the documents should be sent
- Deciding collaboratively with clients the circumstances under which the documents should be consulted
- Predicting the consequences of consulting the documents
- Reviewing with clients the effects of preparing and consulting these documents
- Reflecting on the accuracy of predications contained in such documents
- Reflecting on pieces of information that might be missing from such documents when their predictions are inaccurate.

RE-MEMBERING PRACTICES AND INCORPORATION

Many schools of individually oriented psychotherapy have the goal of promoting individuation of an essentialist self from attachment to significant others. Typically, within such psychotherapeutic traditions the negative influence of the family of origin is privileged over the positive and supportive features. In contrast, within the narrative approach, the family and social network are construed as a resource rather than a liability. One aim of therapy is to help clients find network members who have parallel experiences to theirs and draw on relationships with these members of the family and social network as a problem-solving resource or a source of social support. For example, with girls suffering from anorexia White aims to find parallels between the lives of the anorexic girls and those of their mothers. He encourages discussion of these parallels and invites mothers to support their daughters' fight against starvation.

In traditional grief work, the goal of counselling is often seen as helping the client work through a set of stages such as shock, denial, anger and sadness until a stage of acceptance is reached in which the client separates from the deceased and says goodbye to them in a metaphorical or ritualistic way. In contrast to this approach, with bereaved people, White views the goal of grief-work as re-membering the deceased and keeping their voice alive rather than helping clients to work through stages to forget them. He also argues that often negative reactions to traditional grief work may reflect clients need to re-member the dead and incorporate them into their lives.

TAKING-IT-BACK PRACTICES

In taking-it-back practices clients are invited to share the positive benefits of therapy with others. They may be invited to allow the therapist to share their new personal narratives, knowledges, skills or literary records of these with other clients facing similar difficulties. Alternatively they may agree to meet with other clients and let other clients know directly about their experiences. One aim of taking-it-back practices is to give clients a forum within which to share with other clients the positive impact that their new personal narratives, knowledges, skills have for them in their lives so that other clients may benefit from their positive therapeutic outcomes. For therapists the aim of taking-it-back practices is to give clients a forum within which to hear the positive impact that their participation in therapeutic conversations and their new personal narratives, knowledges, skills have had on therapists. Therapy changes both clients and therapists. The dominant discourse frames therapist-to-client influence as positive and client-to-therapist influence as negative. For example, within the psychoanalytic tradition this type of influence is termed countertransference and within the systemic tradition it is referred to as being sucked into the system. Taking-it-back practices privilege the positive impact of clients on therapists and future clients. Taking-it-back practices let clients know that the benefits of therapeutic conversations are a two way street.

DISCUSSION

Like the work of all pioneers, Michael White's narrative approach to therapy raises as many questions as it answers. Some of the more important questions will now be set out.

- *From an ethical perspective, in what instances is a narrative approach appropriate and in what instances is it inappropriate to engage in narrative therapy?*

For example, in crises involving immediate threats to clients' safety or the safety of family members, may narrative practices be used or are they inappropriate? If they are inappropriate, at what point do they become appropriate and what precisely are these practices?

- *From an empirical perspective, in what instances is narrative therapy effective; in what instances is it ineffective or dangerous; and what are the active ingredients of this approach to treatment?*

These questions may best be answered through rigorous quantitative and qualitative, treatment outcome and process studies.

- *Is narrative therapy inevitably an approach to helping that requires therapists and clients to engage in the social construction of the idea of oppression within multi-professional networks?*

The idea that clients may be oppressed by practices within multi-professional or multi-agency networks may compromise the degree to which therapists who adopt a narrative approach can work co-operatively with other professionals and agencies. This approach contrasts starkly with the trend within other family therapy traditions to use systemic ideas and practices to facilitate co-operation within interagency and interprofessional networks (Imber-Black, 1991).

- *How do we re-member and incorporate those insights that are valuable from the mainstream mental-health movement into the practice narrative therapy?*

A community of scientists who have studied mood disorders and schizophrenia have concluded that the risk of relapse is reduced for clients from particular types of social networks if psychosocial interventions are coupled with the used of medication (Roth & Fonagy, 1996). From a narrative therapy frame, does the

practitioner accord this view the same weight as that of an anti-medication TV documentary. Are both views to be accorded the same status as *local knowledges*, or are the results of rigorous inquiry to be accorded greater weight?

- *How do we re-member and incorporate ideas from the wider family therapy tradition into narrative therapy?*

A number of key insights are central to many forms of family therapy (Carr, 1995). First, is the observation that patterns of interaction within the family and the wider social network may predispose family members to have problems or maintain these problems once they occur. Second, is the observations that family life cycle transitions and crises may precipitate the onset of problems for individual family members. Third, is the observation that therapy which involves both the individual with the problem and significant members of the family and social network is an effective approach to ameliorating many difficulties. Fourth, is the notion that such therapy is not haphazard but is guided by certain hypotheses about the most useful way to proceed. A challenge for narrative therapy is to incorporate these insights into its practice.

- *What are the parallels between knowledges and practices central to narrative therapy and those of other family therapy and psychotherapeutic approaches?*

The idea of a collaborative therapeutic alliance is central to a number of approaches to family therapy, particularly those that fall within the constructivist, social-constructionist and behavioural traditions. The use of identification of exceptional circumstances or stimulus conditions within which problems do not occur and the use of such information as a basis for therapeutic progress are important features of solution oriented (Miller, Hubble & Duncan, 1996) and behavioural approaches (Falloon, 1988) to family therapy. Facilitating therapeutic change through focusing primarily on clients core beliefs about their problems, identities and lives is central to constructivist (Dallos, 1991), social-constructionist (McNamee & Gergen, 1992) and cognitive (Epstein, Schlesinger

& Dryden, 1988) traditions within the field of family therapy. An exploration of these and other parallels between narrative therapy and other approaches may be helpful to therapists wishing to understand the place of narrative therapy within the broader field of family therapy.

- *How do we conceptualize the relative influence of clients and therapists as co-authors within the therapeutic relationship?*

Narrative therapy is essentially a collaborative approach to facilitating therapeutic change. However, skilful expert therapists like Michael White, in certain instances seem to be quite directive in the leading questions that they ask and appear to contribute more than 50% to the re-authoring of clients' lives and their scripts about how to manage problems. This discrepancy between the avowed collaborative non-directive therapeutic positioning of the therapists on the one hand and the skilful leading approach to therapeutic questioning on the other deserves some clarification.

- *How do we avoid allowing narrative therapy to achieve the prominence of a global knowledge within our therapeutic practice?*

One of the refreshing features of narrative therapy is the suspicion with which it treats global knowledges or grand narratives that make claims to being in some way more valuable than local knowledges. As narrative therapy becomes more prominent, there is a danger that communities of therapists will come to privilege the insights and practices offered by this approach in an unquestioning way. In short, an approach that privileges local knowledge will come, paradoxically, to be treated as a grand narrative.

No doubt these questions and others will occupy many of us within the field of family therapy who are impressed by the pioneering work of Michael White.

SUMMARY

In this chapter a systematized description of a number of practices central to Michael Whites narrative approach to therapy is given. These include collaborative positioning of the therapist; externalizing the problem; excavating unique outcomes; thickening the new plot; and linking the new plot to the past and the future. The practices of re-membering and incorporation; using literary means to achieve therapeutic ends; and facilitating taking-it-back practices are also described. The paper closes with a number of questions which it may be useful for those concerned with narrative therapy to address.

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