CHAPTER 4
COLLABORATING WITH THE FAMILY:
THE APPROACH OF NARRATIVE THERAPY

Introduction
Description of Narrative Therapy

Narrative therapy is a recently evolved approach to therapeutic counseling that began gaining ground in the early 1980s. Because narrative therapy has its roots in Australia, its chief progenitor, Michael White, has affectionately termed it a "Down Under therapy style." White also refers to narrative therapy as a "therapy of literary merit," emphasizing its creative authoring of new stories.[1]

The central tenet which drives narrative therapy is that human life is based on stories, and these stories are written out of the experiences of life. Thus, each person plays a fundamental role in the creation of his/her realities, though such realities may be subjective interpretations of experience. William Madsen captures this practice:

> Human beings organize their experiences in the form of stories. Narrative or life stories provide frameworks for ordering and interpreting our experiences in the world. At any point, there are multiple stories available to us and no single story can adequately capture the broad range of our experience. As a result, there are always events that fall outside any one story. However, over time particular narratives are drawn upon as an organizing framework and become the dominant story. These dominant stories are double-edged swords.[2]

The primary idea in narrative therapy, then, is that each person has many choices or versions of reality at his/her disposal. Like a "double-edged sword," each version has the potential benefit of giving meaning, but also the danger of giving negative meaning. The answer for those trapped in a hurtful story, therefore, is to discover the other stories

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[1] Michael White and David Epston, *Narrative Means to Therapeutic Ends* (New York: Norton, 1990), 14.
[2] William C. Madsen, "Inviting New Stories: Narrative Ideas in Family-Centered Services," *Journal of Systemic Therapies* 18, no. 3 (1999): 7.

available to them. People tend to only notice certain details of their lives, and then get

locked into particular scenarios. They then force interpretations of future events to fit the

established grid-work. The resulting problem is an unbeneficial story which, besides

being inflexible and limiting, may not even be sound. Madsen charts the problematic

tendency of getting locked into a particular story:

> Narratives organize our field of experience, promoting selective attention to particular events and experiences, and selective inattention to other events and experiences. In this way, much of our lived experience goes unstoried, it's obscured and phenomenologically does not exist. Particular narratives can become problematic when they constrain us from noticing or attending to experiences that might otherwise be quite useful to us.[3]

Many people suffer from dominant stories that do not fit their identities or

experiences because they are impacted by "cultural discourses" that seek to conform

people to their agendas. As Gerald Monk writes, "The newly born child is instantly born

into a 'cultural soup.' From a narrative perspective, problems may be seen as floating in

this soup."[4] Few are aware of the powerful role this "cultural soup," or discourse, plays in

the formation of a person's views and values. Everyone has a place in propagating these

discourses. A child is taught not just by parents and grandparents, but also by siblings and

schoolteachers, mass media and books. This "soup" determines what he sees, values, and

lives for. The resulting narrative then crowds out aspects that might have been more

appropriate for an individual, fostering a continual source of frustration. According to

Michael White and David Epston, the simple reason:

> That the person's experience is problematic to him because he is being situated in stories that others have about him and his relationships, and that these stories are dominant to the extent that they allow insufficient space for the performance of the person's preferred stories. Or we would assume that the person is actively

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[3] Ibid.
[4] Gerald Monk, "How Narrative Therapy Works," in *Narrative Therapy in Practice: The Archeology of Hope*, ed. Gerald Monk et al. (San Francisco: Jossey-Bass, 1997), 27.

participating in the performance of stories that she finds unhelpful, unsatisfying, and dead-ended, and that these stories do not sufficiently encapsulate the person's lived experience or are very significantly contradicted by important aspects of the person's lived experience.[5]

The basic goal of narrative therapy is not to be a "problem-solving orientation," for such an orientation may be based merely on the premise of "pleasure seeking."[6] Rather, the goal of narrative therapy is to create an entirely new reality with far-reaching influence. White explains that the effort in narrative therapy is to:

> Bring forth and 'thicken' stories that did not support or sustain problems…as people began to inhabit and live out these alternative stories, the results went beyond solving problems. Within new stories, people could live out new self-images, new possibilities for relationship, and new futures.[7]

In this new mentality, the self is viewed not as an object with a problem, but as an entity with huge potential and vast horizons. The self, which possesses vast resources for change, is the key. Carmel Flaskas views the wellspring of self as "an ongoing ever-changing manifestation of potentiality."[8] Harlene Anderson stresses the incredibly flexible nature of the self, saying that it is "always engaged in conversational becoming constructed and reconstructed through continuous interactions, through relationships."[9]

Therefore, the goal, rather than merely dealing with the problem at hand, is to assist clients in solidifying a preferred story. A robust, preferred story needs to replace the dominant story which is failing to encapsulate experience, or is unhelpful, unsatisfying, and dead-ended.[10] The process involves externalizing problems, deconstructing old stories, and re-authoring new stories by implementing well-crafted

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[5] White and Epston, *Narrative Means*, 14.
[6] John Winslade and Alison Cotter, "Moving from Problem Solving to Narrative Approaches in Mediation," in Monk, *Narrative Therapy*, 253-254.
[7] White and Epston, *Narrative Means*, 16.
[8] Carmel Flaskas, "Limits and Possibilities of the Postmodern Narrative Self," *Australian and New Zealand Journal of Family Therapy* 20, no. 1 (1999): 21.
[9] Harlene Anderson, *Conversation, Language, and Possibilities: A Postmodern Approach to Therapy* (New York: Basic Books, 1997), 216, in Flaskas, "Postmodern Narrative Self," 22.
[10] White and Epston, *Narrative Means*, 14.

questions. These questions open up space to create alternate stories. The acceptable result of therapy, according to White, is the "identification or generation of alternate stories that enable them [the clients] to perform new meanings, bringing them desired possibilities."[11]

History: Postmodern Roots

Narrative therapy has already garnered great influence. Since the end of the eighties both the interest in, and the influence of, narrative therapy has rapidly progressed. Paolo Bertrando explains that manuscripts on this approach have represented the largest group of submissions to his journal.[12] As the "systemic vision replaced the previous psychoanalytical orthodoxy,"[13] so now narrative therapy is gaining ground as the new paradigm which "represents a fundamentally new direction in the therapeutic world and is the third wave."[14] However, the evaluation of narrative therapy's effectiveness is still in its infancy. The difficulty in evaluation is intensified by the fact that the entire system is inconsistent with qualitative empirical research methods. Yet even as its effectiveness remains unclear, it continues to grow.

Numerous influences led to the development of narrative therapy. Anthropologist and psychologist Gregory Bateson provided kindling with his views on the subjective nature of reality, as well as with the idea that people do what they do because they are constrained from doing otherwise. The "otherwise" was eventually taken to mean stories that were stifled by familial and cultural discourses.[15] The Milan team also began

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[11] Ibid., 15.
[12] Paolo Bertrando, "Text and Context: Narrative, Postmodern and Cybernetics," *Journal of Family Therapy* 22, no. 1 (2000): 83.
[13] Ibid., 84.
[14] Bill O'Hanlon, "The Third Wave," *Family Therapy Networker* 18 (1994): 19-29, in "Review of Narrative Therapy: Research and Utility," Mary Kleist Etchison, *Family Journal* 8, no. 1 (January 2000): 61.
[15] Alan Parry and Robert E. Doan, *Story Re-Visions* (New York: Guilford, 1994), 17. Here you will find an analysis of Gregory Bateson's influence.

applying Bateson's ideas, and, instead of looking for patterns of behavior, began focusing

on meaning and the premise of "myth" as a shaper of the family.[16] By the mid-seventies,

the social sciences had also moved toward a focus on meaning where "culture itself could

be treated as 'text.'"[17] Ethnographer Edward Bruner, who showed how people develop

stories as a way of understanding and making sense of experiences, also influenced the

rise of narrative therapy.[18] Even as far back as 40 years ago, George Kelly initiated

clinical constructivism and devised techniques like "self-characterization procedure" to

help clients articulate the thematic substructure of their life stories.[19] Second order

cybernetics also had an influence on the formation of narrative. The first order cybernetic

model encouraged therapists to view people as machines, but it was eventually

recognized that such structure models oversimplified life's interactions, and could not

capture the shifts and changes inherent in living organisms.[20] In second order cybernetics,

the issue of the therapist entering into the family system was positively addressed, and

words like "co-evolution" and "co-creation" emerged.[21] Probably the strongest

philosophical influence on narrative therapy has come from postmodern French

philosopher Michel Foucault, and particularly from his equation of power and

knowledge.[22]

The first step in narrative therapy is to begin embracing the postmodern

experience of many selves—that is, the belief that each person has a huge range of self-

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[16] Jill Freedman and Gene Combs, *Narrative Therapy: The Social Construction of Preferred Realities* (New York: W.W. Norton, 1996), 5.

[17] Jerome Bruner, Actual Minds / Possible Worlds (Cambridge, Mass.: Harvard University Press, 1986), 8, in Freedman and Combs, *Preferred Realities*, 16.

[18] Monk, "How Narrative Therapy Works," 7.

[19] Robert A. Neimeyer and Jonathan D. Raskin, eds., *Constructions of Disorder* (Washington, D.C.: American Psychological Association, 2000), 210-211.

[20] Freedman and Combs, *Preferred Realities*, 3.

[21] Ibid., 3.

[22] White and Epston, *Narrative Means*, 1.

definitions available. In other family systems therapies, Steven de Shazer's solution-focused therapy also has postmodern characteristics, but is more late-modern in nature, whereas narrative therapy flows clearly out of the postmodern waters.[23] Narrative therapy initiated the entrance of family systems therapy into the postmodern realm.[24]

Narrative has invaded therapeutic models with an "attitude of modesty and irony in the face of a growing realization that master plans and techniques are no longer so effective in finding a fit for the incommensurabilities of the human situation."[25] Along with the relativism of postmodernism comes the fluidity and evolving nature of narrative definitions. The idea that one's view of reality is only a limited slice of the whole picture provides the basis for establishing new stories. That "any statement that postulates meaning is interpretive,"[26] has been widely accepted, and this is the basis for opening up life experiences to new interpretations.

Thus, each person is deemed to have the capacity to author reality, for reality is but a construction of individuals within a constructed society. In the words of Paolo Bertrando, "Reality must be considered as a social construction, i.e. realities are but the conversations we have about them, and therefore all views are a consequence of language: every theory and every system of ideas is merely a narrative."[27]

The obvious fruit of such a perspective is doubt regarding the objectivity of truth. Alan Parry explains that when we say something is "true," we are merely conveying that

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[23] Parry and Doan, *Story Re-Visions,* 18.
[24] Ibid., 17.
[25] Ibid., 18.
[26] White and Epston, *Narrative Means*, 5.
[27] Bertrando, "Text and Context," 86.

"a significant community considers it to be true"; therefore, "Any definition of the Real is but an old story that is no longer questioned."[28]

The skepticism of narrative therapy in regard to absolutes can be found in its postmodern roots. Postmodernism seeks to be honest in admitting that there are limits to humankind's ability to measure and describe the universe. Postmodernism also doubts the possibility that there is any way to be completely objective in determining what is absolute, if there even is such a definition. The obvious outcome is a suspicious attitude toward the sciences:

Postmodern therapies operate from the premise that all knowledge, including "scientific knowledge," is *perspectival*, rather than assuming that professionals have access to "objective truth" …As seen through a narrative lens, therapists and their scientific theories of personality are immersed in predominant cultural influences and ideologies; thus, their knowledge and solutions for mental health are as biased and subjective as those of their clients.[29]

For generations, science has been the critic, but in the postmodern mind, science is now under criticism. For science is seen as seeking to promote an agenda, and the agenda soils the results of the study. B. Latour and S. Woolgar argue that science is not really scientific at all, for "Scientific activity is not 'about nature.' It is a fierce fight to construct reality. The laboratory is the workplace and the set of productive forces, which makes construction possible."[30]

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[28] Craig Smith and David Nylund, *Narrative Therapies with Children and Adolescents* (New York: Guilford, 1997), 5.
[29] Smith and Nylund, *Narrative Therapies*, 7.
[30] B. Latour and S. Woolgar, "Laboratory Life: The Social Construction of Scientific Facts," (Beverly Hills, Calif.: Sage, 1979), 240, in David Epston, "Internalizing Discourses Versus Externalizing Discourses," in *Therapeutic Conversations*, ed. Stephen Gilligan and Reese Price (New York: W.W. Norton, 1993), 162.

Once the world realizes that science is not objective, it becomes a place free from the grand narratives, a place where "personal narratives essentially stand alone as the means by which we pull together the text of our own lives, as well as the 'intertextual' overlappings of those lives that enter ours. Although this may all be frightening without the legitimating guidance of the grand narratives, it is also a liberating possibility."[31]

Such "outlandish" perspectives have not left narrative therapy without critics. Some are bold in their challenges of this seemingly heretical orientation. Pittman attacks the logic with this harsh criticism:

> Postmodernism entered family therapy in the form of constructivism, espousing that reality is in the eye of the beholder, and that it doesn't matter what people do, only what story they tell about it. What a breakthrough! People don't have to change what they do! They can just use different words instead![32]

However, defenders of narrative therapy offer stimulating points for thought, as well. Bruner says that this world view "does not lead to an 'anything goes.' It may lead to an unpacking of presuppositions, the better to explore one's commitments."[33] Even postmodern philosopher Richard Rorty gives a lighter view on the implications of this thinking when he says, "The repudiation of the traditional logocentric image of the human being as Knower does not seem to us to entail that we face an abyss, but merely that we face a range of choices."[34] It is also remarkable that postmodern greats like Jean-Francois Lyotard and Jacques Derrida do not deny the existence of some sort of reality—they merely encourage systematic doubt about one's premises and theories.[35]

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[31] Parry and Doan, *Story Re-Visions,* 25.
[32] Frank Pittman, "It's Not My Fault," *Family Therapy Networker* (January-February 1992): 58, in Epston, "Discourses," in Gilligan and Price, *Therapeutic Conversations,* 232.
[33] Jerome Bruner, *Acts of Meaning* (Cambridge: Harvard University Press, 1990), 27, in Freedman and Combs, *Preferred Realities,* 21.
[34] Richard Rorty, *Essays on Heidegger and Others* (New York: Cambridge Press, 1991), 132, in Freedman and Combs, *Preferred Realities,* 21.
[35] Bertrando, "Text and Context," 93.

The narrative therapist prefers to see himself/herself – as the compassionate alternative to the "knowing professional" who seeks "disinterested knowledge" through "detached, disengaged objectivity." Instead, narrative therapists prefer a collaborative model, committed to co-creating with the client.[36] Jill Freedman and Gene Combs abhor the method that "regard[s] them as objects, thus inviting them into a relationship in which they are the passive, powerless recipients of our knowledge and expertise."[37]

Narrative therapy is thus far from pessimistic, as it seeks to assist in opening up new and positive stories in peoples' lives. Therapy may be likened to a journey- a process in which the therapist assists the client toward a preferred future. Therapy can even be compared to process of immigration. White elaborates on this theme, comparing it to the process of immigration from an old country to a new one, leaving behind an old identity and transitioning into a new and better one.[38]

The Power of Story

Stories are potent vehicles of meaning and life. In the words of Craig Smith and David Nylund, "Stories can sweep people up in their wake as they gather momentum."[39] Not only do stories wield power to engage one's attention, they seem to hold an almost mystical quality, as well. Joseph Campbell, in *The Power of Myth*, speaks of myth being the public dream, and dream being the private myth.[40] Stories also have a capacity to carry people a person along, and unfold in ways one would not anticipate, because they

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[36] Epston, "Discourses," in Gilligan and Price, *Therapeutic Conversations*, 233-234.
[37] Freedman and Combs, *Preferred Realities*, 21.
[38] Michael White, *Re-Authoring Lives: Interviews and Essays* (Adelaide, Australia: Dulwich Centre, 1995), in *Collaborative Therapy with Multi-Stressed Families*, William C. Madsen (New York: Guilford, 1999), 225.
[39] Smith and Nylund, *Narrative Therapies*, 11.
[40] Joseph Campbell and Bill Moyers, *The Power of Myth* (New York: Doubleday, 1988), 40.

are both "linear" and "instantaneous."[41] In a way, stories are almost like living creatures

in and of themselves. Even the individual words comprising stories seem to possess life.

Rubem Alves, in comparing words to wild birds, says: Flying birds are unpredictable like

the Wind: one does not know where they come from or where they are going. Whenever

they arrive they work havoc on the order which had been carefully written on the text.[42]

In the ordering of life, stories have a critical role. They become the keepers of

reality for humanity, individually and collectively, and the words that compose them can

carry both life and death. Thus, in considering the power of narrative, it is not difficult to

grasp how problems in life might have their roots in problems of story. J.P. Gustafson

noted that problematic periods in life are characterized by gaps in a person's story.[43] D.E.

Polkinghorne drew attention to the way in which narratives 'decompose' or 'disintegrate'

when they become unable to unify new or forgotten phenomena.[44] Gaps in a story

become a critical issue when considering that "personal stories are not merely a way of

telling someone (or oneself) about one's life; they are the means by which identities may

be fashioned."[45] This is the hope of narrative therapy: to employ the power of story and

the retelling of stories in such a way that gaps are filled and reality expanded. This is a

continual process, for, as White and Epston say, "every telling or re-telling of a story,

through its performance, is a new telling that encapsulates, and expands upon the

previous telling."[46]

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[41] Edward Bruner, "Ethnography as Narrative," in *The Anthropology of Experience*, ed. V. Turner and E. Bruner (Chicago: University of Illinois Press, 1986), 153, in White and Epston, *Narrative Means*, 3.

[42] Rubem Alves, *The Poet, The Warrior, The Prophet* (London: SCM Press, 1990), 6.

[43] J.P. Gustafson, *Dilemmas of Brief Therapy* (New York: Plenum, 1995), in "Narrative Disruptions in the Construction of the Self," Robert A. Neimeyer, in Neimeyer and Raskin, *Constructions of Disorder,* 212.

[44] D.E. Polkinghorne, "Narrative and Self-Concept," *Journal of Narrative and Life History* 1 (1991): 135-153, in Neimeyer and Raskin, *Constructions of Disorder,* 212.

[45] Atheria Androutsopoulou, "Fiction as an Aid to Therapy: A Narrative and Family Rationale for Practice," *Journal of Family Therapy* 23, no. 3 (August 2001): 283.

[46] White and Epston, *Narrative Means*, 13.

Assessment/Approach

Narrative therapy is a collaborative therapy. This means, according to White and Epston, that "narrative therapy begins with an attitude of being an appreciative ally of the family who enters their system and works with, not on, them."[47] Included in this definition are a couple of key components of narrative therapy. First, more than being a technique, narrative is an attitude—an attitude of acceptance and appreciation for the client, as well as an attitude of skepticism toward systems of meaning that may have the client trapped. Therefore, even from the assessment stage, it is crucial to begin entering "appreciatively" into the client's system. The second idea is that the therapist enters into the system as a team member who avoids "hogging the ball," ensuring that everyone present might have a part in the process. The therapist acknowledges the importance of each person, then initiates "a process of unearthing dormant competencies, talents, abilities, and resources."[48] The result of this attitude "tends to produce numerous moments of excitement and vivacity"[49] in therapy.

A collaborative attitude is continually attentive to the issue of power, the influence of persons within the system, and is cautious not to imbalance that power, thus undermining the vital position of the client. Instead of making people "passive, powerless, recipients of our knowledge and expertise,"[50] the goal is to empower people to re-create, or at least, co-create their new realities. Thus, in the words of Jeffrey Zimmerman and Victoria Dickerson, "We want to make transparent our thinking about our thinking."[51]

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[47] White and Epston, William C. Madsen, *Collaborative Therapy with Multi-Stressed Families* (New York: Guilford, 1999), 48.
[48] Monk, "How Narrative Therapy Works," 24.
[49] Ibid.
[50] Freedman and Combs, *Preferred Realities*, 21.
[51] Jeffrey L. Zimmerman and Victoria C. Dickerson, *If Problems Talked: Narrative Therapy in Action* (New York: Guilford, 1996), 43.

Such an approach abolishes the therapist's role as the holder of knowledge, and thus,

power. Instead, the client is generally seen as the holder of his/her own keys to a better

future, as the one who possesses special knowledge that must be uncovered. Gerald

Monk describes such a positive view toward the client in this way:

> The co-creative practices of narrative therapy require a particular ability on the part of the therapist to see the client as a partner with local expertise whose knowledge may, at the beginning of the counseling relationship, be as hidden as the artifacts of a civilization buried in the soil of centuries.[52]

The concepts of shared power and client as expert are somewhat peculiar for

many coming to therapy. Often, those seeking help are more acquainted with the

doctor/patient model and expect this relationship to be the same. The conversation Jeff

Chang had with a young male client is a helpful example of how to shift this expectation

to that of a more collaborative relationship:

> Jeff: Do you like going to the doctor? (boy shakes head) Well, when you go to the doctor, like if you've ever had an operation, do you do anything when you're getting an operation?
> Boy: (thinking me a bit stupid) No, you're asleep.
> Jeff: Right, you cannot do much to help if you're asleep. You just go there, the doctor cuts you open, and they pull your guts out… and sew you up, and you don't do anything, just lie there asleep, right? (nods his head). Okay, well what I like to be called is like a coach. Were you ever in sports?
> Boy: Tee ball and soccer…
> Jeff: So what does a coach do?
> Boy: Teach us how to play the game, help us practice…
> Jeff: Right. What about if you lost really bad, 37 to 1, and you were really sad and wanted to give up?
> Boy: He would say, it's not so bad, cheer up, you can do it.
> Jeff: Right. So if you have a really good coach, but the players don't try, will you win the game?
> Boy: No.
> Jeff: And if you have players that try really hard, but don't get shown properly by the coach how to play the game, is that good? Will that be a good team? (shakes his head) And sometimes the coach can see things you can't see from where you are.
> Boy: And sometimes I can see things the coach doesn't see!

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[52] Monk, "How Narrative Therapy Works," 24.

Jeff: Right. So if we work together—I'll be the coach and you can be the player, we should be able to help you with your Temper. Deal?
Boy: Deal! (we shake hands)[53]

The creation of a light, even fun, atmosphere is particularly important for children. Children may feel threatened in a discussion with a group of adults, and this feeling is exacerbated when facing a power figure like a therapist or minister. Jennifer Freeman, David Epston, and Dean Lobovits observed that such "serious discussion and methodical problem-solving may impose on children's communication, shutting out their voices, inhibiting their special abilities, knowledges, and creative resources."[54] Children also have the ability to bring unique resources to the therapy process, particularly in their honesty and creative imaginations. Unfortunately, since children are more malleable and easily overrun, their gifts may be stifled. A collaborative approach, however, is careful to create space for everyone.

In this collaborative approach, the traditional stance of authoritative "knowing" is viewed as unproductive to the client and, ultimately, as the source of disempowering. The use of power, warn the proponents of narrative therapy, can be detrimental when wielded unwisely. Wendy Drewery, John Winslade, and Gerald Monk speak of the dominant doctor/patient model, which is pervasive in the world of counseling, as a model which encourages a negative role for the client:

> Authoritative diagnosis maintains expert power and thereby adds authority to the intervention that follows on the diagnosis. Recipients of medical care are traditionally thought of as patients, and it is no accident that the word *patient* derives from a term that invokes both suffering and passivity or that the role of doctor invokes so much power.[55]

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[53] Jeff Chang, "Collaborative Therapies with Young Children and Their Families: Developmental, Pragmatic, and Procedural Issues," *Journal of Systemic Therapies* 18, no. 2 (1999): 47-48.
[54] Jennifer Freeman, David Epston, and Dean Lobovits, *Playful Approaches to Serious Problems: Narrative Therapy with Children and Their Families* (New York: W.W. Norton, 1997), 3.
[55] Wendy Drewery, John Winslade, and Gerald Monk, "Resisting the Dominating Story: Toward a Deeper Understanding of Narrative Therapy," in Neimeyer and Raskin, *Constructions of Disorder,* 250.

An attitude that is helpful in enhancing a collaborative environment is what H. Anderson and H. Goolishian term a stance of "not knowing," where we are "always moving toward what is not yet known."[56] In this "deliberate ignorance,"[57] as Lynn Hoffman calls it, the therapist seeks to put aside personal interpretations and understand the meaning of people's stories for *them*. Freedman and Combs suggest consciously avoiding expert status:

> This means turning our backs on "expert" filters: not listening for chief complaints; not "gathering" the pertinent-to-us-as-experts bits of diagnostic information interspersed in their stories; not hearing their anecdotes as matrices within which resources are embedded; not listening for surface hints about what the core problem "really" is; and not comparing the selves they portray in their stories to normative standards."[58]

Bertrando, however, argues that maintaining a "not knowing" stance is likely impossible, that interpretation and judgment are inevitable, and that such an attitude is more wishful thinking than possibility.[59] Certainly, to ignore one's training and personal views seems an impossibility. Although one may not be able to eradicate "knowing," the effort to do so may bring about a greater balance of power in the therapeutic process. After all, experts tend to find the very things which they, as experts, have been trained to find. Pathologists will likely find pathology, and thus may only serve to make clients' pain more vivid and oppressive.

A "not knowing" stance will also be characterized by an attitude of curiosity. Besides the fun and playfulness that curiosity can bring, it can open space in the

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[56] H. Anderson and H. Goolishian, "Beyond Cybernetics: Comments on Atkinson and Heath's 'Further thoughts on Second-Order Family Therapy,'" *Family Process* 29 (1990): 159, in Freedman and Combs, *Preferred Realities*, 44.
[57] Lynn Hoffman, "A Reflexive Stance For Family Therapy," in Therapy as a Social Construction, ed. S. McNamee and K. Gergen (Thousand Oaks, Calif.: Sage, 1992), in Monk, "How Narrative Therapy Works," 25.
[58] Freedman and Combs, *Preferred Realities*, 44.
[59] Bertrando, "Text and Context," 92.

discussion for greater breadth and depth. Curiosity comes from believing that each person's story is very unique, and that the differences which make it unique are worthy of being appreciated and celebrated. This "puzzling together posture" means that the therapist works at "facilitating a safe, exploratory therapeutic environment where diverse, nonpathological, alternative perspectives and stories can be entertained, rather than as expertly providing clients with authoritative, complete, or definitive responses."[60]

Deconstruction: Making Old Stories Dubious

The first major stage in re-writing life narratives is that of deconstruction. White explains:

> Deconstruction has to do with procedures that subvert taken-for-granted realities and practices: those so-called "truths" that are split off from the conditions and the context of their production; those disembodied ways of speaking that hide their biases and prejudices; and those familiar practices of self and relationship that are subjugating of persons' lives.[61]

In other words, deconstruction is the dismantling of "cultural discourses that sustain oppression and confer dysfunctional identities,"[62] and of the situations in which "what we are doing doesn't actually fit what we prefer."[63]

The process of narrative therapy has a similar structure to that of ritual. Ritual, in the view informed by Evan Imber-Black, Joseph Campbell, Sam Keen, and Robert Bly, is composed of three stages: the "separation phase," the "liminal or betwixt and between phase," and the "reincorporation phase."[64] Deconstruction in narrative is the process of separating from the old condition and preparing to enter something new. It is getting away from the Popeye mentality of "I yam what I yam" and getting to a place where one

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[60] Smith and Nylund, *Narrative Therapies*, 4.
[61] Michael White, "Deconstruction and Therapy," in *Therapeutic Conversations.* ed. Stephen Gilligan and Reese Price (New York: W.W. Norton, 1993), 34.
[62] Neimeyer and Raskin, *Constructions of Disorder,* 214.
[63] Zimmerman and Dickerson, *If Problems Talked*, 61.
[64] Parry and Doan, *Story Re-Visions*, 61.

can begin to see that there are many choices. This involves a conversation in which the

client begins to question and doubt his/her own connection to the problem and his/her

version of reality. It is, as Jay Efran and Paul Cook observe:

> A conversation that expands clients' options beyond the limits established by their ordinary social affiliations… highlights the reifications, contradictions, hypocrisies, and paradoxes imbedded in their clients' stories…an opportunity to sort through the implications of people's semantic falsehoods.[65]

The conversation is centered around questions in an environment where "a

question is as good as the waves it generates."[66] White and Epston explain, plain and

simple, that the narrative approach is "achieved primarily, although not exclusively,

through a process of questioning."[67] Questions, in lieu of statements, advice, or

interpretations, are central. These questions are not designed to divulge information that

becomes fodder for analysis. Rather, questions are intended to generate experiences that

are therapeutic in and of themselves. Perhaps the most basic questions are, What is my

story? and Who wrote it? The principle deconstructive question is likely, Do you want to

defeat this problem? In answering affirmatively, the client is unified with the therapist.

By this answer, the client is also saying no to the problem, and its very hold on his/her

life is diminished.[68]

Externalizing: The Person is Not the Problem

An important part of the initial deconstruction phase is known as externalization.

This is where the problem is reckoned as separate from the person. Epston captures the

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[65] Jay S. Efran and Paul F. Cook, "Linguistic Ambiguity as a Diagnostic Tool," in Neimeyer and Raskin, *Constructions of Disorder,* 140.
[66] Sluzki, quoted by Salvador Minuchin, "Retelling, Reimagining, and Re-Searching: A Continuing Conversation," *Journal of Marital and Family Therapy* 25, no. 1 (1999): 9.
[67] White and Epston, *Narrative Means*, 17.
[68] Monk, "How Narrative Therapy Works," 15.

centrality of externalization to narrative therapy:

> If I were to restrict myself to only one aspect of White's work that I have taken over, it would be that of "externalizing the problem." This is summarized by his maxim: "The person isn't the problem; the problem is the problem." This provided a rationale and practice to position myself in therapy, that is, to be on everyone's side at the same time and to act with commitment and compassion against the "problem," whatever the problem might be. It freed me from the constraints of some of the prevailing practices that I found distanced me from the family and reduced my fervor.[69]

This is a revolutionary stance that flies in the face of the entire psychotherapeutic approach—that approach wherein "the problem is most often described as something 'in' the other person or something the other is doing *because* of something 'in' him or her (a character flaw)…"[70] Externalizing the problem, taking it outside of the person, allows the person to come out from under the microscope. Instead of scrutinizing the client, the therapist and client together scrutinize the "thing" that is plaguing him/her. Of course, "the discourse of mental disorders" which "invites therapists into patterns of stigmatizing and blaming clients, desecrating traditions, deteriorating relationships and disempowering people,"[71] is considered highly damaging.

Madsen writes of a family services program that lacks workers trained in therapy, but nonetheless has an amazingly high degree of success. Louise, one of the counselors in the program, comments:

> To me pathology is an attacking position. I think to pathologize is to attack…We don't pathologize, but we don't ignore problems either…Our assumption is there's an enormous amount of pain here and we want to go in and as much as we can alleviate some of it or at least have a healthy respect for it without creating more pain.[72]

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[69] David Epston, *Collected Papers* (Adelaide: Dulwich Centre, 1989), 26, in "Discourses," in Gilligan and Price, *Therapeutic Conversations*, 161-162.
[70] Zimmerman and Dickerson, *If Problems Talked*, 48.
[71] Kenneth J. Gergen and Sheila McNamee, "From Disordering Discourse to Transformative Dialogue," in in Neimeyer and Raskin, *Constructions of Disorder,* 333.
[72] Madsen, *Collaborative Therapy*, 19-20.

Not surprisingly, proponents of narrative therapy are somewhat skeptical about the obvious assumptions within the whole categorization of pathologies in the DSM IV.[73] Some view the categorization system as part of the machine of exploitation. Herb Kutchins and Stuart Kirk concluded that "for drug companies, the unlabeled masses are a vast untapped market, the virgin Alaskan oil field of mental disorder."[74] Such labeling also has a potentially negative effect on a young life. According to Jennifer Freeman, " When a therapist listens to, accepts, and then furthers the investigation of a pathological description of a child, the child's identity may suffer."[75]

The chief aim of externalization is to stay clear of "self-attack, recrimination, blame, and judgment, and attitudes which work against positive outcome."[76] Even more than being a method or technical operation, externalization is the language of a particular attitude—the attitude of acceptance. According to S. Roth and D. Epston, "This language shows, invites, and evokes generative and respectful ways of thinking about and being with people struggling to develop the kinds of relationships they would prefer to have with the problems that discomfort them."[77] Epston modeled such an example while counseling a boy suffering from a habitual and life threatening problem with vomiting. Epston asked a question that captured the spirit of differentiation: "Do you mind if I like you a lot but don't like your problem at all?" The boy's response was "Nope."[78] As

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[73] Thomas J. Johnson, et. al., "Constructing and Deconstructing Transitive Diagnosis," in Neimeyer and Raskin, *Constructions of Disorder*, 145.

[74] Herb Kutchins and Stuart Kirk, *Making Us Crazy: The Psychiatric Bible and the Creation of Mental Disorders* (New York: Free Press, 1997), in Gergen and McNamee, "From Disordering," in Neimeyer and Raskin, *Constructions of Disorder*, 342.

[75] Freeman, Epston, and Lobovits, *Playful Approaches*, 9.

[76] Monk, "How Narrative Therapy Works," 6.

[77] S. Roth and D. Epston, "Consulting the Problem About the Problematic Relationship," in *Constructive Therapies*, ed. M Hoyt (New York: Guilford, 1996), 149, in Freeman, Epston, and Lobovits, *Playful Approaches*, 11.

[78] Freeman, Epston, and Lobovits, *Playful Approaches*, 27.

mentioned before, questions are central to narrative, and the language of the questions

reveals the difference in outlook.

The following are examples of typical questions asked during the process:

Externalizing Questions:
What would you call the problem that is most affecting you?
What's your main experience when this problem is around? What are you noticing?

Deconstructing Questions:
When did the problem make an appearance in your life? How did it take over?
How does the problem bolster its position?[79]

Notice also the externalizing aspect of the following questions in contrast to their

psychoanalytical counterparts:

Psychoanalytical:
  How did you become sad?
Externalizing:
  What made you vulnerable to sadness, so that it was able to dominate you?

Psychoanalytical:
  What are you most sad about?
Externalizing:
  In what contexts is the sadness most likely to take over?

Psychoanalytical:
  What kinds of things happen that typically lead to your being sad?
Externalizing:
  What kinds of things happen that typically lead to sadness taking over?[80]

Mapping: Charting the Territory of a Problem

These questions address another vital aspect to of deconstruction, namely,

mapping. Mapping allows one to realize how much his/her life has been dominated by

the problem and how little space is left for the preferred life. This can greatly enlighten a

client because "people inadvertently contribute to the 'survival' and 'career' of the

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[79] Adjusted from Neimeyer and Raskin, *Constructions of Disorder,* 303-305.
[80] Freedman and Combs, *Preferred Realities*, 49-50.

problem."[81] Mapping permits a person to see what is keeping the problem alive and well,

and thus, what is preventing a new story from being written. Mapping is, metaphorically,

like taking a "spy mission" into enemy territory to gain vital and advantageous

information.[82]

In mapping, as in externalizing, the process is carried out through asking and

answering questions. Typical mapping questions might include: What is problematic

here? How does it show itself? What does it feel like to be under this problem? Who has

been influenced by it? How?

Objectifying: A Problem Takes On Its Own Flesh and Blood

A unique practice in narrative therapy, and the key to externalization, is

objectifying the problem. Objectifying usually includes giving the problem a specific

name, which is akin to naming an enemy. Naming helps to target the problem, although

Zimmerman stresses that speaking objectively of the problem is even more important

than naming it.[83] For some people, "naming" may be half the battle, for, as magician

Harry Lorayne says, "most problems precisely defined are already partially solved."[84]

Giving problems names seems akin to the positive practice of using symbol and metaphor

to avert personal identification with the problem. Children may experience particular

benefit in naming, for children tend to experience problems as parts of themselves.[85]

The types of problems in clients' lives that can be named are legion. There are

deficits in behavior, unfavorable relationships, conflicts, hostilities, misunderstandings,

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[81] White and Epston, *Narrative Means*, 3.
[82] Parry and Doan, *Story Re-Visions*, 55
[83] Zimmerman and Dickerson, *If Problems Talked*, 49.
[84] Harry Lorayne, in D. Millman, *The Inner Athlete*, (1994), in Efran and Cook, "Linguistic Ambiguity," in Neimeyer and Raskin, *Constructions of Disorder*, 141.
[85] Chang, "Collaborative Therapies," 50.

and despair. Whatever affects the people, patterns, or relationships has a potential name.[86]

Naming may also help unmask the "cultural truths"[87] and the "toxic effects of cultural

narratives"[88] that suck life out of a family, challenging or endangering its true call. The

progression of deconstruction is simple: naming, knowing, and conquering.

Objectification and naming result in an interesting personification of the problem.

The problem seems to evolve into another "being" which has come uninvited into the life

or home. Zimmerman and Dickerson playfully explore this possibility in *If Problems

Talked: Narrative Therapy in Action*.[89] In this work, the authors invent the thinking and

speech of the problems, entering into dialogue with them, as well. The following are

examples of the self-talk the problems themselves divulge. The name of the problem in

this case is "Rift," referring to the fracture plaguing a family with a teenager. Rift comes

alive through the creative dramatization of its speech:

> I am very powerful. I don't know, though, what I think about being called "Rift."
>
> I put looks of concern and worry on the faces of the parents, and a scowl on the young person's face. Often I have a teenager refusing to come into the room—staying in the car or yelling…I can even jump over phone lines, putting anger in the parent's voice, or tears and frustration.
>
> They think they can get me this way, but I outwit them by masking my effects and getting therapist and clients alike to think that I only have one or two people under my control—certainly not the whole family. I can get each person in the family to develop stories about the others that make them 'bad.' Then I can make a case for separating and isolating, rather than for the family members' working together.
>
> As I've said earlier, I love this way of thinking, confusing me with the person. It lets me hide and be powerful.[90]

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[86] Zimmerman and Dickerson, *If Problems Talked*, 52.

[87] Ibid., 42.

[88] Richard C. Schwartz, "Narrative Therapy Expands and Contracts Family Therapy's Horizons," *Journal of Mental and Family Therapy* 25, no.2 (April 1999): 264.

[89] Jeffrey L. Zimmerman and Victoria C. Dickerson, *If Problems Talked: Narrative Therapy in Action* (New York: Guilford, 1996).

[90] Zimmerman and Dickerson, *If Problems Talked*, 44-49. This book is a creative masterpiece in imagining the viewpoint of a problem, a veritable narrative version of *The Screwtape Letters* of C. S. Lewis. The

By the magic of naming and personifying, a problem can finally be seen as a villain with vulnerabilities. No longer is it shrouded in mystery, but rather, it is a foe that can be conquered. A case in point is the legendary story of Tom and "Sneaky Poo," an oft referred to example in narrative therapy. Tom, a boy plagued with failure in the area of potty training, would typically have been labeled with some pathology. However, he conquered his problem by facing the fact that "Sneaky Poo ha[d] been stinking up [his] pants and life." He rose to meet the challenge by believing that he could "outsmart Sneaky Poo."[91]

The overriding goal of the therapist in the stage of deconstruction is to slightly shift or loosen the hold of an old story. Loosening the problem's grip is what White calls the "unique outcome" and Monk calls the "sparkling moment."[92] Every inch that the dominant story loses becomes acreage on which to build a new narrative. When deconstruction is successful, there are many perks for the family:

Decrease in conflict between people
Reduction in the sense of failure
Uniting of people against problems
Opening of space for reclaiming lives
Liberation of people to view problems in new ways[93]

Re-Authoring

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authors even select age appropriate language for a group of little demons, who are discouraged about their failure in controlling children, by having them lament, "We're so depwessed!"
[91] Michael White's client in Freeman, Epston, and Lobovits, *Playful Approaches*, 9.
[92] Monk, "How Narrative Therapy Works," 13.
[93] Adapted from Parry and Doan, *Story Re-Visions,* 53, and White and Epston, *Narrative Means*, 39. Each author gives a similar, but slightly different list. This list seeks to join and abbreviate both.

What made the difference for the Scarecrow, Tinman, and Lion of Oz? New stories made the difference—stories that radically changed their identities and lives. The three characters' lives were so revolutionized that they were handed the throne of the Emerald City. Of course, the Wizard of Oz is only a storybook, but peculiarly, peoples' lives in the real world are often quite similar to storybooks. Just like any storybook goes through many revisions, so life stories can be revised. Freedman writes that "the key to this therapy is that in any life there are always more events that don't get 'storied' than there are ones that do—even the longest and most complex autobiography leaves out more than it includes."[94] It is through finding these "un-storied" details that lives can be "re-authored." In the words of Monk, re-authoring is merely a "re-description of self."[95] The process of re-authoring can continue for a lifetime.

The narrative therapist operates under the belief that "countless lives inhabit us,"[96] that there are "subuniverses of meaning"[97] to be discovered, and that each person already possesses the experiences that are problem defeating.[98] Thus, the therapist carefully searches for these overlooked experiences, pulls them from the dust, and helps breathe new life into them. Thomas Carlson speaks of "rescuing events" that contradict the problem-saturated story.[99]

Monk uses two potent illustrations for this process. One is that of stringing pearls. The pearls are exceptions to the dominant story and it takes care to string them together one by one together. The other illustration is that of building a fire by focusing on

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[94] Freedman and Combs, *Preferred Realities*, 32.
[95] Monk, "How Narrative Therapy Works," 20.
[96] Neimeyer and Raskin, *Constructions of Disorder,* 207.
[97] P. Berger and T. Luckmann, *The Social Construction of Reality* (New York: Doubleday, 1966), 86, in Freedman and Combs, *Preferred Realities*, 36.
[98] Zimmerman and Dickerson, *If Problems Talked*, 60.
[99] Thomas D. Carlson and Martin J. Erickson, "Re-Authoring Spiritual Narratives: God in Persons' Relational Identity Stories," *Journal of Systemic Therapies* 19, no. 2 (2000): 74.

positively lived events (the kindling, twigs, and logs) and piling them carefully at the right times, taking care not to snuff out the flame.[100]

As the therapist helps the client determine what experiences have been silenced or marginalized, questions are once again at the center of the process. Some questions that aid in finding "pearls" might be:

Did you struggle with the problem this week? Did you win even a little?
Are there some relationships which the problem has not invaded?[101]

Upon finding pearls, one can begin to string them by using other questions of curiosity:
This is a mystery to me. You are getting around the problem.
How could you do that? What's your secret?

Instead of focusing merely on the absence of the problem, one may use questions to focus on the presence of strengths:

What would you like me to know about you first?
What do you want to be known for?
What do you enjoy most?
What is something you are proud of?[102]

As experiences are unpacked and viewed from a different perspective, pearl after pearl is strung, and hopefully knotted in-between to prevent unraveling. These knots are the solidifying quality of making a tight story with no gaps. Freeman writes of the importance of thickening the counter plot, where "characters, their intentions, and their circumstances are as well developed, colorful, and convincing as the problem's."[103] For if the elements are not convincing enough, the story will lack solidity and will forfeit longevity. The careful therapist will skillfully aid the client in bringing living, breathing flesh to a new reality.

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[100] Monk, "How Narrative Therapy Works," 16-17.
[101] Adjusted from Neimeyer and Raskin, *Constructions of Disorder,* 303-305.
[102] Adaptations of Freedman and Combs, *Preferred Realities*, Chapter 5 "Questions."
[103] Freeman, Epston, and Lobovits, *Playful Approaches*, 95.

While simultaneously thinning the plot and thickening the counterplot, there is much room for play and creativity. The "miracle question," namely, If you woke up tomorrow and the problem was gone, what would things look like? The "pretend 'as if'" exercise, where the client imagines what a new life would be like, may also be implemented. Solidifying the new position may also involve practicing and role playing with elements of the new story, or asking a client to describe how he/she will make the changes—will it occur all at once, or will he/she slowly slip into them? Letter writing has also been used extensively in narrative therapy; vital words are penned and woven in a way that provides an anchor for the new story, so it won't be forgotten.[104]

Freeman refers to a case of helping a boy thicken his new narrative without rage. She collected an assortment of toys in a pouch and named it his "Temper Tamers Kit." It contained a spyglass to remind him to be on the look out, a whistle to blow when he saw temper coming, a notebook to record his encounters with temper, and an assortment of other powerful toys.[105] Often, just by telling the story audibly, in a new environment, the client may notice that he/she is already participating in an alternate story or revision. Through this process, the client is empowered, for he/she has a hand in shaping his/her own stories, rather than being shaped by them.

Re-Membering

The final stage in the process of narrative therapy is re-membering, which deals with developing a social setting for the clients that will "assist them in living out narratives that support the growth and development of these 'preferred selves.'"[106] The challenge at this stage is that the system an individual or family lives in will resist change.

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[104] Extensive examples are available in White and Epston's seminal work, *Narrative Means to Therapeutic Ends.*
[105] Freeman, Epston, and Lobovits, *Playful Approaches*, 13.
[106] Freedman and Combs, *Preferred Realities*, 35.

Change is challenging because systems seek to remain cozily stable, and people are well practiced in old narratives. Most narratives have been played out for years, even lifetimes. It is no wonder, then, that increasing the number of "appreciative allies" in the system is crucial. The therapist seeks to help: the people involved in the lives of these young people to engage in practices of language that generate stories of learning, success, and competence, rather than stories of deficit, failure, and incompetence.[107]

In "recruiting an audience" that will advocate this new narrative, the first candidates are those most likely to influence the life of the person or family. This may include the deceased, for psychosocial relationships continue their influence even beyond death. In working with the influence of the deceased, imagination will have to be employed, but to find the influencers who are living, the therapist might ask, Who of the people you admire would be least surprised by the change in you? or Who will notice the change first? These people are then brought into the dialogue and informed of the new narrative and its implications. Their understanding and cooperation is of premium importance. At some point, the therapist may even aim to take a client further by asking, If someone who was struggling with your old problem said, "It's no good. It's hopeless. The problem is too strong for me!" what would you say? Such questioning moves the client to a new level—not just from victim to survivor, but from victim to consultant. In this way, the formerly powerless gain the role of changing lives by helping spread new narratives.

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[107] Smith and Nylund, *Narrative Therapies*, 221.