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An Introduction to Narrative Therapy

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Chapter 30

AN INTRODUCTION TO NARRATIVE THERAPY

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We live our lives according to the stories we tell
about ourselves and the stories that others tell about us.
John Winslade and Gerald Monk

Counseling* in a narrative way is a way of seeing, hearing, and thinking about clients' problems as shaped and given meaning by stories or narratives. Problems are not hard realities that permanently define people; rather, they are problem stories by which people know themselves and are known by. This separating of the problem from the person opens up space for seeing the problem and thinking about it in new ways, and opens up the possibility of authoring a better story—a better way of being and doing, and is based on what has become a narrative mantra: "The problem is the problem. The person is not the problem" (Winslade & Monk, 1999, p. 2).

HISTORY

First introduced by Australian Michael White and New Zealander David Epston about 20 years ago, narrative therapy is based on the ideas of a wide variety of postmodern thinkers (Zimmerman & Beaudoin, 2002). Among them is Gregory Bateson (1979), anthropologist and psychologist. His concepts about the subjective nature of reality and "news of a difference" (p. 79) influenced White's work with clients. He found that many clients needed their attention drawn to the subtle changes that accompanied their work on problems. In sharing this "news," he found he could foster new insights about their own resourcefulness and help them gain a clearer picture of how to move forward in a different, more productive way (Monk, 1997). Seeing differences and drawing distinctions between one set of experiences and another allows people to evaluate which experience is preferred. They are

* The terms *counseling* and *therapy* will be used interchangeably in this chapter.

then able to see they have the ability to choose to act in a different way (Winslade & Monk, 1999).

The story or narrative metaphor came by way of ethnographer Edward Bruner (see Turner & Bruner, 1986), who showed that people construct stories as a way of making meaning of their experiences, and showed that these stories will strongly influence which experiences will be chosen for further expression and performance. In other words, people's stories allow them to know themselves and guide their behavior (Monk, 1997; White & Epston, 1990).

French historian and philosopher Michel Foucault's (1975/1979) ideas about society's controlling and ever present evaluative "gaze," led White to develop a variety of therapeutic approaches that seek to allow people to lead lives of their own design, rather than lives confined and constrained by discourses or standards that may not fit their context (Monk, 1997; White & Epston, 1990). One such approach is the idea that the person and the problem are separate from each other.

KEY CONCEPTS

The ideas of these and other thinkers gave rise to key narrative concepts which Wendy Drewery and John Winslade (1997) have grouped under the headings of language, knowledge, power, and the self. A very condensed synopsis will be given for each.

Language

"Language is not simply a representation of our thoughts, feelings, and lives. It is part of a multilayered interaction" (Drewery & Winslade, 1997, p. 34). The words we choose influence the ways we think and feel about the world, which in turn influence what we speak about. "How we speak is an important determinant of how we can be in the world. So what we say, and how we say it, matter" (p. 34).

Knowledge

From a narrative perspective, knowledge is "something we make—rather than something that is given, separate and apart from us" (Drewery & Winslade, 1997, p. 48). This post-modern making of sense "asserts that there are many truths, and that what one person holds as sensible and true may not be so for another" (p. 49). The therapeutic implications of this include clients being the experts of their own lives rather than the therapist being the expert on client problems.

Power

In narrative therapy, "a major therapeutic emphasis is placed on helping people escape the subjugating grasp of the dominant discourses [or standards] of the culture" (Gergen, 1999, p. 173) that may not fit their personal context. This liberation aim is achieved by exposing or deconstructing the discourses or ultimate truth stories that dictate how people are to live and behave (Monk & Gehart, 2003).

Self

The self, rather than being understood as an entity inside of a person, is as seen as "a process or activity that occurs in the space between people" (Freedman & Combs, 1996, p. 34). Therefore, "what we do matters, but we do not have full control over our circumstances. We have a major part to play in our own becoming, but we cannot simply decide who we will be" (Drewery & Winslade, 1997, p. 47). Note that this perspective emphasizes the influence of context—of the circumstances of people's lives—in producing who they can be, but also leaves some agency or choice with the person.*

These key concepts of language, knowledge, power, and self provide a foundation from which to view narrative therapy. They will re-emerge in the context of the ideas and suggestions that follow.

HEALTH VERSUS DYSFUNCTION

Given the tension between the external contexts that shape people and their self-efficacy, how does one emerge as healthy? As an alternative to the widely held Western view of people as beings who can rationally control themselves and their world, Drewery and Winslade (1997) described this possible path to health: "what most people do is muddle along, making sense as best they can, making decisions and acting on them in the face of the uncertainty, complexity, and novelty of the situations that are constantly arising and demanding a response" (p. 48). Healthy people can identify and pursue preferred identities and ways of living, and in the course of their muddled meaning making, they have the ability to forgive themselves when the story line moves from mere muddle to malfunction (Drewery & Winslade, 1997).

Dysfunction is seen as a problem-saturated story external to a person. Rather than the person being the problem, the problem is the problem (Winslade & Monk, 1999). And where do problems originate? From a narrative perspective, problems are "manufactured in a social, cultural, and political context…, and they come together through the medium of human language to construct and produce our experiences" (Monk, 1997, p. 27). When this happens in people's lives, their stories can feel like they are being written by outside forces and life

* Note that this does not do away with personal responsibility. Although from a social constructionist point of view, a social, rather than an individual lens is the primary optic through which humans may be understood, humans cannot shrug off moral responsibility for the way things are in the world. We are co-constructors—"participants in producing other people's worlds as well as our own" (Drewery & Winslade, 1997, p. 41).

can feel overwhelmingly out of control. This is often when people enter therapy. Their focus is on what is wrong, and their stories become saturated by the problem (Combs & Freedman, 1994). This powerfully influences perceptions. As Freeman, Epston, and Lobovits (1997) described it, "The problem-saturated story limits perspective, edits out threads of hope and positive meaning, and precludes refreshing possibilities and potentials. Change may…seem impossible in spite of a person's best efforts to take control of a problem" (p. 48).

THE CHANGE PROCESS

How do people change? Simply put, through re-authoring their stories. How people speak and what they speak about are their tools for interpreting their experiences—for meaning making (White, 2000). "The argument…is that these ways of making sense are susceptible to change" (Drewery & Winslade, 1997, p. 34). When people change the ways they speak, they can also change much about the way they organize and understand their worlds. Language directs the attention of both the therapist and client, as well as their understanding, their being, and doing (DeSocio, 2005; Drewery & Winslade, 1997; Morgan, 2006b; Muntigl, 2004). The implications of this have everything to do with change.

For therapists it means using language and being vigilant for life stories people would prefer, given that we tend to find what we are looking for. When therapists view the problem-saturated story as separate from the person and his/her preferred experiences, and use language that communicates this, it opens up room for and can orient therapist and client toward "inspiring histories, present strengths, and future dreams and hopes. [Gradually] the way a problem works as a restraint to these is then brought to life" (Freeman et al., 1997, p. 49).

Change can be difficult. Language traditionally used around some of its difficulties, such as resistance or denial, is avoided in narrative therapy—even in consultations with other professionals. According to Winslade et al. (1997), these "internalizing concepts… suggest that we know clients better than they know themselves, [and] locating 'resistance' in the person of the client is a blaming response that lays at the feet of one person what has happened in a relationship" (p. 57). When counselors invite clients to join them in examining any restraints or ruptures between them, it is an acknowledgment that relationships are bi-directional. Jointly examining discourses that position counselor and client in relation to each other and to the culture around them paves the way for a therapeutic environment which honors the client's position as co-author of a preferred story.

THE THERAPEUTIC ENVIRONMENT

A respectful and optimistically curious orientation is central to a collaborative therapeutic environment (Monk, 1997). The therapist is neither the expert nor a neutral participant, but rather takes an "investigative, exploratory, archaeological position…consistently in the role of seeking understanding of the client's experience" (Monk, 1997, p.25). The client is an equal partner with local knowledge that may initially be inaccessible—much like an artifact at a dig

buried in centuries of soil. Together counselor and client sift, probe, excavate, dust off, and name.

An awareness of and respect for each person's culture is imperative (Winslade et al., 1997). As human beings, our cultures locate us in positions relative to others through how we talk, what we look like, where we live, and who we know (Monk & Gehart, 2003). Before we even open our mouths we embody our cultural location—our place in society, which in turn offers "a limited range of position for the other" (Winslade et al., 1997, p. 58). Acknowledging and deconstructing these positions of relative power or of powerlessness are important tasks in creating a therapeutic environment (Kogan & Gale, 1997).

Two obvious positioners include the fact that clients come to counselor's offices and pay for their services, thus creating an uneven balance of power (Winslade et al., 1997). The age difference that exists between counselors and clients who are children also introduces a power differential (Morgan, 1999). Other positioners may include race, ethnicity, gender, sexual orientation, spirituality, or socio-economic status. All clients have need of a respectful orientation from the counselor.

THE THERAPEUTIC PROCESS

The map is not the territory.
Alfred Korzybski

While maps are useful as guides, they are no replacement for the actual territory traveled. This is true for any sort of therapeutic orientation as well. An orientation can provide direction for the therapeutic process, but it is the people therapists work with who will ultimately shape that process. Therapy is never the same twice. In that spirit the following overview of the therapeutic process is offered.

Assessment and Diagnosis

Language shapes people's thinking and doing (Muntigl, 2004), and therefore caution is used when choosing words. Terms like assessment and diagnosis put the assessor and diagnostician in a position of power, and "grant precedence to professional 'regimes of truth' over clients' knowledge about their own lives" (Winslade et al., 1997, p. 56; also see Simblett, 1997). This runs counter to seeing clients as experts on their own lives and offering them the position as first author in the collaborative re-storying of their lives (Eron & Lund, 1996). As Drewery and Winslade (1997) have said, "people work all the time to make sense of their own lives and…it is not up to the counselor to do this work for them" (p. 41).

Labels resulting from diagnoses generally focus on individual deficits rather than strengths, and can powerfully influence the dominant story about a person (Freeman et al., 1997; Nylund, 2000). Internalizing of this diagnosis label can paradoxically take a well-intended focus on what is "wrong," and feed into maintaining the very problem they are trying to eliminate. Clients see themselves as being the label, as do others. "I am ADHD." "She is anorexic." Other important aspects of clients' identities, such as their skill in

sometimes managing the problem successfully, are overshadowed by these totalizing descriptions. When the focus is on the problem, it can obscure what is right, and can limit people's vision-horizon for a better way (Nylund, 2000).

This is not to say that assessment is nonexistent, nor that the problem story is ignored, but rather than a focus on deficits, the therapist will use listening and observational skills to help develop an alternative story (Monk, 1997; Simblett, 1997). "Unlike the Rogerian therapist, whose active listening is intended to reflect back the client's story like a mirror without distortion, the narrative therapist looks for hidden meanings, spaces or gaps, and evidence of conflicting stories" (Drewery & Winslade, 1997, p. 43). To that end, Nylund (2000) developed the SMART Rating Scale for eliciting this sort of less obvious or hidden information from parents and teachers in his work with children diagnosed with Attention Deficit/Hyperactivity Disorder (ADHD). "The scale is a subjective questionnaire to identify a child's strengths and abilities" (p. 59), and helps to fill in the deficit oriented picture typically obtained from symptom checklists. This broader perspective can help create space between the problem and the client, which then opens up room for noticing what is right and for seeing possible preferred storylines. Hoyt (1994) said it well: "How you see is what you get" (p. 2).

Treatment Goals

The objective of narrative therapy is not to find a "solution." Rather, it is to help clients reclaim the authority to author their own stories, or as Drewery and Winslade (1997) have put it, "to enable clients to speak from subjective positions rather than as subjected persons" (p. 43).

Problems can steal people's sense of agency, their sense of "I can do this," and can leave them feeling disabled and at the mercy of seemingly immovable forces. People tell themselves problem-saturated stories in which they are "positioned, or subjected: …not the actor but the passive recipient of the given positioning" (Drewery & Winslade, 1997, p. 42). In order to help clients reclaim authorship, "the narrative counselor looks for alternative stories that are enabling" (p. 42), freeing clients to speak in their own voices and to work on self-identified problems themselves.

Phases of Treatment

Even before clients meet with therapists, professional disclosure statements can already begin to set a cooperative tone. With a narrative approach, language used in a therapist's professional disclosure statement will avoid claims of expert status. This does not at all mean there is no training in or knowledge of the problem area, but there is less likelihood that the contract will be based on an assumption of privilege because of that training or knowledge (Winslade et al., 1997). Rather, therapists would want to present to clients their preference for a collaborative horizontal counseling conversation, and make it clear that they "would want to explore clients' abilities and talents so that these [become] more available for use in addressing … concerns" (Winslade et al., 1997, p. 62).

Following is an overview of the phases that narrative sessions might move through. A more detailed description of several pieces, such as externalizing conversations and mapping the influence of the problem, will be given in the section on techniques.

A first session typically begins with a conversational exchange with each person present—small talk, if you will—a start at building bridges with each member. This joining conversation often moves into mapping the development of the problem as well as its influence on all concerned, including those not present. This is done in an externalizing way to help people see that "their own lives and the life of the problem [are] distinct" (Monk, 1997, p. 12). The session ideally comes to a close with client(s) and counselor aligned together on one side against the problem on the other side. The alternatives may then be laid out: is the preference to continue coping with the current problem story or to explore alternatives? Between sessions, clients might be invited to focus on the ongoing effects of the problem-saturated story and consider any events occurring that are free of those effects (Monk, 1997; Winslade & Monk, 1999).

During session two, client(s) and counselor explore what happened since the last session as well as prior to the start of therapy as a way of identifying any subtle shifts in the clients' relationship to the problem. A useful question for drawing attention to these shifts is: "What sort of thoughts or changes have you noticed since I last saw you" (M. Massey, personal communication, March 26, 2005)? Minimal or contemplated changes are explored as examples of the strength of the dominant story or as signs of the emergence of a new story. Just as the history and influence of the problem story is carefully mapped, so it is with the preferred story. Persistence and curiosity on the part of the therapist is essential, as often clients discount or minimize exceptions (Winslade & Monk, 1999).

Gerald Monk (1997) likened the process to building a fire. First tiny twigs are found and ignited, and only slowly and strategically can more twigs be added or the first sparks will go out. Eventually larger sticks can be carefully added, and "soon the fire has a life of its own" (p. 17). Monk identified the twigs and sticks as the client's "positive lived moments" (p. 17). It is the counselor's task "to identify these favored moments and bring them into the awareness of the client. The art in this approach lies in both knowing where to look and recognizing the unstoried moment when you see it" (p. 17).

Setbacks are a reality and preparing the client for the problem's attempted return is important (Freeman et al., 1997; Winslade & Monk, 1999). Sometimes it can be helpful to encourage the client not to overdo it (Monk, 1997). Enlisting the encouragement of a wider audience can also be helpful. One way to accomplish this is through documenting the changes that have occurred and drawing the attention of an appropriate audience to these changes (Freedman & Combs, 1996; Morgan, 2006a; Winslade & Monk, 1999).

Inviting a client to become a consultant is yet another way to expand the audience, and is a recognition of the client's status as first author in the coauthoring of the preferred story. This recognition of expert status replaces the "helpless, dependent person who needs to be fixed" (Monk, 1997, p. 23), the role previously engaged in by the client in relation to the problem. S/he has something to offer others grappling with similar difficulties.

Termination often comes about when clients find themselves living more and more in their preferred way—the problem-saturated story no longer dominates. Instead the client is authoring the preferred story, and the "fire has a life of its own" (Monk, 1997, p. 17). For those times when the fire may burn low, the door can be left open for occasional future consultations (Freedman & Combs, 1996).

Nature of the Therapeutic Relationship

It may be fair to say that most people entering the counseling profession do so because they want to help others. Indeed, the group term "helping professions" has emerged to identify counselors, therapists, social workers, and others of similar stripe. Therefore this perhaps surprising caution from Winslade, Crocket, and Monk (1997) in their discussion of the therapeutic relationship:

> The compelling desire to be of help is one we take care to avoid in our work with clients, as it can produce harm in the therapeutic relationship. The danger is that it will focus the counselor on her own position of power and blind her to opportunities for helping the client to connect fully with his own competencies and talents. In the quest to be needed, the counselor can be seduced into seeing herself as the only competent and resourceful party in the therapeutic relationship, the client being regarded as fragile and weak. (p. 73)

Truly believing in the agency of clients is important if counselors are to genuinely collaborate, and not merely do lip-service to a shared responsibility for shaping the counseling conversation. In the narrative way, counselor and client are coauthors, and as Winslade et al. (1997) have said, "to be an author is to have the authority to speak - especially in one's own terms and on ones' own behalf" (p. 55). For clients this means an ever growing sense of themselves as major agents in producing a beneficial counseling process, as well as a growing sense of agency in their lives outside of the counseling office. For counselors, this "stance on coauthoring does not need to imply that we give up our authority as professionals…, but we do endeavor to use our authority in ways that put our weight behind the client's preferences for agency in his own life" (p. 63).

Techniques

Narrative therapy does not follow a formula, nor is it so much a collection of techniques as a different way of thinking and seeing, yet there are "techniques" that have come to be identified with the narrative perspective. Some of the more commonly followed narrative approaches or techniques follow. The listing is by no means exhaustive.

Counselors working out of a narrative perspective still use basic counseling skills, but sometimes for different reasons. Questions, for example, are composed and used to "…generate experience rather than to gather information. When they generate experiences of preferred realities, questions can be therapeutic in and of themselves" (Freedman & Combs, 1996, p. 113; also see Zimmerman & Dickerson, 1996, pp. 303-306, for sample questions). Listening, reflecting, summarizing, and paraphrasing are all used to invite clients to hear their own stories—to be an audience to their own life stories. The telling of their stories opens a door for the development of a new relationship with themselves and with their stories (Winslade et al., 1997).

Externalizing Conversations

One of the ways people develop a new and different relationship with themselves and their life stories is done through externalizing problems. Externalizing seeks to separate

people's sense of identity from the problems for which they are seeking help, and is a way of seeing and then speaking that indicates and invites respect for "people struggling to develop the kinds of relationships they would prefer to have with the problems that discomfort them" (Roth & Epston, 1996, p. 149).

To help therapists start thinking in an externalizing way, Morgan (2000) suggested imagining the problem as a "thing" perched elsewhere in the room—perhaps on the shoulder of the client, perhaps on a separate chair. Talking about the problem starts with listening carefully for clients' descriptions of their problem experiences. A client may talk about feeling alone and depressed. The therapist may ask, "How long has the Loneliness been influencing you?" Asking questions where the verbs or adjectives clients use are changed into nouns helps separate the problem from the person, as does putting "the" in front of the capitalized problem name. "How does the ADHD influence your child?" "Where has the Fighting taken your relationship?" Other useful and even playful ways of externalizing the problem that can be particularly useful with children include giving it a name of its own or drawing a picture of what the problem looks like (Carey & Russell, 2002; Morgan, 2000; Nylund, 2000). "When is Mr. Squirmy the strongest?" "What happens when Bossy Cow is in charge?"

Externalizing can have a potent effect on both counselor and client. It can help counselors remain in a position of respect and alertness to clients' abilities in struggling with common human problems. It also "offers a way to listen closely and join with the [client], without confirming limited or pathologizing descriptions" (Freeman et al., 1997, p. 48). For clients, stepping back and separating from the problem changes the footing of their relationship with the problem, and can return a sense of agency. The door opens to hope and to exploring their capabilities in addressing the effects of the problem (Carey & Russell, 2002; White, 2006).

As noted earlier, externalizing does not do away with personal responsibility (White & Epston, 1990). As Carey and Russel (2002) have stated:

> Externalizing is not about separating people from their actions, or the real effects of their actions. A key element of externalizing conversations involves exploring in detail the real effects of the externalized problem on the person's life and also all others who are being affected by the problems. By thoroughly detailing these effects, externalizing conversations are used to enable people to take a position in relation to the externalized problem and then to engage with others in addressing its effects and reducing its influence. (p. 6)

Mapping the Influence of the Problem

Mapping the effects of the externalized problem is done in detail so as to gain a nuanced sense of the history of the problem and its negative and positive effects on the lives of the person, their family, and their broader context. Its past and current cost is mapped out as well as its predicted future, should the story continue in its current direction (Freeman et al., 1997).

Questions used in mapping the influence of the problem often inquire into its length, breadth, and depth of influence (Winslade & Monk, 1999). "When did you first notice the problem?" "How was life different before the problem?" "When has the problem seemed to be the strongest?" "The weakest?" "What percentage of your life is influenced by the problem?" "Where in your life is the problem's influence the greatest?" "The least?" More concrete approaches include drawing pictures of the problem that represent its size in a child's life, using fractions to indicate the extent of its influence, labeling and shading in a pie

chart of the problem's areas of influence, or graphing its intensity over time (Morgan, 2000; Winslade & Monk, 1999).

Landscape-of-Action Questions and Landscape-of-Consciousness Questions

Using psychologist Jerome Bruner's (1986) metaphor of landscape, White (White & Epston, 1990) addressed the landscapes of action and meaning. Important stories take shape in both of these landscapes. Asking landscape-of-action questions probes what clients have done or considered doing that would not be expected given the problem's influence. "What did you do to outsmart the Temper Tiger?" Landscape-of-consciousness questions help clients reflect on their own agency and how they considered doing or did what they did. "What does this tell you about yourself?"

Landscape-of-action questions and landscape-of-consciousness questions aid in uncovering clients' values, commitments, beliefs, desires, intentions, and competencies, all of which may be explored in a "gathering together and sequencing…of unique outcomes" (McKenzie & Monk, 1997, p. 109). These unique outcomes or sparkling moments can emerge at any point, and can initially seem insignificant. Winslade and Monk (1999) bulleted several possibilities to be alert to:

- actions
- thoughts
- intentions to act
- moments when the effects of the problem don't seem so strong
- areas of life that remain unaffected by the problem
- special abilities
- knowledge about how to overcome the problem
- problem-free responses from others
- relationships that defy the problem's persuasions (p. 42)

Questions about clients' actions and agency are asked when such exceptions to the problem are noticed. Gently persisting in fleshing out how clients move counter to the problem helps them experience themselves as being actors in their own lives. McKenzie and Monk (1997) offered a number of sample questions: "What preparations did you make for taking that next step?" "What has been happening in your life that has given you the energy to make the kind of progress you have been making?" "What does this say about the kind of person you are when you can consider going to school even when your world had completely turned upside down?" "What does this say about what you want from your life" (p. 109)? When people respond to these questions, they are in essence telling new stories about themselves. They begin authoring alternative stories.

Therapeutic Documenting

One way of adding to or thickening the new alternative plot is documenting client progress. While this tracking of progress is done regularly via note taking, a variety of powerful therapeutic documents can be generated for clients that can thicken the plot by making their new stories somehow more real by allowing them to see proof of them in living color or in black and white. This documentation can include audio or videotapes, drawings, declarations, certificates, awards, letters, or whatever your imagination can dream up

(Freedman & Combs, 1996; Freeman et al., 1997; McKenzie & Monk, 1997). Often documents are generated in consultation with the client. Some remain private; others are meant to be public. Following are brief discussions of some types of therapeutic documents (for ideas about using all manner of therapeutic documents see Freedman & Combs, 1996; Freeman et al., 1997; Morgan, 2000, 2006a; Nylund & Thomas, 1994; and "Therapeutic documents revisited" in White, 1995).

Note Taking

What therapists choose to write in their notes matters, because as McKenzie and Monk (1997) have said, "what gets written down tends to be given more value or weight" (p. 113). For this reason, detailed descriptions of symptoms and problems are not preferred. Freedman and Combs (1996) suggested that therapists divide their note pages in half. On the left side note things related to the problem story using externalizing language. On the right side note things related to the developing alternative story, marking unique outcomes with an asterisk. It is useful to write direct client quotes here, as this aides in creating letters to clients later.

Narrative therapists will ask for permission to take notes during a session, explaining their method, and then along the way checking in for accuracy (Morgan, 2000; Winslade & Monk, 1999). Many narrative therapists consider notes to be the property of the client, and will make them available for clients to take home, perhaps requesting a copy themselves if desired. These notes can be useful between-session reminders for clients of what has been talked and thought about (Morgan, 2000).

Letters

Client surveys have suggested that a well-written letter from a therapist to a client is the equivalent of three to five good sessions (Nylund & Thomas, 1994; White, 1995). Such letters have a distinctive style and usually consist of the following ingredients:

- a record of a session or sessions that may include an externalizing description of the problem and its impact on the client
- an account of the client's abilities and talents as identified in the session
- the struggle the client has had with the problem
- distinctions between the problem story and the developing preferred story. (McKenzie & Monk, 1997, p. 113)

Certificates and Awards

Certificates and awards can be used to mark important occasions such as turning points or times of celebration (Morgan, 2000). Freedom from the old problem and celebrating the new story can be proclaimed in a format that can be referred to again and again.

Video or Audiotape

One playful way of using video or audiotape is for young persons to tape themselves as live reporters, telling about their newly discovered knowledge and abilities. Reviewing themselves on tapes they have made can be a useful booster for themselves if the old problem story attempts a comeback. With permission, these tapes can also become potential "consulting" tools. Asking clients to be consultants to other young people struggling with

similar problems can help them consolidate gains they have made (McKenzie & Monk, 1997). It sends a strong message that the client is not just a helpless victim needing fixing, but is a person who has much to offer by way of learned experience and expertise.

Therapeutic documents can provide concrete reference points for clients—signposts along the path of progress, and when shared, for their chosen audience as well. And as Morgan (2000) said:

> Whereas the intricacies of a conversation can so easily be forgotten, therapeutic documents can be referred to over and over again. Each reading (or playing or drawing) can act as a retelling of the alternative story, and this in turn contributes to new possibilities. (p. 99)

Widening the Audience

Another way to retell the new story is to share it with a wider audience. Family, friends, and people clients work or go to school with have often been audience to their problem-saturated stories. They can also be powerful supporters of clients' emerging preferred stories. The witness of a wider audience somehow validates the changes clients are making and the new description they are beginning to live by (McKenzie & Monk, 1997; Morgan, 2006a). Monk (1997) stated it strongly: "In order for the client to make a successful departure from the identity offered by the problem account, an audience needs to be recruited to bear witness to the emergence of the client's new description of himself" (p. 21).

There are various ways of widening the audience. One way is to ask clients to identify someone in their lives they admire who would be the least surprised at the changes they are making. Often a family member is identified, sometimes it is an important friend or teacher. Asking clients to imagine what this person might say or do in response to the changes they are making can help clients gain a sense of the effects of their changes. The client also has the option of actually communicating with this person about the changes being made or of showing the new story behaviorally (Freedman & Combs, 1996; Winslade & Monk, 1999). Sometimes the sense of proving the opposition wrong can be attractive (McKenzie & Monk, 1997), so asking clients who would be most surprised by the changes being made can also be useful.

Writing a letter or declaration to a person or persons is a more concrete way of widening the audience. Co-authoring a description of the new developments that are occurring, and sending it to people can be powerful (Morgan, 2006a). For example, students describing evidence of the changes they have made, and sending this to teachers and principals in a school can often shift this audience's attention to a more supportive stance.

A supportive stance from others for the alternative stories clients are telling about themselves is important. Others' stories about them shape how they see themselves and impact how they live their lives. For others to tell new stories about clients, they have to hear new stories. Widening the audience helps clients live their lives according to these new and developing alternative stories.

STRENGTHS AND LIMITATIONS

A narrative approach to therapy is a transparent, collaborative, and even political way of working with clients (Hayward, 2003; Monk & Gehart, 2003; Tomm, 1993). More than a specific sequence or collection of techniques, it is a perspective, a way of seeing, hearing, and thinking about clients and their problems. This is at once a strength and a difficulty—a strength in that it can flex to many settings, people, and problems, but it also means there is no step-by-step path marked out to follow in order to "do" narrative therapy. It takes time and effort to integrate a narrative perspective into one's personal therapeutic style (McKenzie & Monk, 1997).

Narrative therapy doesn't always look much like therapy. Often it looks very much like a regular conversation. This too, can be construed as a strength, but can also present difficulties. A teacher said to a school counselor: "I thought you were going to work with that student I sent you. He says you're not doing any counseling—just talking. What's going on?" Educating your colleagues may be necessary for them to understand you are indeed doing your job (M. Massey, personal communication, March 26, 2005).

Research on the utility of a therapy modality may point to its strengths and weaknesses; however, the research on narrative therapy is very limited. One reason is that it is a "young" therapy so there has not been time for a body of research to accumulate. In textbooks it is still listed as emerging or evolving (Goldenberg & Goldenberg, 2004). Yet an even more basic reason for this dearth of outcome studies may be due to the assumptions about objective truth inherent in empirical research, which are at odds with the social-constructionist assumptions inherent in narrative therapy (Etchison & Kleist, 2000; Prochaska & Norcross, 2003).

In a review of the studies that do exist, Etchison and Kleist (2000) found positive outcomes, summarizing that "narrative approaches to therapy have useful application when working with a variety of family therapy issues" (p. 65). These issues included conduct disorders, family violence, grief related to death as well as divorce, school problems such as academic failure, sibling aggression, ADHD, parent/child conflict, and eating disturbances.

Devotees of any therapy modality tend to see its strengths more easily than its limitations (Hayward, 2003). Indeed, this is to be expected, and perhaps White (1995) is no exception. When asked about the limitations of the narrative approach, rather than responding about the approach, he responded with a list of his own personal limitations. As humans, we all share them.

> These are limitations with regard to language, limitations in my awareness of relational politics, limitations in my capacity to negotiate some of the personal dilemmas that we are confronted with at every turn in this work, limitations of experience, limitations in my perception of options for the expression of certain values that open space for new possibilities, and so on. (p. 38)

For all counselors, extending beyond limitations calls for exploration of them—through personal reflection, reading, and talking with others—both clients and colleagues (White, 1995). Awareness of one's limitations and a transparency with one's clients about them is one way of stretching beyond them.

SUMMARY

This brief overview of narrative therapy offers but an incomplete map of a vast territory that includes ideas, ways to work with people, and actual people. Winslade et al. (1997) cautioned about this very sort of mapmaking. A map has an uncanny power to draw our focus onto itself rather than the actual ground covered—that is to say the actual people we work with. To minimize this risk, we need to realize, along with White (1995), that narrative therapy is more than a therapeutic approach. Perhaps it is a "world-view, [or] perhaps it's an epistemology, a philosophy, a personal commitment, a politics, an ethics, a practice, a life, and so on" (p. 37).

And so onward.

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