❖ **Literature Review—Research**

Review of Narrative Therapy: Research and Utility

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Narrative therapy has captured the attention of many in the family counseling field. Despite the apparent appeal of narrative therapy as a therapeutic modality, research on its effectiveness is in its infancy. This article will review current research on narrative therapy and discuss why a broader research base has yet to be developed. Suggestions for practitioners also will be provided.

Narrative therapy is an increasingly used therapeutic modality (Cowley & Springen, 1995). Narrative approaches to therapy have been discussed in popular written media and academic journals ranging from the *Journal of Consulting and Clinical Psychology* and *Family Therapy Networker* to *The Family Journal*. Hevern (1999) reports more than 2,000 bibliographic narrative therapy resources of scholarly articles, book chapters and full texts, and doctoral dissertations. O'Hanlon (1994) posits that a narrative approach to therapy "represents a fundamentally new direction in the therapeutic world" and is "the third wave" (p. 22).

Narrative therapy refers to a range of social constructionist and constructivist approaches to the process of therapeutic change. Change occurs by exploring how language is used to construct and maintain problems. Interpretation of one's experience in the world serves as the essence of narrative approach to therapy (Cowley & Springen, 1995). Experiences are collapsed into narrative structures or stories to give a frame of reference for understanding and making experiences understandable. White and Epson (1990) state that narrative therapy is based on the idea that problems are manufactured in social, cultural, and political contexts. To deepen understanding, problems have to be viewed from the context in which they are situated. Viewing the context includes exploring society as a whole and exploring the impact of various aspects of culture that help to create and/or maintain the problem. White and Denborough (1998) relate how people's lives and relationships are shaped by the stories they develop to give meaning to experiences. For example, in our culture, people who experience hardships are sometimes seen as failures or deficient in some ways. They may view themselves as the problem and create stories of themselves that depict a lack of power and worth. Problems may not be seen by them as external events that affect and influence their lives and, thus, are maintained. Narrative therapy deals specifically with these stories as the loci of effective therapeutic goal setting.

Narrative therapy is goal directed. Monk, Winslade, Crocket, and Epson (1997) comment that the primary goal of narrative therapy is to form an alliance with clients that accesses, encourages, and promotes abilities to enhance relationships with one's self and with others. Narrative therapy aims to refuse to see people as problems and to help them to see themselves as separate from problems. White and Epson (1990) state that once a person sees a problem as separate from the person's identity, the opportunity for change has been created. This change can take the form of behaving differently, resisting or protesting the problem, and or negotiating the relationship with the problem in other ways. Narrative therapy's goals uniquely affect the therapeutic process.

The creation of alternative stories anchors narrative therapy's therapeutic process (Monk et al., 1997). It is a process that recognizes that humans are growing and that each moment offers opportunities to create an alternative story that builds on strengths and desired outcomes for a satisfying life. Historical acts of resisting damaging stories or depictions of self and relationships are explored as evidence of the person's ability to create alternative stories. Honoring everyday actions of resistance by externalizing conversations is depicted by narrative therapy as a way to begin to reclaim lives. Recognizing these actions as strengths can help people in the process of creating alternative stories. Anecdotal reports of the effectiveness of this process make narrative therapy attractive to clinicians.

Despite the apparent attraction to narrative therapy, research on its utility is sparse. A review of existing literature uncovered a limited number of studies. This review will

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examine these studies, explore possible reasons for the scarcity of research on the utility of narrative therapy, and discuss implications for practitioners.

REDUCING PARENT-CHILD CONFLICTS

Besa (1994) examined the effectiveness of narrative therapy in reducing parent-child conflicts. Besa initiated this research in response to anecdotal reports in the literature of dramatic success in the treatment of parent-child problems using narrative approaches. Parent-child conflict was defined as defiant behavior, keeping bad company, abuse of drugs, school problems, and other conduct problems. Participants consisted of six families with children between the ages of 8 and 17 years old. The families were selected from those families who presented with a parent-child conflict at a clinical setting providing individual, group, family, and marital therapy to low- to moderate-income clients.

The authors chose a single case research design to avoid using methods that relied on classification, pathologizing, or diagnostic categories to study the effectiveness of narrative therapy. Parents were trained to take baseline measurements of the targeted behavior and monitored their child's progress by counting the frequency of specific behaviors during baseline and intervention phases. The target behavior was the child's problem behavior that the family wanted to decrease and around which there was a parent-child conflict. The target behavior was defined in measurable terms, such as not doing chores, arguing, not doing homework, and so forth. A tracking form was developed to monitor the child's behavior, focusing on the specific behavior targeted for intervention. Results were evaluated using three multiple baseline designs.

Treatment used several narrative therapy techniques. Techniques included externalization (speaking of the problem as separate from the individual), relative influence questioning (exploring the influence of the problem on the individual and the individual on the problem), identifying unique outcomes and unique accounts (identifying times when there were exceptions to the problem), bringing forth unique redescriptions (attaching new meaning to behavior), and assigning between-session tasks (continuing work begun in session between sessions). Examples of these techniques included exploring exceptions to drinking and abuse, defining study habits as problems instead of the child as the problem, attaching new meaning to behavior as a desire to cooperate as opposed to attention seeking, and the assignment of engaging in cooperative activities instead of arguing.

Five of six families showed improvements, ranging from an 88% to a 98% decrease in parent-child conflicts with narrative therapy. No improvements were observed in the absence of narrative therapy. The authors concluded that in five of the six cases studied, narrative interventions were the probable cause for the changes observed. It suggests that narrative therapy was effective in reducing parent-child conflicts and would be applicable to families experiencing parent-child conflicts under conditions similar to the families involved in this study. The results supported anecdotal accounts of success in the literature.

CLIENT EXPERIENCE OF NARRATIVE THERAPY

St. James-O'Connor, Meakes, Pickering, and Schuman (1997) examined families' perceptions of their narrative therapy experience and the meaning that these families attributed to this experience. The study sought to discover what families found helpful and unhelpful in their therapeutic experience.

Eight families who were experiencing problems with children ranging in age from 6 to 13 participated in the study. Five families were headed by single parents and three were headed by more than one parent. The families selected presented with serious problems, including conduct disorders, family violence, grief associated with parental divorce and/or death, school problems, aggression with siblings and others, attention deficit/hyperactivity disorder (ADHD), and refusal to obey rules and direction. The researchers selected these families because they were currently being seen in family screenings by the narrative team at a university hospital outpatient clinic.

The researchers used an ethnographic research design guided by the question "What is the family's experience of narrative therapy?" The authors chose this design for three reasons: The research question required the possibility of complex responses, the practice and process of narrative therapy shared similarities with an ethnographic interview, and participants were viewed as coresearchers. The authors employed a semistandardized interview format using four questions aimed at developing a rich description of the families' perceptions: (a) What has been helpful in therapy? (b) What has not been helpful in therapy? (c) What is your overall experience of narrative therapy? and (d) What is an image or symbol to describe your experience of therapy? Each question included subsequent questions that could be used to facilitate a richer description. The interviewers were students who completed a graduate course in qualitative research and training in interviewing skills. The interviews were audiotaped and transcribed verbatim. Data were then coded using latent and manifest content analysis designed to recognize themes, commonalities, and differences.

Six major themes consistent with a narrative therapy paradigm emerged from the data. They were (a) externalizing conversation, (b) unique occurrence and alternate story, (c) developing personal agency, (d) consulting and reflecting teams, (e) building the audience, and (f) the helpful and

unhelpful aspects of therapy. The following examples were noted by the clients:

1. "The therapist was not into blaming anyone for the problem. I like that. In our situation what was found was not one person in particular."
2. "The air is not so thick in the house anymore. It's more like a home. . . . It's nice to hear her laugh and play like a kid should instead of sitting there watching TV."
3. "My therapist and the team behind the mirror told me that I was doing a good job and that I had a lot of solutions myself. I received a lot of compliments from the team and I believed them after a while."
4. "I found that they sat around together and talked to each other about what they saw instead of discussing it directly with me. They discussed it as if I were not there."
5. "So there is a sense that at least I'm on the right track. That is helpful. Solutions may come because there is a process to involve the family, the school."
6. "Both the therapists we had obviously cared. They were supportive and listened."

The authors concluded that the results supported the view of narrative therapy as empowering personal agency in family members. They observed that all of the family members reported some reduction in the presenting problem. The reduction of problems was greater in families involved in narrative therapy for longer periods than in families involved for shorter periods. The authors explain that this result may be due to the family making a number of cognitive shifts during the narrative therapy process. The results suggest that narrative therapy should continue as a viable therapeutic model for working with families. The results also indicate that an ethnographic method of inquiry is congruent with research on narrative therapy.

CHILDREN'S ATTRIBUTIONS ABOUT FAMILY ARGUMENTS

Weston, Boxer, and Heatherington (1998) initiated an exploratory descriptive study to examine children's attributions or stories about the causes of family arguments between marital partners and between parent and child. They sought to increase understanding of children's cognitions and their implications for therapeutic interventions.

Participants consisted of 92 children between the ages of 5 and 12 years old. The children were from predominately White, middle-class, two-parent families recruited by newspaper advertisements and pubic notices. Three single-parent families were unintentionally recruited, and these children participated in the parent-child argument group only.

The researchers used audiotaped family arguments and structured interviews to gather data from participant families. Two audiotaped arguments, one of a parent-parent conflict and one of a parent-child argument, were used as a stimulus for the children to recall arguments from their own families. Two identical versions of the parent-child conflict tapes were used to avoid confounding gender with the parent role. In one version, the parent was the mother, and in the other version, the parent was the father. The actors were a male and a female college student who were both theater majors and an 11-year-old female. The 11-year-old was depicted by the authors as having a gender-neutral voice. Children were randomly assigned to hear one or the other audiotape. In both the parent-parent script and the parent-child script, the argument was of low to medium intensity with a clear presence of conflict. Five structured interview instruments were used to gather data on arguments between parents, child's perceptions of parent's conflicts and parental divorce, parent-child arguments, and affect. Researchers used a pictorial scale to assist the children in identifying their perceptions.

The means from data obtained were rank ordered from the most strongly to the least strongly endorsed causes for parent-parent and parent-child arguments and their solutions. The data were statistically analyzed using a repeated-measures ANOVA.

The authors noted that, consistent with developmental literature, the use of open-ended questions was difficult for some of the children. They stated that the use of more creative information strategies, such as storytelling and the use of props, would be a more useful method. They found that the children between the ages of 6 and 12 were able to easily think about and respond to the structured questions concerning the causes of conflict between parent and parent and between parent and child. The 5-year-old children showed variation in their ability to comprehend the task. Some responded very thoughtfully, whereas others responded more briefly. Overall, the authors concluded that all of the children did make attributions in a meaningful way. There was consistency across ages in the ranking of the children's attributions. For example, in marital arguments, children of all ages viewed each parent differently. Father trait items were consistently ranked higher than father state items. The authors illustrated that children would rank "the dad is the kind of person that likes to argue" higher than "it's because the dad had a bad day." In contrast, mother state items were consistently rated higher than mother trait items. Attributing causes of parental conflict to mothers' traits was consistently low across all age groups. The authors noted that contrary to what would be predicted based on developmental literature and conventional wisdom, the children's stories about family conflict reflected a systemic perception of the conflict. Two highly ranked examples cited were "when parents argue, it's both of their faults" and "when parents and kids argue, it's because the parents want things one way and the kid wants them another way." The children also showed consistency in their hesitancy to rank a lack of affection as a cause of conflict. The

authors recognized that this might be due to the sample of intact, nonclinical families who participated in the study. The authors also acknowledged that denial of such a cause might be defensive. They state that because children are unlikely to embrace this attribution, it could be clinically significant when they do. The authors found that the children's attributions concerning internal traits support literature that suggests that children are more likely to give a favorable attribution when evaluating inconsistent behaviors. They noted that "mom had a bad day" is more likely to be endorsed than "it's because mom is the kind of person who likes to argue." The authors also observed a gender/role difference in attributions. These different attributions may reflect a possible closer affective bond with the mother, more verbalization by the mother, or increased time spent with the mother. The study concluded that most children can easily incorporate the concepts of interpersonal causality and multiple perspectives about the causes of parent-parent and parent-child conflict when they are encouraged to think calmly about family arguments. These findings suggest a compatibility with constructivist clinical approaches, such as narrative therapy and family counseling. The authors posit that appreciating children's stories or attributions of causes of family conflict can aid therapeutic work with the family as a whole. The study demonstrated that a combination of quantitative and qualitative research methodology could be useful for studying narrative therapy.

TRANSFORMING INITIAL CONSTRUCTION OF THE PROBLEM

Coulehan, Friedlander, and Heatherington (1998) studied clients' process of transforming their construction of the presenting problem from an individual intrapersonal perspective to an interpersonal systemic or relational perspective in initial therapy sessions. Building on the work of Carlos Sluzki's (1992) narrative approach to therapy, their exploratory study sought to make explicit the components of the change process involved in therapists facilitating family members' successful transformation of narratives.

Eight families and eight therapists (five Ph.D. psychologists, one psychiatrist, and five master's-level counselors/social workers) participated in the study conducted at an outpatient clinic of a major teaching hospital in the east. The eight families included two intact, one remarried, four single-parented, and one family headed by grandparents. The criteria for inclusion as a participant family were as follows: (a) An adult family member requested help and identified an adolescent or child older than age 8 as the source of the problem and (b) on the basis of the initial telephone call, the therapist believed a transformation was warranted. Multiple problems were identified by the parents during the initial telephone contact, including problems of academic failure, noncompliance, violence, eating disturbances, and so forth. Several of the children were currently or previously placed in foster home or residential settings. All of the therapists were extensively trained in Sluzki's (1992) approach to narrative family therapy. Sluzki asserts that problems are maintained and embedded in the stories that family members use in describing the problem and that the therapist and family members cogenerate qualitative changes in those stories as part of the therapeutic process. Success is achieved when "a transformation has taken place in the family's set of dominant stories so as to include new experiences, meanings, and actions, with the effect of loosening of the thematic grip of the set of stories on symptomatic-problematic behavior" (p. 219). When possible, reflecting teams were used during intake interviews.

Participant families' initial interviews were videotaped, with postsession questionnaires designed to elicit the parent's descriptions of the problems. The researchers also administered questionnaires to the therapist, staff observers, and three master's-level therapists not affiliated with the clinic at the time of data collection to identify sessions in which a shift in constructions did or did not take place.

In addition, researchers used an observational coding system to provide an alternative indicator of the parents' construction of the problem. The coding system was used to code the referring parent's description of the problem during the initial telephone contact and all parents' descriptions in the actual session. The coding process involved locating the problem and causes. The judges first read the transcript in its entirety and then reread it carefully line by line. Three criteria were identified for locating a problem description: when the speaker (a) used words such as difficulty, problem, or conflict; (b) responded to inquiry about the problem; or (c) described a negative emotional state or attitude, problematic reaction, condition, diagnosis, or impasse, implying a need for change. Only those problems coded identically by at least two of the three judges were retained for analysis.

Videotapes were transcribed verbatim. A qualitative method of constant comparison was used to analyze the data. The authors chose this method to mirror the theoretical foundations of the narrative approach under investigation. A multiple perspective and consensual procedure was used to develop the model from the data and reduce the potential of bias.

Twenty-five verbatim problem statements, all involving children, were transcribed and coded for the initial telephone screenings; 76% were coded as intrapersonal. There was no difference in the number of problem statements made by parents in the successful and unsuccessful groups. In all of the sessions, coding of the problems' descriptions made by the parents early in the therapy session reflected the intrapersonal view expressed in the telephone contact. The authors

observed that at the conclusion, in three of the four successful sessions, the parents' descriptions had shifted to an interpersonal and systemic view. In the additional successful session, the parents' descriptions remained intrapersonal, but the description of the problem behavior focused on a different child.

The authors reported, in contrast, that in three of the four unsuccessful sessions, the parents' descriptions remained intrapersonal throughout the session with a tendency for the parents to express individual problems of their own, such as "I have a tendency to scream," as well as those of the children. The parents in the remaining unsuccessful session did not express constructions during the interview.

The study resulted in a three-stage conceptual model of transformation that was consistent with, yet added to, Sluzki's (1992) pioneering work. The first stage describes the process of family members' articulation of multiple views and descriptions of the problem. These multiple descriptions and views formed an expanded content to base alternate descriptions, attributions, and meanings of the problem. The second stage describes the process of a shift in family member's affective tone. The third stage describes the process of family member's exploration of positive aspects of both individual family members and the family as a whole. The authors instruct that successful transformations of the problem will move through each of the three stages, whereas unsuccessful transformations will not. They also posited that the presence of reflecting teams in successful families might have contributed equally or more influentially to transforming problems.

The aforementioned studies provide support for the use of narrative approaches to working with families. However, support for the use of narrative approaches with families is at best tentative given the small number of clinical studies. A variety of reasons for this small number of studies are possible.

POSSIBLE REASONS FOR SCARCITY OF STUDIES

Neimeyer (1993) has stated that meaningful attention to research on the utility of language-based therapy modalities, such as narrative therapy, is limited by the recent emergence of constructivism as a clinical and empirical paradigm. Unique epistemological and methodological requirements for researchers embracing such a constructivist orientation exist that are sometimes inconsistent with traditional quantitative empirical research methods (Gale, 1993), leading to very few outcome studies (Neimeyer, 1993), for example, constructivist's denial of the possibility of objectivity, which forms the foundation of quantitative empiricism (Kelley, 1998). In contrast, constructivist approaches to researching therapy emphasize a qualitative understanding of one's meaning given to experience (Nelson & Poulin, 1997) in context, without imposing the requirement of researcher objectivity. Participants and researchers in qualitative inquiry are regarded as coresearchers (Gale, 1993) who together explore the meaning of experience. Constructivist-based research places importance on the interaction between participants and researcher as a necessary component for quality data gathering and analysis (Merchant, 1997). Qualitative research looks thoroughly into how people make meaning as well as how and why they think and behave as they do (Ambert, Adler, Adler, & Detzner, 1995). The essence of narrative therapy approaches, as stated earlier, is interpreting and giving meaning to experience. Because qualitative approaches to inquiry emphasize understanding experience (Nelson & Poulin, 1997), they are particularly suited to researching the effectiveness of narrative therapy.

Another reason for the shortage of research on the utility of narrative therapy may be researchers' lack of training in qualitative methodology. Merchant (1997) depicts most counseling training programs as emphasizing quantitative research methodology, almost to the exclusion of quantitative modes of inquiry. Because most journal editorial boards are composed of graduates of such programs, journals may be reluctant to accept research using alternative modes of inquiry. According to Ambert et al. (1995),

> Editorial boards of high-profile journals in family studies, psychology, and sociology are composed of well-published scholars, only a minority of whom are experienced qualitative researchers. The result is that a majority of the qualitative articles submitted have to be evaluated by scholars who have little experience in qualitative research, or who have little experience in the substantive area of a submitted article or who subscribe to a different epistemology. (pp. 879-880)

IMPLICATIONS FOR PRACTITIONERS

The studies reviewed in this article demonstrate that narrative approaches to therapy have useful application when working with a variety of family therapy issues. However, the breadth of research on the utility of narrative therapy approaches is limited. Certainly no statement can be made about narrative therapy as the approach to use for any particular family problem. This, however, should not preclude family counselors from using narrative approaches. As has been argued, narrative therapy is based on principles that are congruent with context-sensitive research methodologies (e.g., ethnography, grounded theory) that deemphasize generalizability. For family counselors, the issue, then, turns to tailoring treatment to fit your client. Call yourself a narrative-based family counselor but be prepared to modify (i.e., tailor) your way of doing narrative-based family counseling to the unique dynamics of your clients. These unique

counseling contexts can provide practitioners an opportunity to become researchers, potentially leading to unique outcomes and redescriptions of how narrative therapy can inform the work of family counselors.

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