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Q methodology and a Delphi Poll: a useful approach to researching a narrative approach to therapy.

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Abstract

Q methodology and a Delphi poll combined qualitative and quantitative methods to explore definitions of White & Epston's (1990) narrative approach to therapy among a group of UK practitioners. A Delphi Poll was used to generate statements about narrative therapy. The piloting of statements by the Delphi panel identified agreement about theoretical ideas underpinning narrative therapy and certain key practices. A wider group of practitioners ranked the statements in a Q sort and made qualitative comments about their sorting. Quantitative methods (principal components analysis) were used to extract eight accounts of narrative therapy, five of which are qualitatively analysed in this paper. Agreement and differences were identified across a range of issues including the social construction of narratives, privileging a political stance or narrative techniques and the relationship with other therapies, specifically systemic psychotherapy. Q methodology, combined with the Delphi poll was a unique and innovative feature of this study.

Key words

Q methodology, Q sorting, Q statements, Delphi poll, qualitative methods, narrative therapy, social constructionism, systemic psychotherapy, critical psychology.

Introduction

The aim of this paper is to describe the application of qualitative and quantitative methods, using a Delphi Poll together with Q methodology, to explore current definitions of narrative approaches to therapy within a group of UK practitioners. This combination of methodologies facilitated an exploration of: 1) the range of accounts or discourses in relation to narrative therapy; 2) the commonalities and differences in how narrative therapy is described and applied by practitioners.

Narrative approaches to therapy, specifically White & Epston's (1990) approach to narrative therapy, will be briefly described before discussing the methodology used and results of this study.

Narrative approaches to therapy

The 'narrative turn' has become a major academic paradigm (Roberts & Holmes, 1999) and has influenced psychology (Bruner, 1986; Sarbin, 1986; Polkinhorne, 1988; Crossley, 2000), psychotherapy (Goncalves & Machado, 1999; McLeod, 1997; Schafer, 1992) and psychiatry (Roberts & Holmes, 1999).

Narrative approaches to therapy have made particularly important contributions within the field of family/systemic therapy (Carr, 1998; Campbell, 1999; Hart, 1995; Zimmerman & Dickerson, 1994; Vetere & Dowling, 2005). While there are many strands to narrative approaches to therapy, the development of narrative therapy within systemic/family therapy has been influenced by Michael White, based in

Australia and the collaboration between Michael White and David Epston, based in New Zealand (White & Epston, 1990).

Many systemic/family therapists have taken up White & Epston's (1990) ideas and applied these in their own ways and with different emphases, for example, social constructionism (Freedman & Combs, 1996); discourse, feminism and post-structuralism (Madigan & Law, 1998); hermeneutic/dialogic (Smith & Nylund, 1997) and post-modernism (Hoffman, 1990; Parry & Doan, 1994; Weingarten, 1998). Among British family therapists, narrative ideas have been eclectically applied along with social constructionist and postmodernist ideas, 'broadly in harmony with Milan systemic ideas' (Flaskas, 2002, p.42). The ways in which White & Epston's (1990) approach to narrative therapy is applied and understood are therefore diverse.

Thus, many seem to have found the answer to the question 'What is narrative therapy?' somewhat elusive. Dulwich Centre Publications, an independent publishing house that publishes the International Journal of Narrative Therapy and Community Work and hosts International Narrative Therapy and Community Work Conferences and training programmes, facilitated a group of narrative therapists to produce a consensual definition of narrative therapy:

> Narrative therapy centres people as the experts in their own lives and views problems as separate from people. Narrative therapy assumes that people have many skills, competencies, beliefs, values, commitments and abilities that will assist them to reduce the influence of problems in their lives.

The word 'narrative' refers to the emphasis that is placed upon the stories of

people's lives and the differences that can be made through particular tellings

and re-tellings of these stories.

Narrative therapy involves ways of understanding the stories of people's lives

and ways of re-authoring these stories in collaboration between the

therapist/community worker and the people whose lives are being discussed.

It is a way of working that is interested in history, the broader context that is

affecting people's lives and the ethics or politics of therapy.

These are some of the themes that make up what has come to be known as

'narrative therapy'… different people engage with these themes in their own

ways.

(Dulwich Centre Publications, 2007)

For a full description of the range of practices that constitute White & Epston's (1990)

approach to narrative therapy, Morgan (2000), Carr (1998) and Freedman & Combs

(1996), can be consulted.

However, neither the Dulwich Centre Publication's definition of narrative therapy, nor

Morgan's (2000) detailed account of the practices of narrative therapy, have been

empirically validated. It is not clear whether UK practitioners would endorse the

definition of narrative therapy or whether local, historical or contextual issues

influence how narrative therapy is understood and practised in the UK. The focus of

this study on practitioners in the UK was pragmatic and aimed specifically to capture

the development of narrative therapy in the UK context which may be different to else

where. Furthermore, the growing evidence of practitioners becoming more eclectic

and integrative (Pinsof & Wynne, 2000) may mean that therapists are combining

ideas or practices of narrative therapy within existing approaches (Flaskas, 2002).

Thus the ways in which UK practitioners have taken up narrative therapy in practise

is not clear.

This ambiguity has occurred in a context where there is increasing evidence that the

application of a theoretical model is most effective where there is strong fidelity to the

therapeutic protocol (Margison *et al.* 2000). The emphasis currently being placed on

evidence based practice by such organisations as the National Institute of Clinical

Excellence (NICE) increases the importance of evaluating commonly used but under

researched therapies such as narrative therapy. To develop this evidence base there

needs to be some agreement as to the model's key components, and it is the

purpose of this study to explore the extent of this agreement. The research questions

were: What are the range of accounts or discourses in relation to narrative therapy

and what are the commonalities and differences in how narrative therapy is described

and applied by practitioners?

Method

Rationale for the use of Q methodology and the Delphi poll technique

To address the research questions most effectively and to investigate this approach

to therapy, the research methodology needed to be able to do the following: To

include an adequate number and diversity of people who apply narrative approaches

to therapy; to explore the opinions, experience and therapeutic practice of narrative practitioners; to establish patterns of commonality and difference among the participants; to reduce the subjective influence of the researcher as far as possible; to include a range of sources in the study; to have a proven record of methodological 'robustness'; to be coherent with social constructionist and post-structural concerns (the ontological and epistemological foundations of narrative therapy) and to fit within the practical constraints of the study.

To accomplish the above, the research design had two parts, a Delphi poll and Q methodology, with the study being framed primarily around Q methodology.

Q methodology

Q methodology is suited to answer the research questions of this study as it aims to identify and describe a range of shared stories or discourses among participants (Curt, 1994). In the Q sort, participants arrange cards of statements about a topic into a predetermined grid, ranking them according to a scale according to a specific instruction. In this study participants sorted statements about narrative therapy according to those that were 'most important to their perspective' (+5) and 'least important to their perspective' (-5).

Q methodology focuses on the meanings people make or 'constructions' of a topic rather than the 'constructors' (participants). This focus means that Q methodology is suited to topics that are socially contested or debated (Stainton Rogers, 1995). Examples include studies of lesbian identities (Kitzinger & Stainton Rogers, 1985),

health and illness (Stainton Rogers, 1991), rebelliousness (Stenner & Marshall, 1995) and hearing voices (Jones *et al.* 2003).

Q methodology offers a "unique form of qualitative analysis" (Watts & Stenner, 2005, p.71). It does not reduce data into themes; rather it shows the 'primary ways in which these themes are being interconnected or otherwise related by a group of participants' (Watts & Stenner, 2005, p.70). Moreover, Q methodology identifies "the range of viewpoints that are favoured (or which are otherwise 'shared') by specific groups of participants" (Watts & Stenner, 2005, p.71)

Q methodology has some limitations. It provides a `snap shot' of views at a particular point in time (Watts & Stenner, 2005) rather than a continuity of views over time. These 'snapshots' may be used or discarded by specific individuals in specific situations (Kitzinger, 1987).

Delphi poll

In the Delphi poll method, open-ended questions are asked of a 'panel of experts' to generate data, which is then circulated between panelists. This typically involves three rounds of consultation before statements are rated on a 7-point Likert scale to indicate agreement and disagreement. It provides a way to structure written communication and is often used to generate a consensus of opinion among a group of `experts' (Prochaska & Norcross, 1982).

The first task in this study was to generate data for the Q sort. The Delphi poll involved UK practitioners of narrative approaches to therapy in a collaborative project of defining narrative approaches to therapy. Thus, a small group of people knowledgeable about narrative approaches to therapy were asked to provide written answers to questions about narrative therapy and these responses were used to generate statements for the Q sort.

The application of the Delphi poll in this study deviated from the usual approach as all the successive consultation `rounds' of the Delphi poll were not used to produce a consensus of opinion. Instead Q methodology was applied which facilitated a focus on both the consensus and diverse views of practitioners.

Delphi Panel participants

Delphi panel participants were invited to participate in both the Delphi poll and the Q sort. The aim in recruiting the Delphi panel was to maximise the diversity of participants. The following criteria were applied to recruit the Delphi panel of eight UK 'experts': contributors of articles about narrative therapy to Clinical Psychology Journals, the Association of Family Therapy (AFT) Journal; participants in narrative therapy and AFT electronic mail discussion lists; trainers of Narrative therapy; presenters at Narrative therapy conferences and trainers from key systemic/family therapy training courses, including the Tavistock Clinic, Kensington Consultation Centre, Brief Therapy Press and the Institute of Family Therapy. Consequently, the Delphi panellists included people from different training institutions reflecting the variety of training entry points into narrative therapy.

The Delphi panellists (except one) completed information forms from which the following demographics were noted: Panellists included more males (5) than females (2), a range of professionals (four clinical psychologists, two social workers and a Counselling psychologist) working in a range of specialties (three in child & adolescent services, two in adult services and two people working across specialties). Panellists were highly experienced with ten or more years' experience, five had a Diploma in Systemic/Family Therapy and five had presented aspects of narrative therapy at national or international conferences.

The combination of Q methodology and the Delphi poll method

The Delphi poll contributed to Q methodology in that it facilitated the structured collection of data from a range of 'knowledgeable' practitioners. This allowed for efficient data collection that was not overly time consuming as electronic mail technology could be used. Whilst the Q sort, involving a wider group of participants, enabled a more democratic approach to be taken than is usually adopted by a Delphi poll that involves only a `panel of experts'.

Design

Q methodology involves a number of phases: First, the Q set (pack) of statements about the topic for study was developed from a Delphi Poll, literature search and electronic mail discussion; second, the statements were piloted and, third, a wider group of participants sorted or ranked the statements (Q sort).

Finally, the data was subjected to a principal components analysis (PCA) and varimax rotation. The emerging components were then interpreted using written open ended comments made by participants about their sorting of statements.

Producing the Q set (statements)

Generating the statements: The Delphi poll

In the Delphi poll, panellists were asked to answer the following open-ended questions in writing: 'What is narrative therapy and what is it not?' and 'what do practitioners who apply narrative approaches do and not do?' From this data, ideas and arguments consisting of between one and three sentences were selected: 142 statements resulted. Additional sources for statements about narrative therapy included the Association for Family Therapy (AFT) e-mail list (8 statements) and a literature search of narrative therapy (31 statements).

The statements were then reduced to include all relevant ideas, excluding only duplicate statements, unnecessary elaborations and unclear statements (Capdevila & Stainton Rogers, 2001). Then the theme of each statement was identified resulting in a total of 16 themes.

This resulted in a total of 76 statements that were piloted for the Q sort. A second researcher audited the process of statement selection and reduction.

Piloting the statements with the Delphi panel

Once the Q set (set of statements) was developed, it was piloted with members of the Delphi panel. Delphi panel members were asked to rate each statement according to whether they agreed, disagreed, were uncertain about the statement or found the statement unclear or inappropriate. Consensus statements (to indicate agreement) as well as statements that provoked disagreement, were included. The aim was to produce statements that participants could use to build their particular 'story' (or account) of narrative therapy.

The results of the piloting of statements indicated that 69% of panellist responses showed agreement with the statements; 14% showed disagreement and 17% a uncertainty or a lack of clarity about statements. Although there was a high percentage of agreement about statements, this seemed appropriate as all participants were responding to statements identified as descriptive of narrative therapy by the panel. Given the context, simply inverting items to artificially produce a numerical balance (between agreement and disagreement) would have resulted in an inappropriate distortion of their meaning. For example, inverting statement 31 from: 'narrative therapists should address the evidence base' to 'narrative therapists should ignore the evidence base' shifts the meaning in an artificial way. Thus, statements were included or excluded using theoretical criteria, based on evidence from the pilot study, making possible both consensus and diversity.

Statements were excluded if they were rated as unclear or inappropriate by the panel. Following this reduction, an analysis of the final statements identified four general themes, namely: Theory & practice (15 statements); therapy & politics (11 statements); narrative therapy & other therapies (17 statements) and techniques (12 statements).

The resulting 55 statements constituted the sample of statements that was used in the Q sort.

The Q sort

A pack with the following was sent to each participant: the 55 statements, copy of the grid indicating the number of statements to be placed at each ranking of +5 to -5; markers numbered +5 to -5; a booklet for open-ended written responses; instruction on the process and a return self-addressed envelope.

This study conformed to most Q studies in that the sample contained between 40 to 60 statements and used a range of –5 to +5 with a quasi-normal flattened distribution (Brown, 1980).

The following chart illustrates the number of responses required for each numerical ranking:

-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5	rating

2	3	5	6	7	9	7	6	5	3	2	responses required

The quasi-normal distribution is merely a device to encourage respondents to consider the statements more systematically, rather than being of statistical importance (McKeown & Thomas, 1988).

In the Q sort, participants were asked to rank the statements according to the following 'condition of instruction': namely, 'sort the statements according to what is most important to your perspective (+5) or what is least important to your perspective (-5)'. Participants were also asked to choose the `position' from which they were sorting the statements (personal or professional). This enabled participants to `construct' their Q sort identity.

The ranking of items is a holistic or gestalt procedure (rather than an item-by-item sequential activity) in which all elements are interdependently involved. Participants were asked to comment on their choice of statements by writing comments into the 'Q booklet' (a booklet containing all the statements with space for comments). These qualitative comments contributed to the interpretation of the components or accounts of narrative therapy.

Q-Sort Participants

The participants were recruited to reflect as diverse a group as possible of people applying White & Epston's (1990) narrative approach to therapy. Including a broad group of participants 'maximise(s) confidence that the major factors at issue have

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been manifested' (Brown, 1980, p.194). Forty to sixty participants are more than adequate (Brown, 1980). As the analysis is inverted (intra-individual scores rather than inter-individual ones), the variables-to-cases ratio relevant to hypothetico-deductive statistics is not relevant here.

In this study, forty participants completed the Q sort. In addition to the Delphi panel (7 of whom completed the Q sort), 33 Q-sort participants were recruited: Participants included contacts provided by the Delphi panel (14 participants), a local narrative training group (4 participants), previous colleagues of the researcher or people approached by the researcher (5 participants), general invitations placed on the Association of Family Therapy and Narrative Therapy e-mail discussion lists (9 participants) and the researcher.

The main inclusion criteria for the additional 33 participants for the Q sort were that participants were applying White and Epston's (1990) approach to narrative therapy.

All of the 33 participants provided demographic information which is summarised below: Twenty two participants were females and eleven were males; twenty one worked in the Child and Adolescent specialty, seven worked with adults and five worked in other specialist areas. The professions represented were: Clinical Psychologists (17), Family therapists (10), Social workers (4) and Educational psychologists (2). Most participants (23) had over ten years experience in their profession. With regard to therapeutic training: most (22) had attended 2-day workshops in narrative therapy; 18 had completed training in Family Therapy (2 years

or more) and 7 had received training in a specific `other' psychotherapy (1 year or more duration).

Data Analysis

Q pattern analysis: Principal Components Analysis

The SPSS analysis computed the components using the following steps: First, the components are extracted, using PCA. To determine the inclusion of components, the statistical option of the `eigenvalue' (characteristic value) criterion was applied. That is, components with eigenvalues greater than 1.00 (Tabachnick & Fidell, 2001) were included as this assures that the components identified were shared. Second, the components were rotated using the varimax method to maximise the variance explained by each component (Brown, 1980).

Data interpretation

To interpret the components, the task is to identify or generate a `model Q-sort' or factor array, for each component that has been extracted.

The Q sorts with high loadings (or correlations) on one component and low on others, are the exemplars that are merged to produce a weighted average and obtain a `reconstructed' Q sort for that component (Brown, 1980). In this study, the conventions usually used in factor type analyses were applied and the criteria for including Q sorts as exemplars of a component were: a loading of above 0.6 (a 'very good' loading on one factor) and less than 0.4 (`poor to fair' loading) on any other

factor (Comrey & Lee, 1992; Mrtek *et al.* 1996; Jordan *et al.* 2005). When a component has just one exemplar, that Q sort provides the `best estimate' of that component (Capdevila, 2001). Components with only one exemplar are sometimes excluded unless there is a theoretical justification for accepting the component (Watts & Stenner, 2005).

The positioning of statements (i.e. on the –5 to +5 scale) in the reconstructed or `model' Q sorts, were compared and contrasted. Open-ended, qualitative comments made by participants were used to interpret the components. Where relevant key phrases or ideas from the comments made by participants, were used to label the accounts. To describe the unique aspects of each account, the location of statements was considered as a whole as well as statements rated `most important' (+4; +5) and `least important' (-4; -5). The relative positioning of statements was also considered in comparing the accounts.

Results of the Delphi poll

The piloting of the statements with the Delphi Panel pointed to unanimous agreement on a number of key issues related to theory, politics and the practices of narrative therapy.

Theoretically, the proposition that `problem stories are socially, culturally and politically formed, both interpersonally and through wider influences', was unanimously supported. Moreover, it was acknowledged that narrative therapy deconstructs objective knowledge and privileges `local' knowledge. There was

agreement that ethics, particularly accountability and transparency, are important, as well as a social justice stance.

Furthermore, Delphi panellists unanimously agreed that the role of the therapist could be conceived as a `conversational architect' and that the therapists' `expertise lay in creating a context for change'. Narrative practices that were agreed to be important were the following: seeking unique outcomes or exceptions, making explicit people's skills and knowledge, enhancing connection with social networks, inviting audiences to sessions, writing therapeutic documents, listening to and acknowledging people's experiences, exploring identity though `landscape of action' (questions about what people do) and `landscape of consciousness' questions (questions about identity and meaning) and focussing on the person's preferred outcomes.

Results of the Q sort

The PCA resulted in the extraction of 8 components with an eigenvalue over 1.00, accounting for a high percentage of the variance (74%).

Overall, the main issues distinguishing the different accounts seem to be the different perspectives on narrative therapy as a political stance, the importance of narrative practices, the notion of therapist expertise, the relationship with other therapeutic approaches, specifically systemic psychotherapy and the influence of social constructionism.

The components of narrative therapy

The eight distinct components that emerged in relation to narrative therapy are summarised in Table 1.

Table 1 Q sort components, titles, variance and Eigenvalues

Component	Title	Variance %	Eigenvalue
1	*the political/social justice account*	16.8	6.8
2	*the distinctive, re-authoring account*	15.5	6.2
3	*narrative practices are important*	9.6	4
4	*the flexible – systemic account*	8	3.2
5	*the selective, non-purist account*	6.9	2.8
6	*the irreverent account*	6.6	2.6
7	*the integrationist account*	6	2.4
8	*the reflexive/critical account*	5	2

(For a detailed ranking of statements see Table 2: Ranking of statements for each of the 8 components or accounts of narrative therapy).

However, only five of the components are interpreted here for theoretical reasons: components one to five illustrate the main debates in relation to narrative therapy identified in this study. Moreover, these five accounts illustrate the themes of the paper most effectively given the constraints of the word count.

Statements that seem to typify the account are reported as well as relevant comments made by participants. To compare and highlight the debates around the

topic, statements that may be important to some accounts but not to others are reported.

Component 1 "the political/social justice account"

"The political/social justice account" has three significantly loading participants and explains 16.8% of the study variance. All three participants stated that they sorted the statements from a professional position as clinical psychologists. Two worked in an adult specialty and one in a child and adolescent specialty. One was a registered family/systemic therapist. Their experience ranged from less than 5 to over 20 years experience.

The political/social justice account emphasises the importance of addressing social, cultural and political issues in therapy (26: +5), social justice (44: +4), ethics (38: +4) and avoids pathologising and individualising people (3: +4). Narrative therapy is viewed as more a political position than a set of techniques (1: +4) and the practices identified with this account are deconstruction (45: +3) and identifying unique outcomes (49: +3). From this position, it seems neither important nor unimportant whether narrative therapy is inseparable from systemic ideas (22; -1). Narrative therapy appears not to have any claim to `truth' status (55: -5).

Component 2 "the distinctive, re-authoring account"

"The distinctive, re-authoring account" has three significantly loading participants and explains 15.5% of the study variance. All sorted the statements from a 'narrative therapist' perspective; two were clinical psychologists and one was a social worker;

two worked in child and adolescent specialties and one worked with children and adults in a specialist area. One was a registered family therapist; two had over 20 years experience and one had more than five years experience.

'Social constructionism is an important basis' (participant 10) (17: +5) in this account of narrative therapy. The notion that narratives are constructed socially seems to be shared by practitioners (statement 17 was rated +5 by accounts 2, 4 and 8 and +4 by account 5.

The therapist is viewed as a conversational architect (14: +5) applying techniques from a non-expert position (7: +4). This account emphasises the contribution of narrative therapy to re-authoring: 'I do re-authoring' (participant 10). Techniques highlighted by the "re-authoring account", were also important to other accounts, such as: Identifying unique outcomes or exceptions (statement 49: accounts 1, 2, 3 and 5); centring the person's intentions, values, dreams (statement 35: accounts 2, 3, 4 and 5); making skills, abilities and knowledge explicit (statement 16: accounts 2, 3, 4 and 6) and deconstruction (statement 45: accounts 1, 2, 3 and 4).

From this perspective narrative therapy seemed `distinct' as it "cannot (be integrated)" (participant 10)(2; -5) and can viewed separately from systemic ideas (22; -4).

Component 3 the "narrative practices are important" account

This account had one significantly loading participant and explained 9.6% of the study variance. The participant loading highly on this factor was an Educational Psychologist working with children and families, who has over 20 years experience.

This account highlighted a variety of practices of narrative therapy that contribute to a creative and fun approach with children: 'It's not a 'Literary' emphasis – but great creative fun to make up triumphant stories with kids' (participant 26). Practices emphasised were the following: identifying unique outcomes (49: +5), making explicit skills and abilities (16: +5), deconstructing taken-for-granted 'truths' (45: +4) and listening to and acknowledging people's experiences (39: +4). In this account, techniques are applied from a non-expert stance (7: +4) and the therapist is unlikely to be viewed as 'directive' (15: -5). From this perspective it is not important that narrative therapy is viewed as a political position that one adopts (1: -4) rather, the range of techniques seem important.

Component 4 "the flexible – systemic account"

This account had two significantly loading participants and explained 8% of the study variance. One of the participants sorted the statements from the position of a clinical psychologist and one from the position of a family therapist; one works in an adult specialty and one with both children and adults; one has less than 5 years experience and one has more than 15 years experience.

In this account, narrative therapy is seen as inseparable from systemic ideas (22: +4) and the social constructionism of narratives (17: +5) seems important. Participant 27

commented: 'This is the key – embodiment of such (social constructionist) ideas are

key' (statement 17). Together with social constructionism, addressing social, cultural

and political issues in therapy (26: +4) seems important. Practices such as making

explicit people's skills and abilities (16: +5) and questions linking actions with

meaning (41: +4) seem important in this account. Commenting on the statement

about narrative techniques being less effective if used with therapies based on

different philosophical assumptions (51: -4), participant 13 wrote: "Possibly, but in my

work I need the flexibility to do both narrative therapy and cognitive therapy". This

seemed to reflect a pragmatic, eclectic approach.

Component 5 "the selective, non-purist account"

This account had two significantly loading participants and explained 6.9% of the

study variance. Both of the significantly loading participants sorted the statements

from a position of a family therapist and both were family therapists working in child

and adolescent specialties. One participant had over 20 years experience and one

had less than 5 years experience. Both participants commented that they did not

consider themselves to be 'purists': "I have a struggle between what narrative

therapy is in my practise and my understanding of what a purist may argue"

(participant 25).

This account seemed to incorporate the `hallmark' practices of narrative therapy, for

example, eliciting unique outcomes (49: +5), tracing the influence of the problem over

time (49: +4) and externalising the problem (12: -5), into established family therapy

practice. Social constructionism (17: +4) seems important in this account, while

working from a non-expert stance seems less important (7: -4): "Therapists need expertise… (the idea of therapists not being experts) is a red herring" (participant 25). In contrast, it seemed important to components 2 and 3 that narrative therapists resist positioning themselves as experts (7: +4). Despite the fact that both participants who loaded significantly on this factor were family therapists, it seems neither important nor unimportant whether narrative therapy is inseparable from systemic ideas (22: 0).

Discussion

Defining Narrative therapy: Commonalities

A core of narrative practitioners, the Delphi Panellists were able to agree on a range of techniques key to narrative therapy. Moreover, theoretical issues informing practise, such as the socio-cultural and political context of problems, were noted as important.

There seems to be broad agreement among Q sort participants on the social constructionism of narratives and techniques contributing to a 're-authoring' approach and enabling alternative stories to emerge. Pote *et al.* (2003) noted the importance of social constructionism as a guiding principle of systemic practitioners in the UK. Social constructionism may therefore constitute one of the `known' (familiar) influences on narrative therapists. Moreover, the appeal of narrative therapy for clinicians may be that narrative techniques facilitate an implementation of social constructionist ideas into practice.

The *"distinctive, re-authoring"* account (component 2) highlights specific narrative practices that can be thought of as contributing to a 're-authoring' process. Techniques highlighted by the *"distinct, re-authoring account"*, were also important to other accounts. Although re-authoring has been described as a cliché (Blow & Daniel, 2002), there seems to be some agreement on the `substance' of re-authoring. It may be that techniques associated with 're-authoring' provide a contrast to the `deficit' approach (Gergen, 1990), that is, the focus on 'problems' and the need to 'fix' people, common in therapeutic discourse. However, the areas of debate may influence how practitioners apply narrative approaches in practise.

Differences: Areas of contestation

The Q sort highlighted the following areas of contestation: Conceptions of therapy as a political stance contrasted to a focus on techniques; the therapist as expert and the relationship between narrative therapy and other therapies, specifically systemic therapy.

The "political" account of narrative therapy (component 1) may indicate that part of the appeal of narrative therapy is its political, social justice approach and deconstruction of social norms. However, this view of the importance of a `political stance rather than a focus on techniques', was not shared by component 3 *"narrative practices are important"*.

These results epitomise two different positions, 1) the resonance of the value and philosophical base of the therapy for the therapist and 2) a set of useful techniques. These different positions may lead to different therapeutic outcomes. It may be that the epistemological approach taken is more important to the effectiveness of narrative therapy than the techniques applied (Griffith & Griffith, 1992). Thus, for practitioners this dimension highlights the importance of clarifying one's approach as it informs method or technique (Burnham, 1992).

There seem to be differences about the notion of therapist expertise: that is, whether therapists apply narrative techniques from a `non-expert position' (components 2 and 3) or whether "therapists need expertise" (participant 25; component 5). It is not clear what implications this distinction may have for practise and how this may relate to outcome.

The relationships between narrative therapy and other therapies emerged as an area of debate. While one account viewed narrative therapy is a `distinct' therapy that cannot be integrated with other therapies (component 2), another account seemed to use narrative therapy flexibly with different therapeutic approaches (component 4).

In only the *"flexible – systemic account"* (component 4) did a strong link between narrative therapy and systemic ideas appear important (22: +4). This finding was surprising as White & Epston's (1990) narrative therapy emerged from systemic approaches in the 1980's (Tomm, 1993). It seems that practitioners may have different views on whether narrative therapy has a theoretical base separate from

systemic therapy. Thus, the relationship between narrative therapy and other therapies, specifically systemic psychotherapy remains unclear and requires further exploration.

For therapists, the various accounts identified in relation to narrative therapy indicate that narrative therapy provides therapists with the following: a social justice, political and ethical stance to therapy; a 're-authoring' approach and practices that facilitate the application of social constructionist ideas. These seem to be some of the unique contributions of narrative therapy.

Q methodology and the Delphi poll

The use of the Delphi poll introduced a collaborative approach to deriving the statements for the Q sort. The written material from the Delphi poll focused the source of data.

In contrast to this focussed written data, the 'British' or social constructionist approach to Q methodology (Stainton Rogers & Stainton Rogers, 1990) encourages a broad `cultural analysis'. A 'cultural analysis' of narrative therapy may have been possible if there were more easily identifiable discussion groups, training groups or conferences. However, for a topic such as defining a therapeutic approach this broad 'cultural analysis' may be less relevant and what is needed is a methodology that is capable of defining specific, recognised components (techniques) and ideological positions within a more defined context. Thus, there is a tension between focussing

the data while still obtaining a diversity of views, which the combination of the Delphi poll and the Q-sort facilitated satisfactorily in this study.

Q methodology is a 'powerful' research approach in that it facilitated the expression of accounts of narrative therapy (Stainton Rogers, 1995). However, it has provided a 'snapshot' of views at a particular time (Watts & Stenner, 2005) and these views may change over time. Moreover, Q methodology captured what practitioners say they 'do' rather than their therapy in action. Future studies could connect the accounts of narrative therapy identified in this study to actual clinical practice.

Interpreting the accounts

Q methodology used quantitative methods to extract the components of narrative therapy. Thus, the advantage is that robust mathematical methods are used to identify the complex patterns in the data.

The interpretation of results in Q methodology requires qualitative inquiry, which adds to the richness of the results and discussion. The qualitative material provided in the Q booklets enhanced the interpretation of the accounts of narrative therapy. This contributed significantly to a more nuanced reading of statements. Whilst interviewing the participants would have contributed to a richer interpretation of the accounts, the researcher would have reduced data to common themes. The aim of this particular study was to look at complex patterns across participants and themes rather than focussing on these individually.

Conclusion

The Delphi poll and Q methodology achieved the aims of identifying accounts of narrative therapy, five of which are interpreted here, and the commonalities and differences between these accounts. The Delphi panel unanimously agreed on certain philosophical issues informing narrative therapy and key techniques of narrative therapy.

The identified accounts map how White & Epston's (1990) narrative approach to therapy is understood and practised by a group of practitioners in the UK. These shared viewpoints illustrate what is 'currently being said' (Watts & Stenner, 2005, p.86) about this narrative approach to therapy. Theoretically, the social constructionism of narratives seemed an important and widely shared notion. In addition, key practices contributing to a `re-authoring' approach, were identified. The accounts revealed different positions in relation to narrative approaches to therapy; for example, whether a political stance was to be privileged or the techniques of narrative therapy; whether practices are best applied from an `expert' or `non-expert' position; whether narrative therapy was `distinct' or could be integrated and applied flexibly with other approaches and whether systemic psychotherapy ideas were important to narrative therapy.

These accounts provide a frame of reference to explore the content and boundaries of White & Epston's (1990) narrative approach to therapy by both practitioners and researchers. For research investigating the efficacy of therapeutic models these

findings should encourage the study of White & Epston's (1990) narrative approach to therapy by providing some consensus about its definition and key components. Specification of one's position in relation to the contested areas identified in this study seems important. Moreover, further in-depth qualitative analyses could explore the finer nuances of these accounts and how they relate to practice.

The combination of qualitative and quantitative approaches in Q methodology highlights the usefulness of statistical methods as well as the richness provided by qualitative methods.

Q methodology used in conjunction with the Delphi poll, combines qualitative and quantitative approaches in a complementary way that reduces this traditional divide (Reicher & Taylor, 2005). Moreover, Q methodology enabled a more collaborative approach to research to be taken and provided a robust method to research an emerging psychological therapy that was coherent with the epistemological roots of the model.

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Table 1 Ranking of statements for each of the eight components or accounts of narrative therapy

Statements components/accounts	C1	C2	C3	C4	C5	C6	C7	C8
01. Narrative therapy (NT) is a political position that one adopts, not a set of techniques that can be applied.	+4	-2	-4	+1	-1	+1	-4	+1
02. NT should try harder to be an integrated therapy that builds on and connects with other therapeutic approaches.	-1	-5	-2	-2	-1	+1	+4	-5
03. Narrative practitioners avoid individualising and pathologising.	+4	+2	0	-2	+3	+5	+3	+2
04. Narrative practitioners may apply narrative approaches alongside other influences.	0	0	+3	0	-1	+3	+5	-1
05. NT's believe that the special relationship between the person seeking consultation and the therapist leads to change.	-4	-4	+1	+1	-2	-4	-3	-1
06. Narrative therapists work with feelings.	-2	-2	+3	0	+1	0	0	0
07. NT's resist positioning themselves as experts in relation to people seeking consultation.	+3	+4	+4	+3	-3	-3	+2	+3
08. Those who are ambivalent about change benefit less from NT as it is clearly change orientated.	-2	-3	-4	-5	-3	-2	0	-2
09. The use of pre-determined methods or techniques should be sacrificed to a sensitive approach to those seeking consultation.	0	-3	-1	-1	0	0	-5	+4
10. NT's can slip into using narrative techniques as other techniques which assume that there is a dysfunction to be fixed.	-2	-1	-3	-2	0	-1	0	+4
11. In NT, the literary emphasis brings to therapy all the richness, intrigue, metaphor, plot and counterplot which would constitute a good novel.	+1	+1	-2	-1	-4	-1	-3	-4
12. The narrative technique of externalising the problem has been overemphasised.	-2	-2	-2	-3	-5	+1	-2	+3
13. Adopting a narrative approach involves issues of power: NT challenges institutional power and challenge is resisted by institutional power.	+2	+1	-2	+1	-4	+3	0	+2
14. The NT's role is that of conversational architect providing the scaffolding to enable new stories to be told.	+3	+5	-1	+3	+3	0	+2	-1
15. NT is directed by the therapist with the result that the differential power of roles - remain.	–3	-2	-5	-2	0	-2	+4	-1
16. NT's make explicit and available the skills, abilities and knowledge that people have - instead of teaching `skills' or correcting thinking.	+2	+3	+5	+5	+2	+4	0	+2
17. Narratives are socially constructed rather than insights into the `truth'.	+2	+5	0	+5	+4	+2	-2	+5

This table indicates the rankings (+5 to –5) assigned to each statement within each of the 8 accounts of narrative therapy. Reading the table *by column* reveals the comparative rating of statements which characterise a particular component (or account). In column C1, for example, we can see that Component/ account 1 ranked statement 01 at +5 (very important to that perspective), statement 02 at –3 (not very important to that perspective) and so on. Reading the table *by row* reveals the comparative rating of a particular statement across all the components or accounts. In the row for statement 02, for example, we can see that statement 02 was ranked by Component/account 1 at –3, Component/account 2 at –5, and so on.

Statements components/accounts	C1	C2	C3	C4	C5	C6	C7	C8
18. Narrative approaches are more a collection of ideas and practices that reflect a world-view than an approach to therapy.	+3	-1	-3	+2	-2	+1	-1	+5
19. NT can be seen as a type of family therapy.	-1	0	0	0	0	+2	-3	-5
20. NT cannot be defined as solution-oriented as some narrative practices focus on people's problems.	0	-1	-2	-1	+2	-1	0	+1
21. NT is not always what it claims to be.	-1	-1	-2	-1	0	-3	+3	+1
22. NT is inseparable from systemic ideas.	-1	-4	-1	+4	0	-3	0	-4
23. Narrative practitioners are very attentive to nuances of language.	0	0	+1	+2	+3	-1	-2	+1
24. Involving audiences, such as "outsider witness groups" or reflecting teams, contributes significantly to a rich description of people's lives.	+1	+3	+3	0	+1	+3	+3	+1
25. NT encourages rebellion against traditions (dominant discourses/knowledge), however, this is a limitation as it is better to be in dialogue with our traditions.	-3	-2	-1	-1	-4	+1	-2	-2
26. NT's address the social, cultural and political issues contributing to the `problem story'.	+5	+2	+2	+4	+1	+3	-1	+2
27. Being collaborative does not mean being non-directive.	-1	0	0	+3	+3	0	+5	-1
28. Narrative techniques achieve similar effects to techniques used in other therapies.	-2	-3	0	0	+1	-3	+1	-3
29. The emphasis on the text metaphor in therapy means that the human encounter is neglected.	-3	-4	-5	-4	+1	+4	-2	-1
30. NT questions professional knowledge and so threatens the fundamental basis of professional status.	0	+1	-4	0	+1	-5	-4	+2
31. Narrative therapy should address the question of an evidence-base.	0	+1	-3	+1	+1	-4	+2	0
32. General theories about human problems are relevant.	–4	-3	-1	-3	-1	0	+4	-3
33. Narrative practitioners do not see their work as curing people or fixing their problems.	+1	+1	+2	+1	+2	+4	-1	+4
34. Therapeutic documentation is important in re-authoring lives and relationships.	0	+3	+1	-3	+2	+1	+1	-3
35. In NT, people's intentions, values, commitments, principles, hopes and dreams are central.	+1	+4	+3	+3	+4	0	0	-2
36. Concepts such as `The Unconscious', transference and drives - are useful.	-4	-3	-3	0	-5	-1	-1	0
37. NT's may become `agents of social control' when issues of physical safety arise.	-5	0	+1	-5	-2	+2	-1	0
38. NT emphasises ethics - particularly accountability and transparency.	+4	+2	-1	0	+1	+2	+1	+2
39. NT's listen to and acknowledge people's experiences.	+1	+2	+4	+2	+2	-1	+3	+3
40. NT's contribute to therapy from their own personal experience.	0	0	+1	–3	+4	+2	+2	+3
41. Questions that link actions with the meaning of an event (identity) - are key to narrative therapy.	+2	+4	0	+4	0	0	+2	-2
42. NT is interested in outcomes: that is, the outcomes preferred by the person seeking consultation.	+2	+2	+2	+2	+4	-2	+1	0
43. NT focuses more on individuals than families.	-3	-1	0	+1	-3	-2	-3	0

Statements components/accounts	C1	C2	C3	C4	C5	C6	C7	C8
44. Social justice is important in narrative therapy.	+5	0	+1	-1	+3	0	-1	+3
45. Examining `taken-for-granted' truths (deconstruction conversations) - is a central component of NT.	+3	+3	+4	+3	+1	+2	+1	0
46. Rituals, celebrations and ceremonies are important in marking change.	0	0	+2	-2	0	+3	0	-4
47. NT's help those who consult them to access the special "insider-knowledge" held by others involved in a similar struggle.	+1	+1	+3	-1	-2	-1	-1	0
48. Tracing the influence of the problem over time and its' effects, enables alternative stories to emerge.	+1	+2	+2	+2	+4	+5	-2	-3
49. Identifying unique outcomes or exceptions is important in constructing rich self descriptions.	+3	+3	+5	+2	+5	+1	+1	-2
50. Narrative therapists shift from the role of the expert to a person skilled in conversational techniques.	-2	-1	+1	-1	-3	0	+2	0
51. Narrative techniques are less effective if used with therapies based on different philosophical assumptions.	-3	+1	0	-4	-2	-2	-4	-3
52. Clients should not be assessed for narrative therapy as this implies the notion of an objective reality.	+2	-1	+2	-4	0	-3	-5	+1
53. Narrative approaches reach into areas of morality that are avoided by other therapies.	+1	-2	0	-2	+2	-4	-3	-1
54. Every therapist has practices that are in common with narrative therapy.	-1	-5	-1	0	-2	-2	+1	-2
55. Narrative practitioners think that their approach is better than others'.	-5	0	-3	-3	0	-5	+3	+1