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Transforming evidence: A discursive evaluation of narrative therapy case studies

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### Abstract

A recent shift in American Psychological Association policy for what constitutes as evidence in psychotherapy has resulted in the inclusion of qualitative methodologies. Narrative therapy is a discursive therapy that is theoretically incongruent with the prevailing gold standard of experimental methodology in psychotherapy outcome evaluation. By using a discursive evaluation methodology that is congruent with narrative therapy this study of six peer-reviewed narrative therapy case articles found shifts in client positioning in the transformation from medical pathology discourses to strength-based discourses. It is concluded that five out of six case studies coherently demonstrated the effectiveness of narrative therapy with positive outcomes for clients and that a discursive evaluation has utility in producing a thick description of therapeutic outcome.

Presented here is an argument for a discursive approach to evaluating published case studies of narrative therapy. To date, therapy outcome research in psychology has been predominantly directed around notions of empirically-supported treatments and, lately the somewhat more inclusive evidence-based practice. Such concepts determine what therapies should be used and how they should be assessed in psychological research. The problem with such ‘empirically-supported’ and ‘evidence-based’ notions is that they do not fit with therapeutic approaches that are incongruent with the governing statistical and experimental assumptions in evidence-based practice. Narrative therapy (White & Epston, 1990) is epistemologically based around social constructionist and post-structuralist concepts of language and power relations which (in)form client experiencing and what is real through knowledge. Starting with the assumption that realities are discursively produced, fluid and multiple, is to start from a different point of reference. This contrasts with positivist theories of knowledge, where experimentalism, measurement, and calculability are assumed legitimate ways of determining what *counts* as knowledge. Narrative therapy is sceptical of totalising narratives (i.e., narratives that engulf a person in one ‘truth’ at the expense of other truths) and attempts to involve a power-sharing relationship between client and therapist where both co-author a *counter-plot* of the client’s problem-saturated story using two key concepts: *externalisation* and finding *unique outcomes*. The procedure of externalising separates the problem from the person as if it were a distinct entity and the finding of a unique outcome is a procedure where an aspect of lived experience that contradicts or is outside of the problem story is elicited and elaborated (Monk, Winslade, Crocket, & Epston, 1997). In light of the discursive theoretical premises of narrative therapy and the dominant framings of

evidence-based practice in psychology, this article examines the possibility of doing a *discursive* evaluation of narrative therapy through case studies for the purpose of creating an evaluative outcome.

#### What Constitutes Evidence of Psychotherapeutic Benefit?

The Evidence-Based Practice (EPB) movement in psychology has been aligned to experimental methodological frameworks of psychotherapy research, though there is some realignment taking place as will be clear from what follows. EBP derives from Evidence-Based Medicine (EBM). Coined by medical clinicians from McMaster University in 1988, EBM grew rapidly during the 1990s (Donald, 2002) and facilitated the birth and rise of evidenced-based practice during this time (Tanenbaum, 2003). Empirically-Supported Treatments (ESTs) came about following a task-force report by the Clinical Division (Division 12) of the American Psychological Society (APA) that, following EBM, proposed Randomised Controlled Trials (RCTs) as the gold standard of evaluating psychotherapy outcomes (Task Force on Promotion and Dissemination of Psychological Procedures, 1995). Effective *treatments* so defined, required adherence to *treatment* manuals and had to be demonstrably superior to pill, psychological placebo or another *treatment*. Subsequently other divisions of the APA criticised ESTs for their constrictive and mechanistic employment of therapeutic interventions (e.g., Task Force for the Development of Practice Recommendations for the Provision of Humanistic Psychosocial Services, 2001).

A recent APA presidential report on Evidence-Based Practice In Psychology (EBPP) (American Psychological Association Presidential Task Force on Evidence-Based Practice, 2006) has recommended a wider range of methodologies for evaluating psychotherapeutic outcomes to inform best practice, and this has opened

up possibilities for evaluating and legitimising psychotherapies that have theoretical and philosophical premises that are incongruent with ESTs methodological assumptions. The use of multiple research methods is emphasised in this statement of EBPP, which enables the use of discursive research methods:

Qualitative research can be used to describe the subjective lived experience of people, including participants in psychotherapy... [p]ublic health and ethnographic research are especially useful for tracking the availability, utilization, and acceptance of mental health treatments as well as suggesting ways of altering them to maximize their utility in a given social context ... [p]rocess-outcome studies are especially valuable for identifying mechanisms of change (American Psychological Association Presidential Task Force on Evidence-Based Practice, 2006, p. 274)

However, EBPP still privileges RCTs as the gold standard for evidence-based practice because apparently they are seen as the most sophisticated among methodologies and they “represent a more stringent way to evaluate treatment efficacy because they are the most effective way to rule out threats to internal validity in a single experiment” (American Psychological Association Presidential Task Force on Evidence-Based Practice, 2006, p. 275). So, what is less stringent, less sophisticated and a threat appear to be non-experimental methodological approaches. This contradicts the earlier statements of having a more inclusive and pluralistic methodological approach in EBPP. Freshwater and Rolfe (2004), who deconstructed evidence-based practice, questioned its adequacy using its own assumptions of validity: “As Thompson<sup>1</sup> argues, EBP is not a panacea, but it is the best we have. My

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<sup>1</sup> (Thomson, 2002)

question to Thompson would be: on what evidence is that assumption based?" (p. 125). They point out the anomaly that there can be no evidence base to support the assertion that Evidence Based Practice in its current form is desirable, valuable, or in some way a 'gold standard'. In short the evidence supporting the view that EBP is the best way to evaluate psychotherapy is lacking.

#### Evidence of the Benefits of Narrative Therapy

There is only one quantitative (quasi-experimental) study to date on narrative therapy. Besa (1994) used behavioural analysis with a multiple baseline design across six families whose primary problem was parent-child conflict. Outcomes were assessed by parents in 'measurable' terms such as "not doing chores, attention seeking instead of doing homework, making too many phone calls, and not doing homework" (Besa, 1994, p. 311) and the study concluded that narrative therapy was effective in reducing parent-child conflict. However, Besa (1994) acknowledged that "[i]t would be both hypocritical and illogical to use a form of research based on normal curves and psychopathological classifications to study the effectiveness of NT [narrative therapy]" (Besa, 1994, p. 310) and that "...objective measures were not considered to be especially relevant ... [statistical] reliability is not important when measuring narrative change" (Besa, 1994, p. 324).

Although objective measures of reliability may seem relatively inconsequential in narrative therapy, this does not necessarily mean that a more general concept of reliability is of no use. Examining *discursive consistency* in giving the same approximate or similar answer to a question asked on separate occasions could prove useful in evaluating narrative therapy outcomes. As one example, when clients were asked near the end of therapy if they felt as if they could fight against depression in contrast to before they entered therapy, they affirmed with similar

answers: “Oh, yes, I feel stronger because I found my voice ... I feel I have more of a voice” (Johnson, 1994, p. 93). Likewise, examining discursive consistency from responding to the same question in a following therapy session could prove useful. Such examinations need to be carefully considered within the changing process and context of therapy (e.g., did the goal of the therapy shift and has the problem shifted to another focus/meaning?).

#### Why a Discursive Framing?

An appropriate methodology for evaluating narrative therapy case studies would ideally be situated in a more discursive theoretical base. Studies of narrative therapy are relatively non-calculable by nature, cannot be easily meta-analysed and they do not fit the inclusion criteria for EST studies. Evaluation can be seen as a *hermeneutic* activity “...of judging the merit, worth, or significance of some action...” (Schwandt, 2002, p. xi) and thus it makes sense that the processes of merit judgement for narrative therapy case studies needs to be situated within an interpretative framework. Hermeneutic theory provides such a framework (Ricoeur, 1981). If framed in a hermeneutic practice, evaluation is an understanding-based, moral, and political undertaking (Schwandt, 2002), but because it is an interpretive act it is also, inevitably, a *discursive* practice (Ricoeur, 1976, 1981).

A discourse can be described as “any regulated system of statements” (Henriques et al., 1984, p. 105) which depict a reality and/or as “practices that systematically form the objects of which they speak” (Foucault, 1972, p. 49), and/or “... a set of sanctioned statements which have some institutionalised force, which means that they have a profound influence on the way individuals act and think” (Mills, 1997, p. 62). Discourses exert powerful effects on what clients take to be real. If one of the key aims in narrative therapy is to empower the client to re-author

aspects of a his/her problem-saturated histories and experiencing (and if the co-authoring process of the therapy is successful) the discourses that create what is real and meaningful for the client will change through the influence of the therapist's talk and through the identification of unique outcomes. Accordingly clients' interpretation and understanding of themselves, and their relations to others, will change as they are able to tell a different story to the one articulated at the commencement of psychotherapy.

Interconnected with discourse is positioning theory. Davies and Harré (1990) recognised the constitutive force of discourse in creating subject positions: "Once having taken up a particular position as one's own, a person inevitably sees the world from the vantage point of that position ... within the particular discursive practice in which they are positioned" (p. 46). Often hegemonic discourses can take the form of a totalising story in narrative therapy – a "culturally accepted story, particularly one drawn from professional discourses, that subsumes individual subjectivity under an all-embracing description of personhood" (Monk, Winslade, Crocket, & Epston, 1997, p. 306). If the goal of narrative therapy is to help co-construct a new story of a client's existing dominant, problem-saturated, and often self-pathologising, account, then a discursive-based evaluation that examines the change in clients' subject positions is justified, especially if "*[d]iscourses make available positions for subjects to take up*" (Hollway, 1984, p. 236, my italics). The analysis of discourse and subject positioning can identify the differences between each client's problem-positioned hermeneutic of themselves to their alternative, empowered/strengths-based account. The process of narrative therapy involves a transformation of discourse, positioning, and meaning (Drewery & Winslade, 1997).



Several studies employing discursive methods of analysis of psychotherapy have found that the changes in discourse and the flexibility in employing a diverse range of subject positions (i.e., towards the end of therapy) are associated with positive therapeutic change (Avidi, 2005; Burck, Frosh, Strickland-Clark, & Morgan, 1998; Frosh, Burck, Strickland-Clark, & Morgan, 1996; Madill & Barkham, 1997). However, to date, discursive inquiries of psychotherapy have focused on individual cases rather than reviewing published psychotherapy process-outcome literature. In light of the influence of discourse and positioning, this study aims to conduct a discursive evaluation of narrative therapy case studies by examining the changes in clients' discourses and positionings revealed in each published article.

#### Method

Six narrative therapy case studies were selected. The conditions for selection were that such studies were 1) published in peer-reviewed academic journals, and 2) demonstrated the predominant use of narrative therapy following White and Epston (1990).

There is no one set, standardised mode of conducting a discourse analysis and each analytic method needs to be integrally tailored to each unique research project (Parker, 1992). Narrative therapy theory suggests that clients start with a problem-saturated account that can be made to shift towards a strength-based narrative that is unique to the client. It therefore made sense to focus the discourse analysis on these two key areas because successful narrative therapy should move in such a direction.

The discursive evaluation proceeded with an initial reading of each case study to create a sketch of each case followed by a search for examples of problem-based or pathologising discourses, a further search for moments of therapeutic transformation through the identification of externalisation and unique outcomes, and lastly a search

for strength-based discourses within the text. Discourse analytic research usually involves a search for commonalities of interpretative repertoires<sup>2</sup> or discourses<sup>3</sup> that emerge from the analyser's experience of reading the text, as well as considering inconsistencies and variation in the text.

Each article was treated as a narrative, that is a temporally organised account that has a beginning, a middle and an end (Riessman, 1993)) where discourses are present. For instance, narrative theory leads one to expect that each article will begin with the pathologising accounts of the client, the middle will reveal the therapeutic work of transforming pathology through the process of *externalisation* and *unique outcomes* and the end will reveal unique, strengths-based accounts. This was not always found. For example, lingering but diluted strands of pathologising discourses were present at the end of the articles, and glimpses of non-pathologising self-positionings were also made by clients at the beginning where one would expect to find the initial client story to be problem-saturated according to narrative therapy theory.

Finally, Riessman's (1993) narrative validation concepts of persuasiveness/plausibility (is the article convincing and believable?), and coherence (is the article consistent in argument about the client and therapy or does it contradict itself?) were used as criteria to evaluate each study. It was assumed that the quality of plausibility and coherence would also be reflected in the ease of identifying and making sense of the subject positions and discourses that came out of the analysis.

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<sup>2</sup> An interpretative repertoire is a linguistic resource that is drawn upon to make sense of social interaction and phenomena: it is "basically a lexicon or register of terms and metaphors drawn upon to characterise and evaluate actions and events" (Potter & Wetherell, 1987, p. 138)

<sup>3</sup> I prefer to use the term 'discourse' rather than 'interpretative repertoire' as the latter assumes a cognitivist and somewhat structuralist connotation of having some vocabulary/repertoire that is fixed and limited (and ready to 'pull out' of oneself), whereas 'discourse' is more multiple, shifting, and shaped through interaction of knowledges, which fits more with a post-structuralist conception of linguistic interaction.

Like discourse analysis, there are no standardised procedures for applying narrative validation, but plausibility and coherence can be “appropriate criteria for comparative case studies” (Reissman, 1993, p. 69). Coherence criteria were set around three levels: *global* (goals the author is trying to accomplish), *local* (linguistic devices used to relate events to another), and *themat* (themes predominantly present in chunks of text) where interpretation is reinforced if the three levels of the text are understood (Agar & Hobbs, 1982; Reissman, 1993). For instance it is clear that Wetchler (1999, p.24) wanted to tell a story about his client overcoming panic disorder with the use of narrative therapy as a promising intervention (global coherence); he provided textual devices that helped change his client’s thinking e.g., “Landscape of consciousness questions revealed that she now felt more confidence in herself in her fight against anxiety” (local coherence); and there were themes of control (from ‘losing it’ to ‘gaining it’) present in substantial parts of the article (themat coherence). All three levels of coherence provided a consistent and thus strong understanding of the story, which also constructed a plausible case study and clearly demonstrated a change of position for the client from not having self-control to being ‘in control’. This is contrasted with Claire and Grant’s aim (1994, pp. 87-9) to demonstrate therapeutic change in three clients (global coherence) which is contradicted by a lack of specific examples (local incoherence) or any clear, consistent themes presented throughout the body of the text (themat incoherence). For example, “participants were encouraged to externalise their problems ... and develop their alternative stories” (Claire & Grant, 1994, p. 89) but the only discourse realised in the text (see Parker, 1992) of this was of a client who had “believed her nightmare would stay permanently was able to announce that it had gone to live at the police station (externalizing the problem)” (Claire & Grant, 1994, p. 87). Further,

specific questions centred on therapeutic change were revealed. According to Bruner (1987) and Spence (1986) the omission of detail is as important as the coverage. Thus, the article was made considerably less plausible (and notably harder to analyse how clients were positioned through discourse) than the other case studies due to the omission of detail regarding resources used in the therapy process along with specific examples of therapeutic outcomes.

### Analysis

A synopsis of each case study follows. Elizabeth, an 80-year-old woman, stated she was experiencing depression because her vision and mobility had worsened. (Kropf & Tandy, 1998). Forty-five-year-old Susan was anxious about travelling, had anxiety attacks, and feared losing control of her life (Wetchler, 1999). Richard, 53, was an AIDS sufferer who had attempted suicide and experienced depression (Rothschild, Brownlee, & Gallant, 2000). Nannette, 33, was battling anorexia (Nylund 2002). A 23 year-old woman, Summer, had been suffering from post-traumatic stress disorder (Merscham, 2000). Finally, four intellectually disabled women (ages 16, 22, 27 and 32 years) were survivors of sexual abuse (Clare & Grant, 1994).

### *Medical Pathology Discourse*

In all case studies, there was an initial use of a medical pathology discourse to describe each client. The medical discourse also contained a symptomological positioning of each client. This positioned clients as weak, helpless, and distressed:

As her mobility and vision worsened, she became increasingly disconnected and despondent... entered therapy at the suggestion of her physician, who was concerned about her social withdrawal (Kropf & Tandy, 1998)

Susan and Jim entered therapy complaining about Susan's anxiety attacks ... experienced sudden periods of dizziness, nausea, shortness of breath, feelings of being closed in, and a sense of being out of control ... was diagnosed with an anxiety disorder, placed on medication... (Wetchler, 1999, p. 21)

...she felt frequently stressed, was concerned she was becoming depressed, and noted severe anger toward men ... struggled with eating issues and felt dissatisfied with her personal appearance ... felt like harming herself in the past ... described a current list of symptoms including problems with sleeping, mood shifts, lack of concentration, anxiety, sadness and anger (Merscham, 2000, p. 283)

Medical discourses not only subjugate the client but create totalising stories of their experiences. As a totalising story brings individual subjectivity under an all-embracing discourse of persons (e.g., medical pathology), it constricts the availability of other discourses. An unchecked medical discourse can create a recurring pathological identity (Dallos & Hamilton-Brown, 2000; Dallos, Neale, & Strouthos, 1997). Pathological discourses can create medical self-surveillance (Foucault, 1977) where the clients fearfully examine their own histories.

He was especially concerned about his fatigue and whether it was due to depression or the illness (Rothschild, Brownlee, & Gallant, 2000, p. 4)

...participants had expressed some concerns relating to weight, body size and compulsive eating (Clare & Grant, 1994, p. 86)

Her trauma history, however, has also led her to feel numb and doomed. She reported believing the worst is yet to come for her and that she will not live to see her 24th birthday (Merscham, 2000, p. 284)

About a year ago, Elizabeth became very depressed as her functional abilities declined ... Her new role as someone who required support from others was both difficult to accept and frightening (Kropf & Tandy, 1998, pp. 10–11)

### *Transformation*

The points of change to a strength-based discourse were evident in almost all of the case studies (with the exception of Clare & Grant, 1994). These were initially through the appearance of externalising discourses in the text. For example, “[t]he habit of overworking himself was externalized whereby client and therapist discussed how, at some point in Richard’s life, the work had gained a strong control over Richard” (Rothschild, Brownlee, & Gallant, 2000, p. 7) facilitated a re-storying from being an overworked person to one who had the power to manage his life. A second example of this shift: “Elizabeth is depressed and frightened” (Kropf & Tandy, 1998, p. 12) becomes fear and depression robbing her from her enjoyment of life: “*fear* is identifying the places that are more difficult for you to maneuver. How can you respond to *fear*?” (Kropf & Tandy, 1998, p. 13). A third example of the externalisation process: “How has anorexia separated you from your own version and

thoughts of yourself?” (Nylund, 2002, p. 21) which allowed the client to eventually realise that she could control anorexia rather than vice-versa: “You [anorexia] had control, not me!” (Nylund, 2002, p. 26).

Unique outcomes found expression in various ways in the texts.

The therapist wondered whether depression represented a unique outcome in Richard’s life, whereby Richard no longer allowed work to take precedence over and control his life. Instead, by way of his breakdown and suicide attempt, Richard and the therapist speculated that Richard might have been taking a stand against the work habit having control over him (Rothschild, Brownlee, & Gallant, 2000, p. 6)

One important resource we explored was Summer’s family. Despite them living far away, Summer felt an important connection with them and saw both her parents and her sister as supportive, positive figures in her life ... Summer decided to let them help her more concretely...(Merscham, 2000, p. 285)

Through revisiting Bob’s positive impressions of her and their life together, Elizabeth recreated validations of self ... “I was important to that person. And I still have worth today.” (Kropf & Tandy, 1998, p. 13)

Unique outcomes were articulated as follows: for Richard an individual who had an extensive social life; for Summer a person having deep connections with her

family; and for Elizabeth, a worthy individual and a battler through persistence and survival.

### *Strength-based Discourses*

The shift to strengths-based discourses was evident at the end of each case study. Richard took on a spiritual discourse which brought contentment (Rothschild, Brownlee, & Gallant, 2000); Summer began to feel comfortable with men and reconnected with her family (Merscham, 2000); Elizabeth saw herself as an adapter and survivor (Kropf & Tandy, 1998); Susan recognised herself as a meticulous planner (Wetchler, 1999); and Nannette conceived herself as a successful poet (Nylund, 2002). Clients demonstrated an ability to claim strengths that were previously undervalued or overlooked.

With Elizabeth, her story was changed to one of a woman who had successfully weathered pain and challenges, and accomplished many goals during her 80 years of life. She moved from a story of loss to one of survivorship where she defined herself as someone who had triumphed through eight decades of living! (Kropf & Tandy, 1998, p. 12)

Richard articulated that, as a result of talking with someone who has a non-judgemental attitude about his awareness of a spiritual presence ... he feels more comfortable with dying... (Rothschild, Brownlee, & Gallant, 2000, p. 12)



Summer's new ability to reach out to others for help is a major change in her original story, where she had to be strong and handle all of her problems by herself (Merscham, 2000, p. 286)

... reports that her symptoms have mostly dissipated ... She felt that her attention to detail was one of her strengths and was glad that she could utilize it to resolve her problem (Wetchler, 1999, p. 27)

Five months after ... Anorexia's voice was occasionally present, but Nannette's anti-anorexic voice was very solid ... By separating the problem from her personhood, discussing the cultural and gender discourses that support anorexia and privileging her experience, Nannette was able to remember who she was before anorexia's onset ... [and allowed her to]... reclaim her poetic talents (Nylund, 2002, p. 33)

These articles provide cases that demonstrate the effectiveness of narrative therapy for successful outcomes. However, Clare and Grant's (1994) work remains unconvincing. They mentioned two outcomes for two clients – one client had a fear of Maori women and shifted her stance by joining a group of Maori women, and another announced that her nightmare had gone to live at the police station. In Clare and Grant's account there is little evidence of co-authorship of outcomes. Thus the claims made by the authors would appear to exaggerate the benefits obtained by the clients from the narrative therapy.

In the other five cases, there was much stronger consistency across the three levels of coherence: that the claims made by the authors or the general messages to be

conveyed (global coherence) were consistently matched with specific examples (local coherence), and were connected to particular themes that emerged from therapy (thematic coherence). For example, throughout one article, Kropf and Tandy (1998) conveyed the usefulness of narrative therapy for an older client in deconstructing negative perceptions of being elderly (global coherence), and specific themes were identified. “Elizabeth’s story of her experience with Bob included themes of initiative, risk, and persistence” and “Her new meaning system involved a sense of continued persistence, reconnection, and initiative” (thematic coherence) (Kropf & Tandy, 1998, pp. 13-14). Unique outcomes helped further deconstruct the notion of ‘old as degenerate’ and related to events of initiative and persistence: “I took flying lessons and Bob was afraid that it was dangerous. But I wouldn’t have thought of being afraid ... I still have worth today,” and “...rejected the idea of herself being an old, powerless woman” (local coherence) (Kropf & Tandy, 1998, pp. 13-14).

In another study, global and thematic outcomes of positive contribution to life and compassion for others (that replaced Richard’s feeling of inadequacy) were associated with the recurrent construction of positive self-realizations: “[t]hroughout our talks, the good in my life has been reinforced...” (Rothschild, Brownlee, & Gallant, 2000, p. 12). Also, in Nylund (2002), the letter writing correspondence between Nannette and the therapist constantly enabled her creative poetic talents (a theme consistently present in the text) to emancipate herself from anorexia by developing metaphors of anorexia (in this example, a shoe) to relate to a resistance to anorexic events in her life (e.g., “They kill my feet. They don’t fit me. I grew tired of sitting and sacrificing,” (p. 23) “... I’ll put my stomping shoes on! I’m strong.” (p. 27)) (local coherence).

In summary, five of the six reports demonstrate the effectiveness of narrative therapy in producing change in clients. Interestingly clients themselves contributed to the description of the change process in some of the cases reviewed. Wetchler (1999) asked Susan to review an earlier draft of his article and the majority of what Nylund (2002) wrote was correspondence between himself and Nannette. This suggests that the establishment and fostering of a productive dialogue may lie at the heart of successful psychotherapy.

### Conclusion

In using a discursive approach to evaluating six narrative therapy case studies, this study has found that, except for one case, narrative therapy is an effective therapy that has demonstrated positive outcomes for clients. Transformations of discourse and subject positions were evident in the therapy process-outcome studies, indicating a change in the clients' meaning of their personhood from pathology to growth, from subordination to health expert, to autonomous person.

Evaluation of psychotherapy has been framed by the use of quantitative methods. A discursive-based evaluation has utility in constructing a thick description of therapeutic outcome. A wider framing of EBP qualitative methodologies is both productive and desirable (American Psychological Association Presidential Task Force on Evidence-Based Practice, 2006) if the benefits of psychotherapy are to be acknowledged in ways that are recognisable to both clients and the health professionals who assist them.

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