

Commentary on “Narrative therapy groups for people with intellectual disability: a critical review of the literature”

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Reading the paper by Laura McKenzie-Smith sparked off a number of reflections concerning Narrative Therapy and Practice and the narrative metaphor more generally. This commentary will provide a personal perspective on the intersections of narrative practice and the support of people with a Learning Disability. In doing so it will highlight some possibilities of narrative ideas beyond therapy, using examples of record keeping and research as other places where stories are constructed. I will argue that narrative practice, and the narrative metaphor more generally, offers possibilities far beyond therapy.

Narrative and Learning Disability

My first encounter with narrative therapy was in the late 1990’s. The approach, developed principally by Michael White and David Epston (1990), emerged from the field of family and systemic therapy but soon developed its own unique perspective. As a trainee Systemic Psychotherapist, Narrative Therapy and the narrative metaphor re-authored many aspects of my work in a community learning disability team.

Through a narrative lens referrals and case notes told stories and the conversations I was a part of co-created stories on the fly. A narrative approach highlighted how the sometimes impressively technical sounding language used by professionals to describe persons and problems (and often these were narrated as inseparable) were not only not demanded by the non-linguistic world (Gergen, 1999) but were also not always particularly useful. Stories were contingent. Other stories were always possible. Always.

In this frame, speaking and writing were not merely more or less accurate depictions of the world but were themselves aspects of the world that shaped understanding, emotion, and possibilities. The narrative approach suggested that stories, developed collaboratively with others in a network, using their language, drawing on their experiences, could provide useful perspectives and possibilities. This was more a collaborative endeavour: a joint inquiry. For me this wasn’t relativism but pluralism. It was a tool for enquiring about the social construction of lives and relationships. This opened up many new questions such as:

How useful were these stories and to whom?

Whose voice was loud? Whose was quiet?

What other voices could we include to enrich the stories we had?

What dominant discourses (intersectional such as disability, gender, race, ethnicity, class, sexuality and more as well as powerful cultural stories such as the medical model of mental health) are being drawn upon as these stories are created?

How can we open up space for alternative stories?

What are the influences of problems on peoples’ lives?

When do people have the upper hand over problems?

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5 Narrative therapy and the philosophical orientations that inform it also opened up many
6 epistemological questions such as what kinds of knowledge are being drawn upon (evidence based
7 practice, practice based evidence, family stories, cultural beliefs and folk knowledge, and so on) in a
8 particular conversation, whose knowledge is privileged and how is it influencing how people are
9 understanding and relating to the perceived problem. I could then have conversations with the
10 person and the network about where ideas came from and how well did they serve them right now?
11 For example, a story (sometimes implied, sometimes explicit) that the person with learning disability
12 was unable to change and grow could be deconstructed without blame stifling it (persons and
13 problems and stories are not the same thing) and its 'effects' explored. What might this story
14 obscure? What moments where learning and ability are shown (landscape of action) might be
15 missed because they do not fit the story of 'unable to change and grow' and so aren't currently
16 storied (landscape of identity)? This approach connected very strongly with Person Centred
17 Practices which also led to different (richer, more human/e) kinds of stories by asking different kinds
18 of questions.
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22 At the time of this encounter I made some notes that I still have. These are in the form of reminders
23 to myself to hold space for this approach as I worked in problem-saturated contexts with men and
24 women referred to a community learning disability team. They encouraged me to:
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29 (Notice) the stories that were told of those who were referred, what was left out and what
30 was emphasised;

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32 To... search out exceptions to problems and unique outcomes where developments
33 (feelings, actions (not behaviours – these have functions and actions have meanings, a richer
34 sense of person-in-world), ideas, cognition, events and so on) that would not have been
35 predicted by the dominant problem-saturated story.
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39 **Separating Persons and Problems**

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41 Key to this approach was language. This was not merely window dressing. If a referral was for
42 anxiety, the label seemed to organise the systems around the person in particular ways. We might
43 begin to talk as if we were looking out onto the world as an objective observer of a phenomenon we
44 were already acquainted with (e.g. anxiety). We already knew about the 'anxiety' the referred
45 person 'had' before we had even met them or their family and friends. Also we might defer to a
46 correct way to address this anxiety regardless of the particular experience of it. Language also
47 influences our bodily experiences – stories are embodied (see the work of David Bohm for example).
48 These 'thin' terms might help us to manage hearing difficult stories, perhaps they contain them for
49 us, but much is lost. Narrative Therapy and its separation of persons and problems (externalization)
50 offered a different position and a reflexive focus on professional-story-telling-systems. Words such
51 as 'anxiety' and 'agitation' do not denote an understanding of the unique person referred but are
52 rather shorthand ways of speaking with utility for organisations in their day to day administration of
53 information flowing through their systems. Terms such as these are examples of a small selection of
54 terms describing large numbers of unique individuals. Narrative was also useful (as was the data
55 driven approach to positive behaviour support with its refusal to accept such subjective terms) in
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3 interrogating other common terms in referrals and other conversations such as 'outbursts' or
4 'manipulative behaviour'.
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8 **Co-researchers and Allies against problems**

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10 In paying close attention to the unique stories people are living one becomes a co-researcher
11 (Denborough, 2004) with the person and their allies. This is not always easy. Those who refer to a
12 professional may be in very difficult circumstances and understandably desperately want answers
13 and advice. However, working with people as a co-researcher engages our abilities as helpers
14 without excluding the abilities of others in the network. For me this manifested itself in working
15 with persons with learning disability, their families and teams of support staff in league against
16 problems that had been too dominant. We had conversations about problems (that in service
17 language were challenging behaviour and mental health and wellbeing issues) that influenced lives,
18 identities and relationships and sought out and amplified times when the problem did not get the
19 upper hand and what this taught us about how to keep the problem in check. These unique
20 outcomes, when the person and their supporters had the upper hand were shared in informal
21 meetings and captured for others in letters (rather than formal reports) so we could spread the
22 news. Network members were related to as potential allies against a problem and this required a
23 kind of listening that focused on the impact of problems on the lives of the person and their
24 networks – this listening required curiosity about the stories of all, a position Anderson (1997),
25 writing about collaborative therapy, describes as multipartiality.
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32 **Record Keeping: Telling stories about our work**

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34 Narrative Therapy, as well as related systemic and collaborative approaches, also influenced how I
35 thought about what I wrote about my work.
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37 The way in which we record the work we do is an act of narrative construction. Another description
38 is always possible. As a response to experiences in my practice I have worked on attempting to read
39 my notes through the eyes of others – particularly of course the person to whom they pertain. I ask
40 myself questions such as:
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44 *How might the person experience reading this case note (letter/report/email and so on)?*

45 *What images of themselves and their lives would they see reflected back from this note?*

46 *How hopeful might they feel about our work together?*
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51 I have found this opens space for internal dialogue as I am writing the notes. The note taking forms
52 an extension of the therapeutic conversation. Mann (2002) wrote on this theme and developed
53 what she describes as collaborative representation.
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56 As a hospital social worker Mann (2002) encountered a patient she found to be angry and seeming
57 not to want to work with her. The man was homeless and he did not want the hostel offered to him.
58 Instead the man had requested money and to leave the hospital. Mann describes the words that
59 formed in her mind during this encounter such as 'non-compliant', 'unreasonably angry' and
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'manipulative'. The social worker found support for these kinds of words in the medical registrar's notes and Mann added her judgments to the file not imagining the man might read these notes. The man then left the hospital taking his medical records with him.

Mann reflects that although what she had written could be supported in terms of professional judgment she felt a responsibility for the careless language, evaluations and the certainty of her writing in the context of knowing little of how this man experienced his life and the hospital. This experience encouraged Mann to develop practices of Collaborative Representation. As she notes:

'Trying to find ways to collaborate in relation to written representations is also for me a stand against thin descriptions of people's lives such as 'anxious mother', 'dependant relationship', 'attachment problems'. It is an opportunity to make visible the context of people's lives.' (Mann, 2002,np)

Mann (2002) notes some questions she uses for writing notes collaboratively with clients:

'Where would you like to begin?'

'What would you like the medical team to know about your experience so far?'

'Is there anything in particular you would like the medical team to know so that they might be more helpful to you?'

In doing so the notes become a part of the work and the person's story finds itself in a context of care.

Research as storytelling.

There are many forms of valid knowledge based on different ontological and epistemological beliefs – what we understand reality to consist of and the ways in which it can be known. Narrative therapists have described their work as a form of co-research:

'Taking a position of co-researcher invites us as therapists to recognise that our contribution is significant to the outcome of the research/therapy' (Denborough, 2004, p.33).

This is a position that guides us away from the distancing language of *'the research shows'*, *'people with X benefit from'*, or notions of persons being *'treatment resistant'* or *'unmotivated'* (see Fredman, 2014).

Drawing on a narrative approach we can ask *'what kind of story is being told by a piece of research?'*

All research is partial. Another question might have been the focus of the inquiry, another methodology crafted another data set, another representation of the data offers up another impression. The narrative approach raises similar questions about voice, representation and storytelling as it does in the context of other practices. Bateson (2016), a systemic scholar, writes about these issues in her work - what stories are offered in the representation of the data?

'It is not difficult to see that delivery of data in graphs depicting statistical breakdown of the gathered information implies a methodology. What is not so obvious is the meta-message that life is clear and definable.' (Bateson, 2016, p.162)

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3 Research and its representation may have consequences through its meta-messages. For example,
4 messages about who can know and the kinds of knowing that are legitimate may privilege certainty
5 over evolving complexity, quantification over qualitative detail and distract from the stories of the
6 person and their supporters. What stories and are being offered by a piece of research to people
7 with people with learning disability and their families? Jones and Haydon-Laurelut (2019, p.210)
8 offer the following questions:
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13 *What kinds of data – stories, experiences, numbers, and graphs – are privileged?*

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15 *How is data being delivered? In a presentation by a professional? As a process of discussion*
16 *between the person and those in their network? In the sharing of a story the person with*
17 *learning disability wishes to tell?*
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21 **Concluding Comments**

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23 Laura McKenzie-Smith's review of Narrative group work with people with a Learning Disability has
24 prompted a number of reflections and questions that I have shared here. A theme running through
25 this commentary is that Narrative Practices involve '*an active deconstruction of oppressive and*
26 *unhelpful discourses*' (Brown, 2006, p.3). I have explored this here in relation to a number of
27 contexts beyond the therapy room inclusive of receiving a referral, recording our work and some
28 considerations regarding research.
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