# Narrative Therapy

## With Individual Adults

By TIMOTHY DYCK

A Practicum Report
Submitted to the Faculty of Graduate Studies
In Partial Fulfilment of the Requirements for the Degree of

MASTER OF SOCIAL WORK

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## ABSTRACT

The application of narrative therapy with individual adults is the focus of this report. A thorough review of the literature of narrative therapy is provided. In addition, an explanation of the structure of the practicum, as well as the practicum environment is discussed. Included in this discussion are the methods of evaluation used, including the SCL-90-R by Derogatis (1994), some brief transcribed segments, and a qualitative interview. Next, a complete case analysis is provided, discussing the long term cases that were seen throughout the practicum experience. Finally, the report is completed with summarising the practicum experience, along with revisiting the learning objectives set out, followed by a brief conclusion. Overall, the qualitative and quantitative methods of evaluation point to the successful implementation of narrative therapy with the clients seen.

# CHAPTER ONE

## Introduction and Learning Objectives

### Introduction

I chose to direct my practicum experience toward working with individual adults, as a large number of clients referred for counselling at The Family Centre of Winnipeg fall in this category. Although it may have been beneficial to concentrate on a particular type of presenting problem, I chose to leave the criteria fairly wide open, in order to have a wide variety of clients to chose from. In doing so, the majority of the clients presented with problems of self-reported depression and low self-esteem, and general feelings of dissatisfaction with their current life situations. Narrative therapy was useful with the majority of clientele I have seen. The focus of re-creating an alternative story was a desire for almost all clients I have worked with.

Narrative therapy is consistent with social work values and practice in general. It is congruent due to its use of a collaborative non-expert stance, its strength orientation, and its promotion of self-determination. Further, the belief that people are intelligent, resourceful, and insightful in nature further suggests the importance of the client in the therapeutic process. Finally, the significance that is placed on person-in-environment practice suggests greater compatibility with social work values and clinical practices.

Narrative therapy is consistent with my own belief system. I personally do not find expert driven approaches to therapy to be useful. Such an approach does not acknowledge client's strengths and their ability to change. I believe in

therapy that involves a client in all aspects of the therapeutic process, an approach that empowers the client to make decisions, to create room for an alternative story. Further, I appreciate the emphasis of narrative therapy on the dominant discourses within society that are oppressive in nature. This is a belief I held even before, and consequently makes the approach more congruent with my own understanding of the way people function.

## Learning Objectives

My practicum was completed in the counselling department at The Family Centre of Winnipeg. My main learning objective was to provide service to individual adults who presented with signs and symptoms of depression, low self-esteem, or additional issues. My learning goal was to provide a competent service to the clients that allowed them to make room for an alternative story, or a different way of viewing their life and current unhappy situation. In so doing, the hope was that this would allow the client to make behavioural changes to their current situation, to feel better about themselves, and to change their overall view of themselves. The use of narrative principles were put in place to work with the clients at changing from their problem-saturated stories, to stories where they were able to view themselves as more competent and in control of their life. A second learning goal was to fully understand and implement the narrative belief system and principles of practice in the most effective method possible.

Finally, in order to achieve an accountable practice, it is necessary to evaluate the clinical interventions used in the practicum process, which is the final learning goal. Both quantitative and qualitative methodologies were adopted.

The SCL-90-R by Derogatis (1994) was used. It is a five point likert scale that screens for a broad range of psychological problems that a client may be having, while assigning an overall score to the test (Schmitz et al., 1999). A qualitative measure was also used, which consisted of transcribing the segments of the client's changes in language in the therapeutic process which was analysed in one case. This was completed through videotaping the therapy sessions, and then transcribing the dialogue in order to be fully analysed and discussed. Finally, a qualitative questionnaire was implemented which gave clients a chance to provide feedback on the whole therapeutic experience.

# CHAPTER TWO

## Literature Review: Narrative Therapy with Individual Adults

### Introduction

Individuals present with different problems, but a common feature is that each individual has a story. Narrative refers to the meaning which people attribute to their experience (Dulwich Centre Newsletter, 1991). The individual stories are key to narrative therapy, with particular emphasis on how experience creates expectations and how different understandings and interpretations lead to the formulation of distinctive stories.

In this section, I provide a complete and thorough understanding of the application of narrative therapy with individual adults. First, I provide a brief history of the origins of narrative therapy, specifically introducing the major proponents. Secondly, I present a general overview and explanation of the way in which narrative is understood and used in current practice. Thirdly, I give an overview of key concepts and clinical methods of narrative therapy. The key concepts provide a theoretical awareness of the modality, allowing the reader to gain a better understanding of the belief system behind narrative. The clinical practices are more practical in nature, and specifically speak to the methods used in the actual therapy sessions. The relevance to social work practice is another important concept that needs to be addressed. This allows for an understanding of many of the commonalties between narrative and the underlying principles currently taught in social work today. Finally, some of the

criticisms and research aspect will be touched upon, providing an explanation as to the lack of research available, as well as a discussion of what is accessible.

## History

Postmodernist thought has become increasingly recognised in recent years. "Comparing it to modernity which has emphasised purity, order and analytical abstraction, postmodernism moves toward elaboration, complexity, multiplicity, pluralism and inclusiveness" (Monk, 1996, p. 41). This significant change in thought has led to changes in the methods of therapy, and even change in worldviews of many therapists. "Transcending models and schools and orthodoxies, post modern family therapy crosses disciplinary boundaries and allows a freedom of thinking and action not possible within the old paradigms. The therapist is forever part of a meaning-generating system with the family, not an outside expert applying medical-style treatment to a sick family" (Doherty, 1991, p.42). Narrative therapy is a product of the postmodernist movement, and has gained widespread popularity over the last decade or so (O'Hanlon, 1994; Monk, 1996; Nichols & Schwartz, 1998; McQuaide, 1999). It is necessary to discuss the origins and history of narrative therapy in order to gain a more complete understanding of the approach.

Michael White and David Epston have been instrumental in the promotion of narrative therapy. White is from Australia, while Epston is from New Zealand. The two of them met in Auckland, where both were working together in the field of mental health (O'Hanlon, 1994; Monk, 1996). Both have made a conscious effort not to label their approach with the belief that labelling may limit what may

subsequently be involved in its use (Monk, 1996). Narrative has been referred to as the "fourth wave" of therapy, which is the most recent wave of therapeutic approaches (Monk, 1996).

It is necessary to speak about some of the influential theorists who have helped shape the narrative movement. Gregory Bateson is one of those theorists (Zimmerman & Dickerson, 1994; Monk, 1996). In the early 1980's White began to borrow some of Bateson's ideas of "negative explanation, restraint and news of difference within a therapeutic context" in a new and interesting way (Monk, 1996, p. 42). Using Bateson as a point of reference, White and Epston suggested that humans tend to function within society with their own set of ideas and beliefs about the world around them. These ideas and beliefs establish rules by which each person is able to live and process information about events that happen around them, bearing in mind that each is individual and distinctive from the rest of society (Zimmerman & Dickerson, 1994; Monk, 1996).

Edward Bruner is also a contributor to the narrative school of thought (Zimerman & Dickerson, 1994; Monk, 1996). Bruner noted that people learn about life through lived experience and they tend to make sense out of their lives through narratives or stories (Zimmerman & Dickerson, 1994; Monk, 1996). Bruner believed that it is through stories that meaning is given to lives, and that narratives only take into account a portion of what lived experience really involves. He further added that people tend to develop dominant stories that are used to make sense out of much of life's events (Bubenzer & West, 1994; Zimmerman & Dickerson, 1994; Monk, 1996; Nichols & Schwartz, 1998;).

Though these dominant stories do not really encompass all of what life is about, they do account for certain activities as recorded events. The idea that stories are constitutive and thus able to shape lives and relationships was also developed by Bruner (Monk, 1996).

Michel Foucault has also been a significant influence on narrative therapy. The whole notion of White and Epston's dominant discourses comes from Foucault's ideas on power and knowledge (Dulwich Centre Newsletter, 1991; Becvar & Becvar, 1993; Zimerman & Dickerson, 1994; Bubenzer & West, 1994; Monk, 1996). The effects of dominant discourses or societal beliefs and norms are often quite subtle on the majority of the population, and may be totally unknown to the person on whom they are having an effect. Looking more intensely into everyday taken for granted norms then allows one to better understand how they are affected by the dominant discourses in society. This train of thought led White and Epston to introduce the idea of deconstruction, or taking apart some of the assumed truths and norms, within a society, that are oppressive (Dulwich Centre Newsletter, 1991; Becvar & Becvar, 1993; Zimmerman & Dickerson, 1994; Monk, 1996).

The theorists mentioned have had a significant impact on the shaping and understanding of narrative therapy, and have been important in the development of the therapeutic movement to what it is today.

## Overview

Narrative therapy has a relatively short history, having been developed only about twenty years ago. However, there have been a number of substantial

changes that have occurred, greatly expanding its use and utility. Michael White and David Epston have been the most influential leaders of the narrative movement (Monk, 1996; Nichols & Schwartz, 1998; Walsh, 1998;).

Narrative therapy is a post modernist approach that began in the 1980's. What distinguishes narrative therapy from more traditional therapies is the emphasis on externalising problems and finding out their impact and effect upon families as opposed to the family's effect on the problem (Dulwich Centre Newsletter, 1988; Dulwich Centre Newsletter, 1991; O'Hanlon, 1994; Strand, 1997; Nichols & Schwartz, 1998; Schwartz, 1999). People are socialised to internalise problems and view them as a part of themselves, it is important to be aware of the way in which problems operate on individuals and families (White, 1991; Zimmerman & Dickerson, 1996). "If problems are situated by the therapist in individuals or families, the problem can use this pathologizing effect to further its influence and get bigger, while the person or family gets smaller" (Zimmerman & Dickerson, 1996, p. 2).

Narrative therapy takes on the social constructionist stance that there are no absolute truths, and emphasises deconstructing the firmly incorporated truths that have negative effects on people's lives (Becvar & Becvar, 1993; Bubenzer & West, 1994; Weingarten, 1998). "Social constructionism is anchored in a philosophy of community processing; it treats reality as a group project and actually questions the existence of an essential self apart from others" (Mills & Sprenkle, 1995, p. 371). The emphasis on community is an important concept in

therapy, as it allows the therapist a new understanding of community in order to work with clients.

Narrative therapy focuses on allowing the client to "bring cultural and political realities into the room and open space for marginalized perspectives" (Zimmerman & Dickerson, 1994, p. 235). The therapist him/herself is also expected to look at his/her own life and in terms of the cultural and societal influence on it, rather than just a therapeutic approach.

In addressing larger societal influences upon people's lives, therapists began to realise the significance of stories, as people incorporate life stories that fit with their current belief systems, and it is with the change in their life story that there can be change in the understanding of everyday success and failure (Becvar & Becvar, 1993b; Nichols & Schwartz, 1998). People draw different conclusions from the same events, and narrative therapy attempts to help clients move from problem-saturated stories to preferred stories (Bubenzer & West, 1994; Zimmerman & Dickerson, 1994; Nichols & Schwartz, 1998). The therapist uses a number of therapeutic approaches/questions in order to enable the client to question his/her interpretation of his/her life story, coming up with alternative healthier stories. The therapist looks for experiences in the client's life that do not fit the dominant problem narrative, and questions can be asked that lead to an alternative story.

Narrative therapy takes on a different approach when compared with more traditional forms of therapy. Therapists are encouraged to include the following: a collaborative, listening position with strong interest in the client's

story; a search for incidents in a client's story where they were strong or resourceful; use of questions which take a non-imposing, respectful approach to any new story put forth; a conscious effort to never label people, and instead treat them as human beings with unique personal histories; and a willingness to help people separate from the dominant cultural narrative they have internalised so as to open space for alternative life stories (Nichols & Schwartz, 1998).

## Key Concepts

One of the key concepts of narrative therapy is the idea that people determine meaning in their lives through the stories that make up their lives. People draw from their experience in order to express themselves, and it is the various stories that shape life and have very significant effects in providing the structure of life (Dulwich Centre Newsletter, 1991; Borden, 1992; Becvar & Becvar, 1993b; Zimmerman & Dickerson, 1996). "Stories constitute the basic structures for people to search for meaning of their experiences and to make sense of their lives" (Cheung, 1998, p. 5). The way in which people tell their stories illustrates the way in which they structure their experience, and in this way pass on history (Cheung, 1998). People also determine the meaning of self through being shaped by external stories or discourses (Bubenzer & West, 1994;Zimmerman & Dickerson, 1996; Madigan, 1996; Neal, 1996; Cheung, 1998). Examples of this are identified through the effects of gender stories, as well as experiences with other people that have effects on the meaning people give to their lives.

Stories have also been referred to as a method to "maintain a sense of coherence, continuity, and meaning" (Borden, 1992, p. 135). They are, therefore, effective in coping with negative life changes and losses. This has significant implications for those working within the human service professions, with individual stories holding valuable information. Thus, narratives play a major role in the understanding of human existence and methods of functioning, and are fundamentally important in the practice of social work, and clinical practice in general.

Another one of the fundamental concepts of narrative therapy is that each narrative is legitimate in itself (Parry & Doan, 1994). Each person's story is unique and should not be questioned or disrespected in any way, with all narratives being equally legitimate. Thus it is important to allow the person the freedom to use his/her own language to describe their story, without being concerned about how others may perceive it (Parry & Doan, 1994; West & Bubenzer, 1995). It is consequently important for the therapist to create an atmosphere where clients feel respected in the telling of their story. This involves careful listening, while allowing ample time for the story to unfold. It is also significant to acknowledge the fact that people come with many differing stories (Parry & Doan, 1994), which allows people to construct more than one narrative to encompass their life (Bubenzer & West, 1994). Michael White's unique outcomes emerges from this train of thought, which recognises those times in a person's life when he/she was able to overcome the predominant problem

(White, 1989; Dulwich Centre Newsletter, 1991; Parry & Doan, 1994; Weingarten, 1998; Bitter, 2000).

Another key concept is the story revision process (Parry & Doan, 1994). In the application of narrative therapy, it is imperative to allow clients the opportunity to develop with an alternative healthy story about their lives, thus allowing for an increased sense of control over one's life, with the therapist being an integral part in the dismantling of the problem-saturated story that has caused the client to focus on negativity. The therapist then must be able to point out unique outcomes in order to help author a changed story where the client showed an ability to persevere. This often causes the client to rethink his/her problem-saturated story where weakness and powerlessness is the focus. The client instead then decides how to incorporate the origins of these stories or narratives that are constitutive of people's lives (White, 1989; Dulwich Centre Newsletter, 1991; Weingarten, 1998). The stories that people bring to therapy are constructed and determined by their life experiences and through interaction within their communities. Our own stories are therefore also affected by the dominant cultural beliefs and practices (White, 1989; Dulwich Centre Newsletter, 1991; Bubenzer & West, 1994; Zimmerman & Dickerson, 1994; Madigan, 1996; Neal, 1996).

The concept of indeterminacy within determinacy is also raised (Dulwich Centre Newsletter, 1991). This refers to the notion that the stories that people have about their lives contribute determinacy to life. They, however, do not account for all of the inconsistencies and contradictions that are inherent in these

stories (Dulwich Centre Newsletter, 1991). "It is the resolution of these gaps, inconsistencies, and contradictions that contributes to a certain indeterminacy of life" (White, 1991, p. 28). Coming to a better understanding of these gaps and inconsistencies allows one to come up with one's own unique meaning to life.

Deconstruction is one of the fundamental concepts of narrative therapy. Deconstruction refers to "unpacking the taken-for-granted assumptions and ideas underlying social practices that masquerade as truth or reality" (Monk, Winslade, Crocket, & Epston, 1997, p. 302). This involves looking for inconsistencies and gaps within assumed ideologies or dominant stories in order to open up the possibility for new interpretations (Bubenzer & West, 1994; Neal, 1996; Monk et al., 1997; McQuaide, 1999; Semmler & Williams, 2000). It is significant to understand that deconstruction refers to dismantling many of the assumed truths that have destructive effects on people's lives (Bubenzer & West, 1994; Neal, 1996; Monk et al., 1997; McQuaide, 1999; Semmler & Williams, 2000). Deconstruction is based on a critical constructivist stance, which asserts that people's lives are patterned by the meaning humans give to their experience, and by the language practices and cultural norms that one is a part of. Understanding this is key in enabling clients to understand new possibilities and alternative ways of seeing their life events and interpretations of them.

Deconstructive listening involves using the principles of deconstruction, while listening to the client's story. This means identifying oppressive societal beliefs that the client might have internalised into his/her problem-saturated story, while maintaining a listening position (Neal, 1996). It is important to explore with

clients the ways in which they have come to the understanding and interpretations of everyday occurences. Deconstructive listening is one method by which the therapist can both gain increased knowledge of the client's story, while making suggestions about some of the larger societal influences involved (Bubenzer & West, 1994).

The use of externalising conversations is also effective in illustrating the politics of experience (Bubenzer & West, 1994). This refers to the effect that societal norms and experience in mainstream society have upon a person, and what that person believes about him/her self. This makes it possible to emphasise the importance that experience plays in people's lives by discussing some of the assumed truths and accepted ideologies within a culture that have dramatic effects upon the population. It is through these discussions that there are opportunities for deconstruction (Bubenzer & West, 1994).

## Clinical Practices

### Beginning Therapy

Typically during the first session narrative therapists will spend some time discussing with the clients their daily activities and interests in order to gain a better understanding of how the clients see themselves (Nichols & Schwartz, 1998). The therapist does not get into a lengthy history, but focuses more on positive attributes and competencies that the client has. The ability of the therapist to establish rapport with the client is fundamentally important in allowing the sessions to move toward a more goal directed focus. As is the case in any therapeutic experience, the client must feel heard and understood before he/she

will trust the therapist enough to expose personal information. The client is also given the opportunity to ask any questions of the therapist that he/she may have, in order to begin the collaborative approach to therapy (Parry & Doan, 1994; Nichols & Schwartz, 1998).

Externalisation of Therapeutic Dialogue

The therapist begins by asking the client to tell his/her problem-saturated story, listening and gaining an understanding of what the client has been going through. After the therapist has established some rapport with the client, the therapist usually then begins to ask questions that externalises the problem from the individual or family (Nichols & Schwartz, 1998; Bubenzer & West, 1994; Roth & Epston, 1996; Carr, 1998; Thomas, 1999). Externalisation is more of a worldview than a therapeutic technique, and is based on seeing the problem as separate from the client. The use of externalising language can be helpful, often with the therapist being conscious to separate between the problem and the clients from the beginning of the therapy sessions. In externalising the problems, the therapist and the client come up with a name for the issue, with emphasis on addressing it as an external entity to the person (Madigan, 1996; Roth & Epston, 1996; Semmler & Williams, 2000). This serves to increase the control the individuals have over the problem, as they view it as separate from themselves. "Neither the client nor the family is the problem - the problem is the problem" (Nichols & Schwartz, 1998, p. 402). This view of people and families is unique in that it does not blame individuals for creating or maintaining problems, but refers more to the dominant discourses in society that influence people in negative

ways (Neal, 1996). The focus is on the cultural beliefs and practices as the source of the problems rather than the families or individuals (Madigan, 1996; Roth & Epston, 1996; Weingarten, 1998; Semmler & Williams, 2000). It is significant to acknowledge the communities of discourse, that is the "cultural creation which allows for social norms to be dictated through a complex web of social interchange mediated through various forms of power relationships" (Madigan, 1996, p. 50).

Parry and Doan (1994) refer to two general rules for externalisations. The first emphasises that externalisations tend to move from the general to the specific. The therapist typically begins with a more general externalisation, and then moves toward one that is closer to the situation of the client (Parry & Doan, 1994; White, 1989). The second rule is that externalisations are most effective when they are phrased within the client's own language (Parry & Doan, 1994). This is important in order for the client to gain a better understanding, while likely increasing his/her investment in the process.

White and Epston (1990) also identify how externalisation can be used effectively. One way in which externalisation is useful is through decreasing unproductive conflict between people, especially in disputes over who is responsible for the problem. The use of externalisation allows people to put their energy together to combat the externalised problem, making effective use of efforts previously directed toward unproductive conflict. Individuals can make gains through brainstorming ideas with the therapist about effective means to push the externalised problem away. These strategies then decrease the effects

that the problem can have on people's view of themselves as well as their relationships with others. Externalisation can also be effective through undermining the sense of failure that many people have due to the continued existence of problems despite efforts made to solve them. Finally, externalisation promotes the idea of dialogue about problems as opposed to monologues about problems (White & Epston, 1990).

Establishing the Person as "In Charge"

In more entrenched cases the therapist needs to develop a more extensive repertoire of questions which may involve the therapist to demonstrate over a number of sessions how the problem has managed to negatively affect or dominate the family or individual (Nichols & Schwartz, 1998). The use of "relative influence" questions has been used to identify the influence that the problem has had on different members of the family, in order to illustrate that it is not only one person's personal problem (White, 1989; Dulwich Centre Newsletter, 1991; O'Hanlon, 1994; Monk, 1996;Nichols & Schwartz, 1998). This is an effective method of externalising and objectifying the problem, empowering clients to see the problem as within their control. In mapping the influence of the problem in their lives and relationships, the therapist uses questions that demonstrate the influence the problem has through behaviour, emotions, interactional and attitudinal domains (White, 1989). Further, these questions can illustrate that the presenting problem has caused the client to act or think in ways in which they would prefer not to. The use of relative influence questions can help identify the effects of the problem across various interfaces, including effects on differing

family members and various relationships within a person's life. The use of externalising language is imperative in this method of questioning as well (Mills & Sprenkle, 1995; Nichols & Schwartz, 1998; Fristad, Gavazzi, & Soldano, 1999; Bitter, 2000). The use of these various practices is helpful in refocusing and encouraging the client to be in charge of his/her life situation, creating an empowering experience.

Relative influence questioning and mapping the influence of the problem allows the therapist a natural transition to identifying unique outcomes, accounting for times when the client was able to overcome the predominant problem (White, 1989; Bubenzer & West, 1994; Monk et al., 1997). This is the next important step on which the therapist and client need to embark.

Unique Outcomes

The therapist must be mindful of the tendency of clients to focus on the negativity of their lives, and incorporate only negative stories into their life narrative (White, 1989; Monk et al., 1997; Walsh, 1998). It is, therefore, significant to look for "unique outcomes" or "sparkling events" in the problem-saturated story where the person was able to avoid the problem's effects (Nichols & Schwartz, 1998, p. 412). This enables the client to rethink some of the assumptions that he/she may have been making about his/her life (White, 1989; Nichols & Schwartz, 1998; Walsh, 1998; Weingarten, 1998). Although the client may not be prepared to discuss these exception times, it is fundamentally important that the therapist is able to draw the client into the gradual change of the problem-saturated story, that begins with discussing unique outcomes. It is

these unique outcomes that can often lead to major changes in the forming of alternative narratives that are more accurate and create a more positive outlook on life (Dulwich Centre Newsletter, 1991; Walsh, 1998; Weingarten, 1998). Although this can be a very useful tool in narrative therapy, it is important not to use this practice prematurely. Too much focus too early can cause the client to think that the severity of their problems are not being heard or understood (Nichols & Schwartz, 1998).

Being Aware of Strategies Used to Keep Problem Stories

The therapist needs to be able to identify conscious or unconscious strategies that are used to maintain problem stories. White suggested that these restraints are usually unconscious and take the form of "the network of presuppositions, premises, and expectations that make up the family members' map of the world and that establish rules for the selection of information about perceived objects or events" (Parry & Doan, 1994, p. 54). Clients often describe these restraints as feelings, with feelings such as fear, guilt, self depreciation, perfectionism, and anger being the most common (Parry & Doan, 1994). It is important to be able to explore those feelings with clients, assisting the client in processing the meaning and making attempts to talk about the feelings in an externalised fashion (O'Hanlon, 1994; Parry & Doan, 1994; Weingarten, 1998). The therapist and the client must then come up with a collaborative approach to gain control of some of the behaviours and actions that lead to the emergence of the old story. This process may take a long period of time, but it is necessary to fully work through these issues in order to have positive therapeutic outcomes.

Landscape of Action Questions

Landscape of action questions can be referenced to the past, present and future, and can be effective in bringing forth alternative landscapes (White, 1989; Dulwich Centre Newsletter, 1991). Questions that historicize unique outcomes are very effective in bringing about these alternative landscapes of action. These types of questions are helpful in linking positive developments within the present to the past, where various unique outcomes can be identified along with the circumstances that surrounded them (White, 1989; Dulwich Centre Newsletter, 1991). This encourages people to look back on what they previously had seen as stories that were problem saturated, and see how there are alternative interpretations of their story. The landscape of action questions can focus on either recent history or the more distant history of unique outcomes, depending on whether the therapist wants to concentrate on the more immediate circumstances or not.

Landscape of Consciousness Questions

"Landscape of consciousness questions encourage the articulation and the performance of these alternative preferences, desires, personal and relationship qualities, and intentional states and beliefs, and this culminates in a "re-vision" in a personal commitment in life" (Dulwich Centre Newsletter, 1991, p. 31). This speaks to having clients look at the changes they have made over time, with an emphasis on what this says about them in various ways, and how this can lead to preferred future. This allows for alternative stories being resurrected,

and "alternative modes of life and thought become available for persons to enter into" (Dulwich Centre Newsletter, 1991. P. 31).

Experience of Experience Questions

Experience of experience questions can be very useful in facilitating alternative views of life events and general beliefs about oneself (White, 1989; Dulwich Centre Newsletter, 1991). These types of questions ask the clients to provide his/her understanding of how he/she perceives another person's experience and understanding of them to be (White, 1989; Dulwich Centre Newsletter, 1991). This enables the clients to look back at some of their experiences that they may have forgotten or ignored over the passage of time, and allows for the imagination of a person's perspective to be reflective of their alternative views of themselves (Dulwich Centre Newsletter, 1991). This can be a very empowering experience that further establishes the notion of the alternative narrative.

Re-authoring the Whole Story

The therapist is interested in a change in the client's whole outlook, not only the piece that was related to the problem (White, 1989; Parry & Doan, 1994; Nichols & Schwartz, 1998). This process can begin by reminding the client of his/her competencies in relation to the presenting problem, with an attempt to draw inferences from these accomplishments. The therapist needs to try to broaden the focus toward that of the future, with an emphasis on how the client will be able to cope with similar circumstances due to the abilities he/she has shown. Reinforcing the new story is also important through frequent

acknowledgement of the client's accomplishment within the session and through the use of narrative letters (West & Bubenzer, 1995; Monk et al., 1997; Nichols & Schwartz, 1998; Chen, Noosbond, & Bruce, 1998; Weingarten, 1998). This allows the client to realise that the therapist has been present with him/her through the struggles he/she has defeated, and allows for an increased investment in the new narrative.

Therapeutic Letter Writing

The use of therapeutic letter writing has been on the increase in recent years, and has widespread use within narrative therapy (Andrews, Clarke, & Phillips, 1998; Chen et al., 1998). Within family therapy, the use of therapeutic letters has had many uses including: engaging non-attending partners in marital therapy, as a technique between spouses, as a therapeutic task (with or for) clients before therapy sessions begin, and to commend clients on their progress throughout the entire therapy experience (Andrews et al., 1997).

White and Epston introduce a stage in therapy they call "circulation" (Andrews et al., 1997, p.155). This refers to the idea that when personal meanings shift, and alternative stories are incorporated into the lives of clients, then circulation of the news that these changes are occurring must be utilised (Mills & Sprenkle, 1995; Andrews et al., 1997). There also needs to be an audience to witness the news of these changes in order for the changes to be supported (O'Hanlon, 1994; Andrews et al., 1997). "Through the use of documents such as letters and certificates, news that change is occurring can be spread beyond the therapy room" (Andrews et al., 1997, p. 149). Letters have

been said to be very important to most clients, and according to Epston's informal research, clients read letters from therapists on an average of four times and tend to keep them as valuable objects (Andrews et al., 1997). They allow the client to feel heard and also enable the clients to correct the beliefs that the therapist may have identified within the letters about their life situation. The concept of the "thickening process" is also brought out. This refers to "supporting new and emerging storied experiences that help to re-author clients' lives" (Andrews et al., 1997, p. 150). This also makes room for the accountability of the therapist to be addressed, while also allowing for clients to make use of letter writing if they so desire.

White and Epston are also known to share their progress notes with their clients through the form of letter writing (Mills & Sprenkle, 1995). In performing this task, themes of strength, courage, endurance and perseverance are identified in order to empower the client, and allow complementary feedback on the positive work being done by the client. Using direct quotes in these letters is particularly meaningful, as this creates a more powerful experience that often cannot be replicated in therapeutic conversations. Letters also allow the client more time to reflect, and thus can have a dramatic influence on the client (O'Hanlon, 1994; Mills & Sprenkle, 1995).

The use of therapeutic letter writing within narrative therapy has proven to be a powerful tool that most clients feel is an empowering experience. Its extensive use within narrative has established it as a significant therapeutic technique that can lead to positive results with clientele.

## Relevance to Social Work Practice

It is significant to address the importance of narrative therapy in the field of social work. Many of the fundamental beliefs and aspects of social work that distinguish it from other disciplines are identified within narrative therapy.

The concept of deconstruction is consistent with social work values. It is important to look at the ways that society and culture affect humans (Monk et al., 1997). Deconstruction refers to the process of examining many of the dominant cultural assumptions such as: gender stereotypes, ideas of success and accumulation, the importance of status, and similar ideas that can cause people to view their own personal stories as unworthy. Social work is well known for the importance that it places upon societal influence and ecological practice, which sees the client as the person within the larger environment and community. Narrative therapy, too, takes the approach that the client is not to be treated in isolation of his/her surroundings, but instead the larger communal group is taken into consideration. The idea that the problem is not located within an individual, but in fact is external to the person is also important. Thus, it is significant to dismantle and deconstruct some of the cultural assumptions, encouraging people to come up with their own stories of personal success.

Another concept that is important to social work is the significance that is placed upon empowering clients, promoting this through use of a collaborative approach to treatment. Social constructionism places importance on this type of approach in working with clientele, and narrative therapy is no exception to this. Self determination is actively encouraged in social work, and narrative too uses

this idea to empower clients to change their personal stories and views of themselves (Borden, 1992). Although the therapist is active in encouraging the new stories, the client and therapist work together towards this goal. This is different than more traditional forms of therapy where the therapist acts as an expert, and is more directive in the therapy process. This understanding of self determination is sometimes viewed in a negative light, as clients may desire a more directive expert driven approach. This could be because the client is less actively involved in such directive therapies, and thus takes less responsibility for the outcome of the therapeutic endeavour. A collaborative approach to treatment allows for increased investment and longer term change, with the client being able to take more ownership of the changes that have been made. Such an approach differentiates social work from many other disciplines (Borden, 1992).

Narrative therapy is consistent with social work practice in its ability to take a respectful stance with clients. There is much less emphasis on a hierarchical presence between the therapist and the client, and the therapist takes a listening position as opposed to a more directive approach. In listening to the client's story, the therapist gains a thorough understanding of the environment and circumstances surrounding the client's life. As already mentioned, this allows for a more ecological approach to treatment, which accounts for the person within their environment. This also promotes the idea that the client truly is the expert on his/her own life and situation.

Highlighting moments within a client's story when they were strong and resourceful, and were able to overcome problems is important in narrative

therapy. The understanding that people are generally good, well intentioned, and wanting to improve their current life situation is an assumption of both narrative therapy and social work practice. Discovering unique outcomes encourages the empowerment and self determination of the client, which is consistent with social work values of practice. Although the client may initially be too focused on his/her problem-saturated story to look at the unique outcomes identified by the therapist, over time appropriate questions will likely elicit responses from the client that enable a healthier outlook on life.

Overall, narrative therapy is congruent with the practice of social work. The importance that is placed on: deconstructing harmful societal beliefs, empowering clients, being respectful, using a collaborative approach, self determination and a general belief in the client's abilities to solve his/her own problems can be used effectively by social workers. This type of view is a relatively recent approach to therapy that is proving to be helpful, and should be incorporated increasingly into social work practice today.

## Critique

There has been some criticism of narrative therapy. The critics vary in their educational and professional background, pointing out various inconsistencies and concerns with the approach. Although some claims appear to have more validity than others, it is necessary to provide an overview of some of literature that questions certain fundamentals of narrative therapy and social constructionism in general.

Doan (1998) states that narrative therapy holds the social constructionist view that there are no absolute truths, only points of view. He then goes on to discuss how "narrative therapists have sought to privilege the voices of their clients in the process of delivering them from the oppressive weight of dominant, cultural grand narratives" (Doan, 1998, p. 379). Doan then questions whether narrative therapy has given the same amount of respect to those who practice different forms of therapy, as well as whether narrative has begun to make gurus of leaders. The question of whether narrative therapists have a tendency to be overly harsh about other models of therapy is raised, along with the idea that narrative is moving toward considering any other forms of therapy as less useful. This is seen as differing from the collaborative model that is practised with clientele. If Doan (1998), an advocate for the use of narrative therapy is so concerned with some of the trends, his views should be taken seriously.

Fish (1993) claims that although narrative therapy does well in enabling clients to change their narrative from problem-focused to a more positive view, it does little to address the cultural discourse within which the story is present. White and Epston would argue this point, as they address and acknowledge the oppressive cultural influence upon people's lives, and make a concerted effort at speaking to this very issue with the client. There is validity to the claim that narrative therapy does not make a real effort at creating social change, but concentrates more on exposing the cultural discourse to clients.

Madigan (1996) discusses the issue of the therapist taking into account the "community of discourse" as well, and sees that narrative therapists can use

externalising techniques without acknowledging the discourse (p. 48). This involves active listening on the part of the therapist, being careful to pay special attention to the words used by the client to describe his/her problems or concerns. These can later be used as quotes in therapeutic letter writing, empowering the client and identifying that his/her individual story is important. Without addressing the outside influences on a person's narrative, externalising techniques can become very limited in their use (Madigan, 1996). When externalisation is used without taking into account the societal influences and factors at play within a client's life, it can prove to further internalise the problem, having the opposite effect of what was intended.

A further criticism that Fish (1993) makes is what he sees as narrative's denial of context and power. Fish (1993) states that White and Epston "conceptually isolate the therapist-family system from any social, historical, economic, or institutional context, and to deny the existence or relevance of differences in power at an interpersonal level" (p. 228). Fish (1993) makes an important point in addressing the significance of acknowledging the power differentials that are so prevalent in North American society. Although it is significant to encourage healthier stories that allow for a more fulfilling life, one must be realistic to acknowledge and address the differences that do exist. However, it is also useful to attempt to change the oppressive conditions that exist in order to allow for increased freedom and opportunity for all.

Minuchin directs several criticisms toward narrative therapy. Minuchin (1998) begins by criticising narrative because of its lack of focus on the family.

Minuchin (1998) sees the narrative therapist focusing on individual family members, while having the other family members act as an audience to the interactions. Minuchin (1998) also identifies that narrative therapy neglects the family in its focus on dealing with the larger culture. This focus on deconstructing the accepted norms and culture within a society that are oppressive are seen as marginalizing the importance of family experience. Additionally Minuchin (1998) identifies that the focus on a collaborative non-hierarchical approach to treatment has some negative aspects to it. It is seen as potentially a way of not recognising the knowledge and experience of the therapist as a positive force for healing (Minuchin, 1998). Minuchin's (1998) final criticism addresses narrative therapy's attempt to work with clients in a collaborative fashion, without acknowledging it is impossible for the therapist not to bring some personal opinions and biases into the therapy session.

## Empirical Research

One of the commonly cited criticisms of narrative therapy is the lack of research and empirical studies that support this modality. Although it has gained popularity in recent years, there remain few empirical studies to support narrative. This may be due to its social constructionist orientation that sometimes is inconsistent with traditional quantitative research methods (Etchison & Kleist, 2000). Narrative's focus on qualitative understanding that is given to one's experience is also incongruent with quantitative research, which composes the majority of empirical studies that are currently produced and published. "Participants and researchers in qualitative inquiry are regarded as co-

researchers (Gale, 1993) who together explore the meaning of experience" (Etchison & Kleist, 2000, p.65). This joint effort between the therapist and the client is vastly different than most quantitative methods of measuring effectiveness in clinical practice. Qualitative studies usually are more conversational and interactional, as opposed to quantitative methodology which tends to be more objective and test oriented. Also, the notion of researcher objectivity is incompatible with social constructionist ideals, and this is the case in the application of narrative therapy. These qualitative measurements are not as respected, nor are there as many researchers with this type of qualitative analysis experience (Etchison & Kleist, 2000). This has then led to a lack of research material produced to support narrative therapy, and has some criticising narrative for this reason. These criticisms then call for increased qualitative research to support the newer postmodern ideas and methods of treatment.

Another reason for the lack of research on the effectiveness of narrative therapy may be due to the smaller numbers of researchers who are trained in qualitative methodology (Etchison & Kleist, 2000). Typically most counselling agencies employ more quantitative methods of evaluating clinical practice, as this type of research is generally more respected and less time consuming to apply, in turn resulting in increased funding (Etchison & Kleist, 2000). Unfortunately, most journal editorial boards are also composed of graduates who have been more exposed to quantitative methods, and are somewhat reluctant to accept alternative measurements (Etchison & Kleist, 2000). This criticism again

shows the concentrated effort that will have to be made in order to establish qualitative methodology as an effective means of measuring clinical practice.

Although there has not been a great deal of research-based evaluation of narrative therapy, it is significant to address some of the literature that is available on this subject.

Besa (1994) is one of the few authors who have written about evaluating narrative therapy using a single system design. The article looks at the effectiveness of narrative therapy in reducing parent-child conflict. The parents were trained in measuring the frequency of certain behaviours of their children during the baseline and intervention stages. The results indicated that narrative therapy was effective in reducing parent-child conflict in five of six families, with a range from 88% to 98% decrease in conflict (Besa, 1994). It was noted that improvements only occurred when narrative therapy was applied and were not observed in its absence.

St. James-O'Connor, Meakes, Pickering, and Schuman (1997) have written an article that looks at client experiences of narrative therapy. The main purpose of this study was to find out what families found useful and not useful about the application of narrative therapy. The study looked at eight families that were experiencing problems with children that ranged in age from six to thirteen years of age. The authors used a four-question qualitative semi-standardised interview format in order to get a rich description of the families' perceptions. The overall results of the interview process indicated that the family members generally found narrative therapy to be quite helpful, as all reported some

reduction in the presenting problem. The results also indicated that there was greater reduction in problems with those families that had been exposed to narrative therapy for a longer period of time. These available studies again promote the use of narrative therapy, as well as the ability to effectively measure intervention using qualitative methodology (St. James-O'Connor, Meakes, Pickering, & Schuman, 1997).

Weston, Boxer and Heatherington (1998) have written an article that addresses the ability of children to cognitively understand the causes of family arguments. The main purpose of this study was to increase understanding of children's stories about familial arguments, and to look at the implications this holds for family therapists of a constructivist orientation. The findings indicate that most children are capable of comprehending and verbalising the causality of arguments when given ample time to think about family arguments (Weston et al., 1998). This then indicates a compatibility with constructivist approaches such as narrative therapy and family counselling. Finally, "the study demonstrated that a combination of quantitative and qualitative research methodology could be useful for studying narrative therapy" (Etchison & Kleist, 2000, p. 65).

Finally, Coulehan, Friedlander and Heatherington (1998) attempt to build on the work of Carlos Sluzki's narrative approach to therapy, looking at the therapist's ability to facilitate "family members' successful transformation of narratives" (Etchison & Kleist, 2000, p. 65). A qualitative methodology was used to measure the effectiveness of the narrative approach.

This study involved eight therapists (of different disciplines) and eight families within an outpatient clinic of a hospital. The intake interviews were videotaped and post-session questionnaires were developed to hear the parents' description of the problems. A coding system was used to indicate, demonstrate, record, and show the different ways in which the various parents perceived the problem. The videotapes were transcribed, and further analysed to identify techniques used and changes made by the clients (Etchison & Kleist, 2000).

The results identified three ways in which the family stories were transformed. Transformation refers to "an episode in which the therapist successfully facilitates a shift in family member's constructions of their presenting problems from an intrapersonal or linear perspective, to an interpersonal or systemic one" (Coulehan, Friedlander, & Heatherington, 1998). The first way identified in Coulehan et al.'s study was a change in the way in which the family described the problem, which involved changes in "multiple views and descriptions of the problem" (Etchison & Kleist, 2000, p. 66). The second change that was evident was through the family member's affective tone. Finally, the family was able to explore positive aspects of the family and of individual members. The families' successful story transformation was clearly related to these factors (Etchison & Kleist, 2000).

# CHAPTER THREE

## Intervention

### Practicum Environment

The environment in which I completed my practicum was at The Family Centre Of Winnipeg in Winnipeg, Manitoba between May and October 2000. This facility was incorporated in 1937, following a study of Winnipeg's social service needs by the Junior League. The agency is a non-profit organisation that offers a number of services to communities in Winnipeg. The programs include a counselling and community services program, which offers assistance to individuals, couples, families and groups. Typical issues include: marital/family difficulties, parenting, communication skills, separation and divorce, remarriage and blended family life, loneliness and depression, family violence, anger management, and survivors of sexual and physical abuse. The agency also offers an in-home family support/family education counselling program. This program provides childcare, respite, education, and household help to families with special high needs. Finally, the agency offers a special needs family childcare program, which is a more comprehensive service of family support. The program in which I performed my practicum was in the counselling program, which was offered solely through the centre located on Portage Avenue.

The counselling department employs approximately ten therapists, the majority of whom are social workers. Service is offered to clientele on a sliding scale basis, from zero to sixty dollars per session, depending on the financial situation of the individual or family. The majority of the clients to whom I provided

service, did not pay for the therapy sessions due to limited access to finances. The clients tend to be self referred, filling out an intake questionnaire, which asks some specific questions around the reasons for referral.

## Administrative Procedures

The sessions were held at The Family Centre of Winnipeg offices, and the majority of the sessions were videotaped. Clinical supervision was provided on a weekly basis by Kathy Levine, who is a Master of Social Work, and currently a PhD Social Work student at the University of Manitoba. Arla Marshall of The Family Centre of Winnipeg also provided occasional clinical supervision, and was the agency contact person for me. Arla Marshall is also a Master of Social Work, and is a member of my Advisory Committee. Both Kathy Levine and Arla Marshall occasionally viewed the sessions behind the two-way mirror, but acted more as clinical consultants, discussing the clients on a case by case basis throughout my practicum experiences.

The recording of relevant client information was done as per the policy and procedures of The Family Centre. In addition, the clients completed the necessary consent forms to be videotaped and my personal consent form to be a part of a graduate level practicum was completed as well. Confidentiality and anonymity were maintained throughout the practicum, and clients were fully informed of all of the procedures involved in being a part of the practicum experience.

## Clients

Throughout the practicum, I saw fourteen individual cases. A complete service was provided to eight of the fourteen cases. Of the cases that received a complete service, the range of sessions went from three to fourteen sessions. Of the six remaining cases, there were four cases that came in only for an intake session. Another client decided to seek longer term service elsewhere after two sessions, as she felt that therapy that lasted only three months would not be adequate. Finally, one client attended four sessions, and then suffered from a death within the family, and was unable to complete the therapy process.

The clients that received a longer term treatment had a variety of presenting problems. There were seven cases that presented with problems of depression or low self-esteem in conjunction with additional issues having to do with relationships, communication, sexual abuse and psychosis. The last client presented the issue of coping with losses related to marital break-up and the ensuing custody battle.

Figure 1 indicates the reasons for referral and additional relevant information. The majority of the cases were women, as this compromised seven of the eight full cases, and whose age range was from twenty to fifty three years old.

Figure 1.

| CLIENT | AGE | GENDER | REASON FOR REFERRAL | NUMBER OF SESSIONS |
|---|---|---|---|---|
| A | 39 | Male | Relationship Issues | 1 |
| B | 37 | Female | Self Reported Depression, Bereavement | 1 |
| C | 55 | Male | F.A.S., psychosis | 1 |
| D | 43 | Female | Major Depression | 1 |
| E | 20 | Female | Major Depression | 2 |
| F | 20 | Female | Self Reported Depression | 3 |
| G | 38 | Female | Bereavement Issues | 4 |
| H | 31 | Female | Relationship Issues, Divorce/Custody | 7 |
| I | 25 | Female | Sexual Abuse, Relationship Issues Low self-esteem | 11 |
| J | 35 | Male | Self Reported Depression, Knee Injury | 14 |
| K | 53 | Female | Self Reported Depression, Communication | 13 |
| L | 30 | Female | Self Reported Depression, Familial Issues | 9 |
| M | 48 | Female | Self Reported Depression, Separation/Divorce | 13 |
| N | 47 | Female | Major Depression, Psychosis | 13 |

## Evaluation Measures

There were three methods of evaluation that were used in this practicum. The quantitative method of evaluation was the use of the SCL-90-R symptom checklist by Derogatis (1994), a system used to measure a broad range of psychological problems. The transcribing and analysis of the therapeutic dialogue of one case, and the qualitative questionnaires were used to allow for more of a descriptive response to the therapy received. Therefore, the quantitative and qualitative evaluation measures were used simultaneously to allow for a well rounded measure of the use of narrative therapy.

### SCL-90-R Checklist

This type of evaluation was used as a pre-test and post-test method, in order to determine any changes made from the beginning of the therapeutic process to the end. Six of the eight clients who received a full service of therapy sessions filled out the pre-test and post-test SCL-90-R checklist, as this was a part of the intake and final session, while one client had the post-test mailed to them.

The SCL-90-R was used due to its measure of general life functioning, and its ability to screen for a large range of psychological symptoms. This was most useful for the clients to whom I provided service, because they came with a variety of presenting problems. The SCL-90-R by Derogatis (1994) is a symptoms checklist with ninety questions. It is a five point likert scale that screens for psychological problems, while assigning an overall score to the test

(Schmitz et al., 1999). The answers are made up of nine primary symptom dimensions: somatization, obsessive-compulsive, interpersonal sensitivity, hostility, depression, anxiety, paranoid ideation, phobic anxiety and psychoticism (Appendix A) (Schmitz et al., 1999). This scale was useful in allowing a comparison of the score from the pre-test to the post-test to determine if there had been any progress made throughout the therapeutic process which would be indicated through a decrease in the psychological symptoms. The use of the SCL-90-R was also helpful in determining persuasiveness of qualitative data, which refers to whether the interpretation of findings are reasonable and convincing. The alleviation of negative symptoms as listed in the SCL-90-R after the application of narrative therapy increased the persuasiveness of the study.

In fully explaining the utility of the SCL-90-R, it is composed of nine primary symptom dimensions, and includes three global indices. These consist of the global severity index (GSI), the positive symptom distress index (PSDI), and the positive symptom total (PST) (Derogatis, 1994, p. 12). The test then gives a total of twelve scores for each client, nine that are more specific to certain types of symptoms, and the three global indices, which are able to "communicate in a single score the level or depth of the individual's psychological distress" (Derogatis, 1994, p. 12). The GSI is the best single gauge of psychological distress. It addresses both the number of symptoms reported, as well as the depth of the distress. The PSDI is more a measure of the average level of the symptoms that are reported to be present. In this way it is more of a measure of symptom severity. The PST total is a reflection of the number of symptoms that

the client has reported to possess. It tells the researcher how many out of the possible ninety symptoms are present.

The SCL-90-R is scored relatively effortlessly. There are both raw scores and T-scores that are used in illustrating the results. The raw scores are tabulated by adding each response (i.e., 0-4) for that primary symptom, and it then is divided by the total number of responses. There are a total of twelve raw scores one for each of the nine primary symptoms, and three more global indice raw scores. The raw score is calculated into a T-score by using the T-score table to match the corresponding T-score with the raw score. The T-scores are beneficial because they are more easily understood and interpreted by psychologists and therapists alike. There are also eight different norm tables that are used in tabulating the T-scores, which consist of: male psychiatric outpatients, female psychiatric outpatients, male nonpatients, female nonpatients, psychiatric inpatient males, psychiatric inpatient females, adolescent nonpatient males, and adolescent nonpatient females. All of the clients I provided service to, fell into the female and male nonpatient category. This norm group is made up of close to 1000 people. "It represents a stratified random sample from a diverse county in a large eastern state" (Derogatis, 1994, p.19). The raw scores are converted into higher T-scores than any other norm group. Each norm table translates raw scores into different T-scores, with the psychiatric inpatient T-scores being substantially different from the nonpatient scores, even with the same raw score.

The SCL-90-R is said to be an effective instrument in screening measures for psychiatric disorder in nonpyschiatric populations (Derogatis, 1994). An indicator of a client that falls within the range of "caseness" or considered to be a risk of a disorder, is one that has a GSI score equal or above 63, or two or more primary dimension scores equal or above 63 (Derogatis, 1994, p.58). This definition would then include all of the long term clients that were seen, with the exception of Client "F" and Client "L" in their post-test results. This suggests that all of the long term clients seen at pre-test, and the majority at post-test, were at risk of having as psychiatric disorder. This is rather surprising, as my clinical perception of the majority of the clients was that they were immersed in their problem-saturated stories, and the application of narrative therapy would be a helpful intervention. In my experience and knowledge in the field of mental health, the test results do not appear congruent with the presentation of the majority of clients seen. This was most evident in the elevated scores of the major mental illness measures, such as obsessive compulsive, phobic anxiety, paranoid ideation, and psychoticism. In discussing with the clients their problem-saturated stories, they did not indicate symptoms associated with these illnesses, such as compulsive repetitive acts, fear of public places, fear of people, and having auditory or visual hallucinations. In this way the scores appear inconsistent with many of the clients presenting problems.

Qualitative Measures

Qualitative research and evaluation are valuable in that they provide a natural, descriptive narrative approach to evaluation that can easily be interpreted and analysed.

One type of qualitative research is the use of transcription and the analysis of the therapeutic dialogue indicating change in the client's story. I used various transcribed segments of one case in order to illustrate the change in language by the client in speaking about her presenting problems, and ability to separate from the problems. Another aspect that was measured for that particular case was the ability of the client to indicate unique outcomes from the problem-saturated story. This indicates that the client is beginning to be able to verbalise times when the problem is not as dominant. It shows that there is progress being made in the ability to make some cognitive changes to the narrative.

A qualitative questionnaire (Appendix B) was used during the last session to gain an understanding about how the clients found the therapy process, and the general quality of service they received. Six of the eight clients were a part of this procedure, with one being interviewed over the phone due to missing the last session.

The methods and criteria used to judge the validity and reliability of qualitative research are much different than quantitative. This is due to the multiple interpretations and less objective criteria involved in the process. The main aim in qualitative research is to increase the reader's knowledge about the

subject area, while establishing results that are believable and authentic. The qualitative methods used were successful in this way. The transcription and analysis of the therapeutic dialogue was effective in illustrating a significant change in language on the part of the client. The story became much more positive in talking about the problem in an externalised fashion, and identifying unique outcomes to the problem-saturated narrative. The qualitative questionnaire results allowed for a thick descriptive understanding of how the clients found the therapeutic experience. This method of questioning allowed clients the opportunity to explain their answers, providing greater meaning in understanding their feelings about the effectiveness of the therapy.

# CHAPTER FOUR

## Case Analysis

### Overview and Process of Interventions

This section provides a case by case analysis of the clients seen within the practicum experience. All of the cases are discussed, with a more in-depth analysis of three cases. The focus is the use of narrative therapy in conjunction with the varying client personalities and responses to some of the clinical approaches.

Although the presenting problems were diverse between the differing cases, the types of questions and methods of intervention tended to remain quite similar. All of the approaches took on a strength based approach, allowing self determination of the client to be held as important. Some clients responded more favourably to this than others, as it seemed that some were more interested in an expert driven approach, in which the therapist is more directive. Consistent with a strength based approach, the onus of responsibility for changes in behaviour and life perspective was placed upon the client. Most of the clients responded positively to this empowering approach, but some found it to be different than their anticipation of what therapy entailed. There was also an emphasis on using the client's language, and this was well received by clients as well, as there appeared to be a common understanding between most clients and myself. Not separate from being conscious of the language used, is the joining and rapport building stage. This served to increase the comfort of the clients and myself, and so was valuable in establishing trust, and then allowed us to discuss some of

their presenting problems. After addressing the issues that brought people to therapy, I made a conscious effort to encourage clients to give as much thick, descriptive detail about their stories as they felt comfortable with, in order to allow a thorough understanding of their circumstances. The general approach proved to be helpful in the majority of the cases seen.

I will begin by discussing some of the longer term cases.

## Full Review and Analysis of Case "N"

Client "N," a forty-seven year old Caucasian woman came to therapy with problems she described as depression and low self-esteem. She had been a client at the Family Centre before, and was waiting to be seen by another therapist. The therapy lasted for thirteen sessions, at which point Client "N" requested a transfer to another therapist at the Family Centre due to my practicum coming to a close. This was a collaborative decision between Client "N" and myself, as we agreed that her ongoing struggles with major depression would likely be improved with her continuing to see a therapist.

The use of narrative therapy appeared very helpful in this case, as Client "N" responded very well to the clinical approaches used. The first session focused on coming to a better understanding of what Client "N" sought from therapy, and gaining an idea of the resources and positive people within her life. Client "N" initially presented as quite shy and non-communicative, but would respond to direct questions asked of her. She would identify the positive aspects of her life when asked to do so, but generally would not bring these up on her own.

Client "N" had a history of major depression in her family. Her twin brother committed suicide in 1981, leaving a wife and daughter. Her maternal grandmother had also committed suicide many years prior to this. As Client "N" described it, "my depression is hereditary." This case then presented as initially intimidating, as there clearly was a significant history of mental illness in the family, and the client had completely internalised depression. Further to this, Client "N" also had a history of depression, as she had been diagnosed with major depression in 1989. Subsequently, she had been hospitalised several times, initially for something less than a year before her most recent hospitalisation of a full year. Client "N" also suffered from some psychotic symptoms, which she described as "hearing voices," and was on several anti-depressant and anti-psychotic medications. Client "N" had been divorced two years earlier, and has two grown children in their twenties, whom she currently has contact with. She did not have contact with her ex-husband.

The beginning of the therapeutic process began with having Client "N" come up with a detailed definition of depression. In her definition, there was also an emphasis on her mapping the effects of "depression" within her life, as is consistent with the literature on narrative therapy (White, 1989; Becvar & Becvar, 1993; Bubenzer & West, 1994; Madigan, 1996; Neal, 1996; Combs & Freedman, 1998). Some of the phrases she used to describe the effects of depression were "stopped eating," "not exercising," "sleeping a lot," "not taking care of hygiene," and "feeling bad about myself." The effect of having these feelings was usually that she would have thoughts and desires to hurt herself, and would sometimes

end up in the hospital, due to suicidal ideation which in the past caused her to "overdose" and "slash her wrists." Although many of the effects appeared to be obviously negative, it was necessary to ask whether the effects were positive or negative, in order to allow the client to determine for herself whether she would like to push away the problem that had negative effects in her life.

Deconstructive listening was a major piece involved in the therapeutic process (White, 1989; Dulwich Centre Newsletter, 1991; Walsh, 1993; Zimmerman & Dickerson, 1996; Semmler & Williams, 2000). This involved hearing the stories, and emphasising some of the dominant discourse of mainstream society that has influenced the way in which people view themselves. These societal views are often rather negative in the manner in which the cultural norms can promote people to behave and think in harmful ways. Examples of this nature included pointing out some of the stigma associated with mental illness, and an exploration of the reasons for the way in which many people view mental illness. Another example is the common belief system around gender stereotypes, and the roles of men and women in society that are usually quite paternalistic. Client "N" was able to understand these concepts, and appeared to find them useful and a meaningful way of making sense of some of the beliefs that she held. Client "N" was able to articulate how her brother felt he could not seek treatment for his mental illness, and that in time this had ended up costing him his life. She also described her feelings of inadequacy about her being over weight, and was able to understand and agree with discussions associated with North American beliefs around the importance

placed on women being under weight, and seen as sexual objects. The use of deconstruction was prevalent throughout the entire therapeutic process, as often as discussions would allow for them.

Over time, the clinical emphasis was on externalising "depression" and the "voices," in order to have Client "N" begin to see them as a separate entity from her person (White, 1989; Dulwich Centre Newsletter, 1991; Becvar & Becvar, 1993; O'Hanlon, 1994; Zimmerman & Dickerson, 1994; Zimmerman & Dickerson, 1996; Semmler & Williams, 2000). Client "N" responded very well to the use of externalisation, and often spoke about "depression" and the "voices" in externalised terms. Client "N" appeared to have previously internalised "depression", but seen the "voices" as external to herself. Much of the clinical approach centred on how these externalised problems caused her to think and behave in undesirable ways. Additionally, I looked at ways in which the problems caused her to relate to people, and view herself. In using externalisation, Client "N" and I also came up with some techniques to combat the "depression" and voices. One example centred on trying to push away "depression" when it told Client "N" to remain in bed. The technique we came up with was to make a point of getting out of bed, following her regular morning routine, and then decide whether or not she would remain in bed. This helped negate the ability of "depression" to keep Client "N" in bed when she wanted to get out and pursue different opportunities. With respect to the voices, Client "N" used methods such as "rocking," "telling the voices to stop," "taking a prn medication," and "going for a walk."

The clinical practices also focused on identifying unique outcomes, or those times when Client "N" was able to avoid or push away "depression" and the "voices" when she might have succumbed to their request in the past. Client "N" was almost always able to identify ways in which she persevered when she could have let them control her.

As the therapy process unfolded, we began to focus on ways in which Client "N" would like to re-author her story. In addressing this, we discussed a five year plan, and thought about the way she would be feeling if things were going well for her. Client "N" identified that she would have "fewer down depression days," "be exercising and losing weight," "still not smoking," "feeling more confident," "have self-esteem ," and be "spending more time with cousins." As the sessions continued, discussions addressed the ways in which she was attaining these goals. In attempting to increase her self-esteem , I centred on the views that she had of herself, with reminders of the accomplishments that she has attained. Views that supportive people in her life held were also addressed, with Client "N" stating that she was "slowly beginning to get my self-esteem back."

In the more final stages of the therapy, the use of re-storying questions which asked "how" and "what this says about you" as a person were further used to internalise a more healthy story with Client "N." In the final step, Client "N" wrote letters to her mother, son, and psychiatrist to further circulate the news of the alternative story. This is again consistent with the literature on narrative therapy (White, 1989; Dulwich Centre Newsletter, 1991; Becvar & Becvar, 1993;

Bubenzer & West, 1994; O'Hanlon, 1994; Monk, 1996; Semmler & Williams, 2000). There was a real emphasis on drawing assistance from those people who supported the healthier story of Client "N". Verbal permission was granted by Client "N" in order to provide a sample of the letter to Client "N"'s son, with alternate names being used to protect confidentiality (Figure 2).

**Figure 2.**

Dear son,

I know I don't have much to say when we are together. That is partly because I don't want to be like Grandma and repeat things over and over. I do love you a whole lot and seem to do things wrong around you. I apologize for these blunders.

Lately I have been struggling with the depression and the voices. I'm sure it started after the family reunion and peaked at Thanksgiving. Thank you for being there that weekend. It was really important because I hated leaving Kitty. I am feeling a lot better but the depression waves in and out. I'm trying to exercise each day, but am having trouble doing other things. I have trouble doing house work, laundry, and vacuuming.

The group program is going really well. Hopefully threw it I will get more energy. It is important for me to be there each week. I like sharing what I went threw with the group I would like you to keep supporting me. It makes me feel secure knowing that I can depend on you when I need you. Like I said I love you for who you are and what you mean to me.

Love Client "N"

Transcription and analysis of the therapeutic dialogue is an effective method of representing some of the changes in the therapy sessions themselves. This leads to the reader's increased understanding of how the clinical approach was applied, while displaying the client response.

In the case of Client "N," I transcribed some of the segments of our therapeutic conversations in order to illustrate the change in language by both Client "N" and me. The first session that Client "N" attended she begins by describing her reasons for seeking out therapy, and it illustrates the extent to which she has internalised her diagnosed depression.

THERAPIST: So, kind of, can you tell me a bit about what brings you here today? Or what kind of...
CLIENT: Um, mostly I suffer from depression.
THERAPIST: Do you want to tell me what you mean by depression, and what that means to you then?
CLIENT: Um, I get really down and want to kill myself.
THERAPIST: Okay.
CLIENT: Like last year I spent most of the year in the hospital.
THERAPIST: Oh really.
CLIENT: Yeah, in psych wards.

Client "N" is able to identify that she is depressed, and that it is of a serious nature due to her recently having been hospitalised. In further discussing what her definition of depression is, I ask her both what she means by depression, and the ways in which depression makes itself known. Client "N" is clear about the sequence of events when she is beginning to feel depressed, and the end result of her usually being hospitalised for suicidal ideation.

THERAPIST: What are some of the things that happen?
CLIENT: Um, I stop eating, don't want to exercise, all I want to do is sleep.

THERAPIST: Okay. Is there usually any factors that contribute to it, like um, anything that happens. Maybe if you have a few bad days or bad experiences, does that bring it on?
CLIENT: Yeah.
THERAPIST: And how long do you usually, does it usually last that you feel that way? Or can...
CLIENT: Um, it just progressively gets worse, and usually I end up in the hospital, or...
THERAPIST: And how does that happen that you end up in the hospital?
CLIENT: Um, that I get so down that I want to kill myself.
THERAPIST: And then you admit yourself in the hospital, or?
CLIENT: Usually I phone somebody, or I phone the mobile crisis unit.

Next is session number six, where there is a change in the way in which we talk about depression, as this segment illustrates the use of externalisation and the client response to its use. Client "N" appears comfortable with discussing depression in a way that is external to her.

THERAPIST: So what do you think is bothering you? What, what, what do you think that depression is telling you that you shouldn't come here? Why do you think that is?
CLIENT: I don't know, it just wants me to stay home in bed.
THERAPIST: So what did you do then? How were you able to get up then, and fight that off?
CLIENT: I don't know, because I knew I had to come here today.
THERAPIST: So when you have something set up, you are able to push it away?
CLIENT: (nods)

Later in the same session, Client "N" responds favourably to identifying some of the positive aspects in her life, and how she persevered despite difficult circumstances. She is able to identify a person who has been instrumental in the change process, and how she is able to draw on people in times of need. Often Client "N" would enter a session with complaints of feeling depressed, and statements that indicated that she was not pleased with any portion of her life. This segment illustrates that she can acknowledge somewhat of an alternative story as well.

I had just finished complimenting Client "N" on some of the ways she has been able to persevere, reminding her that her story is not as problem-saturated as depression might have her believe.

CLIENT: Yeah, that's good. I was um, I mean I spent most of the year in the hospital, so.
THERAPIST: Wow, now you've been. Last, when were you discharged from the hospital? In 1999?
CLIENT: The end of September.
THERAPIST: And you have never gone back since?
CLIENT: No.
THERAPIST: So it's been almost a year.
THERAPIST: Have you found someone to be standing with you that has been helpful, that has been a strength you could draw from, or?
CLIENT: My mom. With all her negative stuff, she still stands by me.
THERAPIST: Does she help you fight against depression?
CLIENT: Yeah.
THERAPIST: How is she able to do that?
CLIENT: Well, she lets me come out to her place and, she will let me, if I am getting really depressed, I can phone and talk to her.

This indicates that although it may appear that a client is not ready to see the unique outcomes and positive resources in her life, over a period of time he/she may be able to learn to identify these.

The following segment is the twelfth of thirteen sessions, and we are again discussing the circulation process of the alternative story (White, 1989; Dulwich Centre Newsletter, 1991; Becvar & Becvar, 1993; Bubenzer & West, 1994; O'Hanlon, 1994; Monk, 1996; Semmler & Williams, 2000). The focus here is on spreading the news of the different story that has come about as a result of the use of narrative therapy. Initially, the client is somewhat resistant to the telling of a story that indicates a change in perspective about how well she has been doing. She is able to illustrate this by initially making a general statement about how poorly she has been doing as a result of spending a weekend at the crisis

stabilisation unit. However, this segment also indicates how she is fairly easily redirected to some of the positive aspects of her situation, and the changes she has been able to implement. The bold type highlights some of the changes in language made.

THERAPIST: What do you think you could tell them; do you think that there is any more you could tell your son, or your mother, or some of your cousins who are closer, about where you are at and some of the things you are going through?
CLIENT: Well I just told them how I was doing, when I was in the C.S.U., which means that I am not doing very well, its an automatic thing when I go there, so.
THERAPIST: Do you think you are not doing very well, or?
CLIENT: No, I **am doing a lot better**, but I kind of peaked when I was there.
THERAPIST: Yeah.
CLIENT: And now I am finally beginning to realise **I can stand up to the voices**, and the depression just kind of waves in and out, so.
THERAPIST: Like you said in the letter.
CLIENT: Yeah.
THERAPIST: So you are okay with where you are at?
CLIENT: Yeah.
THERAPIST: Because sometimes it will be okay if you go to the C.S.U. It doesn't mean you are doing badly. Maybe you need, maybe you just need it.
CLIENT: Yeah, I needed it that weekend.
THERAPIST: Because when you are here, when we talk here you have come a fair way you know, from when we first started talking.
CLIENT: Yeah, that is why I need this, so.

This last segment of transcribed therapy session is the moving toward termination, and the last session, which focuses on wrapping up some of the thoughts and feelings associated with the whole therapy experience. Here the discussion centres around some letters that the client was able to write to some of the people in her life that she has found helpful, as an attempt to circulate the news of her alternative story, and to continue to ask for support from them. This is consistent with the notion of creating an audience in narrative therapy (Dulwich Centre Newsletter, 1988; Dulwich Centre Newsletter, 1991; Nicholson, 1995).

Creating an audience refers to illustrating to people the change in story, that is the change from a problem-saturated story to a healthier story. The audience is important in witnessing and supporting the changes made, in order to further encourage the client in their alternative story. In the case of Client "N," she wrote three separate letters to her psychiatrist, mother, and son in an effort to create an audience for the revelation of her alternative story. This is an integral piece of narrative therapy.

The discussion then goes on to a more general understanding of some of the gains which Client "N" views herself as having made as a result of the therapy. There is a definite change in language that Client "N" uses to describe her story, when compared to the first session.

THERAPIST: What do you think you have gained from coming here, seeing as next week is the last one I will be seeing you, and then I will transfer you over. What kind of things do you think you have gained?
CLIENT: Well, the letters helped me **put things in perspective**, it's really helpful.
THERAPIST: Your letter you mean, the one you wrote, these ones you wrote?
CLIENT: Yeah.
THERAPIST: Anything else you found helpful?
CLIENT: Talking to you I realised that **I can too can fight the voices**.
THERAPIST: Yeah, well that's good.
CLIENT: Which is also very helpful to have someone you can talk to and say look, the voices are back, and...
THERAPIST: Someone who can understand that?
CLIENT: Right, without panicking, because if I tell my mom, she tends to panic.
THERAPIST: So ways to gain control over voices, and the ways you use.
CLIENT: Yeah.

Then we finally move to the very final session in which the story transformation goes through its final stages. Again there is a noticeable change in the language both by the client and the therapist, as both are able to acknowledge that the client has made some significant improvements in her life,

with a real emphasis on self determination of the client. The bold type indicates some key changes in the way in which Client "N" describes her story.

CLIENT: What I needed was a place that I could come and talk, where I can **open up** about my depression and stuff, and that type of stuff. It worked, you know **I am feeling better now** that I have got it out in the open.
THERAPIST: Oh okay, well that's great to hear.

(later in the session)

THERAPIST: So looking at all we have worked on here, what do you think you can say about yourself, what does that say about you as a person? I know we have talked about it before, but how do you think like the fact that you have been able to make changes, that you have been so, you have taken it so seriously coming in here every week and not missing an appointment, and being quite able to make improvements and work at things, what do you think that says about you?
CLIENT: Um, that I've **been encouraged**.
THERAPIST: Right, and what kind of person is able to make changes and better them self?
CLIENT: Um, a **happy person**.
THERAPIST: Do you consider yourself a happy person?
CLIENT: Yep.
THERAPIST: That's good to hear, that's quite, wow, that's a dramatic improvement.
CLIENT: (Nods)
THERAPIST: That's good. What other kind of attributes might a person have who's able to make changes the way you have? What does that say about you?
CLIENT: That I am a **good person**.
THERAPIST: Yeah, I think so too. Lots of people couldn't do that, you're a strong person too, I've noticed that. So what do you think this says about your future?
CLIENT: Oh, as long as the voices and that **stay within control**, I'll probably do **pretty good** this time.

This transcribed segment also illustrates the client's tendency to be non-verbal, and how she needed to be drawn out in order to provide a full description of the meaning of her response. This further illustrates the utility of the use of narrative therapy even with clients who are non-verbal, as in some ways this allows the therapist to further structure the session according to the use of narrative questions.

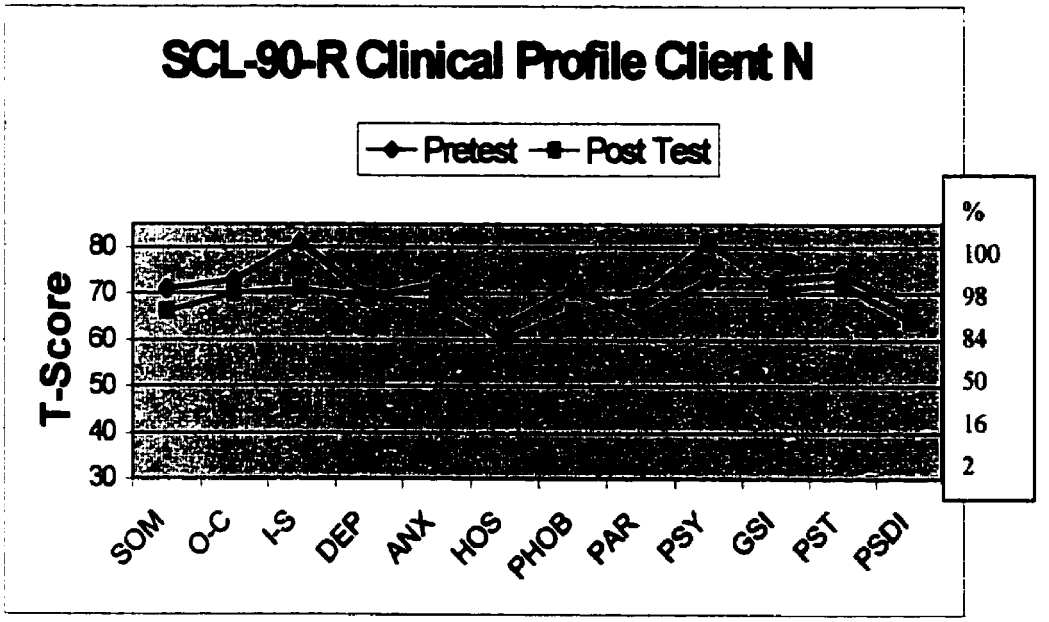
On a different note, the client is able to identify with the changes made, and is able to articulate that she has made significant changes throughout the therapy process. She is able to internalise the changes she has made, and make some positive generalisations about the type of person she is as a result of progress made. Although the segment illustrates that she does not feel totally in control of "the voices," she certainly demonstrates a major change in language and view of her ability to persevere in these circumstances.

It is necessary to look at the results of the pre-test and post-test SCL-90-R checklist in order to measure clinical effectiveness. In looking at the graph, the Y axis illustrates the T-score results, the X axis illustrates the nine primary symptoms and the three global indices, while the right side identifies the corresponding percentile for the norm group (Figure 3). Underneath the graph, the T-scores are written with the corresponding raw scores. This is noteworthy because the raw scores can indicate change that the T-score would not have allowed for, as the highest T-score is eighty one, regardless of the raw score.

Client "N" scored rather high on the pre-test, with nine of the twelve measures being in the ninety seventh percentile or higher for the non-patient women norm group. This may be partly due to the fact that although Client "N" currently is of non-patient status, she has often been a psychiatric inpatient. Her scores would definitely be in the more normal range for either psychiatric outpatients or inpatients, as she has been diagnosed with major depression with psychotic features. In this case then, the elevated scores on the psychoticism and depression measures would be congruent with the presenting problems.

The post-test results indicate a decrease in symptoms, with the exception of depression, which remained the same, and paranoid ideation and psychoticism, which increased slightly. These results are not surprising, and are also congruent with the presenting problems, as Client "N" never indicated that she heard fewer voices, or that "depression" was less disruptive to her routine as a result of therapy. In fact she complained that the "voices" and "depression" were getting worse at times, and discussed medication changes with her doctor. However, the most significant change came more in the form of how Client "N" dealt with the "depression" and the voices, and how she was able to see positive aspects to her life circumstances.

**Figure 3.**




| | | SOM | O-C | I-S | DEP | ANX | HOS | PHOB | PAR | PSY | GSI | PST | PSDI |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Pretest | T-Score | 71 | 73 | 81 | 69 | 72 | 63 | 71 | 65 | 73 | 73 | 74 | 67 |
| | Raw Score | 2.0 | 2.3 | 2.67 | 2.08 | 1.9 | .83 | 1.71 | 1.17 | 1.22 | 1.83 | 73 | 2.21 |
| Post Test | T-Score | 66 | 70 | 71 | 69 | 68 | 60 | 66 | 69 | 81 | 71 | 72 | 64 |
| | Raw Score | 1.42 | 1.8 | 1.78 | 1.77 | 1.4 | .67 | .86 | 1.5 | 1.6 | 1.56 | 70 | 2.0 |

The discussion around the qualitative questionnaire with Client "N" was quite useful as well (Appendix B). She indicated that the therapy was exactly what she needed, and stated it was a "place to come to talk and open up about depression," and that she was "feeling better that it is out in the open." In discussing the most helpful aspect of therapy, Client "N" mentioned the therapeutic letters, and talking to me as a therapist, who understood mental illness. In addressing more specifically the narrative approach, she found the letters she wrote to be very useful, my letters as positive, and referred to my letters as helpful as they made her feel she had "someone back me up." Client "N" did not have any criticisms of the therapeutic process, and suggested I let clients "be open and not judged, and continue with the letter writing."

This indicates a very positive response to the therapy received, and general feelings of being respected throughout the therapy.

**Full Review and Analysis of Client "J"**

Client "J" was a thirty-five year old Caucasian male who came to therapy with issues of being separated from his three children, difficulty coping with past intimate relationships, depression and low self-esteem , and general unhappiness. As time went on, Client "J" mentioned a concern over pain in his knee related to a relatively recent surgery that appeared to have exacerbated the original problem.

The struggle with Client "J" was his not being ready to move past his problem-saturated story to look at unique outcomes, with most of his concern being directed to the pain in his knee. There were many negative aspects

associated with his knee surgery, such as: it caused him to be out of work, fairly inactive, feeling helpless, and feeling poorly about his life situation. There, however, were many positive aspects to his life, and the difficulty lay in attempting to redirect him to some of the encouraging parts of his life, and potential future. Client "J" also had difficulty making decisions to better his situation. Some of the decisions he tended to avoid were: how to live with the current limitations of his knee, to explore options of reunification with his children, ways to remain out of a relationship with his ex-girlfriend, and methods to improve his self-esteem.

Narrative was used to measure the effects of the previously mentioned problems in Client "J"'s life, as well as map the effects of the knee problems (White, 1989; Dulwich Centre Newsletter, 1991; Walsh, 1993; Zimmerman & Dickerson, 1996; Semmler & Williams, 2000). The clinical focus was then on having him identify some of the activities and options that were available to him (despite his knee), that he occasionally took part in, and which were in fact unique outcomes. Eventually when he continued to balk at the various opportunities that were present, my approach was to suggest that his inability to utilise his options was in fact making a conscious choice about not changing his current habits. Although he initially did struggle with accepting this responsibility, he eventually reluctantly admitted this was the case.

The use of narrative's clinical approach also mapped the effects of both his loss of contact with his three children, and his self-reported depression and low self-esteem . In discussing his three children, I eventually suggested that his

not contacting the children was his choice not to initiate contact, regardless of whether he felt he was left with few options. Again, he eventually accepted that he was making a decision about not initiating contact with his children, and that it would be his decision to contact his children in the future. The tactic used with reference to his depression and self-esteem issues was to again map the effects of them upon his life. Identifying unique outcomes when he was able to persevere and make good choices and contradict his problem-saturated story was also emphasised (White, 1989; Dulwich Centre Newsletter, 1991; Walsh, 1993; Zimmerman & Dickerson, 1996; Semmler & Williams, 2000). Client "J" would tend to try to negate these unique outcomes, but the continued presence of them within his story was useful in changing his outlook.

The use of letters that externalised the influence of the "knee surgery" in his life, as well as "past relationships" were also identified by Client "J" as extremely useful. Client "J" stated in the final session that I should "continue to send out letters to people, it boosted me, simplified and clarified things." His advice was to continue to use the therapeutic letter writing in my clinical practice, as he spoke at length about how helpful the letters were to him. Client "J" was the most vocal about how empowering and helpful he found the letters to be. Client "J" stated that he felt the first letter he received was effective in pointing him in the right direction, and talked about how it was simple, yet it reminded him about positive thinking.

There was also an emphasis on pointing out some of the dominant discourses within society that led to Client "J" to see himself in an unfair light.

One of the topics that was covered was the way in which society tends to view men, and the importance of being young, strong, and able bodied. This was used in reference to the devastating effect that his knee disability was having on him, suggesting that some of these common beliefs were having a negative effect on his self-esteem . Client "J" did not entirely agree with this statement, as he suggested that it was more accurate to address the limitations that the knee had caused as being the reason for his negative outlook. Dominant discourse discussions also occurred around the societal beliefs with respect to the importance of being in a relationship. Client "J" felt that this may have been an influence in the past, but presently did not feel a lot of pressure to be in a relationship, and was currently focusing on himself and his own needs. Another topic that was covered was the importance of physical appearance in North American society, and how in reality this is very inconsequential. This discussion related to Client "J" feeling only physical attraction to his ex-girlfriend, but still feeling that she could control him. Eventually he was able to feel more secure in his ability to make a decision to stay out of a relationship with this woman, regardless of the physical attraction he had to her.

As time progressed I became more comfortable with trying to keep Client "J" more on topic, while also confronting him on some more of his contradictory statements and inability to make decisions. Overall, Client "J" stated that he was very pleased with the outcome of therapy, and I believe I became more effective with time. As time went on, the clinical approach was more consistent with the narrative literature, as rapport and joining had been established. I also became

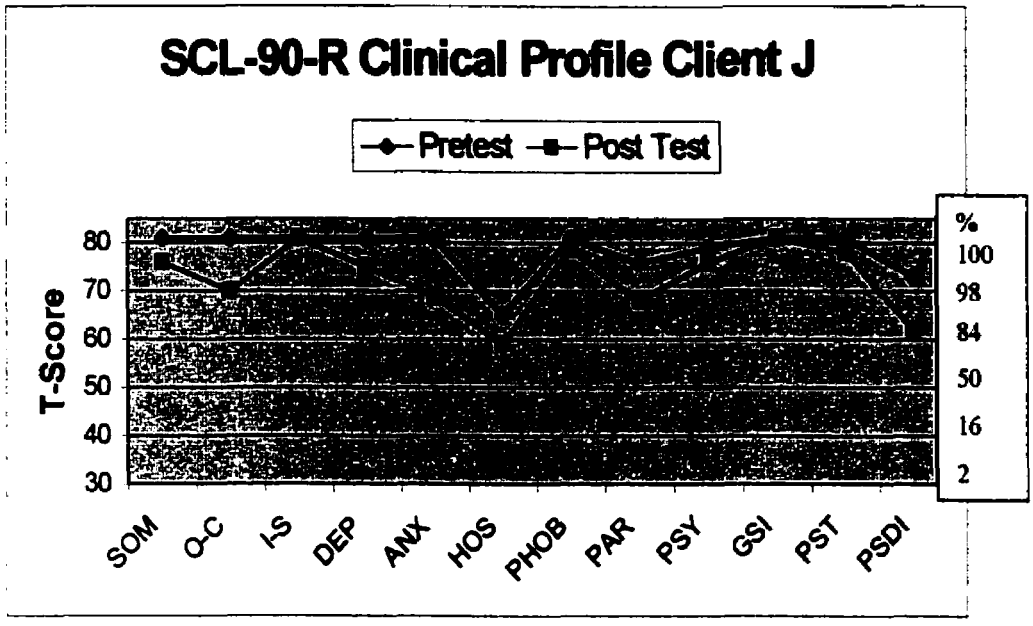
more comfortable with the therapeutic process, and in the end Client "J" appeared to have re-authored his story in his ability to identify with being a competent, level headed, independent individual, with a bright future. This was produced through a concerted effort at continually pointing out unique outcomes in the sessions. In addition to this, the types of questions differed, with questions that challenged how Client "J" was able to make some of the good decisions he had, which forced him to look more at the positive sources in his life. Additional questions were asked that addressed how others viewed Client "J," what qualities a person must have to make similar changes, and an emphasis on re-circulating the alternative story. Regardless of whether Client "J" wanted to discuss in more detail some of the problem saturation, the focus continued to address his competencies and abilities to persevere. The last five sessions really focused on the re-authored story, and proved to be beneficial.

The results of the SCL-90-R pre-test were astounding in how high they were in comparison to the non-patient male category. Client "J" scored in the ninety ninth percentile or higher in ten of the twelve categories, and his lowest score was on the hostility scale, in which he scored in the ninety third percentile. On many of the scales, Client "J" had scores much higher than the corresponding T-scores allowed for, and so was assigned the highest T-score available. Although Client "J" appeared quite distraught upon entering therapy, he did not present as being as severely impaired as the pre-test results indicate. This was based on his ability to function independently within society, and on his general ability to care for himself. The high pre-test results are likely due to Client "J"

feeling very unhappy, and thus causing him to tend to over emphasise some of his responses. Further, he did have some significant medical problems which the SCL-90-R does not account for, and this would have also elevated his scores on many of the questions asked. Client "J"'s scores on scales such as psychoticism, paranoid ideation, and obsessive compulsive are examples of skewed results, as he did not present any behaviour consistent with these symptoms.

Client "J"'s post-test results indicated a substantial decrease in the effect of the symptoms on his life. Although his results continued to be quite high in comparison to his norm group, all of the actual raw scores were substantially lower, thus indicating a change in his view of his situation. I would like to attribute much of these changes to the therapeutic experience, as therapy appeared to have profound effects on him as indicated in the qualitative questionnaire, and in general conversations throughout the therapy process.

**Figure 4.**




| | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Pretest | T-Score | 81 | 81 | 81 | 81 | 81 | 65 | 81 | 76 | 79 | 81 | 81 | 73 |
| | Raw Score | 2.33 | 2.8 | 2.33 | 2.85 | 2.8 | 1.0 | 2.14 | 2.0 | 1.4 | 2.34 | 63 | 2.54 |
| Post Test | T-Score | 76 | 70 | 81 | 75 | 69 | 59 | 79 | 68 | 76 | 81 | 78 | 62 |
| | Raw Score | 1.67 | 1.4 | 2.0 | 1.62 | 1.0 | .50 | 1.57 | 1.33 | 1.3 | 1.48 | 76 | 1.75 |

In the qualitative questionnaire during the last therapy session, Client "J" also chose the answer that stated the therapy "helped very much." He further went on to say that "time will tell" as to whether the changes he made will remain. "I want to strive to be caring, kind hearted, and generous." On the second question of the most useful aspect of therapy, Client "J" responded that "the letters, taking time to make decisions, positive attitude, getting frustrations listened to, and a non biased judgement." In talking about the narrative emphasis, Client "J" indicated that he was reassured about "the new story, don't need to approach with other people." This was in reference to circulating the news of his alternative story, which had been the emphasis of the last few sessions. I believe Client "J" chose not to circulate his alternative story because it

would leave him increasingly vulnerable to tell people around him that he had made a choice to alter the story in his life. In discussing ways the therapy could have been more effective, Client "J" suggested informing clients where the therapy is going, as he felt unsure what direction the therapy was headed. In his last opportunity to respond about the therapeutic experience, Client "J" stated "I am very optimistic" in reference to his future. This again indicated a high level of satisfaction with the service received.

Client "J" was not transferred to another therapist at Family Centre, and terminated therapy with me. My clinical sense was that Client "J" had made significant changes throughout the therapy, and that his high post-test results (that decreased substantially from pre-test) continued to be related to factors such as the pain in his knee, and his general tendency to overemphasise some of the problems in his life. His responses in the qualitative questionnaire led me to believe that he was feeling increasingly satisfied with his life situation, and that he was resourceful enough to seek out further treatment if he required additional intervention. Client "J" did not indicate any interest in transferring to another therapist at the Family Centre.

**Full Review and Analysis of Client "K"**

Client "K" was a fifty-three year old Caucasian woman who presented with issues of communication within her family, anger, and low self-esteem. She also had been diagnosed with Hepatitis C in the last year, although this was not addressed fully in the therapy sessions. This multiple-problem situation led me to believe that she had an overall problem of depression. Client "K" was seen for

thirteen sessions until the end of my practicum, then requested and was granted a transfer to another therapist at the Family Centre.

Client "K" had been to therapy before, and seemed to have some preconceived notions of what therapy involved. She tended to talk at length, and was very disorganised in her communication, making it extremely difficult to structure the sessions to a narrative approach. Although Client "K" appeared to be quite interested in the therapy process, she had concerns over her own ability to change her current ways of functioning.

One of the main clinical interventions used with Client "K" was attempts to externalise "anger" and "stubbornness," which came with mixed results. It appeared as though my efforts to talk about these problems in an externalised way may have confused Client "K," as she never did fully adopt use of the externalised language in this way. To her credit, Client "K" appeared better able to identify unique outcomes to the problem-saturated story, as she usually was able to articulate ways in which she had pushed away "anger."

Deconstructive listening was also a significant piece of the therapy process (White, 1989; Dulwich Centre Newsletter, 1991; Walsh, 1993; Zimmerman & Dickerson, 1996; Semmler & Williams, 2000). Client "K" would often discuss guilty feelings associated with the manner in which she raised her three sons. Client "K" was in a very chaotic, violent situation during this time of her life, and my approach was to remind her of the circumstances, and how her decision-making ability would have been compromised. The dominant discourse around mother blaming was also discussed, with exploration of how Client "K"

had internalised guilt due to these societal messages. The dominant discourse that suggests the mother of the family is to ensure the well being of all within the family, while often blaming mothers when this does not happen. Parallels were also drawn between the relationship she had with her own mother, with emphasis on her not really knowing or learning a way to show love to her sons.

The use of therapeutic letter writing was significant in the therapy process, as Client "K" indicated that she found this to be helpful, and that it made her feel that she "was more than just another client." A copy of a letter sent to Client "K" is displayed (Figure 5).

**Figure 5.**

Confidential

Dear Client "K",

I wanted to thank you for sharing your story with me. I know that you have put a lot of time and energy into the therapy sessions, and I want to thank you for being so committed and attentive to the process. It has been my pleasure getting to know you a little better.

I think you have done some hard work in fighting "anger" and "stubbornness." Although these two have caused you problems at times throughout much of your life, you have shown that you can push the negative effects of "anger" and "stubbornness" away, allowing you to behave in ways in which you want to. At times, we have talked about your occasional tendency to agree with the negative effects of "anger," and think that some people may deserve to be sworn at. Client "K", I need to remind you that it takes much more effort to be in control of your words and actions than it does to not fight against these tendencies. You are the only person who can make choices about the manner in which you interact with people, and the way you want others to perceive you. You have told me that you would like your sons and your granddaughter to see you as a "nice" person. In further defining a "nice person," you indicated "people like me," "I always have made fun and joked around," that you "do nice things for people," and that you are starting to "hug and kiss" your sons and granddaughter. I want to encourage you to continue to promote this "nice" side of Client "K" that has been hidden at times throughout your life due to many circumstances that were beyond your control.

I think it is important to access those people that have supported you in making the positive changes you have. Client "K", you have indicated that you find your sons supportive in seeing you as a "nice" person. You have suggested as well that you could look up some of your old friends, as well as make additional friends at bingo, and in your new neighbourhood. I have also given you phone numbers for those three potential opportunities to make more friends, and have increased opportunity to socialise and learn new skills. It is your choice if you decide to pursue any of these new opportunities, as you know best what you need in your life to give you increased happiness. My suggestion is that spending time with people who support you as a "nice" person, who treats people with respect, and who expects respect from others, would make the changes you have made easier to carry on.

Finally, I want to again thank you for sharing your story with me, and encourage you to make choices that will bring you increased satisfaction in your life. I believe that you are a strong woman, who can continue to do well in whatever endeavours you pursue.

Sincerely,

Tim Dyck
MSW Student Clinician

Client "K" responded favourably to the use of therapeutic letter writing. The two of us would discuss the letter in detail, allowing Client "K" the opportunity to respond to the various aspects of the letter. She was in agreement with all portions of the letter, and commented that it was a good reminder of the changes she was making. She liked the way in which "anger" and "stubbornness" was externalised. She also agreed about the importance of drawing support from a social network, and circulating her alternate story. Additionally, she stated that receiving letters allowed her to feel that she was important, and that she was not just another client.

The clinical focus of reminding her of the unique outcomes to her problem-saturated story was important. Closer to the end of the therapeutic process the types of questions changed to more future oriented, with an emphasis about what the changes said about her future. Client "K" responded well to these discussions, although she would sometimes negate the changes that she had been able to make in her story. The continued discussion about ways she had been able to persevere was significant, with emphasis on the type of person able to make such changes. Client "K" was also commended for her ability to persevere and pursue her goals despite having been diagnosed with Hepatitis C. Over time, Client "K" was able to adopt some healthier understandings of choices she had made in the past, realising that she was in control of her future.

Discussing the mission statement that she wanted to pursue was incorporated into the therapy in order to have an understanding of what she wanted to achieve. Client "K" responded positively to the term mission statement,

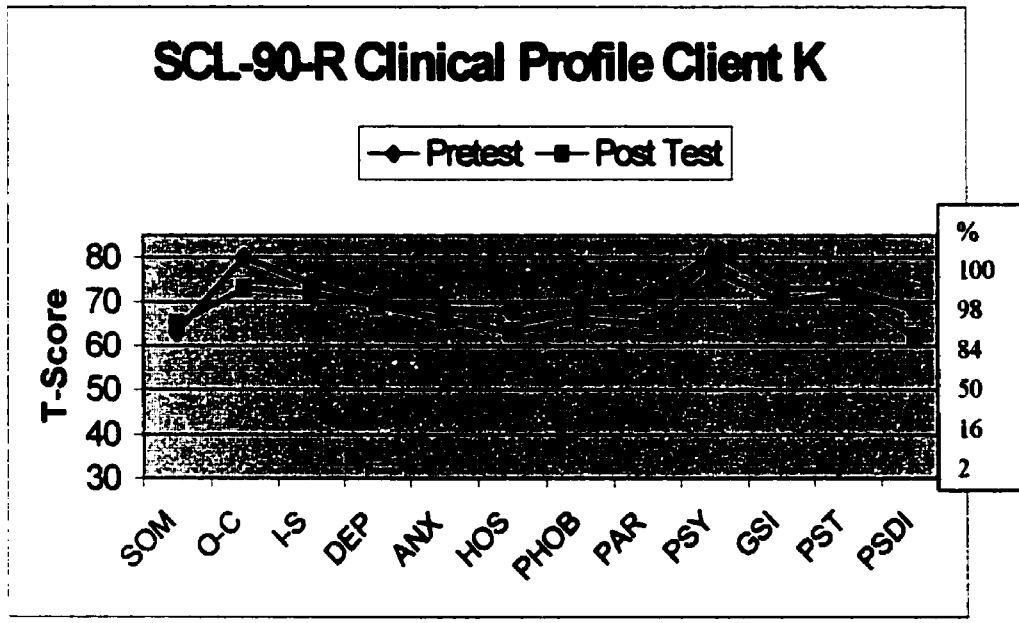
and stated she wanted to be a strong, independent, assertive woman, who had friends and people to spend time with. This was often referred to in discussing behaviours and choices that Client "K" had made that were inconsistent with the mission statement. Closer to the end of the therapy sessions, there was a real focus on circulating the news of an alternative story (White, 1989; Dulwich Centre Newsletter, 1991; Becvar & Becvar, 1993; Bubenzer & West, 1994; O'Hanlon, 1994; Monk, 1996; Semmler & Williams, 2000;). Questions such as "who has been standing with you," were often asked, along with "who supports the changes you have made." These types of questions were key in allowing Client "K" to look to the people who were resources in her life, and the importance of continuing to elicit support from them. Additional questions such as "what would they say about the changes you have been able to make," were used. This refers to experience of experience questions, which encourages the client to look at ways in which other people have experienced them (White, 1989; Dulwich Centre Newsletter, 1991). This focus allowed Client "K" to see the importance of helpful people in maintaining her change in story, and how continued support of the changes will make it more helpful in the long term.

Overall, the therapeutic picture at the end appeared much improved when compared to the presentation at the beginning of therapy. Client "K" felt that she was doing well and benefiting from the therapy ever since the first session, and this is significant. Her extremely strong personality, her tendency to talk in a tangential fashion, and her hearing disability all contributed to her being difficult to work with.

In analysing the pre-test and post-test results of the SCL-90-R checklist, the results are high for the norm group non-patient women. The pre-test indicated results from approximately the ninetieth percentile to the one hundredth percentile. The results were lower than some of the previous results of different clients seen, as the majority of them were not in the one hundredth percentile. Likely the pre-test results were quite high because of an overall feeling of negativity, and concerns over having contracted the Hepatitis C virus. This may have elevated some of Client "K"'s responses to the symptoms.

The post-test results were lower than the pre-test results, except for the one category of somatization which increased slightly. However, the results continued to be high for the non-patient women norm group. The decrease in the symptom scores were likely due in large part to the clinical intervention applied, as well as Client "K" making some positive decisions to improve her current living situation, which is not disconnected from the therapeutic process.

**Figure 6.**

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Pretest | T-Score | 63 | 80 | 74 | 70 | 68 | 68 | 70 | 71 | 81 | 73 | 73 | 68 |
| | Raw Score | 1.08 | 3.0 | 2.33 | 2.25 | 1.4 | 1.17 | 1.43 | 1.83 | 1.6 | 1.83 | 72 | 2.26 |
| Post Test | T-Score | 65 | 73 | 72 | 69 | 66 | 63 | 66 | 65 | 77 | 70 | 72 | 62 |
| | Raw Score | 1.33 | 2.3 | 2.0 | 1.75 | 1.11 | .83 | .86 | 1.17 | 1.4 | 1.47 | 70 | 1.84 |

In the qualitative interview during the final session, Client "K" stated that therapy was "exactly what I needed." In clarifying this, she went to say that it was helpful to "bounce ideas off someone, and feel more understood." For the second question, Client "K" mentioned learning that she cannot control people, and also being able to discuss "anger" and "stubbornness" were the most helpful to her. In talking about the narrative approach, Client "K" stated "you have a lot of good ideas, but you don't push them on me. Gave me choices." She also mentioned the importance of receiving letters. This is consistent with a non-directive collaborative approach. Finally, Client "K" did not have any advice about how to make changes to the therapeutic approach.

My clinical sense was that Client "K" was very pleased with the therapy she received, as she continually made statements of this nature throughout the process. She also explicitly stated this in the qualitative questionnaire.

**Summary and Analysis of Case "I"**

Client "I" was a twenty-five year old Aboriginal woman who came to the Family Centre with concerns about hurtful experiences and abandonment issues in her adoptive family of origin, child hood sexual abuse by an adoptive brother, and issues of low self-esteem and low self confidence.

Although the goals were set up to address the issues mentioned, the way in which the therapy process actually proceeded was addressing issues related to the current intimate relationship she was part of. This involved the use of externalising "competitiveness" between her and her boyfriend, as it tended to cause her to behave in ways that she did not believe were right, or ways she found useful. This was the main issue that was externalised, along with mapping the effects of "competitiveness" in her life. As time progressed, there was also an emphasis on unique outcome times when Client "I" was able to push away "competitiveness" . I believe that therapy went in this direction due to a need to learn to trust me as a therapist before discussing the issues of childhood trauma and sexual abuse. Further, the present chaotic situation with her boyfriend was more of an immediate concern that required ongoing dialogue.

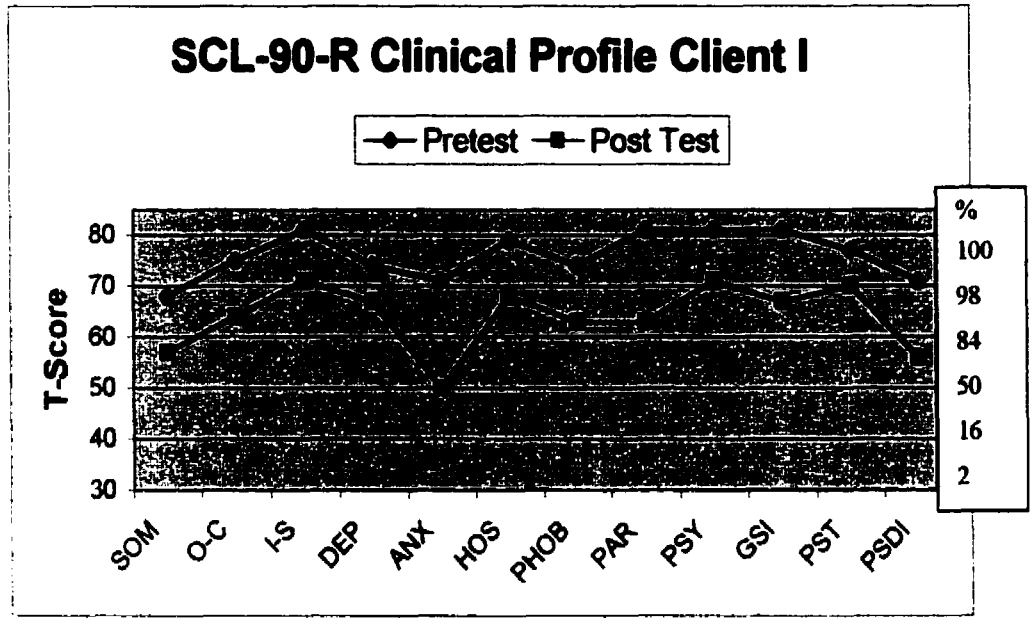
The clinical approach again used the same type of questions around the dominant discourse in society, and the way in which Client "I" had come to believe some of the messages she had internalised about relationships and

women's roles (White, 1989; Becvar & Becvar, 1993; Bubenzer & West, 1994; Madigan, 1996; Neal, 1996; Combs & Freedman, 1998). In discussing some of the experiences as a child, my focus was to allow Client "I" to understand that she did not do anything wrong, and focused on normalising feelings of abandonment and hurt after being sexually abused as a young child, and subsequently being placed in the care of Child and Family Services as a teenager. A significant emphasis was placed on praising her for doing as well as she was doing, and re-authoring her story from victim to survivor. Unfortunately, there was not enough time to fully finish this process, as the therapy had not initially focused on her traumatic experiences as a child. After completing the therapy with me, Client "I" requested a transfer to another therapist at Family Centre to finish this process of discussing her childhood abuse.

The SCL-90-R pre-test post-test results indicated a significant change in symptoms that were afflicting Client "I" from pre-test to post-test. The pre-test scores were all extremely high, indicating high levels of clinical significance. The results ranged from the ninety seventh percentile to the one hundredth percentile of non-patient woman norms (Derogatis, 1994). These results seem rather surprising, especially the one hundredth percentile results of interpersonal sensitivity, hostility, paranoid ideation, and psychoticism (Derogatis, 1994). Although Client "I" did present with issues around sensitivity and hostility, the fact that she scored in the one hundredth percentile is inconsistent with her presentation. She felt she was a sensitive person, and also spoke about sometimes feeling hostile towards her boyfriend, but her behaviour in the therapy

sessions would not suggest she had a psychiatric disorder. Client "I" did not have any difficulty going into public places or interacting with people, and did not frequently get into altercations with people besides her boyfriend. Her scores on the paranoid ideation and psychoticism scales are also completely incongruent with her presentation, as I have done extensive work with clientele with psychotic symptoms. These results indicate a misrepresentation of Client "I," as she must have misunderstood some of the questions being asked. The post-test results were substantially lower than the pre-test, and are likely a more accurate representation of her situation. Although Client "I" continued to score high on some of the same scales as in the pre-test, her scores were much lower. This is an indicator that Client "I" appeared to be feeling substantially better about her life situation as compared with the pre-test results, likely due to the therapeutic process. Overall, the results of the SCL-90-R appear incongruent with the demeanour of Client "I", as she appeared to be rather well adjusted considering some of the difficulties she has been through.

**Figure 7.**

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|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Pretest | T-Score | 68 | 75 | 81 | 74 | 71 | 79 | 74 | 81 | 81 | 81 | 77 | 71 |
| | Raw Score | 1.67 | 2.5 | 3.44 | 2.69 | 1.70 | 2.80 | 2.0 | 2.83 | 2.6 | 2.41 | 83 | 2.55 |
| Post Test | T-Score | 57 | 64 | 71 | 67 | 50 | 68 | 63 | 63 | 71 | 66 | 70 | 56 |
| | Raw Score | 0.58 | 1.2 | 1.67 | 1.62 | .20 | 1.33 | .57 | 1.0 | 1.0 | 1.07 | 64 | 1.50 |

In addressing the qualitative interview at the end of the therapy process, in response to the first question, Client "I" indicated the fourth choice, which stated the therapy "helped very much." She chose not to add any comments to this answer. Her response to the second question of the most helpful aspect of therapy was more descriptive. "Talking about past sexual abuse and my experiences with my parents as a child. This is my third attempt to discuss those issues, and it is the only time I have been able to talk about them. Also, realising it wasn't my fault, and starting not to blame myself. Also, you are a good listener and give good feedback." These responses indicate clearly that she found the therapy useful, and the comment about being a "good listener" indicates a consistency with narrative therapy. In answering the third question which asks

about the therapeutic approach, Client "I" stated "it helps a lot to talk to people. It's helpful to talk to friends about their stories too. Its good to learn from others." This was in response to my query about whether she noticed the focus on changing stories, and gaining support from people in the change in the story. The fourth question, which asks any advice or changes the therapist could have made. Client "I" indicated "it should have been longer term, and you could have been tougher, not so nice, and more challenging."

**Summary and Analysis of Client "L"**

Client "L", a thirty year old Aboriginal woman, initially indicated concerns with low self-esteem, family of origin issues, past emotional and mental abuse, and presented the overall idea that issues from the past were currently affecting her present state in a negative way. In looking at the many issues presented, and the flat affect of Client "L," my clinical impression was that depression was her main issue.

As a therapist I challenged a number of generalised statements that Client "L" had made about herself. Client "L" had a tendency to make self-defeating statements without information to substantiate these.

Client "L"'s upbringing in her family of origin was a negative experience for her. Client "L"'s mother suffered from a mental illness, and therefore her maternal grandparents were the main caregivers in her life. Client "L" never met her father, and to this day does not know who he is. Her experience with her maternal grandparents has not been positive, and she additionally has many negative memories associated with her childhood. She has felt "disrespect" and

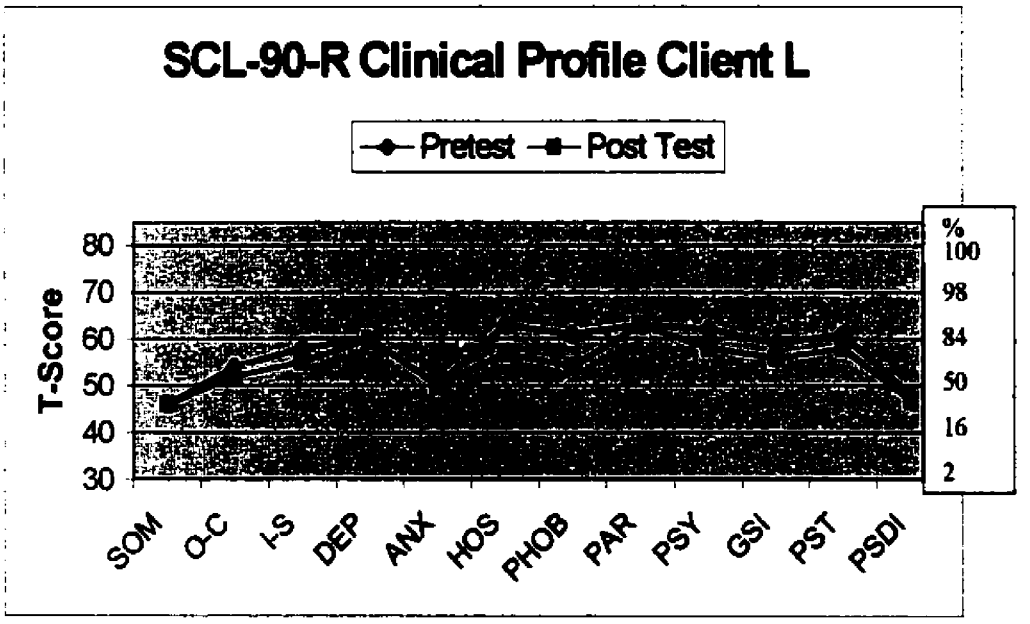
"negativity" from her grandparents and other people for much of her life, and these two themes were externalised throughout the therapeutic process. Client "L"'s language was used in discussing "negativity" and "disrespect" in the therapy sessions, as this is consistent with the literature on narrative therapy (Nichols & Schwartz, 1998). Client "L" was able to define "disrespect" as "not feeling like a person", and "negativity" as people "having a bad influence." The main focus was then on finding ways to combat "negativity" and disrespect, allowing for brainstorming around methods of decreasing the control that "negativity" and "disrespect" has, encouraging Client "L" to see these problems as external to herself.

As time progressed Client "L" was able to identify ways in which she had persevered, and in this way identified some unique outcomes to her situation. This included discussing ways in which she was able to seek out new friendships, make plans and follow through with them, and seek out an alternative place to live to escape the "negativity" and disrespect.

The results of the pre-test and post-test SCL-90-R checklist were substantially lower than that of the previous clients discussed. The highest score indicated was in the ninetieth percentile, while the remainder of the scores were slightly above the normal range for the non-patient women norm group. Oddly enough, the highest score was in reference to paranoid ideation, which may have been a result of seeing these symptoms as more a measure of trust rather than paranoia associated with a thought disorder.

The results of the post-test again showed a decrease in symptoms, with the exception of somatization, which remained the same. It is noteworthy to mention that Client "L" received the post-test checklist ten weeks after last being seen in a therapy session, due to it not being clear whether Client "L" would actually return to therapy or not. This may have affected the results, as the test specifies symptoms experienced in the last seven days. The lower results indicate that the therapy was likely somewhat responsible for the decrease in symptoms, as well as extraneous factors that may have occurred after the therapy had been completed.

**Figure 8.**

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Pretest | T-Score | 46 | 54 | 58 | 60 | 50 | 63 | 61 | 63 | 62 | 59 | 61 | 48 |
| | Raw Score | .17 | .50 | .56 | .85 | .20 | .83 | .43 | 1.0 | .40 | .54 | 42 | 1.17 |
| Post Test | T-Score | 46 | 52 | 55 | 60 | 50 | 57 | 54 | 63 | 58 | 56 | 58 | 47 |
| | Raw Score | .17 | .40 | .44 | .77 | .20 | .50 | .14 | 1.0 | .20 | .43 | 34 | 1.15 |

In performing a qualitative questionnaire over the phone (10 weeks after the last therapy session) with Client "L", we were able to touch on some of her responses to the therapy she received. The first question was a five point likert

scale, and Client "L" chose the second response, indicating the therapy was "a little bit helpful." She further clarified this by stating, "because we didn't go into deeper issues because I couldn't go anymore." I was able to discuss with Client "L" her decision not to return to therapy due to her own personal issues. The second question around what had been most helpful indicated that she "felt respect" from the therapist, and further stated that "talking helped to look at things in a different way from the therapist, someone positive." The third question asked about any response to how the therapy focused on alternative healthier life stories. Client "L" responded by saying, "being around more positive people, point me in a positive direction. Positive people lift you up. I am trying to learn about this." In the fourth question that asked what the therapist could have done differently, Client "L" stated, "talk more, say more than the client. I felt I had to talk too much." This was the last formal question of the questionnaire, and indicated that Client "L" appeared to think she had to do the majority of the conversing, which was actually a positive aspect of the therapy, and is congruent with narrative.

**Summary and Analysis of Client "M"**

Client "M" was a forty-eight year old Caucasian woman. Client "M" came with a number of presenting problems, which included: recent marital breakdown, huge financial debt, pending assault charges and court appearance initiated by an estranged husband, and ongoing health problems. Due to her presentation and number of problems indicated, my clinical sense was that Client "M" was depressed. I suggested to Client "M" that it may be helpful to focus on certain

aspects of her situation. She agreed to focus on her recent marital problems and assault charges that were the cause of the separation, although in reality her health problems were addressed on an ongoing basis.

As the sessions progressed, it became clear that Client "M"'s central problem was her very strong convictions, (which she later named stubbornness) but which also served to help her in some situations. Client "M"'s convictions tended to cause her problems in relationships, as it seemed to turn people off who would then dismiss her. "Stubbornness" often caused her to talk to people in a negative non-communicative manner, did not allow her to see certain aspects of situations, and would sometimes cause her to say things that she did not mean. On a different note, Client "M" stated that if she had not been so "stubborn," she would never have come through so many hard times in the way that she had. Client "M" would only admit that the externalised problem "stubbornness" had served to help her and not hinder her. In this way "stubbornness" continued to serve to protect her from the truth, and it in turn again provided the same function with respect to her marriage.

"Stubbornness" would not allow her to believe that her estranged husband was making the decision to file for divorce or not have the artery operation that she desired him to have. Instead, Client "M" would state that it was not his decision, but in fact the decision of his son, who apparently had a major influence on him. In this way "stubbornness" served to protect her from the likely truth on the matter. I was eventually able to encourage Client "M" to imagine that her husband was making the decisions, and respond about what that would mean to

her. Client "M" stated this then would mean that she would have difficulty trusting people, and the "marriage was over."

At the tenth session, I indicated to Client "M" that termination was going to occur within three or four more sessions due to my practicum coming to a close. Client "M"'s immediate response to this was that she would desire a transfer to another therapist, as she feared she would need help in coping with life changing situations. I attempted to clarify the need for a transfer, and I made mention that I felt that she had not made any significant behavioural changes throughout the therapy sessions. Client "M" agreed with this statement, but stated she was unable to initiate any changes due to her ongoing problems with asthma. I did not attempt to debate this issue with Client "M," but instead pointed out some recent changes when Client "M" was able to attempt to expand her social network, and improve her situation. Client "M" continued to concentrate on her limitations, rather than her abilities to attempt to make changes in her life. I would then gently guide Client "M" back to her strengths and abilities to make changes when she chose to do so.

The overall clinical picture with Client "M" did not involve any significant change, as the client did not take any responsibility for the circumstances that she found herself in. Therefore Client "M" was unable/unwilling to make the necessary changes within her life in order to better her situation. Finally, "stubbornness" did not allow her to look at alternative views of many subjects, and this has caused her to avoid the reality of many situations, continuing to present the belief that she has nothing to do with her unfortunate circumstances.

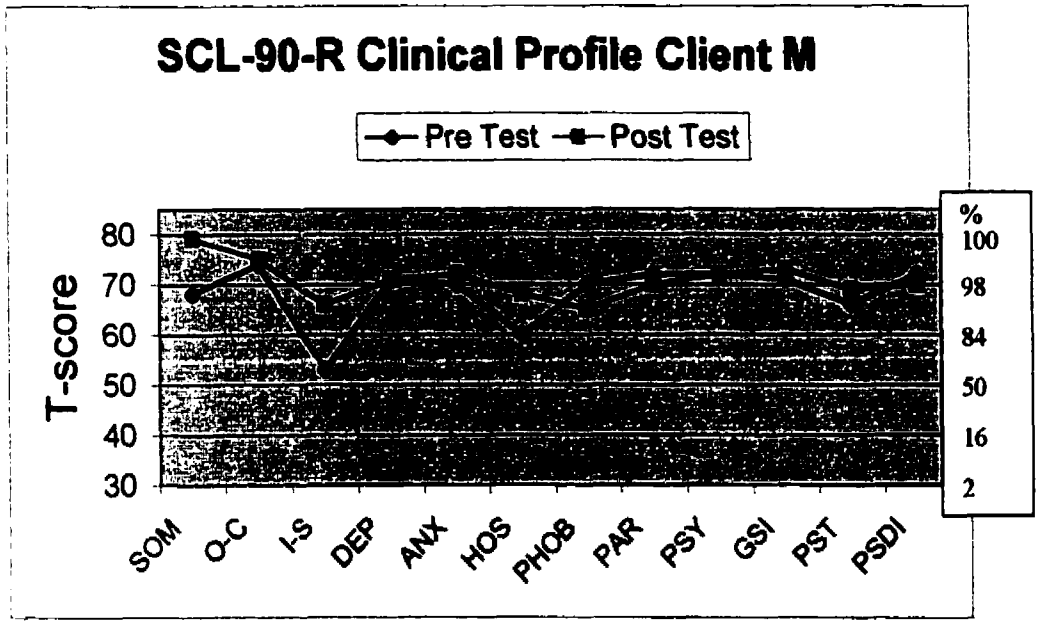
Overall, there was little difference that resulted because of my narrative intervention with Client "M", but it did serve as a social outlet for Client "M" to discuss some of her feelings and frustrations.

In addressing the results of the SCL-90-R checklist, it is necessary to emphasise that Client "M" did not fill out the checklist on her own, but instead had me read it to her due to her bad eyesight. This may have affected the responses given, as at times I needed to clarify with her, her response, as she would verbalise her response without choosing the options on the checklist. I also had the impression that she may have forgotten all of the options allowed in responding to the questions, and may have responded differently if she had read the possible responses herself. I also believe that during the post-test, I made more of an effort to provide all possible responses to her, likely resulting in a more valid test result. With all of that being said, the pre-test results were quite high, with eight of twelve measures being at the ninety eighth percentile or higher. As with some of the other clients, Client "M" scored high on the psychoticism, paranoid ideation and obsessive compulsive scales, but again did not display any behaviours or thoughts associated with these disorders. This likely is a result of misinterpreting the question.

The post-test results were generally even higher, as seven of the measures increased in the post-test score. This, however, is inconsistent with my clinical analysis of how effective the therapy was for Client "M." The post-test results were likely higher because of my greater effort to ensure Client "M" was given the choice of all five options. Additionally, the fact that she attended

thirteen sessions would indicate that she felt she was making some gains as a result of coming to therapy. I believe that Client "M" had difficulty accepting any responsibility for her current situation, and my attempts to have her begin to take responsibility proved ineffective. However, her verbal responses and attendance indicated that she found talking to be somewhat helpful.

**Figure 9.**

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|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Pretest | T-Score | 68 | 74 | 53 | 71 | 70 | 60 | 70 | 72 | 72 | 71 | 66 | 72 |
| | Raw Score | 1.67 | 2.4 | .33 | 2.31 | 1.6 | .67 | 1.43 | 2.0 | 1.1 | 1.57 | 54 | 2.61 |
| Post Test | T-Score | 79 | 75 | 66 | 71 | 72 | 68 | 65 | 70 | 72 | 73 | 69 | 70 |
| | Raw Score | 2.33 | 2.5 | 1.13 | 2.28 | 1.9 | 1.33 | .71 | 1.67 | 1.1 | 1.75 | 62 | 2.52 |

The qualitative questionnaire responses from Client "M" were somewhat different from the other clients. Client "M"'s response to the first question was that the therapy was "somewhere between a little bit helpful and okay." She added to this by stating that the therapist had "different views than I did", and that the therapist had "not been able to back them up." The most helpful aspect of therapy was to have someone to "listen to me, and to see if I am thinking

correctly or wrongly." In discussing the narrative focus, Client "M" stated she "didn't find a new way of looking at the situation in general." Client "M" was also the only client who overtly stated that the therapeutic letter writing was not helpful. In discussing one of the narrative letters sent, Client "M" told me that "I thought you were out to lunch." In clarifying this response, she indicated that the suggestions in the letter that encouraged her to expand her social network were not useful because she had no control over this due to her health. Again, my interpretation is that Client "M" was not wanting to have any responsibility placed upon her to initiate change in her life.

**Summary and Analysis of Client "H"**

Client "H" was a thirty-one year old Caucasian woman who presented with concerns about coping with separation, divorce, custody of two daughters, and having limited access to daughters due to being under suspicion of physical abuse by the police.

The therapy sessions focused on externalising those circumstances which were "beyond her control," with a focus on "aspects within your control." Mapping the effects of focusing on issues beyond her control, such as the behaviour of her ex-husband, the custody of her daughters, and the police suspicions. I then externalised these issues and pointed out unique outcomes, with this being the main strategy used. Again, the use of narrative letters pointed to the importance of ways in which she had been made good decisions, and had not let the whole situation overwhelm her. Encouragement of the re-authored version of Client "H" as an independent, intelligent, resourceful woman was the final focus.

The overall change was significant in her decision-making ability, and methods of coping with stressful situations. By the end of therapy, she was able to rationally look at her options, and make intelligent decisions. Client "H" was also able to identify her changes in behaviour, accompanied by defining herself in healthy terms.

Client "H" unfortunately failed to attend the final session, and therefore was unable to fill out the post-test SCL-90-R, along with the qualitative questionnaire. Attempts were made to contact her by mail, but she did not return the post-test SCL-90-R.

**Summary and Analysis of Client "F"**

Client "F" was a twenty year old Caucasian woman who presented with problems of depression. Client "F" had never been diagnosed with depression, but nevertheless felt she was depressed. She had been given anti-depressant medication from her family doctor, and felt that this had helped her gain control of her depressive tendencies. The therapeutic emphasis focused on gaining a thick descriptive understanding of depression and its effects (White, 1989; Walsh, 1993; Semmler & Williams, 2000). Client "F" defined depression as "feeling sad and miserable and lost inside," and some of the effects as being excessive "crying and sleeping." Some additional effects she identified were, it "keeps me from being a friendly person," and causes me to "dwell on problems." In mapping the effects of depression, questions again were asked about whether she considered these as desirable or undesirable effects. This allowed Client "F" to

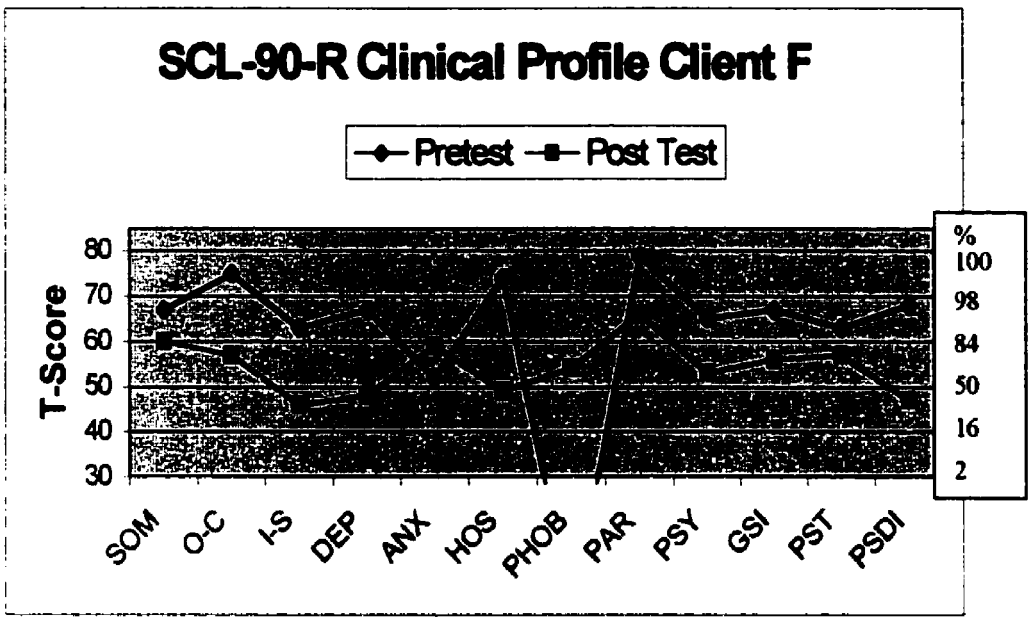
determine whether these were aspects of her life that she wished to change or not.

As time went on, the clinical approach allowed for deconstructive listening, identifying ways in which it appeared the dominant discourse of society had influenced her in her beliefs (White, 1989; Becvar & Becvar, 1993; Bubenzer & West, 1994; Madigan, 1996; Neal, 1996; Combs & Freedman, 1998). Client "F" generally responded quite well to these statements, as she seemed to understand how these dominant beliefs had influenced her in negative ways, although it appeared that she had never thought of second guessing some of the dominant messages of society that have harmful effects on people's view of themselves. Some examples of these types of conversations were around the gender stereotypes in society, as well as the greater acceptance of women being diagnosed with depression. An additional topic that was covered centred around the importance that is placed on status within society, as Client "F" felt her parents did not respect her occupation as a nanny that involved serving people, because it was not deemed a high status position. These types of conversations were quite important in the therapy progression.

There were also beginnings of attempts to encourage Client "F" to look at ways she could push away the externalised depression. The last session, Client "F" indicated that she felt she had improved in her methods of combating depression, and had been feeling quite good. Client "F" attended three sessions, and then indicated that she no longer felt that depression was bothering her, and thus she did not require any further therapy.

Client "F" participated in the implementation of the SCL-90-R checklist, as a pre-test and post-test measure. The post-test results indicate a general decrease in the twelve measures used, with the exception of "anxiety" and "phobic anxiety" (Derogatis, 1994, p.15). Generally both the pre-test and post-test measures indicate clinically significant results when compared to the non-patient women. The pre-test results indicate extremely high levels in the ninety eighth percentile or higher for obsessive compulsive, hostility, and paranoid ideation (Derogatis, 1994). However, Client "F" shows a substantial reduction in symptoms from pre-test to post-test, with paranoid ideation continuing to be in the high range of the ninety third percentile. The remainder of her post-test results fall within the eighty fourth percentile or lower. The high results in pre-test indicate that Client "F" may have been feeling high levels of psychological problems, and may have desired to express these concerns to the person who scored the test. Further, the substantial decrease in the post-test scores indicate that Client "F" was feeling healthier likely due to some therapeutic input, but more likely due to making individual changes in her life, as she only attended three sessions over a span of close to three months.

**Figure 10.**




| | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Pretest | T-Score | 67 | 75 | 63 | 67 | 52 | 74 | 0 | 79 | 65 | 67 | 63 | 68 |
| | Raw Score | 1.6 | 2.5 | .89 | 1.62 | .30 | 2.17 | 0 | 2.67 | .60 | 1.14 | 45 | 2.29 |
| Post Test | T-Score | 60 | 57 | 46 | 48 | 59 | 49 | 54 | 66 | 53 | 56 | 57 | 47 |
| | Raw Score | .75 | .67 | .11 | .23 | .60 | .17 | .14 | 1.17 | .10 | .40 | 32 | 1.13 |

Client "F" completed the qualitative questionnaire after it was mailed to her. Her responses were rather brief, and in hindsight, I should have performed the interview over the phone in order to obtain more descriptive results. The first question asked how helpful therapy had been for the issues that initially brought her to counselling, and Client "F" chose the fourth option which stated it "helped very much." She chose not to further expand on this answer. In the second question which asked "what has been the most helpful aspect of therapy," Client "F"'s response was "being able to talk to someone." From her response, I believe it illustrates that the therapeutic approach was not perceived as a directive approach, but more centred around conversations. The third question which asked for feedback around how the therapist focused on coming up with new

healthier life stories, Client "F" responded, "gave helpful tips," and "was able to have conversations." This is indicative of the narrative approach, which centres on the client telling her story, and conversing with the therapist. Client "F" did not respond to the fourth question, which asked for suggestions for work with future clientele and or any constructive criticism of the approach.

# CHAPTER FIVE

## Summary of Practicum Experiences

### Overall Discussion

It is necessary to discuss some of the shorter term cases that I saw throughout the practicum. There were six incomplete cases which should be reflected on, in order to provide a complete review of the all clients who sought out service. None of these clients completed the pre-test and post-test of the SCL-90-R checklist.

Client "A" and Client "C" were men who came for therapy for intake sessions only. One session only allowed for minimal narrative structure. Client "A" was a Caucasian man in his late thirties who was from a different socio-demographic status than all of the clients seen throughout the practicum experience, as he was a professional, and in a significantly higher income bracket. He therefore had to pay additional funds for the therapy sessions, and this ended up being a factor in his decision to end therapy after one session. Client "C" was a Caucasian man in his mid fifties. After the initial intake session, Client "C" missed several appointments, and I believe that the fact that his life was going to his liking and his not knowing why he would require therapy were factors that resulted in his ending the therapy.

Client "B," Client "D," and Client "E" were Caucasian women who all came to therapy with issues of depression. Client "D" and Client "B" attended intake sessions only, and this allowed for minimal use of narrative therapy.

Client "E" attended two sessions, felt that her life was currently going quite well, and stated that she had not been feeling depressed for quite some time. The narrative clinical approach began with getting a thorough definition of depression, and mapping the effects of depression in Client "E"'s life (White, 1989; Walsh, 1993; Semmler & Williams, 2000). There was a beginning of discussions on the dominant discourse around young women and depression, and the way in which North American society begins to normalise this (White, 1989; Becvar & Becvar, 1993; Bubenzer & West, 1994; Madigan, 1996; Neal, 1996; Combs & Freedman, 1998). This discussion did not prove to be as helpful as I had anticipated, as Client "E" misunderstood the point of the discussion, stating that she had felt people generally accepted her as having depression, and she was not judged in this regard. She appeared not to have understood some of the negative implications associated with society accepting young women as depressed. This further identifies how fully she had internalised depression in her life.

Client "G" was a thirty-eight year old Caucasian woman with a cognitive impairment, who presented with issues of bereavement. Sessions focused on attempting to gain a better understanding of ways in which Client "G" could see herself coping with these losses more effectively, as this was her identified reason for therapy. Therapeutic letters were used to confirm with Client "G" that indeed she was handling these losses well, as she had been going through what appeared to be normal stages of grieving. Part way through the therapeutic process, Client "G" again suffered a loss of an uncle, and did not return to

therapy. In speaking with Client "G", it appeared that she felt overwhelmed by this loss, and wanted to spend time with her family at this time. Client "G" attended a total of four sessions.

## Usefulness of Narrative Therapy in Working with Individual Adults

### Gender and Culture

Narrative therapy proved to be useful in working with women who had brought forth issues of depression. This was the presenting problem of the majority of the female clients seen. It is not coincidental that many of the women believed that they were depressed, as the dominant discourse in North American society has tended to normalise this phenomena.

There were many discussions of the dominant discourse that took a feminist stance that were helpful in allowing the female clients to see some of the ways in which depression had been promoted. Additional conversations also took place that allowed clients to explore reasons why it was seen as less socially acceptable for men to be seen as being depressed. This led to further discuss gender roles and stereotypes of men and women in society that often go unnoticed, but which are generally accepted by mainstream society (White, 1989; Becvar & Becvar, 1993; Bubenzer & West, 1994; Madigan, 1996; Neal, 1996; Combs & Freedman, 1998). Themes consistent with a patriarchal society were also explored, which were informative about ways in which society continues to be dominated by men. These types of conversations led to increased understanding by the female clients about ways they had been socialised to

accept some of these oppressive norms within society. This was one method of externalising some of the problems of depression from these women.

Discussions of culture and the prevalence of racist attitudes were also useful with the Aboriginal clients I saw. It was significant to allow these clients the opportunity to tell their stories about some of the racism they had faced throughout their lives, in order to deconstruct some of the oppressive societal messages that many Aboriginal people face in Canada. It further allowed these clients the opportunity to view their situations with compassion around some of the decisions that they made while facing such onerous racist attitudes. This proved to be an effective way of externalising some of the presenting problems when looking at the societal influences involved.

Letter Writing

The use of letter writing by both myself as a therapist and the clients proved to be useful. The client letter writing was not used extensively, as there was only one client that actually ended up writing letters to those who had supported her in her change in narrative. She, however, found that writing the letters had significant therapeutic value in allowing further understanding of herself and the changes she would like to make. It pushed her to consider the different forces at play within her life, and also allowed her to look at those who had been important in supporting her. It also allowed further circulation of her alternative story, which is consistent with the narrative literature (Andrews et al., 1997). She made several comments that indicated that she was pleased with having written the letters.

The use of the therapist narrative letter writing was helpful in the vast majority of cases seen. All of the longer-term clients received at least two letters, and all except Client "M" had favorable responses to them. The letters also served to circulate the news of an alternative story for the clients, as it emphasized the changes made and the desired direction for change (Andrews et al., 1997). It further served to allow the client to further reflect on the letter writing through re-reading the letter, and using it as reminder of the alternative understanding of life, and the potential future. The letter writing also allowed the client a sense of respect through knowing that the therapist was taking additional time to make a special effort to help them. Finally, the client response indicated that receiving letters that encouraged them allowed an increased sense of control and empowerment in dealing with the problems on an everyday level.

As a therapist, the letter writing I did proved to allow me to think more in-depth about the client case, and to better understand the direction of the case. This allowed me to improve my service to the clients, as often I would have a better understanding of the progress made in the case, with additional ideas that came as a result of the letter writing.

## Critique

### Therapist Style Versus Client Style

The personalities of the clients and myself were significant in the therapeutic outcome. The communication style, ways of establishing rapport, and ability to understand the client's situation are all important factors in measuring the effectiveness of the approach. My tendency was to respond more favourably

to clients who were not verbose, and who took time in between discussions to reflect on what had been said. This is due to its congruency with my own style of communication. I struggled with clients who were extremely talkative, and who tended to wander to different topics, because it was increasingly difficult to structure the session to a narrative focus. Clients who appeared to want to direct the sessions, and only talk about certain topics were more difficult to work with. The more that I had joined with the client, the more at ease I felt about confronting clients, as well as ensuring a narrative questioning approach to the sessions.

It is necessary to discuss some of the personalities of the clients in association with my personality to demonstrate the way in which this affected the therapeutic outcome. Client "N" was very quiet and timid throughout the therapeutic process, yet she was able to make a major shift in her understanding of her situation. She was easily the least verbal client I saw throughout the practicum. This proves that narrative therapy can be effective with non-verbal clients as well. Client "F," Client "I" and Client "L" were also less talkative, but they would respond and discuss without always requiring direct questions being asked of them. Although it was easier to structure the sessions with these clients, this did not in turn end the therapy with more successful outcomes, as Client "F" and Client "I" were able to make changes to their problem-saturated stories, while Client "L" was not ready to at this point in her life.

Client "H," Client "J," Client "K," and Client "M" were all extremely talkative people, who were very tangential in the way they conversed. I had to work much

harder to ensure a narrative approach was used, and the sessions were less of a pure narrative approach when compared to Client "N." Nevertheless, there was a significant change from a problem-saturated story to a healthier story for Client "H," Client "J" and Client "K". However, Client "M" did not make changes in her problem-saturated story, and was less ready to improve her situation.

The different personalities played a part in the therapeutic outcome, but did not necessarily dictate how effective the therapy had been. Clients I felt I had been more successful with occasionally surprised me in the response in the qualitative interview, while some of those that I felt I had been less effective with, were able to find the therapy helpful.

Critical Analysis

In order to gain a fuller understanding of narrative therapy's utility, it is necessary to discuss more specifically how the clinical approach could have been applied more effectively. First, it was noted that discussing the dominant discourse within society came with mixed results, depending on the client. It was generally found that some of the older more experienced clients had difficulty understanding these abstract concepts. I got a sense that some clients found these types of discussions confusing, and that people tended to wonder whether these discussions were relevant to their personal stories. In hindsight, it might have been more useful to allow these types of discussions to be more fully experienced through discussions of the origins of the client's belief system, as this then might have been seen as more relevant to the client. However, such discussions might not have produced the desired change, as longer term

entrenched belief systems are hard to change. Nevertheless, I may have sometimes rushed into making statements of a dominant discourse nature, rather than allowing them to unfold over time.

Another difficulty that was noted was the way in which some clients struggled to identify an internalised problem that we could then speak about in externalised terms. This was especially tricky in working with those clients who presented with multiple problem-saturated stories, as well as with those who had difficulty taking responsibility for their actions or current situation. Eventually an externalised problem would be identified, but not all of the clients were in equal agreement with the truth of these externalised problems. The externalised problem would often not identify all of the problems that the client presented with, and discussions would take place that were not relevant to the identified externalised concept. I may have been more effective had I been able to link more successfully the presenting problems to the main externalised problem.

Another way in which narrative could have been applied more effectively was through exploring more fully ways to work with clients who resisted the unique outcomes that had been identified. Some clients tended to negate any unique outcomes that were identified, and chose to dwell more on the negative aspects of their lives. It was often extremely difficult to refocus on some of the unique outcomes that they had presented, as this would have involved increased accountability on improving their own situation. Some of the clients were not ready to make any change, or even acknowledge that they had any control over their lives. It was difficult to find ways to engage these clients or begin the re-

authoring process with them. It may have been useful to use more landscape of action questions to look at the history of some of the unique outcomes identified, allowing the client to see that they had been more resourceful than they gave themselves credit for. This may have allowed more acceptance of the current unique outcomes identified.

My personal style as a therapist was effective in allowing clients to feel heard, yet I need to improve my ability to confront clients and structure the sessions. This was one Client "I"'s criticisms, as she said "you need to be tougher, not so nice." I found that I was not comfortable talking with clients about some of the inconsistencies in the way they explain their lives, and I could have improved the therapy if I had been more challenging. This also was illustrated in my aversion to attempting to structure the therapy sessions with those clients that were more controlling and talkative. Over time, I was able to improve in this regard, and the more structured sessions were inevitably much more conducive to learning and applying narrative therapy.

## Summary

It is significant to touch on some of the more successful application of the clinical approaches of narrative therapy. One of the most often identified helpful aspects was the use of therapeutic letter writing. Almost all of the clients identified that they found this very helpful and encouraging. As a therapist, I also learned a great deal in writing these letters, as the letters became more in-depth and specific to client experiences as I learned to be more concise and detailed. Some of the client responses about the use of therapeutic letters were: "it

boosted me," "clarified things," "very helpful," "was nice," "it gives you a lift," and "lets you know you are not just another client." These letters also seemed to provide further therapeutic value, as they were read by clients when they needed additional support, and were more succinct and to the point than were the actual therapy sessions. They also allowed me to come to a better understanding of each of the clients, as I was pushed to think more comprehensively of the direction of the case, and ways to improve. Overall, the use of therapeutic letters proved to be very beneficial, and I will continue with this practice in the future.

Generally, the use of externalisation was an effective method of discussing client related problems. Some of the clients were in turn able to talk about their formerly internalised problems as external entities to them, and this seemed to allow some additional control over the problem. In the final sessions, where I performed a qualitative questionnaire with the clients, some of the comments about externalisation were: "it's a better way to see it," and its "nice having someone back me up." Overall this was effective in allowing the client to see that they were not the problem, but in fact the problem is the problem (Nichols & Schwartz, 1998).

Some of the clients were very able to identify with and understand how the dominant discourse in society has negative effects on people. Further, it proved useful in coming to terms with some of these harmful ideas, so to be more conscious of some common societal beliefs that can have damaging results. It hindsight, I may have not put enough emphasis on these types of discussions, as clients did not tend to bring up these sort of topics or ideas.

Finally, I got a sense that the clients that were seen really felt that they were listened to. All of the clients identified that general talking about their concerns was a helpful aspect of therapy. I believe that I was a good listener, and allowed clients' ample opportunity to tell their stories and express their concerns with minimal direction on my part. In this way I was true to the collaborative approach to therapy that emphasised self determination and self direction in making choices and changes.

It is necessary to revisit the learning goals that were set out at the beginning of the practicum. The first goal that was set, was focused on providing a competent service to individual adults allowing room for clients to begin to establish an alternative story that included change in overall views as well as behavioural changes. This goal was met, as six out of the eight cases involved significant change in both view and behaviour. Certainly the application of narrative allowed clients the opportunity to change, with an emphasis on coming up with an alternative story to the problem-saturated story that was initially presented.

The second goal indicated was that I as a therapist learn the theoretical basis, understand the clinical approaches, and apply them effectively. This was also met. Over time, I gained a better understanding of narrative therapy, increasing as I went through all of the stages with various clients. I believe I became more adept at applying the principles of narrative therapy, and the clients who remained on until the end of October 2000 were more immersed in a pure narrative approach.

Finally, I was able to provide a thorough method of evaluation through the use of the SCL-90-R, transcribing and analysis of the therapeutic dialogue, and the qualitative questionnaires. This provided both a quantitative and qualitative method of evaluating the application of narrative therapy. The qualitative piece appeared more useful than the quantitative, as it allowed for a more comprehensive understanding of the therapeutic experience, and asked questions specific to their experiences in therapy. The quantitative questionnaire also identified changes in presenting problems, but did not account for external factors outside of the therapy experience. It also did not allow the clients the opportunity to explain their answers.

The use of the SCL-90-R came with mixed results. Although the scores indicated that the vast majority decreased from pre-test to post-test, there continued to be significantly high levels of clinical significance in the scores. This indicated that the majority of clients seen were at risk of having a psychiatric disorder. This was incongruent with my clinical judgement of almost all of the clients. My interpretation of the reasons why the scores were so elevated was because the clients seen likely overemphasised their report of symptoms due to overall feelings of negativity. The clients probably wanted to illustrate to the person scoring the test that they truly were having difficulty, in order to be understood. Additionally, there was likely some misinterpretation of some of the questions, as many of the clients showed some significantly high responses to some of the symptoms associated with a thought disorder, when they had no psychotic symptoms.

The compatibility of the SCL-90-R with the use of narrative therapy is worth considering. A quantitative analytical tool such as this is significantly different than the understanding that narrative therapy has about people in general. The SCL-90-R checklist assigns overall scores based on responses, and all are measured against their assigned norm group. This is a far cry from narrative therapy's notion that every narrative is legitimate, and should not be measured or compared to another narrative. In hindsight, it probably would have been sufficient to only use qualitative measures in evaluating the change in story by the clients. The qualitative responses of the clients to the questionnaire provided rich, descriptive detail about how they therapy was received, and the transcription and analysis of the therapeutic dialogue also illustrated significant changes.

In reflecting back on my experiences at The Family Centre of Winnipeg, I have been pleased with the general outcomes and feedback from clients, and knowledge I have gained. I believe that I was able to provide a competent service to all of the clients that I saw, and some clients responded better than others. I learned to accept and be conscious of the pace of the client, and not to push the client in ways they did not feel ready to pursue. In providing the service, I further realised that some people are not ready to take responsibility to change their current situation, and that the most well-intentioned therapist cannot necessarily create change in a client who is not prepared. At times I may have personalised some of the issues with clients who were not taking steps to improve their situation or change their behaviour, but in hindsight I have realised that it was not

yet their time to work through these issues. The opposite tendency was more prevalent, as many of the clients I saw were able to make significant changes in both behaviour and overall view of themselves. This was an extremely gratifying experience, allowing me to feel more helpful and satisfied in the overall clinical experience. With that being said, I am pleased about having chosen to apply narrative therapy throughout the practicum, as it is congruent with my belief system and has shown good clinical results.

## Conclusion

The main purpose for taking on the practicum experience was to provide a competent service to individual adults using the principles of narrative therapy. Further, it was important to allow the opportunity for clients to come up with an alternative story that encouraged making changes to lead to a more fulfilling life. It was also established that I expand my repertoire as a therapist in fully understanding the use of narrative therapy, through both research and clinical practice.

The rationale for the practicum was attained through an extensive review of the literature and the incorporation of this into my current methods of practice. The qualitative commentary by the clients has also supported my clinical efforts in generally finding a high level of satisfaction. This has then led to a well-rounded experience and useful method of both providing service to clientele, and increased knowledge on my part. Overall the practicum has been a great learning and growing experience, and I and my future clientele will benefit from this accomplishment.

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# APPENDIX A

## Sample Questions from SCL-90-R

Somatization Dimension

4. Faintness or dizziness

Obsessive-compulsive Dimension

10. Worried about sloppiness or carelessness

Interpersonal Sensitivity Dimension

34. Your feelings easily being hurt

Depression Dimension

29. Feeling lonely

Anxiety Dimension

2. Nervousness or shakiness inside

Hostility Dimension

63. Having urges to beat harm or injure someone

Phobic Anxiety Dimension

75. Feeling nervous when you are left alone

Paranoid Ideation Dimension

43. Feeling that you are watched or talked about by others

Psychoticism Dimension

62. Having thoughts that are not your own

Additional Items

44. Trouble falling asleep

## APPENDIX B

### Qualitative Feedback Questionnaire

I would appreciate if you would be able to take the time to answer the following questions. This will give you an opportunity to give me your feedback about how you found the counselling service.

1. How helpful has the counselling been for the issues that initially brought you to counselling? Check one of the following:

   ___ 1 not at all helpful
   ___ 2 a little bit helpful
   ___ 3 it was okay
   ___ 4 helped very much
   ___ 5 exactly what I needed

   Please add any comments or explanations if you wish

2. What has been the most helpful aspect of therapy for you?

3. What are your thoughts and/or feelings about how the therapy focused on coming up with alternative healthier life stories? What did the therapist do that you found helpful?

4. Was there anything that you think the therapist missed, or could have done differently in the sessions? If so, what do you think could have been done differently to best help you? What advice could you give the therapist for future work with clientele?

5. Is there any other comments or feedback that you would like to provide?