Narrative Therapy: In Theory and Practice

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Abstract

This theoretical review introduces narrative therapy and its influence on the field of counseling psychology. Special attention will be given to the four main components within the theory: (a) telling the dominant story, (b) externalizing of problems, (c) finding unique outcomes, and (d) re-authoring of people’s stories. By unfolding peoples multi-storied lives that make up the nature of their identities, narrative therapists co-investigate how problems affect a person’s life and social experiences with others. This paper reviews the philosophical background of narrative therapy, key concepts and terms, and the therapy process. Articles will be reviewed and summarized to help define and investigate the process of narrative therapy within different theoretic orientations, with different populations and its relationship with neuroscience.

**Narrative Therapy: In Theory and Practice**

 Narrative therapy is a postmodernism concept, emerging out of constructionist and social constructionist theories in the 1970’s and 1980’s. Postmodernism ideas and assumptions originate from one question. What is the truth? It speculates that people *construct* their own truths out of the varied experiences they have in their lives. It focuses on the role of the observer and the stories people selectively and subjectively tell about their experience. Constructionist thought adds that each person has subjective knowledge and interprets reality by storying – and there are many workable alternatives to interpret ones world (Phipps & Vorster, 2009). Social constructionist thought adds that one’s reality is a construct shared by a community. In a social context, people interpret their reality through social interchanges and experiences. Drawing from strong influences from postmodernism assumptions, narrative therapy continues to grow in the counseling psychology field.

 Narrative therapy was officially established in North America in 1990 by Australian native Michael White and New Zealand native David Epston through their foundational book *Narrative Means to Therapeutic Ends*. By capturing specific concepts from several different philosophers and critical thinkers, narrative therapy changed the methodology and thoughts of family therapy from a lineal perspective to a non-lineal perspective – taking into account the metaphors within stories people told and the context in which they were told (Phipps & Vorster, 2010). Although narrative therapy has its roots in family therapy, it has emerged as a powerful therapeutic method in working with other populations i.e. children, adolescents, immigrants, refugees and couples. With its roots in cultural identity and social justice, it has also found its way around the world to places like Africa, Brazil, China, Mexico, Russia, and India (Madigan, 2011). This paper reviews the philosophical background of narrative therapy, key concepts and terms, and the therapy process. Case examples will be reported from literature to help define and investigate the process of narrative therapy within different contexts and with different populations. Finally, the relationship between Neuroscience and narrative therapy will be explored.

**Philosophical Background of Narrative Therapy**

 Narrative therapy was influenced and built upon ideas from many philosophers, anthropologists and critical thinkers. Edward Bruner (anthropologist) proposed that our narratives give meaning to our experience, and that we have many meanings and experiences, thus we are *multi-storied* (Madigan, 2010). Gregory Bateson (anthropologist) also influenced the construction of narrative therapy theory. He suggested that people’s stories have *restraints*; stories are born out of the notion that what we think has to be done or said. Narrative therapy attempts to move away from these restraints to find *unique outcomes* (deviations from the restraints) that lead to new stories being told.

 Humberto Maturana, a famous philosopher, influenced narrative therapy with his idea that “we have no reference point outside of our own perception” (Phipps and Vorster, 2009 p. 35). White and Epston were further influenced by anthropologist Cliffod Geertz’s idea that stories hold metaphors that can be investigated by the therapist. Though narrative therapy is not a therapy of therapist interpretation, it does draw from the thought that storytelling holds metaphors for people that can be subjectively explored through talk therapy (Phipps & Vorster, 2009). More recently, Vygotsky’s ideas influenced White’s writings and research. He suggested that there’s a gap between what a person knows and what they can possibly know (Ramey et al., 2010). By asking incremental (scaffolding) questions, a therapist attempts to move the client away from the known and familiar toward what is possible (Ramey et al., 2010).

 The foundation of narrative therapy is built upon the writings and research of historian and philosopher Michael Foucault. He proposed that society is constructed upon certain *discourses* that are created through political and institutionalized ideas (Madigan, 2010). Through the deconstruction process, questions are asked to explore the meaning and history of problems. By exploring the societal discourse that is created through the *dominant story* of one’s life, the therapist helps to explore the life script one is following. Four concepts are born out of Foucault’s ideas that underpins narrative therapy: (a) exploring the cultural and discursive restraints people use, (b) how people operate within these restraints, (c) where these restraints originated from, and (d) who and what (discourses) supports further movement within these restraints (Madigan, 2010).

 Po**stmodernism**

The concept of postmodernism derives from the notion of moving away from the observed behavior within a social context to focusing attention to the subjective reality and interpretations one has with his or her experiences in a social context. It proposes that one’s observation and interpretation provides more information about a person’s experience rather than the observed behavior within the system (Phipps & Vorster, 2009). Attention is given to the interpreting, constructing and storying of his or her reality. It questions who has true knowledge of experience – the act of knowing is interpretive, allowing people to bring forth their subjective knowledge through stories. The foundation of narrative therapy can be found within two philosophical concepts derived from postmodernism: constructivism and social constructivism.

**Constructivism**

 Constructivism has to do with the concept that one’s reality is constructed out of one’s subjective experience. Constructivist thinking was introduced to the field of psychology in the 1950’s by George Kelly (Phipps & Vorster, 2009). By referencing a certain set of personal constructs a person attempts to interpret his or her reality or experience. Kelly’s theory is based on *constructive alternativism:* there are varying alternative stories to interpret one’s world; new behavior patterns emerge out of exploring how one interprets events in one’s life (Phipps & Vorster, 2009). Freedman & Combs (2002) state that “The culture each one of us lives in plays a tremendous role as a transmitter of ideas, expectations and stories that people tend to experience as taken-for-granted realities” (p. 142).

**Social Consructivism**

Narrative therapy has strong roots in the concept of social constructivism. Social constructivism adds to the concept of constructivism by describing one’s experiences through the social context in which one belongs. Experiences are shared by a community – thus socially derived. Narratives, or individual realities that are told by individuals are derived out of a social context that help’s one give meaning to his or her experience.

 Understanding a person’s behavior in a social context through the storying of their experience and inner motivation defines the practice of *hermeneutics.* Hermeneutics is the practice of interpretation. Edward Bruner further proposed that our interpretation (narrative) of our reality is based on our experience, and our experience is influenced by our interpretation (narrative) of our reality; our reality can then be defined as being an *intra*psychic as well as an *inter*psychic experience (Phipps & Vorster, 2009). Since our experience is subjectively storied, then our *problem-saturated stories* under-represent our experience, thus leading to discourse in our lives (Madigan, 2010). Problem stories that are told by clients are investigated through a series of interview questions that help to “demystify deviations in the problem story being told” (Madigan, 2010, p. 9).

 Narrative therapy was build upon many strong concepts that have their roots in postmodern thoughts, especially social constructionism. People’s experiences are always changing and new relationships are always forming. Through these experiences, we are constantly restructuring our understanding and experiences of our reality (Cobb & Negash, 2010).

**Theory of Narrative Therapy**

 Narrative therapy is an encouraging therapy. It focuses on the rich experiences that people have in their lives. It validates, celebrates and respects peoples lived experiences (Madigan, 2010). “Any narrative is an act of bridging, connecting the teller, who in therapy is the person with the intimate knowledge of the experience, and the listener, who is the therapist” (Freedman & Combs, 2002, p. 141). A narrative therapist attempts to help an individual bring forth his or her *reality* through narrative conversations. The therapy part of narrative therapy includes the sharing of stories with the therapist. The therapist acts as a guide to help one discover new stories that can be more helpful to explain one’s life and life events. Narrative therapists believe that people’s lives are *multi-storied*, thus leading to the notion that there are many stories, many alternatives and many opportunities to help a client re-author their stories (Madigan, 2010). Stories that people tell often do not include the full richness of their lives. When stories do not represent the full richness of experience of one’s life then they are defined as being under-representative or problem-saturated, leading to discourse (Madigan, 2010). If the event of experience is put in a new context then the meaning assigned to it simultaneously changes.

**Mulit-storied Lives**

 A key concept in narrative therapy is that our identities are multi-storied, and our identities are shaped by our narratives. Clients are seen as authors to their own lives, storing their experiences with the therapist through sequences across time: developing a history, discussing the present, and exploring the future (Madigan, 2010; Phipps & Vorster, 2010). White and Epston proposed that people have several versions of their life stories, thus interpreting their experiences in a variety of ways (Madigan, 2010). They believed that stories are influenced by many factors including who is telling the story, from what belief system it’s being told from, and from what political authority they are telling it from (Madigan, 2010).

 White and Epston, drawing from Michael Foucault’s ideas, suggest that society and societal *norms* influence people’s stories. A dominant story that holds true today can be gone tomorrow, thus changing the norm and the influence this experience has over our stories. An example of this can be seen in the creating of the Diagnostic and Statistical Manual of Mental Distorders (DSM). Whereby this manual gives people labels based on a description of symptoms they have, narrative therapy celebrates the individual person and unique outcomes they have that demystifies the symptoms (Madigan, 2010). Furthermore, narrative therapy frowns upon giving people institutionalized labels to describe who they are. White and Epston believe that this type of labeling doesn’t take into account the individual experiences that people have and does not account for the unique outcomes people have that can lead to fuller more rich lived experiences (Madigan, 2010).

 Through exploring peoples multi-storied lives, narrative therapy attempts to (a) investigate the dominant story in one’s life, (b) define the problem or script one is living in, and (c) re-author or re-frame events in order to provide an alternative and more helpful story. The main goal of the therapist is to help the individual reframe his or her experience through the processes of developing a new story (re-authoring). This process has four components (a) telling of the dominant story, (b) externalizing the problem, (c) the search for unique outcomes, (e) and re-authoring an individual’s relationship with the problem.

**Dominant Story**

The concept of telling the dominant story gives life to the notion that one’s life is shaped and or experienced by the context in which the story is being told (Madigan, 2010). The dominant story is the story that the individual is telling or performing that continues to shape his or her subjective experience and interactions with others (societal) (Phipps & Vorster, 2009, p. 39). Narrative therapy suggests that people organize their lives through these stories or metaphors within a societal context that is build upon discourses within societal beliefs (Madigan, 2010). By storytelling or using narrative in therapy sessions the therapist can help explore the *problem-saturated* scripts people create for themselves (based on their experiences) that keep them in their line of movement in life. By connecting past events with current experiences, clients story their problems and create their dominant scripts through a sequence of interpretations of these life events (Madigan, 2010). Through time these stories that we construct from our under-represented or unconscious experiences begin to construct who we are (Madigan, 2010). Current brain research that further explains this phenomenon will be covered later.

 Through the narrative therapy process, therapists attempt to find the stories that are not being told. Clients often find themselves meeting the expectations of their dominant story and leaving out many other rich and fruitful experiences that can further help define who they are. “Within the practice of narrative therapy, problems are viewed as relational, contextual, interpretive, and situated within dominant discourse, expression, and cultural norms” (Madigan, 2010, p. 80). Narrative therapy is an enlightening experience for clients as the therapist helps to explore other more helpful stories of their lives aside from the problem-saturated dominant story. Once the dominant story is told and the problem is defined, the narrative therapist challenges the problem by externalizing it from the client.

**Externalizing**

 Narrative Therapy celebrates people’s experience in their lives, and views problems they have as separate from the person. By *externalizing* problems and seeing them separate from the person, people can begin to story their experiences with these problems and see for themselves the influence problems may have over their thoughts and actions. The externalizing process challenges cultural discourses that often categorize people and hinder the full actualizing potential of an individual (Phipps & Vorster, 2009). “Externalizing in narrative therapy involves naming, objectifying, and even personifying the problem to separate people from dominant, problem-saturated stories.”(Ramey, Young & Tarulli, 2010, p. 75). The process can be broken up into three distinct processes: (a) defining the problem, (b) dialoging about the problem, and (c) indentifying neglected aspects of lived experiences.

 By having an externalizing conversation with the problem, clients begin to reexamine the dominant story and begin to construct new stories (Cobb & Negash, 2010). In the narrative therapy process, the therapist attempts to help the client name the problem and begin processing and dialoguing with the problem as being separate from the person.

 The narrative therapist acts as an *investigative reporter* in the therapeutic relationship, asking questions to elicit a person story. In In the APA video *Narrative Therapy Over Time with Stephen Madigan* (2010), Stephen Madigan worked with a client who described his problem as anxiety. Madigan referred to anxiety throughout the six sessions as a separate entity that had influences over the client’s thoughts and behavior. He explored the client’s relationship with anxiety, how the client defines and lives with anxiety, and how the client stories his life around the anxiety.

 By utilizing stories that are constructed by clients, narrative therapists use the method of *deconstruction* and re-authoring to help provide more helpful open ended stories for the client. “Deconstruction is accomplished by questioning the meaning and history of problems and other significant constructs that arise in therapy.”(Ramey et al., 2010, p. 76). The externalizing and deconstruction process provides individuals with an autonomy from the problem, allowing labels to no longer fit, allowing for multiple interpretations of the problem, encouraging cooperation in the therapy session, and allowing for new discoveries (Ramey et al., 2010).

 White and Epston (1990) state that “the problem is the problem, and the person’s relationship with the problem becomes the problem” (as cited in Cobb & Negash, 2010, p. 55). By objectifying the problem, the therapist can begin to ask a series of questions that helps to view the problem as separate from the individual. These questions bring to the here-and–now the problem-saturated stories that the client is living through. Further, White and Epston describes the client as now having a relationship with the problem (through questioning) that is set in the context of power/knowledge that is now separate from the person (Madigan, 2010). Once separated, the therapist can then help the client search and identify neglected aspects of lived experiences that were not part of the dominant story.

**Unique Outcomes**

 Finding unique outcomes is the cornerstone of finding more helpful solutions to one’s problem. Through the questioning process the therapist encourages clients by finding unique outcomes that defy or contradict their problem-saturated stories (Madigan, 2010). The concept involves questioning clients to find instances that fall outside of the societal influence that created their problem-saturated dominant story. These unique outcomes allow for growth and re-storying as clients forgotten past lived experiences become more powerful and celebrated.

 Questions by the therapist elicit “unique outcomes, unique accounts, unique possibilities, and unique circulations” within the client’s narrative story (Madigan, 2010, p. 35). The narrative therapist then uses these new story lines to help the client re-author his narrative – leading to a more helpful and healthy outcome. White and Epston often used *unique redescription* questions to find new stories. These are investigative questions that lead to outcomes that explore the person and his or her societal relationships (Madigan, 2010). The main goal of these investigative questions is to help the client see new possibilities as they discover where the problem-saturated narrative originated from and what it means. This new contextual understanding helps the client to begin re-authoring his narrative.

 In the APA video *Narrative Therapy Over Time with Stephen Madigan* (2010), Stephen Madigan demonstrated this process by using a series of questions that helped the client see how anxiety doesn’t *always* make him act a certain way. He explored other stories and instances and questioned how they could happen if his anxiety (problem) was keeping him isolated (dominant story). These other stories or unique outcomes helped the client to find new meaning within his identity of being shackled down by anxiety. Further, Madigan demonstrated through his questions that the behavior the client used in the past may have helped him then, but does not help him now. By exploring the client’s unique outcomes, both the client and the therapist were able to find stories that defied the problem saturated dominant story and helped to explore past experiences that fell outside the scope of the problem. Madigan began to help his client re-story his underrepresented life experiences as positive experiences that have meaning.

**Re-authoring Stories**

 The meaning that we assign to our stories and our experiences give meaning to our lives; however, there are always stories that are underrepresented or left out in one’s dominant story (Madigan, 2010). These untold stories often hold the key to revising or reinterpreting one’s lived experiences, especially when a person’s dominant story doesn’t fit with one’s lived experience anymore. These stories that are not told also have meaning – we select the stories we tell and assign meaning to them through narrative conversations. In order to move from a problem-saturated dominant story to a more useful narrative one must explore unique outcomes and contribute to re-authoring conversations in the therapy process. This process involves revising or re-storying our relationship with the problem.

 Re-authoring stories involves finding alternative stories that hold new meaning for the client. The client begins to move away from the problem-saturated dominant story of the past toward a more helpful narrative that is based on lived experiences and is future driven. This *reconstruction* process provides the client an opportunity to gather new information and define new meaning to past narratives that are not helpful in one’s current life. “A shift in narratives can essentially be a shift in outlook, which may then alter the ways in which clients experience and interact with their world.” (Cobb & Negash, 2010, p. 56). This is the ultimate goal in the narrative therapy process – to help an individual re-author an alternative story to find new meaning that celebrates their lived experiences and provides a more helpful, open-ended narrative (Phipps & Vorster, 2009).

**Article Reviews: The Narrative Therapy Process**

 Since its inception, narrative therapy has been an ever growing and expanding field, finding its way from family systems theory to play therapy, art therapy, neuroscience, multicultural counseling and school counseling. Populations range from children with trauma to adults who need help with parenting techniques – there is a wide scope of narrative approaches (e.g. mapping, scaffolding) therapists use to help these populations re-story their lives. The following article reviews will provide information as to how the theory is used within current practices. They will give the reader an example of how narrative therapy can be used in various modalities and with various populations. Two articles will be reviewed to help explore how narrative therapy concepts are used, and the methodology of the narrative therapy process. The last section will review the integration of recent neurobiology research with narrative therapy techniques.

**Altered Book Making as a Form of Art Therapy: A Narrative Approach**

**(Cobb & Negash, 2010)**

 The purpose of this technique reported was to explore how clients can externalize their problems through the altered book making process in order to create a more meaningful, helpful relationship with the problem. The art process aids narrative therapy by helping to visually and concretely bring forth ones’ dominant story in order to help to externalize the problem. Once externalized through the altered book, the therapist can help the client explore unique outcomes, develop new stories and be able to share these new outcomes with others. This process is especially helpful for children and adolescents. As the externalized problem is contained it helps children move away from feeling like victims to a place of having more power and control (Sori, 2006). The problem is now situated outside of the client and can be discussed within the context of the book. Cobb and Nash (2002) use art as a platform to help release the internalized discourse and allow it to take form (p. 58).

**Procedure**

The book itself is used as a *catalyst* to help explore the relationships the client assigns to existing and new text (journaling), and old and new pictures; ultimately creating new meanings and new stories. The books themselves can be old books, new books, hardcover or soft cover. The client chooses the book that best fits the needs of the therapy goals. Some of the ways clients can alter the book are by cutting, ripping, painting, and drawing, folding or collaging.

 During the altered book making process, clients are creating or externalizing their problems – illustrating to the therapist what the problem is and the influence it has over the client’s life. These pages are then used as a springboard to help explore the problem and find unique outcomes. The therapist may ask the client to create new pages to try and elicit new stories and outcomes for the client. The stories are brought forth by the client to help explore old and new meanings. This reconnection process helps children and adolescents work on relationships and their connection (feeling of belonging) to the world (Sori, 2006).

 Cobb and Nash (2010) explain how the narrative therapist uses questions and directives to help the client explore (a) the problem or dominant story, (b) unique outcomes, and (c) new stories with new meanings. An example of the questions used in the externalization process are: (a) explain how this problem has influenced your life, (b) how does this problem control you?, (c) explain how this problem has influenced your relationship with others (p. 63). An example of directives to help identify unique outcomes include (a) create a page where the problem does not have control over you , or (b) create a page that represents a time or event when the problem did not control you (p. 63). After exploring these unique outcomes, the narrative therapist may ask (a) what do you think this means?, or (b) what does it mean to you that this page (dominant problem) and this page (unique outcome) look different? (p. 63). Clients begin to explore their new stories and new meanings through the altered book.

**Findings and Future Research**

This is an example of how narrative therapy can be used in conjunction with another form of therapy. The altered book making process helps clients to freely express their feelings, fantasies, memories, thoughts, and dreams through pictorial images. These pictorial images in combination with narrative therapy allow clients to further explore the meaning they assign to their images – allowing for the facilitation of re-storying. The process is non-threatening and encouraging for clients as they visually see for themselves how their new meanings are more helpful. Altered book making is a universal process allowing for self-expression for not only children, but for adolescents, couples, families and the elderly.

 Research indicates that there have been no formal empirical studies done in the area of combining these two techniques, however, the processes itself seems to be promising in eliciting and dialoging with the problem (externalization), finding alternative suggestions in relationship to the problem (unique outcomes), and exploring more helpful new meanings (re-storying) through a finished product that can further be altered in the future as new discoveries are being made.

**Coping with Trauma: Narrative and Cognitive Perspectives**

**(Tuval-Mashiach, Freedman, Bargai, Boker, Hadar & Shalev, 2004)**

 The following is a review regarding research on the effectiveness of narrative therapy techniques on post trauma exposure narratives. The authors explore trauma narratives and the sequential development of these narratives. Working with trauma victims in other parts of the world has been one of the future research areas that narrative therapists have been studying (Madigan, 2010). Narrative therapists call this work *collective narrative practices* as it has expanded narrative therapy methodologies i.e. collective timelines, mapping, Tree of Life (narrative approach working with vulnerable children) and , Kite of Life (strengthening relations across generations in immigrant or refugee communities (Madigan, 2010, p. 149).

 We learned earlier that one’s identity takes shape by the story he or she tells and we get to know ourselves and reveal ourselves to others by our narratives. Thus, our narratives shape who we are and how we interact with others (Tuval-Mashiach et al., 2004). When there is a break in our narrative or life-story as is with a traumatic event there is a break within our identity and a disruption to our whole self. Research done by Tuval-Mashiach et al., (2004) suggests that “most coping happens within the first weeks and months following the traumatic event (p. 280). Narrative therapy techniques can be useful for the early stages of intervention, when most coping happens. Narrative therapy is used in conjunction with cognitive perspectives to help elicit the written narrative trauma in order to evaluate the process of recovery within the early stages after the trauma.

 There is a relationship between the construction of stories or narratives and the factors that that shape these narratives (a) psychological, (b) situational, and (c) cultural. Further, the three factors associated with coping are (a) continuity and coherence, (b) creation of meaning, and (c) self-evaluation (Tuval-Mashiach et al., 2004). Trauma narratives are used to help explore these coping factors, how one perceives trauma and their reaction to the trauma – thus leading to an evaluation of how one sees themselves, others and the world.

**Procedure**

 The five participants in the study that were studied were admitted to the emergency room in Jerusalem between 1998 and 2001 following a traumatic event. The study attempts to follow the development and perceptions within of the trauma narratives of these five men. Each subject was given a narrative questionnaire that measured (a) coherence and continuity (e.g. What is the first thing that comes to your mind when you think of the event?), (b) meaning (e.g. What is the most important thing for you to tell about the event?), and (c) self-evaluation (e.g. When you think of yourself at the time of the event [functioning, feelings, thoughts], what do you remember most?) (p. 284).

**Findings and Future Research**

 Through the questioning (evaluation) process, researchers found that each of the five men had different realities of the event, thus their (perspectives) narratives were different. Further, they also found that their development of their narratives were vastly different (e.g. who got hurt, time of the story). Through questioning the subjects through time they found several things to be true: (a) a person’s reality is subjectively constructed, (b) meaning-making takes place at several stages and is time driven, and (c) meanings that were assigned to the event within their narratives changed over time.

 Narrative therapy questioning helped to determine that after a traumatic event one’s narrative “is not yet a coherent organized story with significance” (Tuval-Mashiach et al., 2004, p. 290). When a traumatic event is given meaning and significance within one’s life-story then healing and recovery can take place. If the story is not coherent, organized or assigned significance there is a greater chance for someone to develop symptoms related to Post Traumatic Stress Disorder (PTSD). Narrative therapy helps people who have been exposed to trauma construct narratives to help explore understanding and meaning of the event – thus externalizing and assigning meaning that becomes part of one’s life-story and not one’s life story. When meaning is assigned that processed then the healing process can take place. Through narrative conversation, a therapist can measure when a clients story becomes coherent, organized and assigned meaning, thus leading to catharsis.

**Narrative Therapy and Interpersonal Neurobiology**

 This section reviews narrative therapy practice within the context of the most recent advances in brain research. Daniel Siegel, a Clinical Professor of psychiatry at the UCLA School of Medicine has identified several functions of the brain that affect our thoughts, actions and emotions (Codrington, 2010). The brain is where we regulate and interpret *affect* loaded experiences; retaining the negative affective experiences for longer than cognitive based material (Beaudoin & Zimmerman, 2011). Simply put, the amygdala, located in the limbic region, regulates our emotions and our prefrontal cortex regulates our ability to reason, think and plan ahead (Codrington, 2010). By consistently exposing the brain (limbic region) to negative affective experiences the prefrontal cortex begins to reinforce these negative experiences by assigning meaning to them. “The brain may have neural networks associated with preferred experiences, but these are much less developed than the networks associated with problem related experiences, which can metaphorically be described as superhighways” (Beaudoin, 2010, as cited in Beaudoin, 2011, p.2). When this happens we end up with negative problem-saturated stories that we begin to identify our “selves” with.

 Neuroscience has been found to support the idea of assigning meaning to stories to help separate and weaken negative thought patterns (Beaudoin & Zimmerman, 2011). The neural networks within the brain begin to structurally change as more and more positive connections are made between understanding and assigning meaning to the problem. Narrative conversations are used to help recognized “affect infused” unique outcomes that reinforce positive thinking and identity conclusions (Beaudon & Zimmerman, 2011).

**Purpose**

 The purpose of integrating neuroscience brain research within the modality of narrative therapy is to help people give meaning to their experiences, therefore changing the structure of the brain to help reinforce retention of positive information. Narrative therapy assists clients in externalizing their problems, separating their identities from their problems and assigning meaning to these problems in order to re-author their stories. This is the ultimate goal in the narrative therapy process: to help an individual re-author an alternative story to find new meaning that celebrates their lived experiences and provides a more helpful, open-ended narrative (Phipps & Vorster, 2009). Interpersonal neurobiology describes this experience in the brain as (a) the limbic region defines an experience as either positive or negative, and (b) the pre-frontal cortex reinforces this by assigning meaning to the experience.

**Narrative Therapy and the Brain**

 White and Epston proposed that people have several versions of their life stories, thus interpreting their experiences in a variety of ways (Madigan, 2010). “Neuroscientists understand these patterned ways of responding as brain states, acknowledging that any individual will have many possible states (Siegel, 1999, as cited in Beaudoin & Zimmeraman, 2010, p. 3). Narrative conversations help to externalize and deconstruct the negative assumptions (stories) clients may have about themselves. This process of deconstruction helps clients develop new beliefs or underrepresented beliefs with new or forgotten values and dreams (Beaudoin & Zimmerman, 2010).

 Daniel Siegel uses the term “name it to tame it” to describe the process of defining the problem in order to sooth limbic firing in the brain. Narrative conversations help to provide an identification of the problem outside of the individual, thus helping the frontal cortex to manage the limbic danger messages. “If this linking is done correctly, externalization will help clients notice, at least implicitly, that ‘depression’ is but a mental product, the union of the amygdala firing ‘negative’ affect, and the prefrontal cortex putting words to this experience” (Beaudoin & Zimmerman, 2010, p. 5). Implicit affect is defined as unconsciously absorbing aspects of experiences that we are not aware of. If this implicit affect is absorbing negative messages then our narratives become problem-saturated, in turn, affecting our thoughts, emotions and behavior. Through the process of narrative conversation, the amygdale that was once reinforcing the negative implicit affect is now slowing down, allowing the prefrontal cortex to interpret experiences with new meaning. The narrative therapist can link the negative implicit affect (problem-saturated story) with newly defined (re-authoring) ways of identifying with the problem (externalization). Neural connections are consistently being reinforced and constructed as clients re-author their stories (Beaudoin & Zimmerman, 2010).

 By the use of careful mapping and scaffolding of questions, narrative therapists can help reinforce the positive connections and limbic firing in the brain. Questions help to externalize problem-saturated stories, make sense of, manage, and re-story them. The narrative therapy process helps clients become more aware and knowledgeable of their experiences, thus strengthening more preferred neural pathways in the brain (Seigel, 2009 as cited in Beaudoin & Zimmerman).

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