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Narrative, Poststructuralism, and Social Justice: Current Practices in Narrative Therapy

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Abstract

This paper is a review of current practice in narrative therapy with a focus on how it is attractive and useful for therapists who wish to work for social justice. The authors describe narrative therapy's roots in poststructuralist philosophy and social science. They illustrate its major theoretical constructs, including *the narrative metaphor, Foucault's notion of "modern power,"* and narrative therapy's emphasis on *problems as separate from people*. The authors then describe specific practices: narrative questions, externalizing conversations, utilizing the "absent but implicit," the development and "thickening" of preferred stories, the documentation of preferred stories, outsider witness practices, and practices for connecting people around shared purposes. After reviewing research that supports narrative therapy as useful and effective, the authors specifically address the ways narrative therapy deals with issues of social justice, showing how its focus on the discourses of modern power helps therapists be especially attuned to these issues.

Keywords

narrative therapy, social justice, poststructuralism

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Some years ago we met a physician from New York at a conference. The time was early in the AIDS epidemic when a diagnosis of AIDS was a death sentence. The physician had watched countless young men enter his hospital to live out their final days. These men were almost always surrounded and supported by friends and partners. The physician attended numerous funerals for these men. He said that at the funerals, the friends and partners who he had seen so lovingly care for these young men were always delegated to the back of the hall. The biological families, who rarely appeared during hospital stays, laid claim to the young men in their deaths. They sat at the front of the halls and gave the eulogies. Strange and sad to the physician was how the stories family members told about these young men ended at about the age of 14—before they had publicly claimed sexual identities. Although the partners and friends of the men may have recognized the allowed-at-the-funeral stories, the physician was sure that they did not recognize the people with the sexless, truncated lives that these stories described.

We found the physician's words quite distressing but also intriguing. As practitioners of narrative therapy, an approach originated by Michael White and David Epston (Epston & White, 1992b; White & Epston, 1990), we thought about the physician's experience as an illustration of the narrative metaphor (Bruner, 1986) in action.[1] It shows how people's identities are defined and constructed through stories. It illustrates the power involved in being in the position to decide which stories will be told and retold, and which will not. It shows how the sharing and circulation of different stories contributes to building different communities. It illustrates how stories give meaning to lives and relationships, privileging some people and relationships and making others invisible.

We told the physician what we were thinking. He smiled and said, "But now, more and more men are composing videos of their lives to show at their own funerals!" We found this development encouraging. For us, it illustrates how people can assert a position as privileged authors of their own lives.

Narrative therapists believe that people give meaning to their lives and relationships through stories. As narrative therapists, we are interested in joining with people who consult us (clients) in what White often called "rich story development." We work to facilitate the development, telling, and retelling of stories from people's lives that speak of experiences and intentions that they prefer. Through these tellings, we facilitate experience of possibilities not apparent in the problem story. We are not focused on solving problems, but rather on helping people immerse themselves in life stories that offer different possibilities and directions than those offered by the problem stories. From within these stories, people's relationships to problems change.

White often said that people do not invent problems. Instead, they are recruited into actions and ways of thinking that create problems. Narrative

therapists ask questions with the intention of bringing the ways that people have been recruited into problems to light. In their inquiries, they examine the effects those problems have on people's lives and relationships. In answering the therapist's questions, people are able to notice gaps in their problem stories. These gaps can provide openings to other stories. As people develop and live out preferred stories, narrative therapists look for ways to link them with other people who have struggled with similar problems. This allows people to both contribute to and partake of a growing body of insider knowledge. Also, as people join their voices together, they are more likely to be heard in the larger society. They are less marginalized. This linking of lives through shared purposes is one of the fundamental and recurring ways that narrative therapy supports social justice.

Philosophy and Assumptions

Narrative therapists base their ideas in poststructuralist philosophy (Combs & Freedman, 2004; Foucault, 1988; Lye, 2008; Thomas, 2004; White, 1997, pp. 220-235). Poststructuralism is a response to "structuralism," which is one label for a worldview that is still dominant in a range of fields, including counseling and psychology. In this section we discuss some poststructuralist ideas important in guiding narrative practice. We contrast these with structuralist ideas.

In the structuralist approach to knowledge, scholars study systems by analyzing and describing their structures, assuming that every system has a definite, discoverable structure. To structuralists, structures are the "real" things underlying surface appearances. Structuralist scholars work to identify the universal, general laws by which structures function. Poststructuralists (perhaps a bit loosely) use the term *structuralism* to refer to those approaches to knowledge that seek universal truths and value expert knowledge of complex systems of classification. The application of what we refer to as structuralism in psychology has led its proponents to study people as individual entities with essential, stable characteristics that can be grouped and graded according to universally applicable norms.

Poststructuralism is not antistructuralism; it grew out of structuralism. As some scholars tried to classify finer and finer levels of complex systems, they encountered ambiguities and paradoxes. For instance, anthropology students sent to study "primitive" peoples found wisdom and wondrous events that they could not fit neatly into the categories they were learning in school. Their experience was that no system of universal categories could capture people's lives in all their complexity. These scholars became more interested in local, particular stories than in universally applicable generalizations. At some point people with such interests began to describe themselves as poststructuralists.

Poststructuralists believe that it is useful to focus on contextualized meaning making, rather than on universal truths or an all-encompassing reality. In this meaning-focused approach, culture, language, and discourse are explored in terms of how they contribute to the experience and identity of people in context. Proponents of poststructuralism seek specific details of particular people's experience. Lives are valued in terms of how they embody exceptions or uniqueness, rather than how they fit general categories.

Narrative practitioners assume that people's experiences of problems are shaped by stories, which are constructions. But these are not individual constructions. In any social group, small or large, we are all participants in each other's stories. We each shape, and are shaped by, the beliefs, intentions, and actions of others. Collectively, we participate in discourses. Rachel Hare-Mustin (1994) defines discourse as "a system of statements, practices, and institutional structures that share common values." She goes on to say that "discourses bring certain phenomena into sight and obscure other phenomena. The ways most people in a society hold, talk about, and act on a common, shared viewpoint are part of and sustain the prevailing discourses" (pp. 19-20).

The norms and expectations of a culture are communicated through discourses, and they become taken for granted. Unless we look, listen, and feel for them, they are invisible. For example, gender discourses still often suggest that in a heterosexual couple the man should earn more money than the woman. Such discourses have been the basis for many couples' worries about their relationship. If the woman earns more, both partners in the couple may think there must be something wrong with their relationship. This discourse-based comparison shapes their relationship and contributes to their judgment that they have a problem.

Poststructuralism includes the assumption that since we are all part of culture we can all be caught up by discourses, and therapists can undoubtedly reproduce these discourses in the therapy room without even recognizing it (Hare-Mustin, 1994). For poststructuralists, no one is in a position to be an objective expert on someone else's experience. Furthermore, as members of a culture we recognize that power influences the political context of people's lives both in and out of the therapy room. This leads narrative therapists to work to expose discourses and power differentials that support problems and to work from a position of collaboration, recognizing clients as the privileged authors of their own stories. We believe that this dedication to exposing taken-for-granted power relationships supports narrative therapists in pursuing social justice.

Recognizing clients as the privileged authors of their own stories reflects a movement in the social sciences known as "the interpretive turn" (Bruner, 1986; Geertz, 1983). The interpretive turn is a shift in who is doing

the interpreting. Specifically, it refers to a shift away from experts making interpretations about other people's lives and toward people making interpretations and meaning of their own lives. This shift favors local, personal, contextualized knowledge rather than universal, generalized expert knowledge. Although recognizing people as the privileged authors of their own stories does not completely change the power relations in the therapy room, it does encourage us to find ways of collaborating rather than imposing our interpretations.

Major Theoretical Constructs and View of the Person

There are a few ideas that are especially important as guides in the process of narrative therapy. The narrative metaphor—the notion that we make meaning of events through stories—is central to our work. Michel Foucault's concept of modern power shapes our thinking about the micro possibilities of therapy. Conceptualizing problems as separate from people is perhaps the most widely known theoretical construct from narrative therapy. A more recent concept, the absent but implicit (Carey, Walther, & Russell, 2009; White, 2000), helps immensely in the search for meaningful directions in life when problems seem overpowering. We also discuss how narrative therapists view people and personal agency.

The Narrative Metaphor

The narrative metaphor suggests that we experience our lives through stories. Therapists who use the narrative metaphor in the tradition of Epston and White focus on collaboratively enriching the narratives of people's lives. We work to bring forth and develop "thick descriptions" (Geertz, 1978; Ryle, 1971/1990)—rich, meaningful, multistranded stories of people's lives. When people consult with a therapist, they are usually caught up in rather thin stories that focus on only a few of their many life experiences. These are stories that they have told themselves and have been told about themselves. These "thin" stories reflect a very small amount of lived experience. The meanings people draw from them are often quite limited and not what they want for their lives.

The narrative metaphor alerts us to orient to these accounts as stories, rather than as truths. We see them as reflecting only a few of many possible stories. This perspective helps us engage in listening both to understand people's experience and to notice when people make implicit or explicit reference to events that would not be predicted by the plot of the problematic story. We listen not only for literal exceptions or counterexamples to the problem, but also, more generally, for events that don't fit with the problem

and for clues to what people treasure and how the problem speaks of the absence of something that is treasured.

Once we identify an event that lies outside the problematic story line, we can ask questions that invite people to step into that event and to tell us (and themselves) about it and its meaning, developing it into a memorable and vivid story. Over the course of therapy, people tell more and more life stories, each offering meanings and possibilities that are different from those they drew from the problematic story. This process leads to the development of multiple story lines that speak of multiple possibilities for people's lives.

Engaging in the process of rich story development does not take away problematic stories, but problematic stories usually have a different meaning when seen from the perspective of other life stories. The alternative stories may offer different ways of responding, or they may make the problematic stories feel less significant (as they are now only one strand of a multistranded story).

Modern Power

Narrative therapists find Foucault's (1965, 1975, 1977, 1985) notion of modern power helpful in working with problematic stories. Foucault contrasted traditional power, which comes from a central authority—a king, a pope, or some such figure—and is enforced publicly and dramatically through executions, floggings, and the like, to a new, more subtle, and pervasive type of power, which he called "modern power."

Modern power, instead of coming from a central authority, is carried in discourses. Through lobbying, advertising, participating on school boards, and a thousand other means, the more privileged people in a society have more influence on its discourses. We don't usually notice the powerful influence of these discourses—certainly not in the way we would notice a public flogging. Modern power recruits us into policing ourselves. Influenced by the media, by what is readily available at the supermarket, by the standard curriculum for high schools, and by the clothes we see on pop stars, just to name a few, we tend to accept the dominant norms and discourses. We tend to try to live up to dominant discourses, to compare ourselves to what they deem good, or normal, or successful, and to judge ourselves through these comparisons. However, once we learn to look for the workings of modern power, we can question its influence. We can choose to align ourselves with other discourses and commit ourselves to other purposes.

In describing the effect of his initial encounters with Foucault's work, White (2002) wrote,

> Upon first reading Foucault on modern power, I experienced a special joy. This joy was in part due to his ability to unsettle what is taken-for-granted

> and routinely accepted, and to render the familiar strange and exotic. Apart from other things, I found that this opened up new avenues of inquiry into the context of many of the problems and predicaments for which people routinely seek therapy. (p. 36)

This joy in being able to unsettle the taken for granted is an important part of the narrative ethos.

Following Foucault, we believe that even in the most disempowered of lives, there is always lived experience that is obscured when we measure those lives against abstract, universalized norms. Narrative therapists seek to continually develop ways of thinking and working that bring forth the stories of specific people in specific contexts so that they can lay claim to and inhabit preferred possibilities for their lives.

Problems as Separate From People

Rather than viewing people themselves as problematic or pathological, narrative therapists look at the relationships that people have with problems. This theoretical construct, first suggested by White (1987, 1988-1989, 1989; also see Epston, 1993), is often expressed this way: *The person is not the problem. The problem is the problem*. This way of thinking biases us to interact differently with people than we would if we thought of them as intrinsically problematic. One important consequence of this idea is that we can support people in changing their relationships with problems, which is a much easier task than helping someone change his or her basic nature or adjust to living with deficits. When we work with couples or families, we can facilitate family members in joining together to keep the problem out of their relationship or family. This creates a very different atmosphere in therapy than when family members locate the problem in each other.

In training ourselves to perceive problems as outside of individual people, narrative therapists increase their abilities to see how problems reside in or are supported by the discourses of modern power. For example, we worked with a heterosexual couple who had been married more than 25 years. Over the course of the marriage, Henry's multiple physical disabilities had worsened, leaving him with chronic pain and an inability to perform many tasks that most of us take for granted. Henry felt despair and hopelessness, which led him to spend more and more time immobilized in bed. Ruth, witnessing this immobilization, told the story of how she had to do more and more of the work to maintain their household and life. Ruth felt anger about this. Henry told stories about witnessing Ruth's anger, and Ruth told stories about Henry's depression and the fights that resulted from their attempts to talk about it.

In the therapy they were able to recognize one of the discourses that had a part in their problems—the idea that partners of a couple should contribute equally. In answering our questions, they came to see how this taken-for-granted idea led Henry and Ruth to evaluate their marriage as a failure, and thinking they had failed helped the problems of anger, hopelessness, and fighting to grow. Once they decided that they could have a good marriage even if physical disabilities kept them from making equal contributions, it was easier to notice, describe, and appreciate moments of joy and cooperation that wouldn't have been predicted by the stories of hopelessness, anger, and fighting. After telling stories about enjoying their garden together, helping their daughter cope with a friend's death, and staying up late one night planning renovations on a cabin they had inherited, Henry and Ruth found themselves enjoying and appreciating their relationship. They experienced slips back into hopelessness, anger, and fighting, but the preferred experiences continued to grow. Once they were situated within an experience of appreciation, they could plan together how to respond to each other when the old discourse of equal contributions helped bring on a reappearance of anger, hopelessness, or fighting. Identifying problems such as anger, hopelessness, and fighting as entities that are separate from the people they afflict, and locating those problems in discourses such as "equal sharing," helps people join together in responding to the problems rather than blaming and fighting with each other.

This externalizing stance supports a focus on social justice. It guards against the marginalization that can occur when people's identities are subsumed by pathologizing diagnostic labels. White's work over the years with people who had been diagnosed as "chronic schizophrenic" is an illustration of externalization in support of social justice.

Instead of accepting the dominant labels, White entered into conversation with labeled people and learned that, in their way of thinking about it, many of them were in a struggle with voices and visions. The notion of externalization let him orient to the voices and visions as external entities that did not speak of anyone's essential nature. He interviewed people about the influence of the voices and visions on their lives, and also about their knowledge and skill concerning how best to relate to the voices and visions. Orienting himself more like an anthropologist than like a conventional therapist, White brought forth and documented stories of people's struggles with voices and visions. He took notes that documented the insider knowledge of how to function in the face of the voices and visions. The Power to Our Journeys Group (Brigitte, Sue, Mem, & Veronika, 1996) has written about how they applied an externalizing approach in making formal documents so that they could remember each other's tips and tricks.

The nonpathologizing stance of externalization offers alternatives to the marginalizing effects of pathology-focused treatment. All narrative work is social justice work in that it always has the intent of countering and undermining the marginalization that can happen in pathology-based approaches to "mental health."

The Absent but Implicit

Drawing on his reading of Gregory Bateson (1980) and Jacques Derrida (1978), White (2000) became interested in the idea that the meaning we make of any experience comes from contrasting it with some other experience or set of experiences. No experience has meaning independent of other experiences. We make meaning through operations in which we say (or think, or sense) "this is different from. . . ." This means that a single description of any experience can be thought of as a figure that we can see because of a contrasting background. A story about a problem is made in contrast to some experience that is preferred and often treasured. If we listen closely, using what White has called "double listening" (listening for the ground as well as the figure) we can hear implications of the experiences that are being drawn on as the background for the present experience. These implied experiences are a rich source of preferred stories. For example, if a person has the experience of frustration, he or she must be pursuing purposes, values, or beliefs, but not attaining them. If a person experiences despair, he or she must have hopes, dreams, or visions of the future that are not being fulfilled. If a person experiences injustice, he or she must have a conception of a just world (White, 2003). It follows that if a person is speaking at length of frustration, we can ask questions that invite him or her to notice the purposes, values, and beliefs that are being frustrated, and so on.

Engaging in double listening puts therapists in the position to ask about subordinated stories that reflect ideas, experiences, and commitments that people give value to, long for, or hold precious. White called this sort of inquiry asking about the absent but implicit.

To begin this kind of inquiry, we ask questions to unpack the problem, listening for what people are contrasting in their experience. We listen for expressions that indicate that something important has been frustrated or betrayed or seems impossible to realize. When we ask more about this, and particularly how it relates to the person's purposes, hopes, wishes, dreams, and so on, we are engaging in a conversation about the absent but implicit. This inquiry can be a launching point for a reauthoring conversation that documents the history of what the person gives value to, the people linked

with this value, what this value means about the person's identity, and what the person has achieved, even in very small ways, that fit with this value.

Personal Agency

People's sense that they have done nothing to stand against injustice or harm or that they are helpless to act can lead them to negative conclusions about their identities. We assume that even in the most limiting and abusive situations people are always responding (Wade, 1997; Yuen, 2009), perhaps in ways that are quite small and may have previously gone unnoticed, but they are responding nonetheless. Simply recognizing that he or she responded, regardless of whether the response made an immediate difference, contributes to a person having a sense of agency, of being an agent in his or her own life.

For example, in working with a refugee who as a political prisoner in another country had been routinely sexually abused, we discovered that she always prayed silently to block out all awareness of physical sensation when she was being abused. In therapy, the prayer and numbing can be brought forth as acts of resistance, as ways that the person actively responded to the situation. The story of praying and going numb indicates something important about the person, but that meaning could be lost if the focus is only on the abuse. People's responses, even when extremely small, are openings to preferred stories. They show that the person in some way has managed to separate from the problem. Narrative therapists assume that it is important to look for stories of personal agency in the face of disempowering circumstances. Because it assists people in not being defined by unjust circumstances, this is another theoretical concept that is linked to social justice.

View of the Person

Narrative therapists view identity as relational, distributed, performed, and fluid.

By relational, we mean that our stories of who we have been and who we can be wouldn't exist outside of our relationships with other people; they are shaped by our experiences with others and our sense of how they perceive us.

By distributed, we mean that the stories and experiences that shape our moment-by-moment sense of "self" are located in different places. Stories and experiences that support our sense of self are distributed in other people's memories, in hospital records, in graffiti, in the Facebook pages of high school friends, and in many other places. At times stories from several of

these places can come together to solidify a particular sense of identity. At other times, stories from different sources can give a sense of multiple possible identities. One's associates at work may describe a different person than would the members of that same person's once-a-month poker game, and the members of the grade-school soccer team that person coaches may describe yet a different person.

When we say that our sense of self is performed (Combs & Freedman, 1999), we mean that we are all participants in each other's ongoing dramas. Each of us is always performer and audience at the same time. On one hand, we become who we act like we are. We constitute ourselves through the choices we make. On the other, we are shaped by the responses and expectations of those around us. Our notions of how we can act in a given event are influenced by our memories of how people have responded in similar past events, and by which particular people are present in the current episode.

This relational, distributed, performed self is also fluid. It is not the "deep, true, authentic" self proposed by structuralism; it happens between people and is always changing, although there is also a trace that runs through all the stories of our history. One implication of this fluid sense of self is that change is practically impossible to avoid. Rather than trying to help people be "true to themselves," we can focus on different experiences of "self," and either help people choose the relationships, contexts, and commitments that support their preferred ways of being or help them bring other aspects of themselves into problematic contexts in ways that will change their experience.

Overview of Intervention and Specific Techniques[2]

Narrative therapists prefer to speak of practices rather than interventions and techniques. We find this language less objectifying of people and less mechanistic. We also like the two meanings of practice: It is what we do, and it is ongoing preparation for and revision of what we do.

Questions

Narrative therapy is a therapy of questions. The primary purpose of asking questions in narrative therapy is to generate experience (Freedman & Combs, 1996). This is a very different purpose than gathering information. Epston once said, "Every time we ask a question, we're generating a possible version of life" (cited in Cowley & Springen, 1995, p. 74). Using questions rather

than statements allows therapists to practice in ways that are "de-centered" (White, 2000, pp. 200-214)—that keep the spotlight on the client's experience.

Externalizing Conversations

Through externalizing conversations, we put into practice the idea that people and problems are separate. Externalization allows narrative therapists a space in which they can work to understand problems without seeing people themselves as problematic or pathological. As problems are externalized, we begin to inhabit a world where, rather than being problematic in and of themselves, people have relationships with problems. When told in the context of an externalizing conversation, people's stories almost always become less blame and guilt ridden and less restrictive.

We once saw a young heterosexual couple. The man told us that anxiety attacks were waking him in the middle of the night as if someone were holding a gun to his head. When we asked him what he would name the problem, he called it "the thief" because it was trying to steal his sleep. His partner, who had been scornful of the fear and difficulty sleeping until this point, could easily relate to the terror of an armed burglary in the dark of night. She began to appreciate her partner's bravery in facing it alone. She suggested that he wake her so that she could help him face the thief. His poetic and compelling name for the problem helped her sign on for a project of helping him stand up to it, and they were soon telling stories of how they worked together to ward off the thief.

Once the problem was named in this way and the couple was working together, they began to have conversations about what was figuratively holding a gun to the man's head. He spoke of the pressure he was under to falsify research data. To be a good member of the research team, he felt pulled to go along with the group. He feared the consequences for his job if he did not. But if he did, it was at the cost of his integrity. He was caught between discourses of loyalty, success, and personhood. Once these discourses were exposed, the couple could decide together how the man could respond. The narrative practice of externalizing conversations created a context in which the young couple could experience themselves as heroes in a story of standing up to injustice. This is a radically different outcome than anything that might emerge from therapy that was focused on helping the man learn to cope with a (pathological) anxiety disorder that was located in his internal physiology.

When we ask externalizing questions about contextual influences on the problem, we can expose the effects of norm-based discourses: What "feeds" the problem? What "starves" it? Who benefits from it? In what settings might

the problematic attitude be useful? What groups would proudly advocate for the problem? What organizations would definitely be opposed to it and its intentions? Questions such as these invite people to consider how the entire context of their lives influences the problem and vice versa. For example, when men who have acted abusively begin to consider how they were recruited into ways of thinking and acting that support violence, they can often step back from those discourses enough to begin to look at the effects of the violence both in their own lives and in the lives of those they have abused. From this position, they can begin to glimpse other possibilities that would have preferred effects.

Listening for Openings to Preferred Stories

There are a number of pathways that can be openings to preferred stories. Unique outcomes offer one such entryway. A unique outcome may be a plan, action, feeling, statement, desire, dream, thought, belief, ability, or commitment (Morgan, 2000). It can be an exception to a problem, but unique outcomes can also be distinguished even though the problem is still happening. For example, if the problem is stealing and the person hesitates before stealing, the hesitation could be a unique outcome that shows a gap in the problem story. If someone struggling with bulimia usually avoids eating in public because of fear that she'll find herself being observed in the middle of a binge, yet she accepts an invitation to go out to dinner with friends, the acceptance of the invitation may be a unique outcome, because it is an action that wouldn't be predicted by the problematic story. Unique outcomes constitute openings that, through questions and reflective discussion, can be developed into new stories.

As we ask people about the effects of problems on their lives and relationships, openings to preferred stories often develop "spontaneously." If openings do not develop spontaneously, we can inquire more directly about them. When we are working with an externalized problem, a straightforward way of looking for openings is to ask about a person's influence on the life of the problem. That is, we ask questions such as, "Has there ever been a time when the problem tried to get the upper hand, but you were able to resist its influence?" or "Have you ever been able to escape the problem for even a few minutes?" or "Is the problem always with you?" When questions of this sort follow a detailed inquiry into the effects of the problem on the person, people can usually find instances in which they were able to avoid the problem's influence. Each such instance is a potential opening onto an alternative life narrative.

We may also ask about experiences outside of the effects of the problem. For example, a lesbian couple's fear of the repercussions of coming out to family and colleagues may lead to isolation. If we ask about times they were not isolated, we might discover that they enjoy singing together as part of a chorus on the other side of town. Through this opening, we can develop stories of connection even though the fear of coming out is still present.

We can also come on openings to preferred stories through double listening and asking questions about the absent but implicit. Carey et al. (2009) explain absent but implicit this way:

> In relation to the accounts of life that people who seek counseling often present with, the "absent but implicit" is the out-of-focus background against which the expressed experience of distress is discerned; a back drop which distinguishes and illuminates what is in the foreground. If we accept the proposal that people can only give a particular account of their lives through drawing distinctions with what their experience is not, then we can tune our ears to hear not only what the problem is, but also to hear what is "absent but implicit" in their descriptions—what the problem is not. (p. 321)

This understanding of what the problem is not can guide us in asking questions about experiences that the person prefers.

Questions such as "What does this say about what you treasure?" "If this problem is a protest against something, what would you say that something is?" and "Could we say that your naming this as problematic means that you don't go along with it? In not going along with it, are you standing for something else?" can help us in entering these conversations.

When Diego described the distress he felt at the prospect of going back to high school in the fall, his parents worried about their son, who up to that point had always enjoyed school, particularly because of his participation in sports. Diego spoke slowly and in a monotone. When we asked questions to unpack what it was that he wanted to avoid in avoiding high school, we learned that teammates had made racist remarks toward Diego during the previous school year.

We began to wonder with him if his distress was a way of staying clear of something that was not okay with him. He agreed it was. As we asked more about this, Diego began to talk about his vision of a team as a group built on respect and inclusion. We had a conversation about the importance to Diego of respect and inclusion and his experiences of it. A tear trickled down Diego's father's face as he listened to Diego describing what he had learned

and treasured being part of a team, how these experiences shaped his ideas about life, and how they had been threatened. Diego's parents told stories of the way Diego showed respect and included others and how that contributed to how proud they were of their son. One of the important effects of this conversation was that Diego's father expressed a desire to join Diego in standing for respect and inclusion and as a way of doing this initiated a conversation with the coach about how to keep these ways of participating foremost in the team.

Developing Preferred Stories

Once we are alert to an opening to a subordinated story, we ask questions that invite people to develop it into a full and memorable alternative story. In telling the story of a preferred event, people are performing meaning (Myerhoff, 1986). Ideally, we want people to reexperience the events surrounding a unique outcome as they tell them. Narrative therapists facilitate this kind of experiential involvement by asking questions to develop a story rich in detail and meaning (Freedman & Combs, 1993, 1996).

We ask questions with an eye to enhancing those aspects of the emerging story that support personal agency (Adams-Westcott, Dafforn, & Sterne, 1993). Narrative therapists work to help people experience and appreciate the skills and knowledge that they use in making choices, and the power they exercise in choosing. People constitute themselves differently as they describe the details of what they know and what they can do, through each new small choice or initiative becoming other than who they were before.

Developing a "History of the Present" and Extending the Story Into the Future

We want to link preferred events to other preferred events across time, so that their meanings survive, and so that the events and their meanings can thicken people's narratives in preferred ways. Therefore, once a preferred event is identified and storied, we ask questions that might link it to past events and develop the story of those events. Questions that might identify such events include "When you think back, what events come to mind that you might be building on, that reflect other times when you could have given up hope, but you didn't?" and "If we were to interview friends who have known you throughout your life, who might have predicted that you would have been able to accomplish this? What memories might they share with us that would have led them to predict this?"

As people's preferred stories become more deeply rooted in the past, they are able to envision, expect, and plan toward more hopeful futures. To bring forth experience of such futures, we might say, "We have just been talking about an accomplishment and several events in the past that paved the way for this accomplishment. If you think of these events as creating a kind of direction in your life, what do you think the next step will be?" or "You have learned some things that have changed your view of the possibilities for your life. If you keep this new view in your heart, how do you think the future might be different?"

Documenting New Stories

Because therapy is only a small part of what people do in life, it is important to consider how to keep preferred stories available between therapy conversations. Narrative therapists rely on documents as one way of doing just this (Epston, 1998, 2008; White, 1995b; White & Epston, 1990). These documents can record a variety of different things: They can provide a summary of a therapy conversation, note knowledge a person has gained, announce news of developments that may be shared with others, or play a part in a rite of passage (Fox, 2003). Epston (1999) writes that what is important is that they document "knowledge-in-the-making and they reveal it as such" (p. 149). Documents can take the form of letters, certificates, written announcements, audio or video recordings, artwork, or poetry. Documents can be collected in anthologies and become handbooks for dealing with particular problems (Freeman, Epston, & Lobovitz, 1997). They can be made by the therapist, the people who come to therapy, or as a collaborative effort by both. Our hope for all these documents is that they will thicken and extend people's experience of the steps they are taking to become other than they have already been, to pursue their preferred directions in life.

Outsider Witness Groups

After Tom Andersen (1987, 1991) introduced reflecting teams to the therapy world, narrative therapy practitioners began to experiment with this practice (see, e.g., Friedman, 1995; White, 1995a). A reflecting team is a team, usually composed of therapists, who observe a therapy session and, during a break in the session, have a conversation reflecting on the therapy that the family or client observes. The family is then invited to reflect on the reflecting team's conversation. Over time, White (2005, 2007) introduced a structure for reflecting teams that he called "outsider witness groups." The term

outsider witness comes from the writings of anthropologist Barbara Myerhoff (1986). Myerhoff worked with a group of elderly Jews who had been displaced from their Eastern European origins and were now living rather marginalized lives in Southern California. Speaking of a set of murals they painted in a community center, and a parade they organized to show valued aspects of their lives to the larger community, she said, "By enacting their dreams publicly they have altered the world in which they live. . . . Skillfully the old Jews have managed to convey their statement to outsiders, to witnesses who then amplified and accredited their claims" (p. 284). The outsider witness groups of narrative therapy serve an analogous function—they create a setting where people can tell their preferred stories to a group of outsiders who then amplify and accredit the stories they witness.

Outsider witness groups can be made up of therapists or of people who are invited to join, either because they have insider knowledge about a particular problem or because they are important in some way to those being interviewed.

Some years ago we worked with a family that had been living together only a short time. Emma was 14 years old. Her biological parents had divorced 8 years previously, and after the divorce she lived with her mother. Her mother had recently remarried, and the new stepfather had sexually abused Emma. She was removed from the home, and her biological father, Maurice, who lived in Chicago, flew across the country to bring her back with him. He too had recently remarried, and Maurice, Emma, and Jan (the stepmother) came to see us because their lives had taken this unexpected turn of living together and they wanted help in adjusting to their new situation.

It happened that Michael White was scheduled to be at our center very shortly, so we asked the family if they would like a consultation interview that would include an outsider witness group. They accepted the invitation.

When we saw the family the week following the outsider witness group consultation, they agreed that the group had provided an amazing experience. We wondered what it was that made it so amazing. We recalled that the group members had referred to a number of moments in the therapy conversation and had speculated about what they implied. We wondered if that was what they found amazing. The family members shook their heads no. Jan said, "What was truly amazing was that they all called us 'the family.'" "Yeah," said Emma. "A whole group of therapists called us 'the family!'" In the consultation, Maurice, Jan, and Emma (who had previously experienced worry and fear at being suddenly thrown together) had presented themselves as a family to witnesses, publicly enacting their desires rather than their fears. The witnesses calling them a family amplified and accredited their status as a

family. Such was the power of this accreditation for this particular family that it didn't even matter what else was said.

Practices Incorporating Other People

The notion of relational identity alerts us to find ways of including other people whenever possible, sometimes in the therapy room, as we have described in outsider witness groups, and sometimes in other ways. Here we briefly discuss a few possibilities for including people without physically bringing them to therapy.

Circulating documents. If documents can serve to thicken a story, sharing those documents with others can alert them to the preferred story and change others' perception of the person. For example, when a child was referred by his school for therapy, sharing a document with his teacher about the ways that he was taking charge of his life helped the teacher notice his efforts instead of focusing on times that fit with the problems she originally noticed. She could then encourage these efforts and join with the child in seeing their fruits.

Leagues and teams. Documents can be shared with others facing similar problems so that a league is formed. The documents (which capture knowledge gained from hard-won struggles, news of steps forward, and responses that people have found helpful in facing dilemmas) become an archive that all league members can consult and contribute to. Therapists can become archivists, sharing the documents with an ever-growing league of people who struggle with similar problems. Through therapist-mediated conversations, members join together and learn from each other. Epston's work (Epston, 1998, 1999; Madigan & Epston, 1995; Maisel, Epston, & Borden, 2004) as an archivist and enthusiast for the Anti-Anorexia/Anti-Bulimia League has shown the power of leagues to transform people who came as clients into experts who have the knowledge, experience, and skill to help others.

The leagues that Epston archives are virtual, joining members together exclusively through letters and the Internet (e.g., http://www.narrativeapproaches.com) Other leagues and groups actually meet and work together to create documents of insider knowledge, such as the documents on how to respond to voices and visions created by the Power to Our Journeys Group (Brigitte et al., 1996). The Anti-Anorexia/Anti-Bulimia League of Vancouver (Grieves, 1997) has shown how people can join forces to engage in political action to protest the social pressures that support a problem.

Re-membering practices. Re-membering conversations are shaped by the conception that identity is founded on an "association of life" rather than on a core self (White, 2007, p. 129). These conversations provide the opportunity

for people to upgrade some people's membership in their lives, restrict or revoke other memberships, and add new members. Members who might be upgraded include—to name a few—people who played a small but important role historically, figures the person hasn't actually met who have or who could contribute to their life (such as authors or fictional characters), people no longer living (Hedtke, 2000; Hedtke & Winslade, 2004; White, 1988), and pets (White, 1997). Through questions inviting the person to tell stories about the member and reflect on the relationship with the member, even if hypothetical, that member can become a closer member in the person's association of life.

Another re-membering practice is to assemble a virtual team to stand with someone for a particular purpose. The act of deciding who will be members of such a team can draw the person closer to those members.

Research Support

The most common form of research for narrative practitioners is co-research (Epston, 1999; Maisel et al., 2004), in which, throughout their time together, clients and therapists research the workings of problems—what supports them, what works in resisting their influence. We take careful notes, in people's specific language and terminology, about the distinctions they draw concerning problems and how they work. From these notes, we make documents. Sometimes these documents become numerous enough to be considered "archives" of insider knowledge about certain problems. In the practice known as "consulting your consultants" (Epston & White, 1992a), we conduct detailed interviews of people as their therapy draws to a close, asking them to help us document all the important things they have learned, and want to pass on to others, about how to deal with the particular problem that brought them to therapy. This collection and circulation of insider knowledge has much in common with the research methods of anthropologists (for a vivid illustration of the existence and usefulness of large archives of insider knowledge, see Maisel et al., 2004).

A few quantitative studies and literature reviews concerning narrative therapy have been published. None of them involves large numbers of subjects or randomized control groups, but they all support narrative therapy as an effective treatment modality in which clients improve. When Etchison and Kleist (2000) reviewed the published studies on narrative therapy, they concluded, "Narrative approaches to therapy have useful application when working with a variety of family therapy issues. However, . . . no statement can be made about narrative therapy as the approach to use for any particular family problem" (p. 65). Searching the literature ourselves, we have found studies

supporting narrative therapy's effectiveness for several particular types of problems.

Vromans and Schweitzer (2011) found evidence that eight sessions of manualized narrative therapy reduced symptoms of depression. In their group of 47 adults with major depressive disorder, 74% achieved reliable improvement. Follow-up at 3 months documented maintenance of this improvement.

Seymour and Epston (1989) analyzed the results of a narrative approach to childhood stealing with 45 children. They found a high level of initial behavior change. Follow-up by phone call 6 to 12 months after completion of therapy revealed that 80% of the children had substantially reduced stealing or had not been stealing at all.

Besa (1994) used single-case methodology to assess the results of treatment for six families with an approach that used the narrative practices of externalizing problems, relative influence questioning, identifying unique outcomes, bringing forth unique redescriptions, facilitating unique circulation, and assigning between-session tasks. Five of six families showed improvement in parent–child conflict in the 88% to 98% range.

Silver, Williams, Worthington, and Phillips (1998) did a retrospective audit of therapy for soiling in 108 children. Of the children, 54 were treated with an approach that featured externalizing and 54 were treated by "standard methods" (p. 413). The results for the externalizing group were better, and parents rated the externalizing therapy as more helpful.

Weber, Davis, and McPhie (2006) reported on a study of seven women from rural Australia who experienced depression and an eating disorder. These women participated in a weekly group that was conducted with a narrative therapy framework for 10 weeks. Each woman filled out a questionnaire pregroup and postgroup. All women reported a change in daily practices and less self-criticism. They rated themselves as less depressed and at less risk for eating disorders.

Issues of Individual or Cultural Diversity and Social Justice

Writing about White's use of externalizing conversations Karl Tomm (1993) says,

> By introducing a clear separation between the problem and the person, he not only averts the reactionary response that inevitably results from a protest directed against a person, but also opens space for that same person to join him in the protest against the problem. And when the

> person (who participates in an unfair practice) begins to oppose that practice (as enacted by the self), a significant shift in power dynamics takes place. Not only is the protest channeled more precisely against the externalized problem, but a supplementary protest arises as well, that is, an injunction against allowing the self to submit to the problematic beliefs or habits. The resultant augmentation in the power of the protest makes it possible for patterns of injustice to be altered far more quickly. The shift can be likened to a move from a situation in which a victim alone is trying to stop abuse to one in which the perpetrator also takes initiative to stop it. (pp. 63-64)

Once there is a separation between the person and the problem, people are in a better position to make choices about their preferred directions in life. Narrative therapists work to support people's preferred life choices, regardless of whether those choices have been marginalized by the dominant culture. We help link people who are working to overcome particular kinds of marginalization together so that they do not have the experience of being alone in their struggle. We referred earlier in this article to using leagues and teams and circulating documents to link people through shared purposes.

Narrative therapists also consider relational politics as it is at play in the therapy context. We recognize that as part of the culture we can be complicit in reproducing dominant discourses that are "othering" and marginalizing of those we work with. In recognition of this, we work to examine the effects of our therapy relationships and participate both with colleagues and with people who come as clients to reflect on our work and evaluate its effects. For example, after a therapy interview, we invite family members to join with the outsider witness group in asking us questions about our work (Cohen et al., 1998). We recognize that a therapy relationship is a two-way relationship, and we acknowledge the effects each therapy relationship has on our life and work, which are often quite profound. Rather than speaking as representatives of expert knowledge, we situate ourselves so that people know something of what shapes our ideas and biases.

Narrative therapists recognize that each of us comes from a particular culture, and we are interested in recognizing and questioning our own cultural biases so that we can try to make therapy culturally fitting for those who come to see us. Members of the Family Centre in Lower Hutt, New Zealand, have described and advocated culturally appropriate ways of working with people (Tamasese & Waldegrave, 1990; Waldegrave, Tamasese, Tuhaka, & Campbell, 2003). Their workshops and writings have influenced therapists worldwide. They make clear how important it is for therapists to be of the

same culture as those with whom they work. When that is not possible, they advocate for the therapist to be supervised by a person from the same cultural group as the family. A third choice is for the therapist to become as knowledgeable as possible about the family's culture of origin. The staff of the Family Centre have developed and described a bottom-up accountability process within their agency in which more powerful and dominant groups are required to be accountable to the less powerful and less dominant groups. The narrative therapy community has been enriched and challenged by the ongoing, loving, but unflinching example of our colleagues at the Family Centre.

Narrative therapists take an active stand for social justice rather than for neutrality. This stand owes much to the feminist critique of family therapy (see Avis, 1985; Carter, Papp, Silverstein, & Walters, 1984; Goldner, 1985a, 1985b; Hare-Mustin, 1978; Laird, 1989; Taggart, 1985). That critique has helped us recognize that it is important to notice and work to counter power imbalances. If we do not address them, we are supporting an unjust status quo. This has led us to learn how to ask questions that respectfully expose power differences, to invite people to look at the effects of these power differences, and to consider what they want in their own lives and relationships in the light of these differences.

There is a growing interest among narrative therapists to work in marginalized communities where people have been the subjects of trauma (Denborough, 2006; Denborough et al., 2006; Denborough, Freedman, & White, 2008; Mitchell, 2006; Ncube, 2006; Sliep, 2003; White, 2003). Narrative ideas and practices are being adapted and new ones are being developed to address the situations of hardship that people face in particular communities. One practice in particular, the use of collective documents (Denborough, 2008)—documents that include ideas and skills gathered from a number of people addressing a particular purpose—has created a way for people in marginalized positions to be heard and to draw support from others. For example, in response to a collective document written by the workers of Ibuka in Rwanda titled "Living in the Shadow of Genocide: How We Respond to Hard Times" (Denborough et al., 2008), many people and communities made new documents reflecting how the Ibuka workers' document had affected them. On a trip to meet again with the workers of Ibuka, we began each day with a document from a different group. These documents included letters from African American social activists, a writing group, and a group of therapists from Israel. An Aboriginal group in Australia sent a traditional drawing and a DVD with a song they had composed. For people who had been the subjects of genocide while most of the world did little, to receive this outpouring of solidarity from around the world was quite significant.

In the words of Denborough (2008),

> Collective narrative practice is based on externalizing principles and on taking them one step further. It becomes possible to externalize the problems people are facing and enable possibilities for collective contributions. In this way, "The person is not the problem, the problem is the problem, and . . . the solution is not only personal." I am interested in ensuring that, once the problem is externalized (therefore placed in the social realm), the solution does not simply return to a personal one, and that, instead, opportunities are created for collective contribution; opportunities are created for people to contribute to "social movement." (p. 192)

Concluding Remarks

Narrative therapy is as much a worldview or a way of living as it is a model of therapy. People who are drawn to narrative ways of working tend to be more interested in meaning than in facts, more interested in complexity and multiple possibilities than in standardization and uniformity. Becoming a narrative therapist involves learning how to bring forth the knowledge and skills of people who come for therapy, and how to do that in an influential but decentered way. Because of its focus on the discourses of modern power, narrative therapy helps therapists be especially attuned to issues of social justice. In this review of current narrative practice, we, the authors, have attempted to illustrate how the poststructuralist philosophical underpinnings of narrative therapy lead to a set of practices and a way of viewing the world that can be very personally rewarding and satisfying for therapists and clients alike.

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1. We have chosen to call people by both their first and last names to recognize them as people, rather than objectify them as experts.

2. We use this heading at the editor's request to preserve a unified format for the articles in this section.

References

Adams-Westcott, J., Dafforn, T., & Sterne, P. (1993). Escaping victim life stories and co-constructing personal agency. In S. Gilligan & R. Price (Eds.), *Therapeutic conversations* (pp. 258-271). New York, NY: Norton.

Andersen, T. (1987). The reflecting team: Dialogue and metadialogue in clinical work. *Family Process, 26*, 415-428.

Andersen, T. (Ed.). (1991). *The reflecting team: Dialogues and dialogues about the dialogues*. New York, NY: Norton.

Avis, J. M. (1985). The politics of functional family therapy: A feminist critique. *Journal of Marital and Family Therapy, 11*, 127-138.

Bateson, G. (1980). *Mind and nature: A necessary unity*. New York, NY: Bantam Books.

Besa, D. (1994). Evaluating narrative family therapy using single-system research designs. *Research on Social Work Practice, 4*, 309-326.

Brigitte, Sue, Mem, & Veronika. (1996). Power to our journeys. *AFTA Newsletter, 64*, 11-16.

Bruner, J. (1986). *Actual minds/possible worlds*. Cambridge, MA: Harvard University Press.

Carey, M., Walther, S., & Russell, S. (2009). The absent but implicit: A map to support therapeutic enquiry. *Family Process, 48*(3), 319-331.

Carter, E., Papp, P., Silverstein, O., & Walters, M. (1984). *Mothers and sons, fathers and daughters* (Monograph Series 2(1)). Washington, DC: Women's Project in Family Therapy.

Cohen, S. M., Combs, G., DeLaurenti, B., DeLaurenti, P., Freedman, J., Larimer, D., & Shulman, D. (1998). Minimizing hierarchy in therapeutic relationships: A reflecting team approach. In M. F. Hoyt (Ed.), *The handbook of constructive therapies: Innovative approaches from leading practitioners* (pp. 276-292). San Francisco, CA: Jossey-Bass.

Combs, G., & Freedman, J. (1999). Developing relationships, performing identities. In *Narrative therapy and community work: A conference collection* (pp. 27-32). Adelaide, Australia: Dulwich Centre.

Combs, G., & Freedman, J. (2004). A poststructuralist approach to narrative work. In L. Angus & J. McLeod (Eds.), *The handbook of narrative and psychotherapy: Practice, theory, and research* (pp. 137-155). Thousand Oaks, CA: Sage.

Cowley, G., & Springen, K. (1995, April 17). Rewriting life stories. *Newsweek*, pp. 70-74.

Denborough, D. (Ed.). (2006). *Trauma: Narrative responses to traumatic experience*. Adelaide, Australia: Dulwich Centre Publications.

Denborough, D. (2008). *Collective narrative practice: Responding to individuals, groups, and communities who have experienced trauma*. Adelaide, Australia: Dulwich Centre.

Denborough, D., Freedman, J., & White, C. (2008). *Strengthening resistance: The use of narrative practices in working with genocide survivors*. Adelaide, Australia: Dulwich Centre.

Denborough, D., Koolmatrie, C., Mununggirritj, D., Marika, D., Dhurrkay, W., & Yunupingu, M. (2006). Linking stories and initiatives: A narrative approach to working with the skills and knowledge of communities. *International Journal of Narrative Therapy and Community Work, 2*, 19-51.

Derrida, J. (1978). *Writing and difference*. Chicago, IL: University of Chicago Press.

Epston, D. (1993). Internalizing discourses versus externalizing discourses. In S. Gilligan & R. Price (Eds.), *Therapeutic conversations* (pp. 161-177). New York, NY: Norton.

Epston, D. (1998). *Catching up with David Epston: A collection of narrative practice-based papers*. Adelaide, Australia: Dulwich Centre.

Epston, D. (1999). Co-research: The making of an alternative knowledge. In *Narrative therapy and community work: A conference collection* (pp. 137-157). Adelaide, Australia: Dulwich Centre.

Epston, D. (2008). *Down under and up and over: Travels with narrative therapy*. London, UK: Karnac Books.

Epston, D., & White, M. (1992a). Consulting your consultants: The documentation of alternative knowledges. In D. Epston & M. White (Eds.), *Experience, contradiction, narrative & imagination: Selected papers of David Epston & Michael White* (pp. 11-26). Adelaide, Australia: Dulwich Centre.

Epston, D., & White, M. (1992b). *Experience, contradiction, narrative & imagination: Selected papers of David Epston & Michael White*. Adelaide, Australia: Dulwich Centre.

Etchison, M., & Kleist, D. (2000). Review of narrative therapy: Research and utility. *Family Journal, 8*, 61-66.

Foucault, M. (1965). *Madness and civilization: A history of insanity in the age of reason* (R. Howard, Trans.). New York, NY: Random House.

Foucault, M. (1975). *The birth of the clinic: An archeology of medical perception* (A. M. Sheridan Smith, Trans.). New York, NY: Random House.

Foucault, M. (1977). *Discipline and punish: The birth of the prison* (A. Sheridan, Trans.). New York, NY: Pantheon Books.

Foucault, M. (1985). *The history of sexuality, vol. 2: The use of pleasure* (R. Hurley, Trans.). New York, NY: Pantheon Books.

Foucault, M. (1988). The political technology of individuals. In L. Martin, H. Gutman, & P. Hutton (Eds.), *Technologies of the self* (pp. 145-162). Amherst: University of Massachusetts Press.

Fox, H. (2003). Using therapeutic documents: A review. *International Journal of Narrative Therapy and Community Work, 4*, 26-36.

Freedman, J., & Combs, G. (1993). Invitations to new stories: Using questions to explore alternative possibilities. In S. Gilligan & R. Price (Eds.), *Therapeutic conversations* (pp. 291-303). New York, NY: Norton.

Freedman, J., & Combs, G. (1996). *Narrative therapy: The social construction of preferred realities*. New York, NY: Norton.

Freeman, J., Epston, D., & Lobovitz, D. (1997). *Playful approaches to serious problems: Narrative therapy with children and their families*. New York, NY: Norton.

Friedman, S. (Ed.). (1995). *The reflecting team in action: Collaborative practice in family therapy*. New York, NY: Guilford.

Geertz, C. (1978). *The interpretation of cultures*. New York, NY: Basic Books.

Geertz, C. (1983). *Local knowledge: Further essays in interpretive anthropology*. New York, NY: Basic Books.

Goldner, V. (1985a). Feminism and family therapy. *Family Process, 24*, 31-47.

Goldner, V. (1985b). Warning: Family therapy may be dangerous to your health. *Family Therapy Networker, 9*, 19-23.

Grieves, L. (1997). From beginning to start: The Vancouver Anti-Anorexia/Anti-Bulimia League. *Gecko, 2*, 78-88.

Hare-Mustin, R. (1978). A feminist approach to family therapy. *Family Process, 17*, 181-194.

Hare-Mustin, R. (1994). Discourses in the mirrored room: A postmodern analysis of therapy. *Family Process, 33*(1), 19-35.

Hedtke, L. (2000). Dancing with death. *Gecko, 2*, 5-16.

Hedtke, L., & Winslade, J. (2004). *Re-membering lives: Conversations with the dying and bereaved*. Amityville, NY: Baywood.

Laird, J. (1989). Women and stories: Restorying women's self-constructions. In M. McGoldrick, C. Anderson, & F. Walsh (Eds.), *Women in families: A framework for family therapy* (pp. 427-450). New York, NY: Norton.

Lye, J. (2008). Some post-structural assumptions. Retrieved from Department of English Language & Literature, Brock University website: http://www.brocku.ca/english/courses/4F70/poststruct.php

Madigan, S., & Epston, D. (1995). From "spy-chiatric gaze" to communities of concern: From professional monologue to dialogue. In S. Friedman (Ed.), *The reflecting team in action: Collaborative practice in family therapy* (pp. 257-276). New York, NY: Guilford.

Maisel, R., Epston, D., & Borden, A. (2004). *Biting the hand that starves you: Inspiring resistance to anorexia/bulimia*. New York, NY: Norton.

Mitchell, S. (2006). Debriefing after traumatic situations—using narrative ideas in the Gaza Strip. In D. Denborough (Ed.), *Trauma: Narrative responses to traumatic experience* (pp. 103-113). Adelaide, Australia: Dulwich Centre.

Morgan, A. (2000). *What is narrative therapy? An easy-to-read introduction*. Adelaide, Australia: Dulwich Centre.

Myerhoff, B. (1986). "Life not death in Venice": Its second life. In V. W. Turner & E. M. Bruner (Eds.), *The anthropology of experience* (pp. 261-286). Chicago: University of Illinois Press.

Ncube, N. (2006). The tree of life project: Using narrative ideas in work with vulnerable children in Southern Africa. *International Journal of Narrative Therapy and Community Work, 1*, 3-16.

Ryle, G. (1990). *Collected papers: Critical essays and collected essays 1929-68*. Bristol, UK: Thoemmes Press. (Original work published 1971)

Seymour, F., & Epston, D. (1989). An approach to childhood stealing with evaluation of 45 cases. *Australian & New Zealand Journal of Family Therapy, 10*(3), 137-143.

Silver, E., Williams, A., Worthington, F., & Phillips, N. (1998). Family therapy and soiling: An audit of externalizing and other approaches. *Journal of Family Therapy, 20*, 413-422.

Sliep, Y. (2003). Building partnerships in responding to vulnerable children: A rural African community context. *International Journal of Narrative Therapy and Community Work, 2*, 56-66.

Taggart, M. (1985). The feminist critique in epistemological perspective: Questions of context in family therapy. *Journal of Marital and Family Therapy, 11*, 113-126.

Tamasese, K., & Waldegrave, C. (1990). Cultural and gender accountability in the "just therapy" approach. *Journal of Feminist Family Therapy, 5*(2), 29-45.

Thomas, L. (2004). Poststructuralism and therapy—What's it all about? In S. Russell & M. Carey (Eds.), *Narrative therapy: Responding to your questions* (pp. 91-99). Adelaide, Australia: Dulwich Centre.

Tomm, K. (1993). The courage to protest: A commentary on Michael White's work. In S. Gilligan & R. Price (Eds.), *Therapeutic Conversations* (pp. 62-80). New York, NY: Norton.

Vromans, L., & Schweitzer, R. (2011). Narrative therapy for adults with a major depressive disorder: Improved symptom and interpersonal outcomes. *Psychotherapy Research, 21,* 4-15. doi:10.1080/10503301003591792

Wade, A. (1997). Small acts of living: Everyday resistance to violence and other forms of oppression. *Contemporary Family Therapy, 19*(1), 23-29.

Waldegrave, C., Tamasese, K., Tuhaka, F., & Campbell, W. (2003). *Just therapy—A journey*. Adelaide, Australia: Dulwich Centre.

Weber, M., Davis, K., & McPhie, L. (2006). Narrative therapy, eating disorders and groups: Enhancing outcomes in rural NSW. *Australian Social Work, 59*(4), 391-405.

White, M. (1987, Spring). Family therapy and schizophrenia: Addressing the "in-the-corner" lifestyle. *Dulwich Centre Newsletter*, pp. 14-21.

White, M. (1988, Spring). Saying hullo again: The incorporation of the lost relationship in the resolution of grief. *Dulwich Centre Newsletter*, pp. 7-11.

White, M. (1988-1989, Summer). The externalizing of the problem and the re-authoring of lives and relationships. *Dulwich Centre Newsletter*, pp. 3-20.

White, M. (1989). *Selected papers*. Adelaide, Australia: Dulwich Centre.

White, M. (1995a). Reflecting teamwork as definitional ceremony. In *Re-authoring lives: Interviews and essays* (pp. 172-198). Adelaide, Australia: Dulwich Centre.

White, M. (1995b). Therapeutic documents revisited. In *Re-authoring lives: Interviews and essays* (pp. 199-213). Adelaide, Australia: Dulwich Centre.

White, M. (1997). *Narratives of therapists' lives*. Adelaide, Australia: Dulwich Centre.

White, M. (2000). Reflections on Narrative Practice: Essays and Interviews. Adelaide, Australia: Dulwich Centre.

White, M. (2002). Addressing personal failure. *International Journal of Narrative Therapy and Community Work, 3*, 33-76.

White, M. (2003). Narrative practice and community assignments. *International Journal of Narrative Therapy and Community Work, 2*, 17-55.

White, M. (2005). *Outsider-witness responses*. Retrieved from http://www.dulwichcentre.com.au

White, M. (2007). *Maps of narrative therapy*. New York, NY: Norton.

White, M., & Epston, D. (1990). *Narrative means to therapeutic ends*. New York, NY: Norton.

Yuen, A. (2009). Less pain, more gain: Explorations of responses vs. effects when working with the consequences of trauma. *Explorations, 1*. Retrieved from http://www.dulwichcentre.com.au/explorations-2009-1-angel-yuen.pdf

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