This is a pre-print of an article published in *Clinical Psychology Forum*. The definitive publisher-authenticated version for Brown, R., Sole, J. Ferguson, S. & Nolte, L. (2016) Creating ripples: Towards Practice-Based Evidence for Narrative Therapy within NHS Contexts, Clinical Psychology Forum, 284: 48-52 can be found here: <http://shop.bps.org.uk/publications/publication-by-series/clinical-psychology-forum.html>

**Creating ripples:** **Towards Practice-Based Evidence for Narrative Therapy within NHS Contexts**

**Rachel Brown, Jennifer Sole, Scott Ferguson and Lizette Nolte**

*This article describes the experiences of three trainee Clinical Psychologists of introducing a Narrative therapy approach in their workplace. Reflections from a clinical tutor who supported this work are also provided.*

Whilst ‘evidence-based practice’ currently holds greater influence within policy and governance standards, there is considerable interest in extending the potential of practice-based evidence to inform clinical practice. As Barkham & Mellor-Clark (2003) state, policy makers, practitioners and researchers’ need to value multiple paradigms which, together, can provide a more robust knowledge-base for psychological therapies. As such there is a challenge for us all to carefully consider our clinical practice, evaluate what we do and report on good outcomes of a wide range of clinical interventions used in everyday clinical practice.

This article describes how Narrative therapy approaches were implemented within three different NHS contexts and assesses the effects and outcomes of this therapeutic work. Whilst Narrative therapy may not hold as much influence within NHS contexts as therapeutic models that sit with greater ease within a medical and empirical framework, there is a growing body of research and practice-based evidence highlighting its potential value and effectiveness (e.g. Byrne, et al., 2011; Disney, 2011, Hughes, 2014 and see Dulwich Centre, 2009). It is argued here that a Narrative approach offers opportunities to create ripples of difference that can expand and enrich current dominant NHS practices.

**A Narrative therapy approach**

Narrative therapy places people as the ‘experts in their own lives’. That is, it draws upon people’s skills, values and commitments that can assist them in reducing the influence of problems upon their lives (Morgan, 2000). Central to this approach is a belief that people create meaning of their experiences through stories. These stories in turn impact on the ways in which people live their lives. Dominant problem-saturated stories about difficulties can develop, which limit people’s opportunities in the present moment and the future and exclude alternative stories that may be more helpful to the person. Narrative therapists employ a curious stance in order to facilitate ‘re-authoring’ or ‘re-storying’ conversations that explore alternative narratives of people’s strengths, skills and values with the aim of creating new possibilities for their lives (White and Epston, 1990).

**‘Tree of Life’**

The ‘Tree of Life’ group is a collective Narrative therapy practice developed by Ncazelo Ncube (Ncube-Millo & Denborough, 2007) that uses the metaphor of a tree to facilitate the telling and elaboration of strength-based stories. The aim of the group is to give people an opportunity to connect with their abilities and acknowledge their dreams and thus to position them on ‘firmer foundations’ to begin talking about losses or trauma, thus avoiding potential re-traumatisation. Each group member draws their own tree, including roots, skills, meaningful connections and hopes and dreams before the trees are joined into a ‘forest’ to explore collective strengths and skills. This collective story is used as a grounding to discuss how to stand strong in the face of collective challenges. The group was developed for work with children in Southern Africa, but has been successfully applied in a variety of mental health settings both with client and practitioner groups in England, e.g. with African and Caribbean men living in the UK (Byrne et al 2011), and children with emotional needs in a school setting (Disney, 2011).

**‘Tree of Life’ group for staff in a Palliative Care setting**

Whilst on placement in a Specialist Palliative Care Team, I (RB) co-facilitated reflective practice sessions with the team. I noticed a theme of problem-saturated conversations with a shared narrative within the team of ‘not working well together’. In exploring this further I learnt that the team wished to move closer together and understand each other’s perspectives and unique contributions. The Tree of Life group was presented to the team as a way to help them learn more about each other’s unique skills, values, contributions and ultimately their collective strength.

The team were initially concerned about the level of self-disclosure the exercise would involve and the vulnerability this may bring. Therefore, individuals completed their professional trees prior to the group exercise and shared it with a trusted team member, rather than the larger group. The workshop then began with inviting reflections on the skills and abilities each person brings to the collective, followed by reflection on gifts given and received (contributions people made to each other), thereby constructing a collective tree. The second half of the session focused on how they may be able to draw on their collective tree (skills, abilities, unique contributions) to negotiate the level of distress and bereavement they experience in their daily work. The workshop concluded with discussion focused on individual and collective commitments, hopes, and goals for taking things forward.

A qualitative feedback questionnaire was administered one month after the group session. Multiple perspectives emerged from this. People reported feeling a better appreciation and value of difference within the team; however, some responses also indicated that they had not felt able to be completely honest, that there was not room in the team for potentially more difficult stories to be told and explored. This reflection in itself appeared an important outcome, a valuable foundation for continued reflection for the team. Interestingly, two months later feedback was received from the manager of the service that she had observed clear benefits of the group in the form of increased team cohesiveness and was intending to roll it out in other teams within the service.

**‘Tree of Life’ group for school transition**

Whilst on placement in a Child and Adolescent Mental Health Service (CAMHS), I (JS) facilitated a ‘Tree of Life’ group with seven children making the transition to secondary school. This transition can present children and their families with an enormous change that can result in experiences of challenging emotions, behaviours and concerns, which can be even more of a challenge for those children who have presented to services with mental health difficulties (e.g. Thompson et al. 2003). Narrative therapists understand problems as separate from people (Morgan, 2000). Thus, it was hoped that engaging children in ‘re-storying’ of their experiences to bring forth stories of strengths, skills and resiliency would assist the children in managing the transition.

The ‘Tree of Life’ group included four stages: ‘Creating the Tree of Life’, ‘Forest of Life’, ‘Storms of Changing Schools’ and ‘Celebration’, facilitated over six weekly sessions. Conversations between facilitators and the children aimed to build more enabling stories, connecting the children with important people and experiences that could help them navigate the possible challenges of the transition. Through the group the children were able to broaden the narratives about their lives. The sharing and the celebration of these alternative narratives with their parents in the final session strengthened these stories further.

As the intervention was preventative rather than aimed at ‘symptom’-reduction, effectiveness was primarily measured through a self-report questionnaire. This suggested that the majority of the children enjoyed the group and felt the group had helped them. The CAMH-team highly valued the group and decided to re-run it the following year.

**‘Team of Life’**

The ‘Team of Life’ group is a collective Narrative therapy practice developed by David Denborough (Denborough, 2008). It uses sporting metaphors to create a space in which boys and young men can explore their personal stories of resilience in the face of adversity, co-creating alternative stories around strength and resilience. Each group member develops their own ‘Team of Life’, which identifies roles that family and friends may play in supporting one another through difficult times. These roles are discussed in terms of sporting positions on the pitch (e.g. the role of a goalkeeper as the protector of the family). The group ends with a definitional ceremony in which the group members share their experiences of the group with their ‘Team of Life’ members (e.g. a young person’s parents). Definitional ceremonies are sessions that encourage re-telling of alternative and preferred stories to those who are part of group members’ everyday lives, as a way to further strengthen these stories (White, 2000).

**‘Team of Life’ group for boys struggling with anger difficulties**

I (SF) came across ‘Team of Life’ while on a CAMHS placement. At the time I was struck by the number of referrals that colleagues and I received requesting therapy for adolescent boys with ‘anger management and behavioural problems’. Families, schools, professionals and the boys themselves were frequently highlighting just how ‘bad’, ‘naughty’ and ‘difficult’ they could be.

Using Denborough’s programme as a guide, a colleague and I developed a 10-week group intervention using sport as a metaphor to explore alternative narratives around emotional expression for these boys. The group explored dominant narratives of emotional expression in both sport and everyday life. Struggles and challenges were identified and the boys were encouraged to draw on each other’s experience of overcoming adversity and pick out themes of strength and resilience. Each boy created their own ‘Team of Life’ and this was shared with ‘team-members’ in the final group.

This definitional ceremony proved extremely powerful as the boys shared that they felt more confident in talking about and coping with their emotional experiences. ‘Team of Life’-members reported noticeable changes in the self-confidence of their children and a reduction in problem-focused descriptions of their children’s behaviour. It has been argued that definitional ceremonies “provide a way of generating therapeutic outcome evidence through collaborative re-search processes that sit more congruently with …Narrative Therapy practices” (Speedy, 2004, p. 43).

**Supporting Narrative therapy work within NHS contexts**

When approached to consult on the above therapeutic interventions, I (LN) was expecting some cautiousness or resistance in the respective NHS teams. Contrary to this expectation, colleagues were curious and came to embrace the Narrative approaches. Providing a clear rationale for the groups, working with teams in a transparent and collaborative way, and allowing for the Narrative techniques to be adapted to the individual needs of the contexts may have significantly contributed to the positive response.

Some challenges did however present themselves. Firstly, it was challenging at times to move away from an individualistic towards a more shared community approach. Within the NHS context, concepts of emotional safety and confidentiality are highly valued and can appear to be contradicted by communal approaches encouraged within Narrative therapy. These issues required explicit consideration and negotiation whilst holding the needs of the group attendees at the fore. Secondly, an approach that does not focus on problem descriptions and/or praise is counter-cultural and even where people are in theory committed to focus on resilience and strengths, in practice habits of problem-orientated talk and locating difficulties within the individual might be difficult to break. Interestingly the approaches were well received, suggesting a strengths-focused approach can be welcomed in such settings. Finally, within contexts where Narrative work might not be supported outside the group, it might be difficult for the conversations within the sessions to fully take root and be sustained beyond the group itself.

Despite these challenges, the accounts describe how the groups created ripples of difference that had and continue to have interesting and unexpected influences within these teams.

**Final reflections and recommendations**

When considering using a Narrative therapy intervention the following might be worth considering:

* It is helpful to provide detailed information to teams, colleague, and clients attending the programmes about what the intervention entails as well as a clear rationale for its introduction. Only through doing this will teams and clients embrace an approach that may sit somewhat differently to the dominant problem focused discourses in services.
* It can be helpful to provide colleagues with space to consider Narrative practices without being too rigid about how the ideas should be implemented. Adaptations to interventions in line with the specific context can encourage the team to take ownership of the intervention.
* It is important to find clear ways to assess the effectiveness and value of Narrative interventions. This fits with the expectation for evidence-based practice, while also responding to Speedy’s (2004) invitation for Narrative practitioners to “contribute to an international Narrative Therapy outcomes re-search conversation” (p. 43).

**Conclusion**

In this paper we presented three examples of how collective Narrative therapy practices were adapted to be useful and effective in NHS contexts. It is our experience that many NHS clinical psychologists draw on Narrative therapy in their work. However, in contexts where this model falls outside of the familiar and dominant paradigm, practitioners perhaps feel less able to explicitly cite the model of therapy they are drawing from. The difficulty is that when these stories of Narrative practice in NHS contexts are not made explicit, we simply perpetuate a ‘thin’ story (obscuring richness, diversity and complexity) about what constitutes effective practice. Through sharing these examples of practice-based evidence we hope to create ripples of change through encouraging others to explore similar opportunities to embrace Narrative therapy approaches.

**Authors**

Rachel Brown, Clinical Psychologist, Independent Practitioner, [contact.incontex@gmail.com](mailto:contact.incontex@gmail.com)

Jennifer Sole, Clinical Psychologist Islington, Community Child and Adolescent Mental Health Service

Corresponding author: Scott Ferguson, Clinical Psychologist, Bedfordshire Acquired Brain Injury Service, [scott.ferguson2@sept.nhs.uk](mailto:scott.ferguson2@sept.nhs.uk)

Lizette Nolte, Clinical lecturer, Doctorate in Clinical Psychology course, University of Hertfordshire, [l.nolte@herts.ac.uk](mailto:l.nolte@herts.ac.uk)

**Acknowledgements**

The authors would like to thank North Hertfordshire Specialist Palliative Care Team, Loughton Community Child and Family Consultation Service and Stevenage Child & Family Clinic.

**References**

Barkham, M., & Mellor‐Clark, J. (2003). Bridging evidence‐based practice and practice‐based evidence: developing a rigorous and relevant knowledge for the psychological therapies. Clinical Psychology & Psychotherapy, 10(6), 319-327.

Byrne, A., Warren, A., Joof, B., Johnson, D., Casimir, L., Hinds, C., Mittee, S., Jeremy, J., Afilaka., A & Griffiths, S. (2011). “A powerful piece of work”: African and Caribbean men talking about the ‘Tree of Life’, Context, October: 38 – 43.

Denborough, D. (2008). Collective Narrative Practice: Responding to individuals, groups and communities who have experienced trauma. Adelaide: Dulwich.

Disney, A. (2009). A narrative ethnography: stories from within and beyond a Tree of Life group. Unpublished doctoral thesis, University of Hertfordshire, Hatfield, United Kingdom.

Dulwich Centre (2009). Research, evidence and Narrative practices, retrieved from <http://dulwichcentre.com.au/narrative-therapy-research/>.

Hughes, G. (2014) Finding a voice through the ‘Tree of life’: a strength-based approach to mental health for refugee children and families in schools, Clinical child psychology and psychiatry, 19(1): 139-153.

Morgan, A. (2000) What is Narrative Therapy?: an easy-to-read introduction. Adelaide: Dulwich Centre Publications.

Ncube-Millo, N. & Denborough, D. (2007). Tree of Life - mainstreaming psychosocial care and support: a manual for facilitators. Randburg: REPSSI.

Speedy, J. (2004). Living a more peopled life: definitional ceremony as inquiry into psychotherapy ‘outcomes’, International Journal of Narrative Therapy and Community Work, 3: 43-53.

Thompson, A.E., Morgan, C. & Urquhart, I. (2003). Children with ADHD transferring to secondary schools: potential difficulties and solutions. Clinical Child Psychology and Psychiatry, 8(1): 91 - 103

White, M. (2000). Reflecting teamwork as definitional ceremony revisited. In M. White: Reflections on Narrative Practice: Essays and Interviews. Adelaide: Dulwich Centre Publications.

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

**WORD COUNT: 2500**