

Narrative Therapy And Abused Women:
Effectiveness of Narrative Therapy For Sheltered / Abused Women
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This paper will evaluate the effectiveness of Brief Narrative Therapy in treating abused women who are in shelters. In addition to living with violence, many women who seek shelter have been living in poverty, dependent on humanitarian aid, and suffering from trauma. Being abused undermines virtually every aspect of a woman's life; her physical as well as her mental health. Psychiatric effects may include depression, suicidal thoughts, dissociation, Post Traumatic Stress Disorder, eating disorders, adjustment disorder with depressed mood, Obsessive Compulsive Disorder. In the delivery of effective clinical interventions with abuse survivors specific narrative practices and approaches will be addressed. The paper draws on theory, in class lectures and the personal experiences gained from working with women who have encountered domestic violence and are currently sheltered.

For some groups of women in Canada, experiences of discrimination, racism, poverty, and social and geographic isolation create additional barriers. These women often must deal not only with the consequences of being abused but also with the effects of their marginalized position in society, and the reality of limited services. A therapist working in this environment should be aware of the lack of adequate community resources, and the prejudice the client is more likely to have experienced in the "system". This lack of external resources means the therapist may need to reconceptualize their role, shifting from "one of many" providers to being the primary or even only point of intervention for sheltered clients. When dealing with this population the most important role for any therapist is to allow for an intervention that offers choice, something these women have been denied as part of their traumatic experience.

It is unclear how many of these women suffering from abuse trauma seek and accept therapeutic aid or even have access to psychotherapeutic assistance that might provide relief. It is also questionable if any psychological assistance can be successful given that treatment protocols for trauma and PTSD typically require the establishment of a safe and reassuring environment, conditions that are difficult to meet within the context of a shelter. Maslow's hierarchy of needs (Maslow, 1943), for instance, claims that treatment for psychological problems can hardly be addressed as long as the basic needs of nutrition and safety are pressing.

In traditional treatment, individual therapy for victims of domestic violence begins with a primary focus on safety, particularly if the woman is coming from an abusive relationship. In addition to assessing the danger, in many shelters it is also the role of the therapist together with the client to develop a safety plan which contains a strategy for how to keep away from a dangerous situation. Shelters provide an important resource for abused women in that they offer emergency shelter, support, and access to community resources that can aid in establishing long-term safety for women and their children. The metaphor of "therapist as host" can shape therapeutic alliance with the victims because it ascribes a range of ways in which those seeking relief can be welcomed to the experience of therapy.

Treating someone as a cherished guest addresses the power differential undisputable in a therapeutic relationship by elevating the status of a person who comes to consult the therapist.

(Jodi Aman, 2006)

A woman's entry into a shelter may mean that she is no longer in immediate danger but safety still remains a concern. As such a woman may be ready to seek relief and that the longer-term goals of any necessary psychological treatment for the woman can be addressed. These goals include helping the woman identify the impact of abuse on her life and helping her work toward empowering herself. The treatment of survivors of chronic abuse presents many challenges, including complex diagnosis,

treatment staging, and relational dilemmas. Any therapy method or approach used must be adaptable to shelter environment and should be easy to implement. This is because a woman who is overwhelmed by histories of trauma may not immediately identify trauma as the main problem when she is requesting therapy.

Narrative approaches emerged from the various schools of family therapy, sitting alongside structural family therapy, systemic family therapy, constructivist family therapy, brief therapy, solution-focused therapy, linguistic systems approach and various others.

(Alice Morgan, Dulwich Centre Publications, 2000)

The narrative therapy premise is that each of us have “narratives” or stories that we tell about ourselves. Narrative therapists are interested in joining with people to explore the stories they have about their lives and relationships, their effects, their meanings and the context in which they have been formed and authored (Morgan 2000). Story telling and verbal expression is a concept shared amongst all humankind, and does not necessarily obtrude western concepts of psychotherapy. As such narrative approaches seem ideally suited to cross-cultural applications. The opportunity for an individual to tell, re-tell their story and express their emotions can be therapeutic in itself.

Dominant practice models for social work were originally developed and intended for work with voluntary clients. Some sheltered women have been sent to shelters by powers they don't trust and for reasons that they may not fully understand. In this case women will approach a session cautiously, with the belief that she is powerless to set the treatment goals. With mandated clients, therapist can begin the co-construction of cooperation through adopting a not-knowing posture, focusing on and amplifying what clients want, focusing on clients strengths and successes, and asking questions to generate possibilities for change specific to the mandated context

Many of the ways of working that are referred to as narrative approaches originated from work with people who had no choice but to attend therapy (involuntary clients), who were living in situations in which they had little choice over aspects of their lives (as in locked psychiatric wards), or who initially were unwilling to join a conversation with a worker (people who were not speaking to anyone, who were living reclusive lifestyles). Narrative practices derived from a desire to find ethical and effective ways of working in these situations. Many workers are continually refining ways of working in such contexts.

*(Commonly asked questions about narrative approaches to therapy, community work and psychosocial support **Collective paper**)*

Narrative therapists work with clients who are forced into treatment by maintaining a delicate balance between acknowledging that the client doesn't want to be there and trying to find a goal the client would be willing and motivated to work on. It is important to first listen to the clients' experience of being mandated into treatment and any complaints they may have about by whom and how they were mandated. The theory of person-centered therapy suggests any client, no matter what the problem, can improve without being taught anything specific by the therapist, once he/she accepts and respects themselves (Shaffer, 1978).

Julie, a single mother of two boys was mandated to stay in the shelter in order to keep her children.

Therapist:

what would you like to talk about today?

Julie:

whatever will get CAS (Children Aids Society) off my back? They don't even want to know what is going on they just want to take my children away from me

In this case the therapist is not the expert who comes up with the right answer. Instead he/she is a listener who is assisting the client in becoming more aware of the many forces pulling her into a particular and often negative narrative. The therapist builds a narrative therapeutic alliance whose main goal is to give space for the client to explore and re-vision her past and reconnect with her social, and

cultural resources while focusing on addressing current interpersonal problems, personal decisions, and plans and hopes for the future. The procedure is flexible and open to modification depending on the client's specific needs.

Julie started talking about how CAS got involved in her life. In that session she indicated that one of the conditions of keeping her children was that she maintained a clean house and ensured that her children were never left unattended.

Therapist:

how has the conditions affected you and your children

Julie:

*I think they(children) like it, I am always home these days. They are in daycare , I think they like daycare more than **being in the room (Shelter room).**But I am going to go back to school. I registered to go finish my hospitality course. I am waiting for OSAP (Ontario Student Assistance Program) to come through then I will know for sure. Who would have thought, eh*

Here the therapist provides a safe, empathic and informed space in this session for Julie to explore her own parenting and attachment dilemmas, and how these dilemmas interact with her children's wellbeing. She is able to look at the situation differently and start working towards change.

Therapist:

who do you think would not be surprised to hear this

Julie:

my friend crystal. She knows I can do it, I was doing it for a while until I got pregnant and could not pay rent. Anyway they (CAS) want me to be able to have a place. I have to be able to pay rent, right? So I got to stay in school

Therapist:

what abilities or skills do you think have helped you get to this point

Inquiry about how the problem (condition) has been affecting Julie and her children lives helps Julie view herself as separate from her problems by externalizing the problem. White and de Shazer (1991)

follow strengths based approaches seeking solutions to problems and looking for exceptions to the problem and unique outcomes or stalled initiatives. The aim of externalizing practices is therefore to enable people to realize that they and the problem are *not* the same thing. Through the identification of these exceptions or unique outcomes, it is conceived that one is able to move past the problems. The fact that Julie was able previously to maintain housing is something she can appreciate about herself and an ability she can now understand as special.

Questions are the most effective means of “thickening” exceptions engaging in re-authorizing with persons around favorable developments in their lives. When we ask rather than tell it is up to the client to revive the threads of alternative stories
(David Pare’ - thickening exceptions- Hincks- 2007)

Julie came in with a narrative that was comprised of stories of impossibility, blame, shame, guilt and minimal sense of her ability to find her own solutions. The therapist thickens Julie’s descriptions of unique outcomes by using landscape of action (sequence of events) and landscape of consciousness (making meaning of events) questions (White 1994). By becoming more aware, Julie can see the alternative story, that the conditions put in place by CAS are not a barrier to her success but that in fact, they have actually brought her children some stability. Julie’s plans to go back to school can also be considered a unique outcome in this session. She has realized obtaining a job will enable her to maintain her housing.

The experience of homelessness results in the loss of routines, community, possessions, privacy and security. A home is important for its role as one of the relatively few spaces in people’s everyday lives over which they exercise (near complete) control. Notions of what privacy and control mean are in fact deeply tied up in our experience of our homes and once this controlled environment is interrupted, it can cause strain. A large number of women point to housing as the priority issue of concern.

Therapist:

What is your goal for this session

Julie:

it is simple . I want to live in my on place, no rules, no curfew, no living with stupid people; always being watched and told what to do

One of the practices of narrative therapy is that it is easy to translate into therapeutic practice for clients where cultural sensitivity is important. The therapist can consistently check with clients about their experience of therapy in order to offer them choices about which direction should be pursued in the session. In fact narrative therapy proves extremely culturally sensitive, since clients can tell their own stories, in their own fashion and ways of cultural expression, related to their own traditional and personal background and setting. When therapy methods are culturally familiar, it is easy for clients to tap into past childhood, community and religious roots and thus release a rich source of associations that can be helpful in therapy and the healing process.

The primary tasks of the therapist can be described as listening to what the client says and making space for what the client has not yet said. According to Anderson and Goolishian, (1987) the therapist should take a not-knowing stance in this dialogic process. Here the holding of not knowing and knowing together provides a narrative container for personal meaning and thinking to develop.

To “not know” is to have found an unfounded or inexperienced judgment but refers more widely to the set of assumptions, the meaning that the therapist must bring to the clinical interview (Anderson 1992)

As such narrative therapists working with minority battered women need not be overly knowledgeable about cross-cultural differences in the experience of abuse and disclosure patterns This “not knowing” position adapted by the therapist is what a postmodern psychoanalysis has in common with family therapy; both are ways of being with persons to help them develop and hold their own knowing.

Grappling with issues such as guilt, loss of control and powerlessness, so important in the western cultures may not be that fruitful for people coming from third world cultures. However, shame, loss of face, trust, fate and blame can be more important in third world settings. In this case the client is openly acknowledged as the expert in relation to her narrative and how she can best learn new coping skills.

*Just as with any way of thinking or working, there will be many aspects of narrative practices that cannot simply be applied from one culture to another. Differences across cultures (such as whether the culture is informed by oral or written traditions, whether or not direct questions are appropriate, variation in ideas about family and community life etc) mean that great care needs to be taken so as to ensure that dominant cultural ideas are not enforced upon others . ((
(Alice Morgan, Dulwich Centre Publications 2000)*

Narrative therapy has been associated with the assumptions of postmodernism and social constructionism; both of which support the notion that there are no truths, just points of view. Thus, narrative therapists have sought to privilege the voices of their clients in the process of delivering them from the oppressive weight of dominant, cultural grand narratives. Therefore, vigilant attention must be paid to the use of language from the very beginning and throughout the therapeutic conversation. Our concern is not only how people interpret language and circumstances, but also, how we interpret their interpretations (Duvall 2007)

Lina is an ethnic minority single mother of a one year old boy

In order to apply for priority housing Lina had to disclose her abuse in details and what effects it is having on her and her child. She went on to say that sometimes she feels “like dying”. The housing worker takes this to mean that the woman is suicidal and as such her child could be in danger. The woman is sent to see a therapist. In that first session the

therapist calls CAS, sends the woman to emergency and as a result she is put on anti-depressants.

In her complaint Lina indicated that she did not feel listened to and that the therapist overreacted. She said that because of her child she had found the strength to move on and was upset that anyone would think she would do anything to hurt him. She also said that it “only took half an hour for her (Therapist) to say I am crazy”. These people (Caucasian therapist) take things literally.

Clearly, treatment can become impossible when the client's motivation is misunderstood or neglected. Even the most experienced therapist can easily overlook what the client wants to accomplish while focused on what the therapist believes might be best. A storied approach to therapy provides opportunities for the interpretation of experiences that represent a person's preferred ways of being and relating in the world (Duvall 2007). We are reminded of the work of Carl Rogers and his empathic and client-centered approach. The theory of person-centered therapy suggests any client, no matter what the problem, can improve without being taught anything specific by the therapist, once he/she accepts and respects themselves (Shaffer, 1978).

Lina continued to see a therapist as per shelter recommendation. She however indicated she had no time for therapy as she was still in a shelter with no home and no job. She felt that she was wasting time talking about the past while she should be concentrating on finding work.

Lina was expressing those things that are important to her in her life. The therapist by making space in the conversation allows her to express her voice and articulate her preferences. In this case success will occur if the therapist is able to accommodate to the client's frame of reference and the client's theory of change is honored. Presenting therapists as the heroes of the therapeutic dialogues, liberating clients from their discursive shackles, amounts to privileging therapists and diminishing clients (Anderson, 1997)

Change can occur without it being imposed; in fact imposing change can lead to adaptations that are undesirable. Sometimes it is not possible to express the raw experience of suffering in a narrative frame, and the worst suffering is probably expressed in silences (Charmaz, 2002). Women will gauge the safety of the session and the therapists responses to the story before taking the risk of telling a more delicate story of violence. As such, stories told in the beginning of the session may be less delicate in comparison with stories that are told later in the session. The narrative therapeutic model presented for complex PTSD is a non- pathologizing developmentally informed approach that moves away from the idea of understanding discrete “symptoms,” towards a more sophisticated and integrated understanding of how survivors adapt to and cope with the long-term effects of abuse.

The aim of externalizing practices in narrative therapy is to enable clients to realize that they and the problem are *not* the same thing. Once the overall problem and specific components of it have been externalized, clients take notice of an opportunities to take action against the externalized problem(s). Large numbers of women who are poor and/or homeless consider it shameful, but they consider it their own shame. By externalizing these labels, the therapist invites the clients to escape the oppression of the labeling and to set their lives in the direction that they prefer (White, 1987). According to White, the practice of externalizing also help in de-labeling the clients. Regardless of whether they have been labeled, the client is no longer “homeless” or “depressed” rather “the homelessness” and “the depression” is having an effect on their life.

One of the most significant aspects of externalizing conversations, is that within them, broader considerations can also be taken into account. When it is understood that people’s relationships with problems are shaped by history and culture, it is possible to explore how gender, race, culture, sexuality, class and other relations of power have influenced the construction of the problem (The International Journal of Narrative Therapy and Community Work, 2002 No.2)

In narrative therapy outsider witnessing practices serve as ‘meaning attractors,’ highlighting images or alternate perspectives on the stories and experiences the outsider witness group experiences during the interview. (Kriz, 1998). Most clients in this situation have only problem-saturated descriptions that have encompassed or have become "their identities". When the reflecting team acknowledges their experiences of the problems, clients are provoked by the neglected aspects of their lives, aspects that might provide a point of entry for the generation and/or resurrection of the alternative stories of their lives (White 1995). It changes a person’s relationship to problems, and shifts the conversation to a focus on the relationship between the person and the problem instead of a focus on a problem-person. Through this process people begin to see themselves as authors, or at least co-author's of their own stories. They begin to move toward a greater sense of agency in their lives.

Conclusion

Levinas, a Jewish philosopher suggests that we attempt to let go of our certainties and our knowledge in order to engage in an ethical interaction with the other so that we can be fully present and open to new ways of knowing and understanding the stories of those people. This stance contributes to a sense of curiosity and tentativeness which is needed in collaborative work.

Our lives are multi-storied. No single story of life can be free of ambiguity or contradiction. No self narrative can handle all the contingencies of life. (White 1994) Narrative therapists are influenced by the idea that the people coming to see them in therapy are so much more complex and interesting than the narrow descriptions they often come to therapy with. The therapist helps people resolve problems by enabling them to separate their lives and relationships from specific historical ideas, influences and stories they judge to be impoverishing. He/she assists people on ways to challenge certain patterns of daily living (and thinking) that they find distressing, subjugating, hopeless and abusive.

Narrative therapists are highly encouraging of people to discover ways to re-author their lives according to their own preferred stories of identity and relationships and he/ she provides discussion on how best to support these preferred ways of living over the long term. The narrative therapist's role in the therapeutic alliance "is to bring these alternate stories out of the shadows and to elevate them so that they play a far more central role in the shaping of people's lives." (White, 1994). If this is accomplished positive emotions are increased and the pleasant life is promoted by exercises that increase gratitude, that increase savouring, that build optimism and that challenge discouraging beliefs about the past.

The primary focus of a narrative approach is people's expressions of their experiences of life. Clients tell their stories in their own words and in their own way. As such narrative therapists can work even with people who have literacy issues and who are not as eloquent or as articulate. Narrative therapy exploits sites of resistance , unpacking the constraining aspects of the told stories and resurrecting the suppressed voice by recognizing and emphasizing the agency and creativity available to individuals in re-authorizing their identities. In that it is through expressions that people shape and re-shape their lives, expressions are not an 'academic' matter (White 2004

Narrative counseling is based on the premise that stories, rather than fixed realities, shape our lives. By changing the stories that negatively label and define clients, narrative therapists help them open up new avenues and opportunities. According to White 1995 thinking about identity as fluid allows for the possibility for movement from an identity that focuses only on being victimized by the trauma to one that includes having survived and resisted it.

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