II - Narrative letter

Different ways of thinking…

Dear reader

Time and my lived experience evolved and enriched my narrative perspective in context of the process of my Doctoral study to date (January 2004). At the time of describing the theoretical and practical contexts as regards a literary overview, I have completed the experiential process and transcription of the data collected as well as an oral examination involving the reading of a broad literature base. Consequently, the description of both contexts with regards to a literary overview is my view on narrative ways of thinking at this point in time. I don't assume that my assumptions about written text on narrative ways of thinking are cast in stone. As this thesis enfolds, I would like to reflect throughout making space for different possibilities of meanings through the medium of written language.

Concerning the matter of taking a reflexive stance throughout the letters in this study, MacLeod (2002) states that while there is a clear rationale for investigator reflexivity, there are dangers associated with it as well. In the first instance, a focus on the construction of the account by the researcher rather than what is being accounted for can be problematic. Secondly, there is a danger of the exercise slipping into a personal confession either of the reflexive positioning (the discursive positioning assigned to him/herself by an individual – Davies & Harré, 1990) of the researchers or of their emotional investments. In this study the researcher also becomes a researcher-therapist. Regarding this issue, Mills and Sprenkle (1995) state that therapists' greater awareness of personal issues, however, is not simply a training issue. This awareness is an increasing expectation in the field for all therapists who are bringing themselves into client systems and influencing these systems in the tradition of the therapists' own interpersonal histories.

MacLeod (2002) further questions the maintenance of the crucial aspect of researcher reflexivity while avoiding the dangers. MacLeod addresses two important aspects, namely:

- a researcher's reflections of self in the research process need to be explicitly linked to political practice,
- researcher reflexivity should address the interactional, relational and power dynamics of the research at hand, rather than focusing on a confession of emotional or discursive positioning of the individual researcher.

In this study the theoretical and practical are two main contexts for describing narrative ways of thinking.

Theoretical context with regards to a literary overview

In today's world context Mills and Sprenkle (1995) state that family values, for increasing numbers of people, are less rooted in sacred principles of church and community than in a very private mix of personal, situational beliefs. Anderson (1990) proclaims that the transition from the modern era to the post-modern era is marked by a flagging societal belief in one absolute, fixed reality for all people and an increasing acknowledgement that our culture embodies an infinite variety of equally valid ways to view the world.

This study's theoretical context with regards to a literary overview is set in the post-modern era, social constructionist perspective and narrative ways of thinking. A post-modern and social constructionist world is described by Parry and Doan (1994) as a place without any single claim to a truth universally respected, and a growing realisation that no single story sums up the meaning of life. It is also a place in which so much is happening to so many so fast that no story or theory is sufficient to correspond fully to its subject matter.

The post-modern era is described by O'Hara and Anderson (1991) as:

> A society enters the post-modern age when it loses its faith in absolute truth – even an attempt to discover absolute truth. The great systems of thought like religions, ideologies and philosophies, come to be regarded as social constructions of reality. These systems may be useful, even respected as profoundly true, but true in a new, provisional, post-modern way. Few people expect that one truth ought to work for everybody (p.22).

Freedman and Combs (1996) structure the post-modern and social-constructionist worldview according to four ideas about realities as follows:

- realities are socially constructed;
- realities are constituted through language;
- realities are organised and maintained through narrative; and
- there are no essential truths.

Writings on post-modernism frequently focus on ideas regarding text and narrative, paying attention to the importance of dialogic multiple perspectives, self-disclosure, lateral versus hierarchical

configurations, as well as to process rather than goals (Lax, 1992). Further emphasis is placed on the self being conceived not as a reified entity, but as a narrative; text is not something to be interpreted, but is an evolving process; the individual is considered within a context of social meaning rather than as an intra-psychic entity; and scientific knowledge or what would be considered undeniable facts about the world, yields to narrative knowledge with emphasis placed more upon communal beliefs about how the world works (see Gergen & Davis, 1985; Lyotard, 1988; Sampson, 1989; Sarup, 1989).

The main focus in this study's therapeutic context is on creating a space, where women can tell their stories about food. Neimeyer (1993) defines reality by the stories people live and the stories people tell. Amundson (2001) argues what a story is or is not measured against the ability of a story to perform specified tasks in the real world. Empirically then an idea – be it scientific or ideological – is never left to rest. Narrative ways of thinking offer useful ideas about how power, knowledge and truth are negotiated in families, the media and other social contexts surrounding women's relationship with food in excess. For example: The media or social context (power source) depicts a successful woman as someone with a perfect and thin body-image, therefore the truth about overweight women must be that they are out of control concerning their relationships with food in excess.

Consequently, a description of some ideas surrounding the social constructs of power, knowledge and truth is given within a social scientific paradigm.

An argument on power relations begins with Bateson's ideas about power that centres on two themes, already familiar within the family therapy literature (Flaskas & Humphreys, 1993).

- The *first theme* is that the concept of power is an epistemological error, that one individual cannot hold unilateral power over another because people are always subject to the constraints of being part of a relationship (Bateson, 1972). Later challenges were made to the Batesonian equation – the equation beginning with a commitment to understanding relationships in terms of circularity and complimentarity, leading to the impossibility of unilateral power, and this in turn leading to a negation of power in the theory and practice of family therapy. Bateson's writings on power brought critiques from different psychological perspectives to the fore in the 1980's (Flaskas & Humphreys, 1993). See critiques on Bateson's discussion on power (Goldner, 1985; MacKinnon & Miller, 1986; Dell, 1986; Imber-Black, 1986; Luepnitz, 1988; Hoffman, 1988, Goolishian & Winderman, 1988).

- The *second and connected idea* is that a punctuation of the world, using the notion of power, is potentially unethical and toxic in its effects (Bateson, 1972).

However, Foucault argues that we predominantly experience the positive or constitutive effects of power that we are subject to power through normalising truths that shape our lives and relationships. These truths, in turn, are constructed or produced in the operation of power (Foucault, 1980). The will to truth is a notion that Foucault derived from Nietzsche in *The Genealogy of Morals* (Nietzsche, 1956/1887). It involves traditional philosophical questions such as; what is the world? What is man? What is knowledge? How can we know something? (Foucault, 1988). Foucault suggests that today this has changed to the historical reflection on ourselves and asks; what are we today? (Foucault, 1988). This opens the possibility of exploring how our lives are produced through cultural knowledges and practices (White, 1997).

In reaction to Bateson, Foucault radically departed from any idea of power as monolithic and unilateral. In this sense, he developed an idea of power that is intensely interactional, thus power cannot be seen as something in itself, but rather shows itself through the evidence that can be found in everyday interactions. Foucault drew an inseparable link between knowledge and power; the discourses of a society determine what knowledge is held to be true, right, or proper in that society, so those who control the discourse control knowledge. For Foucault, power is knowledge and knowledge is power (Freedman & Combs, 1996).

In summary, Foucault's most important ideas are the ideas of the productive potential of power, the notion of power as relational, the need to study power in the context of the specific social relationships in which it occurs, and the possibility of resistance (Flaskas & Humphreys, 1993). Phillips (2001) states, regarding the concept of resistance, that a great deal of learning comes from recognising the polarities in resistance. It is necessary for self-regulation, and without it people cannot maintain their boundaries. So when you choose a particular course of action, not only will you need to accept a loss, you will also need to work with the resistance.

In concluding the reasoning regarding power and knowledge, Flaskas and Humphreys (1993) explored intersections between Foucault's work on power, and the way in which systemic family therapy has engaged with the task of theorising about power. Intersecting Foucault's ideas with the problem of theorising about power in family therapy revealed both a firm point of connection as well as major points of contrasts. The point of connection is Foucault's commitment to a radically relational analysis, which resonates strongly with systemic family therapy's commitment to

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recursive analysis, and to Bateson's first theme of an opposition to any unilateral conception of power. The parallel difference, though, is that Foucault came to centre on a relational analysis of power, whereas family therapy initially censored power altogether from its theory horizons, and has subsequently been restricted in its discussions to theorising about power around the oppositional poles of Bateson's original two themes.

Another contrast is family therapy and Bateson's concept of power-as-restrictive-only versus Foucault's focus on the productive forms of power. While Foucault's work always potentially enables an analysis of oppressive power relationships, there are major limitations in his work as a political philosophy and theory. However, Foucault rejects a politics of knowledge that searches for a prescriptive theory base, while systemic family therapy has embraced the more traditional approach to knowledge (Flaskas & Humphreys, 1993). Narrative inquiry is used as research design in this study.

Regarding a theoretical framework for this study James (1907) notes:

> No theory is absolutely a transcript of reality, but any one of them may from some point of view be useful. Their great use is to summarise old facts and lead to new ones. They are only manmade language, conceptual shorthand, as some would call them, in which we invent our reports of nature; and language, as is well known, tolerates much choice of expression and dialects (p.25).

James tells us clearly that theories and facts regarding people always emerge in *language* and in *context*. According to Amundson (2001) in *language* there are many ways to express things, and in *context* there are dynamics which relativise our theories and facts. Both concepts are described as follows;

- Anderson and Goolishian (1988) state that by *language*, they do not refer to a specific focus on signs, structure, or style. Rather, they refer to linguistically mediated and contextually relevant meaning that is interactively generated through the medium of words and other communicative action. It is in language that people are able to maintain meaningful human contact with each other and through which they share reality. To be in language is a dynamic, social operation. It is not a simple linguistic activity. To be in language is, however, a distinctively human process because it is through language that people are capable of forming the shifting communities of meaning to which they belong and that are for them the inter-subjective realities in which they exist (Anderson & Goolishian, 1988).

- The *context* is described as that language that is part of a culture; it is based on public criteria or rules (agreements in practice), and these rules cannot be learnt explicitly, as they are the products of deep cultural agreement that form the background against which sentences make sense. In other words, we become socialised into a language and cultural system and we cannot just assign any meaning to language, as we see fit (Besley, 2002). In this study the label of obesity could be placed within a cultural context, because as Besley stated specifically, the participants and the researcher-participant of this study became socialised into a language and cultural system.

In this study the focus is to adhere to a narrative way of thinking, within a post-modern context, in talking about women's relationships with food in excess, thus narrative ways of thinking being the post-modern *context* and therapeutic conversations, letters, drawings and a reflexive diary being the medium of *language*.

Epston and Madigan (1995) state that adherents to narrative orthodoxy have brought gendered considerations to the treatment of formal eating disorders. In this study the focus is on the telling of food stories of the female gender, which makes the mentioning of the influence of feminism in the post-modern era inevitable. Goldner (1991) writes that the feminist "preoccupation with and critique of power, secrecy, hierarchy, control, and expertise produced a commitment towards creating alternative, participatory, democratic forms of therapy" (pp.120-121). Goldner (1991) also cites the influence of feminism on respect for process as a therapeutic end in itself, and argues that feminists have been major contributors to the popular post-modern idea of *conversation* over *intervention*.

In other ways, the feminist critique has been wielded with political fervour and insistence that is seemingly incompatible with the post-modern denunciation of absolute truth (Mills & Sprenkle, 1995). Addressing this issue, Goldner (1991) asserts that the post-modern tradition is potentially paralysing for both feminist and traditional strategic therapists because it questions the absolute truth of each theory. Recognising this restriction, Mills and Sprenkle (1995) argue that the feminist critique has taken the post-modern theory of social constructionism to new levels, critically examining their nation's social construction of gender roles and asking therapists to use their voice in the therapeutic conversation to challenge the roles they feel are unhealthy for families.

Important to note that the participants of this study are obese women only and the research aims to create a space for their voices to be heard and adheres to the feminist idea of conversation over

intervention. The possible danger could be that women tell their food stories and then what? A further research question arises, what will be the aim of merely telling the meaning of their stories and reflecting upon it? What would the end be, if the narrative means to a therapeutic end are not clearly defined?

Theory on narrative therapy in practice as context in regards to a literary overview follows.

Narrative therapy in practice as context with regards to a literary overview

Narrative therapy evolved in the family therapy arena in the late 1980s in Australia and New Zealand (Besley, 2002). Since then it has been extended to other counselling settings and a burgeoning literature has arisen around it. Narrative therapy offers new ways of thinking about people and about therapy and counselling (Besley, 2002). The question arises, what are these new ways of thinking?

The Dulwich Centre, Adelaide, founded by Michael White, describes narrative therapy as being premised:

> …on the idea that the lives and the relationships of persons are shaped by: the knowledges and stories that communities of persons negotiate and engage in to give meaning to their experiences: and certain practices of self and of relationship that make up ways of life associated with these knowledges and stories. A narrative therapy assists persons to resolve problems by: enabling them to separate their lives and relationships from those knowledges and stories that they judge to be impoverishing, assisting them to challenge the ways of life that they find subjugating; and, encouraging persons to re-author their own lives according to alternative and preferred stories of identity, and according to preferred ways of life. Narrative therapy has particular links with Family Therapy and those therapies which have a common ethos of respect for the client, and an acknowledgement of the importance of the context, interaction, and the social construction of meaning (http://www.massey.ac.nz/~Alock/virtual/narrativ.htm).

White and Epston (1989, 1990) make it clear that narrative therapy is considerably informed by Foucauldian notions. They argue that notions of power have been "much overlooked in the therapy culture generally, and in benign view that we frequently take of our own practices" (White & Epston, 1990, p.18). Besley (2002) underlines the necessity for therapists to always assume that they are participating in domains of power and knowledge and are often involved in questions of

social control. Considering this view, therapists must work to demystify and unmask the hidden power relations implicated in their techniques and practices.

Doan (1998) argues that social constructionists shun expert domain of knowledge in favour of the lived experience of individuals. It seeks to privilege the voice of the individual and the liberating of their passions, intentions and preferences. In the context of clinical practice and narrative way of thinking about power and knowledge narrative therapists are sometimes misunderstood in the sense that they are seen as only giving voice to the client and defeating the expert domain of knowledge. I agree with White in saying, it is about equalising the power and knowledge, the individual as well as the expert knowledge must have a space to be heard. Power and knowledge could be productive and are not just destructive. In this study knowledge within the context of women's experiences of obesity is relevant. For example: The therapist's research done on obesity and therapeutic skills, participants' and researcher-participant's stories, media, societal views as well as the story of the role of genetics in theory and practise on obesity.

Knowledge within the cultural context of women's experiences of obesity could by narrative means be deconstructed, with a therapeutic end in mind. White (1993) says that the purpose of the deconstruction process is that people "might become aware of the extent to which certain modes of life and thought shape our existence, and that we might then be in a position to choose to live by other modes of life and thought" (p.35).

> Deconstruction has to do with procedures that subvert taken-for-granted realities and practices: those so-called truths that are split off from the conditions and the context of their production; those disembodied ways of speaking that hide their biases and prejudices; and those familiar practices of self and of relationship that are subjugating of persons' lives (White, 1993, p.34).

The purpose of the deconstruction process in this study is to become aware of genetic predisposition in some obese women according to literature and the medical treatments of obesity and this could be helpful in making informed decisions with regards to such treatments. Thus, not to discount the effect of the role genetics and medicine play in women's relationship with food in excess or obesity as described in Letter of different concepts-III. As Doan (1998) argues, the self can be viewed as a socially constructed entity, but genetically likely stories influence this process throughout.

Genetics as a relevant knowledge within the context of women's experiences of obesity are noted in Doan's (1998) question "is the notion of genetically likely stories invalid"? (p.383) and replies:

> Dismissing any account of genetic or biological underpinnings of human behaviour in the name of social constructionism actually renders it more likely that such genetic essentials will control us. Evolutionary psychology tells us that most genetic influences are just that: predispositions rather than predeterminations. But our ability to rise above such genetic invitations depends in large part on being aware that they exist. Knowledge brings empowerment – the chance to override genetic impulses. It helps us realise that we're going to have to do it, that genetics is not going to help. This process is analogous to being aware of cultural discourses so that one can make decisions in relation to them (p.383).

Wright (1994) states that people have the tendency to self-deceive, that is, to pretend that our stories are more privileged than others. We are therefore more prone to construct some stories about the self than others. In this study the role of genetics in the origin of obesity could be denied, which could have an effect on the holistic story – thus only knowing in part, while the aim of this study is to incorporate different parts of the meanings of the stories (including the role of genetics) of the women regarding their relationships with food in excess.

Furthermore, the familiar notion of diagnosis embraces the idea that there is an objective problem, and that the therapist can arrive at an objective description of that problem (Anderson & Goolishian, 1988). A shift from social structure to the linguistic domain, as a way of describing and understanding problems, moves us from the notion of empirical objectivity and representational language. It is not easy, however, to give up the notion that there really is data waiting to be discovered. For the patient or client, the expert's diagnostic label of their self tends to become seen as part of their essential nature and of their identity. Gergen (1990, 1991) suggests that the language, power and use of diagnostic deficits can be totalising and thus totally affect the past, present and future of a person's life so that the self becomes saturated by the pathology. Although the intent is to help the client, the treatment or intervention can end up inadvertently totalising (totally describing), pathologising and disempowering the client, as well as producing social hierarchies that erode notions of interdependence and community. The expert knowledge and the scientific outlook of traditional Western psychology which is based on the biomedical model of mental illness objectifies, individualises and normalises the subject through diagnosis that has the effect of locating the problem within the person (Besley, 2002).

The narrative approach challenges the way Western psychology generally emphasises the individual subject. It especially challenges the mental health areas where experts often appear to know more about people's lives than the people do themselves, and where the professional focus upon personal deficits emphasises one's failures or weaknesses rather than one's accomplishments and strengths (Besley, 2002).   As stated above, narrative therapy uses Foucault's analytics of power which involves the notion that power can be positive and productive and not just repressive and negative (Foucault, 1977). In its challenge to the truths of humanism, of the traditional psy-sciences, of deficit models, of objectively neutral expert stances, narrative therapy as a counter-therapy could perhaps be considered to be post-psychological (McLeod, 2000).

Rather than viewing the word as revelatory – a carrier of mind, spirit, observation or truth – the emphasis is on language as a form of social action. Words are used by people in the living of communal life – to bring others closer, to keep them at a distance, to send them in this way as opposed to that, and so on. Words are more like significant glances and warm laughter than mirrors of the truth (Gergen, 1995). White and Epston (1990) argue that when engaging in language, we are not engaging in neutral activity. There exists a stock of culturally available discourses that are considered appropriate and relevant to the expression or representation of particular aspects of the experience, including those that we refer to as self-understandings, are mediated through language. And it can be expected that those truth discourses of unitary and global knowledge contribute significantly to this mediation of understanding and in the constitution of personhood and of relationship (White & Epston, 1990). In a sense a culturally available discourse could be described as a dominant narrative.

According to Polkinghorne (1988) a discourse is a unit of utterance – it is something written or spoken that is larger than a sentence. A discourse is an integration of sentences that produces a global meaning that is more than that which is contained in the sentences viewed independently. There are various kinds of discourses, and each kind links the sentences that compose it according to distinct patterns. Macleod (2002) chooses the word, 'conceptualisations' in a post-modern context rather than the word, 'definition' that supposedly gives the impression of definitive closure. The conceptualisation of discourse is linked to theoretical issues, and thus is in a constant state of re-appraisal and re-working. According to MacLeod (2002) various authors attempt to grapple with the nature of discourse. Various features emerge from their attempted conceptualisations, namely:

- an underlying regularity;
- the constructive effects of discourse; and
- implications in terms of meanings and practices

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(see some; Burman, 1994; Henrique, Hollway, Urwin, Venn & Walkerdine, 1984; Davies & Harré, 1990; Fairclough, 1992).

MacLeod (2002) summarises the concept of discourse as having constructive, but also restrictive power in the cognitive, emotive and behavioural process of an individual, families and communities. It has a dual character, simultaneously constructing and restricting what can be known, said or experienced at any particular socio-historical moment. Discourse allows for shifts and flexibility, as a tension is constantly created between the constructive and restrictive, productive and undermining aspects of a discourse.

White, following Foucault, writes that we tend to internalise the dominant narratives (discourses) of our culture, easily believing that they speak the truth of our identities (Freedman & Combs, 1996). White (1997) notes that people come to therapy either when dominant narratives are keeping them from living out their preferred narratives or when

> …the person is actively participating in the performance of stories that she finds unhelpful, unsatisfying and dead-ended, and that these stories do not sufficiently encapsulate the person's lived experience or are very significantly contradicted by important aspects of the person's lived experience (p.14).

Gergen (1985) says:

> Social constructionism views discourse about the world not as a reflection or map of the world, but as an artefact of communal interchange (p.266).

Hoffman (1990) reports that the social construction theory sees the development of knowledge as a social phenomenon and holds that perception can only evolve within a cradle of communication. Social construction theory posits an evolving set of meanings that emerge unendingly from the interactions between people. These meanings are part of a general flow of constantly changing narratives. Social constructionism is anchored in a philosophy of community processing (Hoffman, 1990).

Hoffman (1990) explains that social construction theory is really a lens about lenses. Hoffman's (1990) term the lens of a second-order view comes from mathematics and merely means taking a position that is a step removed from the operation itself so that you can perceive the operation *reflexively*. These views are really views about views. They often make you more aware of how your own relationship to the operation influences it, or allow you to see that a particular

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interpretation is only one among many possible versions. A second-order view would mean that therapists include themselves as part of what must change; they do not stand outside. The social constructionist perspective shifts from the therapist as primary mover to therapist as participant (Mills & Sprenkle, 1995). Pragmatically in a narrative context, the process of determining the purpose of therapy should, in a narrative sense, be as co-created and collaborative an endeavour as possible.

This study's orientation with therapy practice as context with regards to a literary overview follows.

Orientation in Therapy

Where several theoretical approaches differ is in their beliefs about the most helpful way to steer (or not to steer) the conversation (Mills & Sprenkle, 1995). Anderson and Goolishian (1988) propose that we live with each other in a world of conversational narrative, and we understand ourselves and each other through changing stories and self-descriptions. To be in dialogue is to attempt to understand others and to involve oneself in the co-evolution of understanding and meaning. According to Anderson (1990) therapy is aimed at; "the form-giving, meaning-making part, the narrator who at every waking moment of our lives spins out its account of who we are and what we are doing and why we are doing it" (p.137).

Anderson and Goolishian (1988) pose fundamental questions with regards to therapy, based on five premises:

- *What is therapy?* Human systems are language-generating and simultaneously, meaning-generating systems. The therapeutic system is a linguistic system.
- *What are the goals of therapy?* Meaning and understanding are socially and intersubjectively constructed. A therapeutic system is a system for which the communication has a relevance specific to itself.
- *How is the target of treatment identified?* The therapy system is a system that is distinguished by the problem rather than a social structure that distinguishes the problem. The therapeutic system is a problem-organising, problem-dis-solving system.
- *What is change?* Therapy is a linguistic event that takes place in what we call a therapeutic conversation. Change is the evolution of new meaning through dialogue.
- *What is the role of the therapist?* The role of the therapist is that of a master conversational artist – an architect of dialogue – whose expertise is in creating a space for and facilitating a dialogical conversation. The therapist is a participant-observer and a participant-manager of

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the therapeutic conversation. A position of not knowing does not imply that the therapist has no expertise, but it does imply that the therapist must leave all preconceived notions about clients and an ultimate standard of their health out of the therapy room (Atkinson & Heath, 1990). In contrast to the post-modern view that the new-style therapist must come from a position of not-knowing, Hoffman (1990) suggests that it is better to be aware of these ideas than not. Kelly (1955) argues that the therapist must expertly maintain an open and intensely curious stance regarding all of the possible meanings inherent in the problem system. The task is not to edit problematic stories or identify faulty narratives, but to elaborate the complaint. If the therapist is able to create a context, through intensely respectful inquiry and listening, change will follow as a matter of dialogical course (Mills & Sprenkle, 1995).

Anderson and Goolishian (1988) claim that understanding in the therapeutic conversation, is always a process which is never fully achieved. We only understand descriptions and explanations. We do not understand events because, in this view, there is never a single event to describe, and no particular understanding exhausts all the potential infinities of meaning. Epston (1994) reflects upon the meaning of reconstructing a conversation as that "two of us conversing even minutes before may not agree on what was actually said because we each hear selectively" (p.31). Through the therapeutic process, we co-create and co-develop the systemic realities around which we have meaning for each other, and through which we continually reorganise our mutual living and our self-descriptions (Anderson & Goolishian, 1988).

A narrative therapist uses language that is deliberately non-sexist, ethnically neutral, and avoids medical model terms that many mental health professionals use which unthinkingly objectify and 'pathologize' people; like referrals, case notes, clinical work (Besley, 2002). Gergen (1995) argues that if language is a central means by which we are related; then it is from relations that we draw the sense of things, thus it is this consciousness of relatedness that also creates an enormously exciting dialogue within the therapeutic realm.   Both the language and how it is used are important. Language can blur, alter or distort experience as we tell our stories; it can condition how we think, feel and act and can be used purposefully as a therapeutic tool (White, 1995).

Narrative therapy consists of a disciplined questioning process. White and Epston (1990) describe *relative influence questioning*:   In this way the problem is externalised and objectified as an influence outside the life of the family members and is subject to their influence and control. Externalising the problem helps the person to gain a reflexive perspective on their life and to

challenge the truths that define, objectify or subjugate them as they explore new options (Besley, 2002). Mills and Sprenkle (1995) describe *unique outcome questions*: The family story pits the entire family against the externalised problem, rather than the problem attaching itself to the character and worth of the clients themselves. Written narratives of client's lives are also powerful therapeutic tools used in this approach.

O'Hanlon (1994) remarks that through use of their most well-known technique, externalisation, narrative therapists are able to acknowledge the power of labels while both avoiding the trap of reinforcing people's attachment to them and letting them escape responsibility for their behaviour. Externalisation offers a way of viewing clients as having parts of them that are uncontaminated by the symptom. This automatically creates a view of the person as non-determined and as accountable for the choices he or she makes *in relation* to the problem. Roth and Epston (1996) believe that the process of engaging in externalising conversations is a form of resistance to the culture of pathology that often pervades professional conversations. Such 'pathologizing' conversations invite those struggling with problems to blame themselves, to feel guilty or ashamed for having problems, and to experience themselves as helpless to act against problems without acting against themselves.

Epston (1994) notes that assisting clients to see that their problems are separate from who they are as people, creates a possibility that they can intervene and make changes, rewrite their stories so that the problem has less influence over them. *Thus people are not the problem themselves, but are beset by a problem that is external to their personhood.* White (1993) believes that as persons become engaged in these externalising conversations, their private stories cease to speak to them of their identity and of the truth of their relationships. Thus, people experience a separation of their stories and become "free to explore alternative and preferred knowledge of whom they might be" (p.39). O'Hanlon (1994) states that if narrative therapists don't believe unequivocally, that people are not their problems and that their difficulties are social and personal constructions, then they won't be seeing transformations where clients live out their preferred realities. Relating externalising as a narrative technique to this study could be helpful in exploring new options in the participants experiences and the effects it has on how they think, feel and act rather than their and society's set ways of thinking about being obese or fat.

According to O'Hanlon (1994) separating clients from the labels they bring is no easy task and the appeal of the narrative approach may stem, in large part, from its unique approach to doing just that. Following the therapeutic sequence is a bit like building an arch, brick by brick. If you try to do the

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last step without having patiently spent time doing the first ones, your arch isn't going to hold up. Here follows O'Hanlon's (1994) description of the fundamental structure of the narrative approach:

- The collaboration with the person or the family begins with coming up with a mentally acceptable name for the problem. Naming something gives it a different place. As soon as you name it you frame it (Phillips, 2001).

- Personifying the problem and attributing oppressive intentions and tactics to it.

- Investigating how the problem has been disrupting, dominating or discouraging the person and the family.

- Discovering moments when clients haven't been dominated or discouraged by the problem or their lives have not been disrupted by the problem.

- Finding historical evidence to bolster a new view of the person as competent enough to have stood up to defeated or escaped from the dominance or oppression of the problem. The narrative therapist wants to root a new sense of self (in solving problems) in a past and future.

- Evoking speculation from the person and the family about what kind of future is to be expected from the strong, competent person that has emerged from the interview so far.

- Finding or creating an audience for perceiving the new identity and new story. Narrative therapists use letters, asking for advice for other people suffering from the same or similar problems, and arranging for meetings with family members and friends, to accomplish this social validation.

The aim of externalising conversations is to reach unique outcomes. In narrative ways of thinking the battle over specified ways/means of achieving particular outcomes is useful to the extent that it helps us to feel more confident. Specified means however must bow to particular context, namely *this patient, with this problem, in this time and place* (Amundson, 2001). Furthermore, outcome or unique outcome is perhaps the most salient aspect of an empirically informed therapy – the ability to answer the question "How will we know when we are done?" Borrowing from the solution-focused and behavioural therapies, it is outcome that drives therapy. Therapy then calls to service that which is useful. Reflection and experimentation mean considering outcome and the ends to which therapy might be put (Amundson, 2001). In narrative therapy unique outcomes differ from the solution-focused ideas, however, because the emphasis is on helping families realise times when they were able to decline the invitation to cooperate with the problem (White, 1993; White & Epston, 1990).

The narrative therapist looks for experiences that are not currently being storied, which do not fit into the dominant (problem) narrative (Zimmerman & Dickerson, 1994). When unique outcomes which are experiences from the past are selected, they contribute to a past history for a new story, but historical examples of unique outcomes are unlikely to be recalled unless the therapist intentionally draws them out (Hewson, 1991). Hewson (1991) highlights the reconstruction of the past history of the new story as a powerful literate means. White (1993) argues for the development of a new story that has a rich past history. Hewson (1991) explains that the new story is not a turn-off from the old road, but the continuation of a different, old road – one on which the person had been travelling without previously recognising that they were doing so, thus the new story is really a new-old or alternative story. Furthermore, Hewson (1991) remarks that the dilemma is not whether the person should change direction at some hypothetical cross roads, but whether they want to maintain the old story as their dominant story or side step that story (path) and give another well-trodden path (the new-old story) dominance in the future.

The pragmatic question for this study arises, what does my practise of narrative therapy entail? The client is the expert and stays the expert in narrative conversations. I am thus a conversational expert and an expert on my own story about my relationship with food in excess, as well as a well informed expert on literature concerning eating disorders. In the same way, the women in this study are the experts on their stories surrounding their relationships with food in excess and as the researcher-therapist I will listen to them from a not-knowing position and with an inquisitive attitude.

I have grown up in a society where I was taught to see myself as being the problem, for example: I am a dominating person, rather than I stand in relationship to a monster of fear that I will be rejected, therefore I must control the situation. I am thus part of the problem or I am the problem. With narrative ways of thinking in practise, I became aware of the power that I have as an individual when I externalise the problem and say that I am not the problem, but that the problem is the problem. This allows me to see clearly that I stand in relationship to a monster of fear of rejection and I can take direct action against this fear. I am then in control of how much I will allow this fear-monster to affect my behaviour, thoughts and feelings.

In search of my own theoretical position in therapeutic practices, I have read many texts with regards to the different schools of thought in psychology and came to the following understanding of the literature. The psychological view of a person started off with seeing so-called abnormal behaviour as a result of a person being possessed by demons, to the person being labelled as having

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a pathological problem, thus having the problem inside the person, to the problem existing in relationships with other people. The paradigm shift for me is to see individuals and their problems as an equation where the person stands in a relationship with his or her problem.

This paradigm shift has been difficult for me, because it was safer for me to label and diagnose a person with certain pathology. From the literature and my Masters Psychology training I have learnt that by placing a person's problem in a certain category, it is thought to be possible to explain all human behaviour. If all human behaviour could be labelled or explained, then human behaviour could be predicted and necessary treatment plans implemented. For example: with obese women the suggested treatment, according to the literature and weight management programmes is often that the person must lose some weight to gain a positive self-esteem and body-image. This troubles me, because my opinion is that women have more stories than just an obese story and that if we challenge or question dominant discourses, new-old stories or alternative stories may emerge. Consequently, challenging the assumption that women must loose weight to gain a positive self-esteem and body-image.

During my Masters degree in counselling psychology I did not consider the possibility of questioning scientific observations or labelling people or categorical systems. I know that this has to do with the discourse I maintained which dictated that I must follow the leader assumptions under all circumstances, even if it means jumping into the fire. My knowledge of human behaviour fitted into neat little boxes. This gave me structure, but at the same time made me fearful to trust my instinct and knowledge that a person is an expert on his or her own life. Foucault (1980) speaks about power and knowledge as if they are the same concept. I think that my knowledge that a person is an expert on his or her own life was previously dominated by my perception that power structures in the psychology-training milieu reflected the equation that knowledge equals power.

One further discourse that was deeply ingrained into my belief system was that I could only help a client as far as I have learnt or grown in a certain area and if I don't deal with my problems and sort myself out, I cannot help anyone. By questioning this discourse through a narrative way of thinking I have come to an enriched understanding that I am the expert of my life, and the client is the expert of his or her life. I make the choice then that my therapeutic helping could be of value when I respect, listen and challenge the client about his or her life story with the aim of reflecting in a compassionate way.

In the past four years I enjoyed using different narrative ways in conversations with clients. I have experienced and seen clients realise their own potential/skill in standing against problems. I am thus excited about this study and what I am going to learn together with the participant women about their meanings with regard to their experiences of their relationships with food in excess.

From my personal notions in practice to a description of the narrative tools used during the therapeutic conversations with these specific participants.

Narrative tools used during the therapeutic conversations

Important to note that in this study the following specific narrative tools are used:

- *Externalisation of the problem* is used to focus the individual woman's attention away from seeing herself as the problem, instead opening up more possibilities for her to realise the choices she has within her relationship with food in excess and her choosing to, or not to take responsibility to live out her preferred story(s).

- The aim is to reach a fuller description of the story through the art of *deconstructed questioning* of the dominant narratives or discourses and re-constructing the discoveries of significant new-old stories. Telling your story involves understanding what has happened for you, the context in which it happened, and its impact on your current way of being. Telling and understanding what your story means to you, helps you to decide what story you want to tell in the future and what you will have to do in order to make the story happen (Phillips, 2001).

- A general *narrative letter* as narrative tool is used. Like Epston (1994) letters allow my thinking about my clients and about therapy to be as transparent as possible. Letters ought to be moving experiences, doorways through which everyone can enter the family's story and be touched by the bravery, the pain and even the humour of the narrative.

- The researcher-therapist as well as each individual woman makes use of the *reflexive stance* at the conclusion of each conversation with the aim to obtain learning experiences from the therapeutic process and relevant life stories told during the conversation. I like to call these warming down exercises. I propose that alternative or new-old stories are also highlighted through a reflexive stance collaborated between the researcher-therapist and each individual woman.

- *Art therapy* as a tool in narrative therapy is used. According to Carlson (1997) narrative and art therapies share certain theoretical beliefs that are consistent with one another. Among these are the ideas of recapturing hidden aspects of self-expression or lived experience, the

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principle of co-construction in understanding the therapeutic relationship, and the belief in the creative abilities of persons.

- *Externalising women's internalised beliefs formed at the developmental age of a child*: This narrative tool, was used during narrative conversations with several participants, especially in the context of traumatic experiences in their childhood. According to DeFoore (1988) we all entered the world wide open, totally vulnerable. People have found that there is no such thing as forgetting, that unneeded or painful memories are only blocked from conscious memory so we can move forward and continue to function. This means that subconsciously each of us remembers that experience of being totally open and vulnerable. We knew the greatest love and the greatest pain in that stage of our existence. This is why it is safe to say that within each of us is a soft vulnerable self (*the inner child*), however deeply it may be buried in the subconscious mind (DeFoore, 1988). In a narrative context the construct 'inner child' are externalised and could be viewed as women's internalised beliefs formed at the developmental age of a child.

Some specific taking-it-back practices used in this study

White's (1997) taking-it-back practices as a narrative tool is a means for therapists to decentre their power as being supposedly the only expert in relationship to clients in a given therapeutic context. Important to note that in this study the following specific taking-it-back practices are used based on White's (1997) readings on taking-it-back practices:

- *Re-membering conversations*, which bring to the centre of this work the knowledge and skills that have been generated in the significant memberships of persons' lives through their histories, and that identifies options for new memberships that are potentially generative of other knowledge and skills of living. *Re-membering practice* as taking-it-back practice is used during the therapeutic conversations in the form of the co-creation of a fictitious celebration party where significant members in relation to the individual woman's experience are invited. This is for the validation or compassionate witnessing by significant others of each woman's meaningful experiences told during the therapeutic conversations.
- *The telling and re-telling of stories* of persons' lives that contributes to the multiple contextualisation of the actions and events of life, that links the stories of person's lives to shared purposes, values and themes, and that is generative of 'thick' description. This thesis is based on *the telling and re-telling of stories* of specific participants, researcher-participant, as well as stories within literature regarding women's relationships with food in excess.

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- *Therapists embrace an ethical responsibility* to identify the ways in which these therapeutic conversations are shaping their work and lives, in which they acknowledge the contributions of the persons who consult with them. My ethical responsibility in this sense is to acknowledge the participants contributions to this thesis not in only shaping my personal food story and their own food stories, but also contributing to creating a space for other women in my private practice as well as other women who the participants encounter in the future. Recognising the fact that I claim to be the co-author of this thesis in conjunction with the participants and literary voices on this particular topic.

- *Transparency* that engages therapists in situating their expressions by rendering visible, to persons seeking consultation, the different contexts of these expressions, including those of culture, race, gender and class, and this will encourage therapists to embody their speech acts by acknowledging the purposes and the lived experience that shape these acts. In this study the therapist-researcher and researcher roles are transparent in the sense that culture, race, gender and class issues are addressed in different letters throughout this thesis.

Reflected conclusions upon the literary overview

Theory and practice are not a problem to be resolved in any final sense, but rather a problem to be solved case by case; and historical moment by moment (Amundson, 2001). Doan's (1998) concluding thoughts in *The king is dead; long live the king: narrative therapy and practicing what we preach* questions narrative therapists' and in this study, my own, will to recognise theoretical assumptions as assumptions, and be aware enough not to be fooled into believing that they are true.

On the basis of Doan's (1998) proclamation that if postmodernism has a rally cry, it is most likely **"beware of the tyranny of singular accounts"** – especially those claiming to have the truth, the whole truth, and nothing but the truth. In contrast, Doan (1998) depicts a growing concern that narrative is falling prey to the tendency of reifying its metaphors, making gurus of its leaders, and acting as if its underlying assumptions are somehow more privileged than those of the other therapies. Further, Doan states that one would expect a great reluctance on the part of its practitioners to embrace **"the one, true way of doing narrative therapy."**

O'Hanlon (1994) critiques narrative therapy by highlighting scepticism with regards to claims of narrative therapists being nondirective. There is a clear and consistent therapist agenda. Therapists often introduce a metaphor or some new language to the client. Narrative therapists would generally bristle at the suggestion that they use hypnosis, but they do. The biggest concern about

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narrative therapy; like most other popular movements, is that many therapists will use it merely as a clever device. O'Hanlon (1994) also argues that inevitably many therapists will ignore the heart of narrative therapy, its fierce belief in people's possibilities for change and the profound effects of conversation, language and stories on both therapist and client.

Parry and Doan (1994) have suggested that narrative is particularly suited to the challenge of life in a post-modern world that may have arisen due to the post-modern context in which all of us increasingly find ourselves. According to Doherty (1991) narrative therapists see there jobs not as providing insight, promoting differentiation, clarifying boundaries or prescribing tasks, but as dissolving problems through the liberating process of dialogue.

In reflected conclusion Amundson (2001) says:

> Narrative types would do well to attend forensic conferences, biomedical discussion and work with ethics and discipline. They would benefit from drawing circles to pull these perspectives in, rather than try to climb fearfully higher away from them. Find a home for these narratives and you will be richer. Add to this process a bit of irony and self-depreciation, think small and local, leave the big questions outside the consulting room for those who think themselves grand, visit the outlanders in cognitive science, medicine and naturalistic philosophy, even steal from them the useful, and then how can our patients lose (p.187)?

Leaving this letter with so many more ideas to explore and narrative stories to tell, the story of my thesis can continue making meaning and reflecting upon the specific dominant narratives, such as obesity and self-esteem issues regarding obesity in Letter of different concepts-III.

Narrative greetings
Co-author and researcher