Exploratory Research on the Effectiveness of Narrative Therapy Practices in Outpatient Mental Health Group Work.

MSW Clinical Research Paper
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Abstract

Is narrative therapy effective in outpatient mental health group work? This research uses narrative group therapy designs to outline the potentials for treatment measures in group process for people seeking community mental health support and treatment services. This exploratory qualitative research design is a platform for further study, with attempts to bridge what’s known in practice and what is measurable in group work research. Results of this analysis identify insight, cohesion and catharsis as primary components in measuring group process when using narrative approaches. Implications of these findings for practice and research are discussed.
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Introduction

As motivational speaker, Karen Kaiser Clark states, “Life is change. Growth is optional. Choose wisely.” The simple notion of choice for growth in one’s life could be a sales pitch for choosing mental health therapy services. As simple as that sounds, client choices are often driven by accreditation standards, insurance providers, and the requirements of professional treatment options, with the voice of the client frequently overlooked (Miller and Duncan, 2004). In recent years, research has shown effective results in therapy services using cognitive-behavioral and psychoanalytic theories (Shapiro & Shapiro, 1987, Kelly, et al, 1993, U.S. Department of Health and Human services, 1999) both of which show progress as determined by the clinicians’ set of standards as the expert. This research focused on highlighting the client’s role as the expert in their own lives, a value emphasized in the practice of narrative therapy.

Narrative therapy is an approach different from other theoretical perspectives primarily because it preferences the voice of the client (Morgan, 2000). As a client’s wellbeing may be the focus of all therapy approaches; the effectiveness of community-based, client-centered treatments, including therapeutic interventions in group work using narrative approaches, lack research based explanations for what is known in practice. The intent of this exploratory research was to gain helpful information that could bridge the main parties involved in providing mental health services while legitimatizing group therapy through a client-centered approach like narrative therapy.

Current research shows that group therapy is as beneficial as individual therapy yet more time and cost-effective (Gordon et al., 1988, Johnson et al., 2006, and McRoberts et al., 1998). Group therapy supports and promotes a mutual aid system,
which validates meaning in an individual’s life highlighted through the group process (Gitterman, 2006). Yet, how do we measure group progress apart from cognitive knowledge gained or subjective observations? How do we measure internal components of change also known as “growth” in Clark’s above quote? Would it be possible to measure this change through a person’s story, specific words, metaphors and reactions dialogued in group process? According to Hennepin County Medical Center’s (HCMC) quality assurance liaison and program managers in HCMC’s outpatient psychiatric clinics, the Joint Commission on Accreditation for Healthcare Organizations (JCAHO) is currently pushing for providers to document a client’s specific response to treatment interventions as a clinical measurement in providing quality care (S. Joncas, & S. Murphy, personal communication, August 22, 2006). This has pushed new documentation efforts in mental health programs such as the one represented in this research project. Therefore, if an accreditation organization values a client’s response to treatment; can such documented responses be considered measurable data for therapeutic effectiveness?

As validation of the intervention and protection for the consumer are emphasized as a rationale for outcome based treatment (U. S Department of Health and Human Services, 1999), it seems only natural to consider the consumer’s expertise of their own lives in the delivery and approaches of various therapeutic services included in group work. A therapist’s validation of a client’s viewpoint can demonstrate new ideas and therapeutic directions often revealed in the moment, through an unidentified route, one often never dreamed by therapist or client (Duncan, Miller, Hubble, 1995). Honoring a person as the expert in their own life and externalizing the problems a client presents, is
the essential premise to narrative therapy approaches (Morgan, 2000), a theory currently being practiced in outpatient mental health programs. The narrative therapy approach also supports the social work emphasis of the strengths-based theory (Saleebey, 1996). So, the key question this research project asked: Are narrative therapy approaches effective in outpatient mental health group work and can we measure the effectiveness based on client response?

This research study attempted to identify themes that could improve validation and measurement of group process in the social service arena. The research focused on adults in a voluntary outpatient mental health setting of an urban Midwest City, who were receiving group therapy treatment utilizing narrative therapy approaches. The group members in this study varied in age range and diagnosis, yet none were currently acute or unstable. Despite population parameters, the last question remained: does narrative therapy assist individuals who participate in a group process to achieve greater control over their own lives by ultimately defining and choosing personal growth based on individual meaning? Findings of this study demonstrate a new methodology for credible qualitative research using cohesion, catharsis, and insight as primary components to measuring group process while validating such measurement through a client’s own words and expressions.
Review of the Literature

*Subjective and objective realities*

Demonstrating the change process in mental health therapy services has typically been based on clinicians’ experiences or empirical studies that appear moderately removed from the every day work and concerns of practitioners in the field (Shapiro, 1987). A 1987 study reviewed both philosophical (subjective realities) and empirical (objective realities) approaches, of both process and outcomes of diverse psychotherapeutic methods (psychodynamic, client-centered, and behavioral/cognitive) in search for an improved understanding of the change process experienced in psychotherapy (Shapiro, 1987). In Shapiro’s (1987) study, the researchers reviewed over fifty years of psychoanalytic process, theory and empirical data and found that theories of therapy are generated more rapidly than they can be empirically tested. Furthermore, they concluded that empirical investigators should devote more effort into theoretical integrations of scientific literature to link process to outcome while devoting attention to clinical utility of models constructed (Shapiro, 1987). The important use of language in a narrative story plays a central role as the shift from objective to subjective reality, which is often constructed through social discourse (Cooper & Lesser, 2005). The argument for linking subjective and objective realities in therapeutic efforts is stated elegantly in Shapiro’s (1987) discussion, “The more clinically meaningful our current scientific theories of the change process, the more likely they are to enhance the effectiveness of psychotherapeutic practice, and the more their refinement will be facilitated by data from everyday practice.” (p.440)
Annette Simmons, president of Group Process Consulting, a firm that helps organize public and private sectors build more collaborative behaviors for bottom-line results (2003), writes a convincing argument on the use of stories, poetry and metaphors to endorse the power of subjective solutions for subjective problems. Much of what she applies to various public and private business organizations could also speak volumes for the health care industry and therapy services as most services aim to meet bottom line objective criteria while attempting to not lose sight of subjective realities that make a universal human experience unique and individual (Simmons, 2003). She states, “re-connecting people to their wisdom or common sense is difficult to explain in objective terms…many groups suffer from untended subjective issues invisible to objective criteria and quantitative analysis…often objective, analytical methods make subjective truths disappear before they can be tended.” (p. 3). Furthermore, she argues that “no matter how right a plan is by objective measures, if people don’t accept it at a subjective, emotional level it’s not going to succeed.” (p. 4). She uses stories, metaphors and poetry to express the value of subjective realities as she explains that “a story has the power to breathe real-life experience into charts, tables, numerical analysis, and statistics so listeners can see, hear, and feel enough of an alternative perspective for it to become real. Once an idea or initiative feels real…people are more likely to do what it takes to make it real in the physical world.” (p. 2). Lastly, Simmons (2003) reports on the value in context of the subjectivity of human beings through story as she eloquently states, “change what people see and feel and their behavior will change accordingly” (p. 5).

Further support in utilizing metaphors and stories as valuable subjective realities in a therapeutic context, is published in case examples by Henry Close (1998) a writer,
therapist, and workshop leader. Although he speaks from the value of the practitioner’s use of metaphors, his work validates the general power of metaphors and stories in practice as he shares the following observations from his case studies. He states, “Stories address a different level of consciousness than conceptual replies. They elicit a different level of response. Stories tend to be more believable than ‘objective’ statements. A brilliant comment is what the therapist is “supposed” to say. A metaphor is not presented as something to be evaluated, but rather as a work of art. It is to be enjoyed and experienced on the basis of its’ own criteria.” (p. 16). Furthermore, Duncan and Miller (2000), write about precise use of client’s words as they complete research that supports improved outcomes toward change when conducting therapy within a client’s own theory of change. Duncan and Miller (2000) also refer to a client’s frame of reference in the therapeutic relationship, which includes such subjective realities as respect, genuineness, validation, and collaborative exploration. Similarly, Duncan and Moynihan (1994) find that even objective outcomes are affected by subjective theories. Finally, the subjective recasting of the story attempts to improve empirical evidence by giving the client heroic control of the change process as it unfolds (Duncan & Moynhan, 1994).

Narrative Therapy Model

Narrative therapy is a modern counseling method that bridges therapy and community work. Its co-founders, Michael White, Cheryl White and David Epston developed the narrative therapy movement based on the principle of individual people as the experts in their own lives, with the view of the individual as separate from their presenting problems (Dulwich Center Website (DCW), 2006). In general, a narrative
provides structure and meaning that assist people in awareness of their own roles relating to the wider social and cultural environment (Cooper & Lesser, 2000). It could be assumed that this stance of the therapist intervention is congruent with the passive client-centered psychotherapy approach where the locus of control for the change process is firmly placed with the client rather than the therapist (Shapiro, 1987). Alice Morgan (2000) defines the practice of narrative therapy clearly as she states, “Narrative therapy seeks to be a respectful, non-blaming approach to counselling and community work, which centers people as the experts in their own lives. It views problems as separate from people and assumes people have many skills, competencies, beliefs, values, commitments and abilities that will assist them to reduce the influence of problems in their lives.” (p. 3). Other important components to this style of counseling include an understanding and living of lives through story telling. For the therapist this means focusing on the questions we authentically do not know about our clients and allowing the clients to formulate and reformulate their stories. The therapist role is likened to that of a researcher who listens to a client’s dominant story and through intentional inquiry, assists a client to describe the dominant problems by visualizing the problem outside of the self. While using a client’s words to validate their theory of the problem and potential change, the therapist then inquires about dominant problems in the client’s language and reflects hopeful insights and possibilities, assisting a client to visualize, shape and share the development of their alternative story. As the therapist attempts to find the client’s theory of change, it is in the validation of the client’s viewpoint, even when it seems bizarre, that opens the conversation to possible new ideas and directions, uncharted imaginable territory by either therapist or client (Duncan, Miller & Hubble, 1995). In
turn, sessions are guided by the client not clinician (Morgan, 2000); yet, the clinician assists the client in empowering their view to explore hope and change possible within their world (Miller, 2004).

A fundamental philosophy in narrative therapy includes the use of metaphors and the discovery of a dominant story (Epston, 2006). However, metaphors are not given to the client from the therapist as practiced in some forms of psychotherapy (Close, 1998); but instead metaphors are developed by the client and used by the clinician to enhance the description of the story while searching for the meaning in a client’s words. The process of intentionally asked questions by the listener/therapist poses a potential to see beyond the expected by the storyteller and listener combined, while ultimately creating an alternative story to assist in a turning point toward change (Epston, 2006). Narrative therapy stems from an optimistic proclivity, where stories interactivity change the teller as well as those witnessing the story such as therapists, family, and group members. The therapeutic conversation is told by the client or storyteller, who is viewed as an achiever with vivid stories instead of a problematic individual (Monk, 1997). Narrative conversations are collaborative and interactive, guided by the strengths of those clients consulting the therapist (Morgan, 2000). While attempting to use narrative approaches to ask questions of the storyteller, a client’s specific choice in words are highlighted for further inquiry when the entire process develops as the teller’s story unfolds (White & Epston, 1990).
Group Process Variables Explored

McCallum, Piper, Ogrodniczuk and Joyce (2002) noted that group process effectiveness could be measured through variables such as affect, cohesion, group climate and therapeutic alliance. A logistic regression analysis was used to investigate relationships between therapy process and group members who drop out. The group work study was based on short-term group therapy for individuals with complicated grief. The results implicated that there were no significant interaction effects for a type or model of therapy; yet, results indicated that dropouts experienced significantly less positive affect than those remaining group members. More positive affect included pleasure, warmth, acceptance and optimism thus indicating those feeling positive about experience remained in the group. The concept appears simple as the discussion implies that for patients to benefit and remain in therapy they must feel positively toward the experience, which can be measured by the cohesiveness of group support (McCallum et al., 2002). There is a positive emotional experience in a group for both listener and teller (Simmons, 2003). The perception of a positive emotional experience differs from a clinician’s perception of focus on negative feelings such as sadness, pain and grief when assessing the value of therapy sessions (McCallum, et al., 2002). The results from the above study would also support Helen Northen’s (cited in Vassallo, 2002) model of group work used in Vassallo’s narrative group work case study which proposed that group facilitators need to devote attention to group members that isolate or withdraw, by focusing on conscious observable material such as affect while promoting an atmosphere of positive and optimistic flexibility. This defined atmosphere of flexibility would in turn
support White & Epston’s (1990) design of the narrative approach in reflecting a co-
creative practice of conversation that is reciprocal in gaining knowledge and under-
standing for all involved in the process (Monk, 1997).

Lastly, such therapeutic factors identified within the group process by Yalom
(1983 & 1995), lists that instillation of hope, catharsis, interpersonal learning, insight and
group cohesiveness as the therapeutic benefits of psychodynamic group therapy. Recent
research has found that the factors of cohesion, catharsis and insight are the top three
measurable therapeutic factors in group work (Johnson et al., 2006). In group process the
following are defined by Johnson et al. (2006): cohesion, “belonging to a group of people
who understood and accepted me” (p.139), catharsis, “learning how to express my
feelings” (p.139), and insight, “discovering and accepting previously unknown or
unacceptable parts of myself” (p. 139). This research examined all three factors as
representation of effectiveness for using narrative therapy approaches in groups.

Narrative Approaches in Group Work

Using narrative therapy in a group work setting is a relatively modern approach
among support and therapy group work practices. In groups where narrative approaches
have been attempted, the power of group process assists in organizing themes around
dominant stories identified by group members. Furthermore, the narrative process then
involves re-authoring the story through the enhancement and discovery of alternative
stories within both the individual member and the group as a cohesive unit (Morgan,
2000).
A recent case study published by Tony Vassallo (2002) incorporated such narrative approaches in a group work setting for adults who have experienced psychosis. Individuals with a history of psychotic illnesses were referred by a community and rehabilitation staff member to the researcher. The facilitators then extended both written and verbal invitations. Nine out of ten invited individuals voluntarily joined the group. The group ran for eight sessions, two hours each session. In this case, outsider witness techniques were performed by the facilitators who were professionals trained in narrative therapy. Such techniques included specific observation by facilitators with a time to process such observations in front of group members. Group members then listened to debriefing of the observers/facilitators and in turn responded in further dialogue based on their new roles as witnesses. Facilitators were not giving advice but instead reflecting on what they witnessed utilizing specific quotes from stories shared by group members and noting interactions between group members that appeared significant within the group process. In this case, because the facilitators acted as observers not judging the experience but reflecting and questioning observed dialogue, this encouraged the independent development of beginning, middle and end stages of the group process while centering the group members as the experts in their shared stories. The professional therapeutic skill/stance included an intentional alignment into the perspective of the group members. This technique is unique in that in typical group therapy practices, group facilitators reflect on the group’s process, dynamics and observations behind closed doors, unprivileged to client observation and witness. Furthermore, open dialogue among the witnesses (therapists) of the group not only validates the group members’ perspectives but additionally boosts a client’s hopefulness and expectation to reaffirm
their belief in change. According to Snyder (1999) as cited in Miller (2004), a client’s, “hopefulness and expectation for change account for 85% of the variance associated with treatment outcome” (p. 7).

The narrative approach of ‘outsider-witnessing’ allows group members to hear processing from the observers and have an opportunity to respond to the observers’ reflections (Vassallo, 2002). Another unique concept in outsider-witness practices highlights the focus of listening from different perspectives while highlighting themes. For example, third party observers may also be asked to use written reflective techniques as they are intentionally asked by the facilitator/therapist to write down specific words that represent a theme in either the story of a group or the story of an individual (Carey & Russell, 2004). The storyteller’s words are not judged but instead stand on their own merit through reflection. This audio reflection of themes is similar to inductive data analysis often used in qualitative research. Both the group and third party observers/audience utilize the thematic reflections as a therapeutic tool. This tool is similar to the therapeutic stance of not judging a feeling in that the group or observers would not be judging words or experiences of the storyteller, yet joining in the validation of the experience of the storyteller as perceptions of hope, meaning and change are explored together to accumulate a therapeutic component (Carey & Russell, 2004, Freedman & Combs, 1996, Duncan & Miller, 2004, and White, 1999).

Furthermore, the theory of narrative therapy and the validation of therapeutic services assist personal choice and growth, which is rooted in the concept that our individual stories when witnessed by others can facilitate change (Carey & Russell, 2004). Again, the mutual aid provided by the nature of group work services has
potentials to remove the negative pathology of individual problems, diminish stigma, reduce social and emotional isolation, and support individual growth and change (Gitterman, 2006). The narrative process in group work can be further be explained by Nichols & Schwartz (2001) who have shared their work through published cases studies, “Clients are encouraged to create audiences of support to witness and promote their progress in re-storying their lives along preferred lines.” (p. 414). Preferred lines are also referred to as alternative stories, or identified words and/or strengths that are moving in the direction of hope, opposed to self-defeating, negative self talk. The therapist enriches these words of hope by reflecting them in questions of possibility or inquiring on what the alternative to problems would actually look like. Furthermore, when group members reiterate another member’s specific words, insight and hope are highlighted in the possibility of validated strengths; thus change in the development of the alternative to problems is witnessed by others as a viable reality. The elements of group work can be ideal for assisting clients to choose growth within these possibilities of hope that exist in life changes (Morgan, 2000).

Narrative approaches in group work have been implemented in practice settings, but minimal evidence based research has been published. Attempts to provide evidence based research about group work through other models has been determined effective in measuring changes in individual knowledge or behaviors interpreted by “an expert”, the therapist or researcher (Rutan, 1993). However, in such research the client figures into the equation as an object of assessment and intervention with the identity of a problem as part of their internal being (Duncan, 2000). The difference in therapist’s role when using narrative approaches is that the clinician stance takes lead from the client as the treatment
focus is organized through the client’s perceptions, experiences, words and ideas (Miller, 2004). Similar then in group work, the therapist/facilitator models this client led approach as group members establish group progress and separation from problems by validating feelings, experiences and gaining insight among one another throughout the beginning, middle and end stages of group development (Vassallo, 2002).

Finally, the object of this exploratory research is measuring group process through client-directed outcomes such as those used in narrative approaches, which include but are not limited to a client’s specific words and language. Can specific words spoken from the consumer measure group process through themes of cohesion, catharsis and insight? Efforts to identify themes as measurement of curative potentials could be used as validation for therapeutic changes recognized by all parties invested in treatment outcomes including, the consumer, accreditation organizations, and the insurance payee.
Conceptual Framework

Because group process tends to be more of an art than a science, it is difficult to measure in an objective research design. This research attempts to examine the concepts of a narrative therapy approach for the purpose of validating art verses science in group work. The concept of a narrative approach stretches the listener and storyteller toward the creative expressions that are frequently disregarded in the scientific world of therapeutic interventions. Since no human being is the same, science is challenged to appreciate the complexities of the human mind. Therefore, why would one not honor the art of who we are as individuals when working with the whole person? Narrative theory is a postmodern theory, where the story line is examined as the plot, characters, and timeline are reassessed for meaning (Cooper & Lesser, 2005). Constructivism and post-structuralism provide a conceptual framework that informs the narrative approach to clinical practice (Cooper & Lesser, 2005 and Thomas, 2002). This exploratory study attempted to identify potential value in the use of subjective data, as emphasized in importance from the mentioned conceptual frameworks, measured in words and themes, as undiscovered opportunities for evaluation.

Constructivism informs the narrative approach to clinical practice as it focuses importance on the client’s subjective perception and experience of a problem. This postmodern theory assumes that there are no universal truths and that realities are as many as there are perceptions. This theory places emphasis on the respectful understanding of a trustworthy therapeutic relationship, as the therapist is the learner and facilitator of new stories that empower hope within the client (Cooper & Lesser, 2005).
Another conceptual framework used by the creators of narrative therapy compares structuralism and post-structuralism to explain art verses science in the delivery of therapy. Challenging the theory of structuralism through post-structuralism can be helpful in grasping the large dilemma of art verses science in group work. The medical model of health care services in the United States tends to follow the objective influences of structuralism.

Structuralism in the area of psychology and family therapy influenced thinking within the therapy world by instilling the belief that a person’s identity lies within the ‘inner-self’ or ‘inner-psyche’. This leads to the explanation that undesirable behavior is attributed to some disorder, distortion, or deficit within the individual. This theory also suggests that people could be studied in the same scientific way objects can be studied.

In contrast to structuralism, post-structuralism thinks it’s important to draw attention to the real effects of the process of looking for ‘essential truths’. Focusing on the process of looking for ‘essential truths’, what people believe and where they come from will shape how they look and what they find. The meanings that people assign to the events in their lives and how they organize these into stories about themselves and others, shapes their lives. Post-structuralism encourages a therapist to assist people to stop measuring their lives by social norms, questions therapist objectivity and expertise, questions possible assumptions from the language used in therapy, and take seriously how every therapy conversation may shape the identity of both client and therapist (Thomas, 2002).

One authority in the field of social work concludes that the strengths perspective in social work practice continues to develop conceptually. The strengths perspective as
defined by Saleebey (1996) is a different viewpoint of looking at individuals, families and communities where the focus is on capacities, talents, competencies, possibilities, visions, values, and hopes of these groups despite circumstances of oppression, trauma and problems that are present. While the strengths-based approach is well established in case management of individuals with mental illness, it is more recently practiced with other client groups and communities. To enhance resilience, healing and wellness, the narrative and personal stories have provided supports to the strengths-based perspective including humor, independence, insight, cultural revival, and renewal of energies (Saleebey, 1996). The difficulty facing this research is the conflict of delivering therapy and measuring therapy.

As previously noted, the objective of this exploratory research is to bridge theory and measurement of group process through client-directed outcomes. Can specific words spoken from the consumer measure group process through themes of cohesion, catharsis and insight? Efforts to identify themes as measurement of curative potentials could join the delivery and measurement of therapy and theory.
Methodology

Research Design:

This qualitative study was designed to explore the effectiveness and potentials of narrative approaches in group work. This research design explored four separate therapy groups currently using narrative approaches in group work in an urban outpatient mental health setting. A semi-standardized questionnaire, as described by Berg (2001) used predetermined questions asked in order but with flexibility that allowed for the participant to digress beyond the standardized questions. This questioning style fit the theory of the narrative therapy approaches, which allows clients to tell their story in their own words.

This questionnaire was designed around three specific factors (cohesion, catharsis and insight) as representation of effectiveness for using narrative therapy approaches in groups. The questions were formulated with reference to the Curative Climate Instrument (CCI), a self-report instrument that measures helpfulness of therapeutic factors present in group therapy, analytically derived from Yalom’s (1995) twelve-factor theory of curative influences in groups and used in Johnson’s et al. (2006) recent research on group process. As stated above, group process defined by the CCI in Johnson et al. (2006) correlated with the questionnaire as follows: questions that looked for responses yielding cohesion included questions 4, 6, and 7 as these questions sought responses that indicated belonging, acceptance and being valued as a member within the group; questions 1, 5, and 7 sought responses that yielded catharsis, an expression of feelings and/or opinions as a result of experiences; questions 2, 3, and 7 searched for responses that yielded insight, based on the discovery of new perceptions in self or others such as
recognizing skills, values, or behaviors that could inhibit or create change. See appendix B for questionnaire sample participants received, see appendix C for questionnaire researcher used to identify group process themes of cohesion, catharsis and insight. Again, the intent of this research project was to explore outcome measures in client responses that may help validate group therapy interventions through a client-driven approach like narrative therapy.

Narrative therapy approaches are currently being implemented at Hennepin County Medical Center’s partial hospital program, an urban outpatient mental health program that services adults with varying mental health symptoms and/or diagnosis in Minneapolis, Minnesota. The group will be lead by the researcher, a master’s of social work student and Certified Therapeutic Recreation Specialist with specific training in narrative therapy approaches. The group protocol for the narrative approaches used in this research is outlined in table 1.0.

Upon completion of a regular scheduled 45-minute group facilitated by the researcher, group members voluntarily completed a questionnaire on their group experience. This questionnaire was given to group members by a staff member of the partial hospital program in order to protect confidentiality of client’s receiving treatment in the program. Yet this staff member was not associated with this research other than to administer the questionnaire and consent form. All participants who volunteered to participate in this research were also given a consent form (see appendix A). No signatures were required for consent therefore this researcher did not have a record of who consented to participate in the research. Questionnaires and consent forms specifically asked participants to evaluate the group experience, not the skills of the
facilitator. The participant involvement in the study will remain anonymous to the researcher. A sample of this questionnaire is included in appendix B. Table 1.0 is a group protocol established by the researcher.

Table 1.0: A Therapeutic Recreation Group Protocol

| Group Protocol for a Narrative Therapy Group Utilizing Expressive Art Modalities |
|---|---|
| **Group Size:** | 3-12 people, no more than 12 recommended for this specific exercise. |
| **Space:** | Open Room with table accessible. |
| **Equipment:** | 1. Story cards with reference to one of the following emotions (loneliness, fear, separation, chance, hope, etc.). 2. Paper, markers, color pencils, colored tape (if using tape art as expressive modality) magazine photos (if using collage as the expressive modality) or “chiji cards” (cards of symbols, shapes and objects). |

**For purpose of this research:** the following story cards were used (loneliness, fear, separation) and the ‘chiji cards’ were the selected as the expressive modality.

**Activity Description:** Narrative Therapy and expressive art exercises in group work.

**Therapist facilitates**

- One group member volunteers to be the storyteller after a brief description of group activity is introduced as follows: “We are going to complete a story exercise together. To begin the group I need a volunteer to be our story-teller. I will assist the storyteller by asking questions; yet the storyteller has full control on how they would like to answer the questions.

- The storyteller chooses a “story card” with an emotion listed from those provided by facilitator. The storyteller then reflects on a personal experience related to their chosen card/emotion and is asked not to share the card/word chosen with the group, yet is asked to respond to the facilitator’s inquiries using their own ideas/words which starts the basic narrative of the session.

- Questions from the facilitator use the storyteller’s specific descriptive words. These questions may include but are not limited to the following:
  1. As you think of your experience related to your story word/card, could you think of a time where you viewed this feeling or circumstance as “a problem”? 2. Can you imagine this experience outside of yourself and describe its shape or size? 3. What colors, sights, sounds, smells come to mind as you reflect on this experience? 4. How does this (use client’s descriptive words) affect you and your relationships with others? 5. Have you overcome this (client’s words/metaphor) before? 6. When has the (client’s words/metaphor) been most powerful in your life? 7. Do you want to change this (client’s words/metaphor)? 8. Have you changed this (client’s words/metaphor) circumstance before or in other areas of your life? 9. Can you describe what this change may look like in shape, size, color, sound, smell, etc? 10. Can you picture the alternative to this (problem metaphor) and describe it (use similar descriptive prompts as question 3)? What does it look like for you to encompass or embrace this
As noted above in question examples, using specific words shared by the storyteller, the facilitator then asks various descriptive questions including size, shape, sound, etc. of the problem as the client describes their story.

Following the example of the facilitator, group members are also encouraged to use the storyteller’s words to formulate/ask specific questions that assist the storyteller in enriching the description of their story/experience.

Other group members are listening for specific words and descriptions that resonate with them and will have the opportunity to describe, draw, or express these themes and words back to the storyteller when the storyteller has completed sharing the story with the group.

The storyteller then assumes the role of listener as the group members’ work together to retell the story they witnessed to the storyteller while sharing their interpretation of the story through an expressive art modality.

All group members then engage in dialogue around the experience of listening, telling and relating to the story. Similar and different perspectives are shared in relation to the group and individual experiences.

At the close of the dialogue, the storyteller may choose whether or not to share their story card that assisted in visualizing and sharing the story with the group.

The group may decide to carry over this exercise into the next session, giving each member an opportunity to share their story in the role of the storyteller.

Of note: All storytellers in this research project chose to reveal their story card at the end of the group process.

**Sampling and Protection of Human Subjects:**

Participants volunteered to participate in the open ended anonymous questionnaire. Participants were those who had just participated in narrative approaches in group work as part of regular programming. Participants were not persons classified with serious and persistent mental illness and were currently voluntarily participating in the program and this research; thus minimizing vulnerability risks in this population.

Group members who voluntarily chose to participate in the research remained anonymous by completing the questionnaire and placing them in a sealed envelope. A group representative volunteer collected the sealed envelopes and placed them in an inner
department mail envelope addressed to the researcher. Four separate groups were completed prior to reaching the data collection goal of greater than or equal to fifteen participants. The volunteer combined all participant envelopes into one interdepartmental envelope, which was then mailed internally to the researcher. No names or other identifying information was used to collect this data. Data collected remained confidential and unbiased due to anonymity. The Hennepin County Medical Center Institutional Review Board gave written consent to complete this research through an exempt review application due to the following conditions: the status of this researcher as a staff member completing the group intervention, no confidential information collected, and the University of St. Thomas Institutional Review Board’s approval of this research. In retrospect, limited demographic information was collected; participants could choose to enter their information in the categories of gender, age and race. As graph 3.1, indicates the demographics of gender represented sixty-one percent female, thirty-three percent male and six percent unknown. Next, graph 3.2 shows the ages of both females and males, which ranged from 19 years old to 65 years old. Lastly, graph 3.3 illustrates the ethnic diversity of this sample, prompted by the word ‘race’. The ethnic information indicated that the majority of the respondents (seventy-two percent) were of Caucasian descent and the smallest minority was of Native-American decent (six percent). Eleven percent of the respondents were of African-American decent and another eleven percent declined to indicate race. Finally, it is important to note that not all participants chose to enter their demographic information, which supports the open-ended format of the questionnaire, the voluntary nature of participation and theoretical framework of this study. See figures 3.1, 3.2, and 3.3 below.
Figure 3.1: Respondents by gender

Figure 3.2: Age of respondents by gender:

Figure 3.3: Ethnic Diversity of respondents
Data Collection and Data Analysis:

Data was collected upon completion of a regular scheduled recreation therapy group that is currently participating in narrative therapy applications in group work. Data was collected from four separate open-ended therapy groups in an outpatient mental health treatment program with a total of 18 voluntary participants. Data Analysis was completed by the researcher who looked for words and themes that emerged among participants’ responses. Themes that supported the literature and identified the following measurements in group process emerged in the following categories: a positive emotional experience, cohesion, personal insight and catharsis. The data collected was also reviewed by a research volunteer that is unassociated with this research thus acted as an independent reviewer for the purpose of increasing validity in this study.
Results/Findings

This qualitative study, designed to explore the effectiveness and potentials of narrative approaches in group work, developed a new methodology measurable through a client’s own words. Group process components identified in the results and supported in the literature included themes of cohesion, catharsis and insight. Four separate groups were facilitated with a total of twenty five group members. Eighteen of twenty-five group members voluntarily participated in the research. When asked if this approach was helpful, ninety-four percent of the participants responded favorably, affirming that the overall group process helpful and that they would recommend this approach to others. Some of these respondents expanded on their support of the process stating, “very thought provoking-forces thoughtful listening which many of us do too little of,” “this approach made me appreciate the storyteller’s story and tied me more to the storyteller,” “it makes my emotions more concrete and measurable,” “power of group process,” “a unique way of getting to know someone without the exact story but by senses,” and “it moves us outside ‘the box’.”

Data analysis involved themes identified by the researcher and an independent reviewer. The independent reviewer had no prior knowledge of this research study or design, and no knowledge of the specific approaches used to facilitate the groups. The independent reviewer was given the exact questions distributed to respondents in addition to the raw data of transcribed responses for each question. The themes identified by the independent reviewer demonstrated increased validity of the measurement (participant’s words) discovered in this research study. No prior knowledge of what the researcher intended to look for or later identified was provided; yet similar interpretation of the data
by researcher and reviewer support inter-rater reliability within these results. As more specifically explained below, themes of cohesion, catharsis and insight were highlighted congruently by both researcher and reviewer (see Table 2.0).

Table 2.0: Responses from participants, categorized in themes by both researcher and reviewer.

<table>
<thead>
<tr>
<th>Cohesion</th>
<th>Catharsis</th>
<th>Insight</th>
</tr>
</thead>
<tbody>
<tr>
<td>“You can relate to them and realize you are not alone-or learn different things and broaden horizons.”</td>
<td>“Using metaphors allows me to better describe my feelings- having a seemingly thoughtful audience is always therapeutic.”</td>
<td>“Very thought provoking- forces thoughtful listening which many of us do too little of.”</td>
</tr>
<tr>
<td>“I'm not perfect. I'm human and can identify with others.”</td>
<td>“I shared my feelings of loneliness and isolation.”</td>
<td>“another's perspective”</td>
</tr>
<tr>
<td>“It pulls people together by relating.”</td>
<td>“feelings about loneliness”</td>
<td>“Helps in getting to a truer understanding, 2 inputs.”</td>
</tr>
<tr>
<td>“This approach made me appreciate the storyteller's story and tied me more to the storyteller.”</td>
<td>“I felt a relief as well as a better understanding of my [own] emotion. It helped me deal with it.”</td>
<td>“It expands my own awareness.”</td>
</tr>
<tr>
<td>“It bonds listeners to Storyteller.”</td>
<td>“freedom, miserable, sad”</td>
<td>“It helps listeners get more insight into the storyteller's life.”</td>
</tr>
</tbody>
</table>

Specific analysis of the data by both researcher and independent reviewer, identified themes of cohesion, defined as a sense of acceptance, belonging, and value in group membership. Eighty-eight percent of respondents indicated cohesion when
answering questions about the group process by expressing belonging using such words as ‘connection,’ ‘bond,’ ‘relate,’ ‘universality,’ as well as other phrases indicated in table 2.0. Furthermore, both researcher and reviewer congruently identified themes of 
\textit{catharsis}, defined as \textit{a feeling and/or opinion of feelings} disclosed in the group process. Ninety-four percent of the respondents actually stated feeling words and/or specifically used the words ‘feeling’ or ‘emotion.’ Additional respondent phrases indicating catharsis are noted in table 2.0. Lastly, the researcher and reviewer both found expressions of 
\textit{insight}, defined as \textit{new perceptions of self and/or others}. Ninety-four percent of the respondents expressed the words ‘insight’ and ‘perspective’ in addition to phrases that represented insight gained such as those named in table 2.0.

Again, unaware of the researcher’s intentions to evoke themes of cohesion, catharsis and insight in the questionnaire, a thematic summary on the data supporting all three themes was written by the independent reviewer stating, “Description (metaphor), connection, perspective and identification reoccurred in the data. Words connected to feelings help express emotions. Telling a story engages the group - all who are involved (person telling, those listening). [Participants] can remove self from situation…to identify with something ‘bigger’ than themselves – look at issue in a new or different way.”
Discussion

General Impression

Overall, the data collected indicated the powerful potential of group process through the precise words of the participant. Open coding from both researcher and independent reviewer resulted in themes of cohesion, catharsis and insight embodied in the group process and evidenced in client responses. This was true in both the role as a storyteller and/or as a listener within the group. Additional conceptual elements also emerged within these three measures of group process. They included but are not limited to, the value of therapeutic alliance, expressions of metaphors, and the insightful discovery of the tension of opposites. Lastly, group members from diverse backgrounds and experiences expressed helpful connections that increased human acceptance within the group process despite differences in their own stories.

Literature Reviewed

Cohesion

According to previous research (Marmarosh et al, 2005) and Yalom’s (1995) definition of group process, the importance of group cohesion has been empirically supported as a primary factor directly related to the relationship between client and therapist as measured in individual psychotherapy. Results from such research on cohesion and/or therapeutic alliance show a correlation between group cohesiveness and client satisfaction (Marmarosh et al, 2005). Factors of cohesion and hope appeared to be rated by group members in Rutan’s (1993) research, as the greatest level of importance in improved functioning. The data retrieved from the questionnaire in this current study
supports the research noted above. All but one respondent mentioned the importance of relating and belonging within the group. In addition, the same number of respondents expressed satisfaction with the intervention process by stating a willingness to recommend this experience to others.

This data also supports the concept reviewed in the literature, that for individuals to benefit and remain in therapy, they must feel positively toward the therapeutic experience. Such benefits can be measured by the cohesiveness engendered through group support (McCallum et al., 2002). As noted in the results, the data reveals an overall positive experience by respondents who reflected on the use of narrative approaches. Group cohesion is named as a benefit by sixteen of eighteen respondents who used words including, “connection,” “two perspectives,” “bond,” and “thoughtful audience” to describe cohesion.

During group process, cohesive hope is also reflected in each member’s personal strengths when group members learn from and relate to one another (Vassallo, 2002). When using narrative approaches, the storyteller’s words are not judged but instead, stand on their own merit through reflection. This audio reflection of a storyteller’s themes is similar to inductive data analysis often used in qualitative research. Both the storyteller and the listeners utilize the thematic reflections as a therapeutic tool. This is similar to the therapeutic stance of assisting all group members in not judging the words or experiences of the storyteller, but rather to join in the validation of one another’s experiences as perceptions of hope, meaning and change are explored (Carey & Russell, 2004, Freedman & Combs, 1996, Duncan & Miller, 2004, and White, 1999). A female respondent in this study noted significant value and implied cohesive hope within the
narrative group process as she reflected on opinions she shared during the group session. Her words speak for themselves as she stated, “group participation…driven by group conscious; adding ideas without judgment; power of group process, owning process…it was engaging.”

Lastly, in Rutan’s (1993) research on group psychotherapy processes, curative measures for its group members were recognized by factors of ‘universality’ and the ‘installation of hope.’ A male respondent in this narrative study spoke to both of these themes. When asked what words or themes he related to during the group process, his response was “chaos, order.” Hope is implied in moving from “chaos to order”. When asked why the words he identified were meaningful, this participant responded with the word “universality”, the same concept and specific word used in Rutan’s (1993) research on curative measures in group process.

*Therapeutic movement through catharsis*

The therapeutic processes identified in psychodynamic group therapy models are mechanisms that promote imitation, identification and internalization (Rutan, 1993). The mechanism of internalization in personal change is most similar to what narrative therapy describes as “therapeutic movement” (Morgan, 2000). The internalized change is explained in psychodynamic terms as “a shift in the psychic structure of the individual so that his experiences, both conscious and unconscious, are shifted to a more mature level of functioning” (Rutan, 1993).

The data from this exploratory research demonstrates that expressed words and feelings by group members, can be measurements of catharsis and more importantly, that
a client’s own words can indeed have value in measuring change. Questions one, five and seven on the questionnaire prompted reflection or expression of feelings. Results indicated that seventeen of eighteen respondents used the words ‘feeling’ or ‘emotion’ when describing reflections. Some respondents disclosed a specific feeling such as fear, loneliness, sadness, curiosity, etc. in at least one of the three questions. In narrative therapy approaches, the facilitator intentionally uses a storyteller’s own words to further explore details of an individual’s narrative, thus modeling the value of a person’s story while facilitating group dynamics (Dulwich Center Website, 2006, Freedman & Combs, 1996, White & Epston, 1990, White, 1999). This careful selection of words shared by the storyteller and reflected in the facilitator’s questions helped reveal catharsis and insight through mirrored expressions of emotions in participants of this study. Specific words of two female respondents of different age groups and ethnic backgrounds demonstrate therapeutic movement through similar reflections on their participation in the group process, evident through expressions of feelings (catharsis) in question one. The first respondent is a 59-year-old Caucasian female who identifies the feelings she shared during the group as, “curiosity, apprehension, insight, clarity.” The second respondent is a 19-year-old bi-racial Native-American/Caucasian who names similar feelings and therapeutic movement as she reports, “I talked about fear and how it looks to me, and then the opposite of fear. I shared my good feelings of confidence and power and also those of irritation and chaos.” As mentioned in the literature review, therapeutic realizations like feelings and insights are documented as productive steps toward change and are often used in outcome evaluations (Shapiro, 1987). This movement is noted from insight statements of each participant. Respondent one stated, “It expands my own
awareness…from discomfort to comfort.” Similar therapeutic movement from respondent two is expressed in the statement, “I felt a relief as well as a better understanding of my [own] emotion. It helped me deal with it. It is an abstract and creative way to work through emotions.”

*Facilitating from the unknown to create change through insight*

When looking at insight as a therapeutic factor within a group process, such words as ‘metaphor,’ ‘insight,’ ‘identification’ and ‘perspective’ thematically emerged in the data. Ninety-four percent of the respondents commented on insight as part of the outcome of the group process (see table 2.0). Their comments support the literature which suggests that evaluation and determination of change improved therapeutic outcomes when conducting therapy within a client’s own ideas of change (Duncan & Moynihan, 1994). Furthermore, a client’s perspective of change through insight is evidenced in this study by the respondents’ use of metaphors.

Another component of insight is interpersonal learning as noted by Yalom’s (1983 & 1995) theory on therapeutic benefits of psychodynamic group therapy. In narrative therapy, insight and interpersonal learning includes the use of metaphors (Epston, 2006), but unlike those used in psychodynamic therapy (Close, 1998), the metaphors are developed by the client not the clinician. As mentioned previously, the group facilitator then uses a client’s words to enhance the description of the metaphor within a client’s own story, thus assisting the client to search for meaning and insight into self (Epston, 2006). It is significant to note that in this research the word ‘metaphor’ isn’t prompted by the clinician/facilitator during the therapeutic intervention; rather, it is the
process of questioning and development of a client’s story that metaphors evolve. In retrospect, the words and/or descriptions of a metaphor are expressed by at least seven participants in questions that asked about value or benefits of the group process. For instance, respondents noted that “selecting symbolic representations of the story is interesting and enlightening,” “giving shape/form/words to the problem helps as part of the recovery/healing process,” and “it moves us outside ‘the box’.” Furthermore, insights into feelings are also expressed in examples of metaphor which include respondent statements such as, “fire and heat referring to great discomfort and fear,” “dark, heavy, buoyant, organic, lonely” or “shapes, colors, sounds; from discomfort to comfort.” Such data supports the ‘subjective vs. objective’ dilemma in therapy practices (Duncan and Moynihan, 1994), as it appears that individual responses remain subjective, yet collectively their value can appear objective. Ultimately, this study’s data indicates that subjective realities have value.

**Tension of Opposites as insight to self and others**

In *Tuesday’s with Morrie*, author Mitch Albom (1995) conveys a valuable message when he dialogues with his sociology professor, Morrie Schwartz, about ‘the tension of opposites’. He describes this as life pulling us back and forth; learning from what hurts us as much as what loves us. This ‘tension of opposites’ was a repeated insight noted by participants who commented on their narrative group experience in this research study. Sixty-one percent of respondents expressed some value in the awareness of opposites within a story. For example, the statement “the regeneration of life after the pain” indicated specific opposite reactions that may instill hope. Further examples of
opposite insights emerged in the data as sixty-one percent of the respondents expressed themselves using words such as, “chaos, order”, “sorry about the bad part, happy about the good part”, “still connected, broken”. These themes support the narrative therapy approach, which includes the use of metaphors to assist in the discovery of a dominant story and its helpfulness in the transformation to the possibilities that exist in an alternative story (Epston, 2006). Ultimately, the alternative story holds hope for change. This researcher and independent reviewer noted that the polar responses and metaphors used by the clients convey a heightened awareness in the movement from problems to possibilities. They also become tools to measure the client’s progress in group process.

Strengths and Limitations

Theorists argue that groups are effective in creating change within the individual. This research intended to extend theories of practice and research in group work by joining clinical practice with theory. Limitations to this study included a relatively small sample size, which restricted the ability to generalize the application of the data to other mental health therapy groups. Furthermore, the sample size limited the diversity of the sample, while the anonymous nature of the study prohibited some specific analysis of such demographic information. In contrast to the demographic limitations, the subjective approach to collecting demographic information could be considered a strength, as it allowed participants to describe themselves as they see fit and/or omit information that they interpret as identifiable to the researcher. Having such choices to omit information may increase validity in responses.
Another strength and limitation could be the influence and/or familiarity of the principle researcher/group facilitator with the participants who are responding to the study. In order to minimize this limitation of pleasing the facilitator/researcher, the participants’ identity remained anonymous to the researcher. However, familiarity with the researcher and among group members may be noted as a strength within the research design. By the time the group members participate in the intervention, there is often an established trust level, which may not be present with a focus group designed specifically for research purposes. The established comfort and trust level among the group participants may also encourage honest responses, which are a vital component to this research. Due to the researcher’s role as a staff member/group facilitator, permission to complete this study was approved by the agency’s hospital institutional review board.

One final limitation of this study may be the lack of validity and reliability in the questionnaire since the questions have not been tested in previous research. However, the instrument used to design the questionnaire (Curative Climate Instrument) is based on the anticipated response themes of cohesion, catharsis and insight, which demonstrated a moderately high internal reliability coefficient of .93 (cohesion), .87 (catharsis), and .84 (insight) in the Johnson’s et al. (2006) study of group process measures.

Implications for Social Work Practice

There is limited clinical research on group work and narrative therapy. Efforts in bridging clinical and community work are rooted in social work practice; yet research remains incomplete. Using narrative approaches that respect a client’s story at face value (Morgan, 2000) can support a client’s perspective of change (Duncan & Miller,
2004) and honor the strengths-based practices (Saleebey, 1996) rooted in social work practice. Using narrative therapy approaches in group work through the qualitative measurement of a client’s words, such as those in this study represented by themes of cohesion, catharsis and insight are future building blocks to creating evidence-based changes within the individual and the mental health system simultaneously. Such efforts empower self-advocacy in a field that continues to carry strong stigmas. Renouf and Bland (2005) sum up challenges and opportunities for social work services within newer models of therapy practices that bridge community and clinical work by stating, “…social work - human rights, self determination, family, relationships and welfare, employment, housing, community, life chance – are central to mental health. We need to continue to argue for a broader agenda in mental health, beyond narrow clinical concepts of illness and treatment.” (pp. 430).

Implications for further research

As previously stated, current research shows that group therapy is as efficient as individual therapy, yet more time and cost-effective (Gordon et al., 1988, Johnson et al., 2006, and McRoberts et al., 1998). However, the studies that measure group process are limited. With the high cost of healthcare and the push to provide more services with fewer resources, evidenced based practice and research in group work will become more necessary. Better measurement of group process will contribute to increased reimbursement for services. Although this study yielded significant measures of cohesion, catharsis and insight reoccurring thematically as evidenced by the participant’s own words, this sample was limited in size. The importance and validity of a client’s
specific words is an exciting start to the development of measuring group process and therapeutic change. Further research is needed using narrative approaches in group work in a variety of outpatient mental health settings, as well as a wider diversity sample of participants in order to determine a general effectiveness.

Conclusion

As earlier stated by Karen Kaiser Clark that life means change and growth is optional, this research demonstrates that narrative therapy and the clients’ voice are a valued measure for growth and change. The validation of our individual experiences and stories can flourish in meaning when shared with others. Narrative approaches in group work appear to support this optimistic perspective, yet clinical research in narrative therapy and group work is limited. This exploratory research touched on the potentials of narrative approaches in group work as valid measures of individual responses through new insights, expressions of feelings, and connections to others. Bridging the art of group process and the science of evidence-based research may not be as difficult as once presumed.
References:


McPhie, L. & Chaffey, C. (1999). The journey of a lifetime: Group work with young women who have experienced sexual assault. In Dulwich Centre Publications,
Extending narrative therapy: A collection of practice-based papers (31-61).

Adelaide: Dulwich Center Publications.


http://www.narrativeapproaches.com/narrative%20papers%20folder/mentalill.htm


Appendix A

CONSENT FORM
UNIVERSITY OF ST. THOMAS

Narrative Therapy Practices in Outpatient Mental Health Group Work.

I am conducting a study about narrative therapy and group work. I invite you to participate in this research. You were selected as a possible participant because you are a member of a group who has just participated in narrative therapy approaches. Please read this form and ask any questions you may have before agreeing to be in the study.

Background Information:

The purpose of this study is to explore the outcomes of narrative therapy approaches in group work for people who have participated in a mental health group therapy treatment program.

Procedures:

If you agree to be in this study, I will ask you to participate in a brief written questionnaire reflecting on your most recent group experience. No identifying information will be disclosed by completing this questionnaire and your participation is strictly voluntary. Your identity will remain anonymous to your group leader, as will your decision to participate in the research. Your responses will be collected by a staff member in your program to preserve confidentiality but this staff member is not associated with this research project.

Risks and Benefits of Being in the Study:

No there are no perceived risks or benefits.

Confidentiality:

The records of this study will be kept private. In any sort of report I publish, I will not include information that will make it possible to identify you in any way. Research records will be kept in a locked file and destroyed upon completion on May 31, 2006.

Voluntary Nature of the Study:

Your participation in this study is entirely voluntary. Your decision whether or not to participate will not affect your treatment at Hennepin County Medical Center or your current or future relations with the College of St. Catherine or the University of St. Thomas. You may withdraw at anytime prior to turning in the questionnaire. Once the
questionnaire is collected there will be no way to withdraw the information submitted due to the anonymous intentions of collecting this information.

Contacts and Questions

This study will be conducted by Kirsten Romness Rosenberg, CTRS, MSW student of the College of St. Catherine/University of St. Thomas in fulfillment of an academic requirement to complete a Masters in Social Work. This research will be conducted under the supervision of Randy Herman, PhD, the College of St. Catherine/University of St. Thomas institutional review board and the Hennepin County Medical Center institutional review board. You may ask any questions you have now. If you have questions later, you may contact Kirsten at 612-873-4352. You may also contact Randy Herman at 651-962-5818 with any questions or concerns.

You will be given a copy of this form to keep for your records.

Statement of Consent:

I have read the above information. My questions have been answered to my satisfaction. I consent to participate in the study. Please place an X on this form to consent to participation in this research.

“X” by Study Participant        Date

____________________________________   __________________________
Signature of Researcher           Date
Appendix B

This questionnaire is NOT an evaluation of the therapist but instead, questions about narrative approaches used in your group today. The goal is to hear in your words if this approach is helpful or not helpful.

1. What feelings and/or opinions did you share during this group session?

2. As a storyteller, is there value in sharing your story with others? (explain)

3. As a listener, is there value in hearing another person’s story? (explain)

4. When you were listening, what specific words or themes did you hear & relate to?

5. Why do you think these words were meaningful?

6. Were there benefits of retelling the story to the storyteller as a participant in the group?

7. Would you recommend this approach to others and why?

Demographics: Please fill out the information below.

Gender: Age: Race:
Appendix C

Reader’s guide to identification of themes in questionnaire on group process

1. What feelings and/or opinions did you share during this group session?

   *(catharsis)*

2. As a storyteller, is there value in sharing your story with others? (explain)

   *(Insight)*

3. As a listener, is there value in hearing another person’s story? (explain)

   *(Insight)*

4. When you were listening, what specific words or themes did you hear & relate to?

   *(cohesion)*

5. Why do you think these words were meaningful?

   *(catharsis)*

6. Were there benefits of retelling the story to the storyteller as a participant in the group?

   *(cohesion)*

7. Would you recommend this approach to others and why?

   *(Response could yield insight, catharsis or cohesion)*