

# Narrative Behaviour Therapy? Integration in Practice<sup>1</sup>

Michael Griffin

This is a clinically-oriented paper which seeks to describe the integration of narrative and cognitive-behavioural approaches in working with children and adolescents. It is suggested that a CBT model can be augmented by typical narrative manoeuvres. For example, it is often helpful to relieve children as quickly as possible of the 'problem-saturated story' with which they and their parents enter therapy. The narrative approach of 'externalising the problem' can achieve this within the first session, and helps the family to a) find a good working relationship with the therapist, b) clarify goals, and c) embrace the possibility of change. The use of CBT and narrative therapy in conjunction is illustrated by a case study of obsessive compulsive disorder in a young adolescent girl.

Martin Seligman played midwife to a major text on empirically validated or 'gold standard' therapies, *A Guide to Treatments that Work* (Nathan & Gorman, 1998). In his Afterword to that volume he then expressed concern that the power of the research findings might diminish and require adjustment at the coalface of clinical reality (Seligman, 1998). Andrews and Wilkinson (2002) have posed the same dilemma as a question: How large is the gap between efficacy (research findings based on randomised controlled trials) and effectiveness (the impact of an intervention when delivered as therapy or as a program in the general community)? There has been an invitation from researchers like Seligman for clinicians to adapt gold standard treatments to fit the vagaries of clinical conditions, with an understanding, for example, that developmental considerations will often require such adaptation when working with children and adolescents (Braswell & Kendall, 2001).

I practise as a clinical psychologist in a rural setting, working with young people and their families. I often go 'on the road' for up to a week at a time, taking a CAMHS service out into smaller communities and beyond. Clients are seen at community centres, in schools, and at home or on the farm. On occasions we have met in the family car or under a shady tree. Sessions usually take about 60 to 75 minutes. There is scope and need for adaptation: program

packages and other resources may not be available or easily delivered, but therapy has a rich supply of models to choose from and adaptation includes the possibility of integration across models (e.g. Neimeyer & Raskin, 2001).

I want to tell you a story about some of my clinical work with young people, which has involved integration across two models of therapy. I am thinking of several young clients, all around the age of transition from primary school to high school, and all coming to therapy for the treatment of Obsessive Compulsive Disorder (OCD). For the purpose of this story, I take as an example Lisa and her battles to overcome debilitating OCD symptoms after the illness and hospitalisation of her mother. Mum eventually recovered but Lisa was unable to rid herself of her rituals. They became so numerous and so pervasive that friends soon noticed at school and family members were becoming irritated and concerned.

Lisa was a bright young adolescent from an intact family, which seems to function well. There were some anxious personalities in the extended family, but only to a mild degree. Lisa is a popular and successful student, with excellent coordination and a healthy sense of humour. Her Mum had fully recovered from her illness by the time we started therapy and she accompanied Lisa to all sessions. Mum allowed Lisa to speak for herself, which she did assertively. They appeared to have a very sound relationship, although Mum was worried about her daughter's dilemma and unable to reassure her that all was now well.

Lisa is a good example of several children whom I have come to call 'patterners'. This is a term which young clients can easily understand and apply to themselves, and which they find less stigmatising than the diagnostic term Obsessive Compulsive Disorder. 'Patterners' are people who have a natural tendency to order their world with little



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patterns of behaviour which normally come and go, but which are at risk of developing into compelling rituals when the child is feeling unusually anxious or stressed. These 'patterns' have a mathematical flavour, involving balancing or evening up (like touching each item of clothing twice to the floor before it can be put on in the morning), repeating an action or a phrase several times, angling the body with regard to objects or patterns in a room, or counting and placing with precision. Patterns can jolt themselves out of their habits once they become aware of them, but significant stress can produce a rapid proliferation of rituals complete with underlying belief system to lock them in place (e.g. 'If I do not count every fence post between here and home, Mum'll get sick again').

### Inspiration from the Literature

As I said in my introduction, one of my quests these days is to find valid ways of tailoring research-based therapies to the needs of younger people in rural settings where there is often a paucity of resources. It helps in such a quest if we know there are common elements across models of therapy, which may then allow us to integrate apparently disparate treatment components to cater more flexibly for our clients in a way which maintains the gold standard. That's quite a task, so let us begin. I have three books and a journal article beside me, and I want to make reference to each one as a way of introducing a) the idea of narrative behaviour therapy, b) the research on commonalities across therapeutic models, and c) the application of cognitive behaviour therapy (CBT) as the 'gold standard' treatment of OCD. Of course I could have chosen other books and papers, but these are the four which particularly stimulated me in my thinking about what I call 'narrative behaviour therapy'.

There are many recent books about narrative therapy. One in particular appeals to me as a therapist working with young people and their families. It is called *Playful Approaches to Serious Problems*, which nicely catches the flavour of the book and its suitability for work with children and adolescents (Freeman, Epston & Lobovits, 1997). This book provides a useful demonstration of what narrative therapy in practice is all about. It also provides a good illustration of how narrative approaches often incorporate behavioural elements, as well as aspects of other therapeutic models such as de Shazer's brief family therapy. Narrative shares with CBT a preference for conscious cognitive strategies. I was encouraged when reading this book to think that integrative approaches were alive and well.

Let me now draw attention to the second edition of the volume edited by Keith Dobson, *Handbook of Cognitive-behavioral Therapies* (Dobson, 2001). Reading this is an excellent way to catch up with developments in CBT, an area now rich with models and diverse applications. It's encouraging to read the final chapter of this book (by Neimeyer & Raskin) and to find that recent 'extensions' of CBT include narrative approaches. Once again, integration seems to be sanctioned by published precedents.

The third book may seem a curious choice in the context of working with young people, because it deals with couple therapy. I am referring to Kim Halford's *Brief Therapy for Couples* (2001).<sup>2</sup> I have chosen it for several reasons. For a start, it is an excellent example of the scientist-practitioner at work. Kim integrates research findings with detailed clinical applications. His model is also an example of the 'stepped' approach to treatment we are beginning to see used more these days. More importantly for my story, Kim's book reminds us of the commonalities across therapeutic models.

Kim and his colleagues have found that about 80% of change in couple therapy occurs during the first two or three sessions. These are often assessment sessions, highlighting the importance of several common factors, which sit at the early stages of any therapeutic approach. We know how crucial it is to a) *establish a clear and shared understanding of the problem(s) to be addressed*, b) *build an effective working relationship between therapist and client(s)*, and c) *set clear goals*, knowing the process of reaching the goal and *how to recognise when the goal has been reached*. Kim emphasises the importance in couple therapy of addressing the above issues by connecting with each partner separately as well as with the couple together, which hopefully echoes our aim with families.

It has been my experience that the above factors are constant across diverse models of therapy, and I have argued (Griffin, 2001) that complex cases often drift or go

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sour in some way when we have neglected to address adequately these common factors. My interest in paradoxical psychotherapy (see Griffin, 1985) also leads me to add a fourth common element, which is arguably pivotal for any therapeutic solution: perspective change. The notions of reframing, decontextualisation, and of finding a new 'spin' or a different angle, are examples of this. When we come to tackle Lisa's 'patterning' behaviour, we will do well to address these four factors early on in therapy.

The fourth publication I want to spotlight here is a journal article, whose short title is 'CBT for OCD' (Sofronoff, 2001). It provides an up to date review of research, illustrating with a case example the use of CBT as the treatment of choice for OCD. Although we will learn a few things about the CBT approach for OCD when we return to Lisa and her mother in therapy, let us summarise the main ingredients of the approach, at least as they apply

to adults. Kate Sofronoff uses the case example of a 54-year-old woman in her article, so we may have to make some adjustments for 12-year-old Lisa.

OCD occurs when obsessional thoughts have become associated with anxiety, which has then been 'neutralised' through the development of compulsive rituals, or through avoidance of anxiety-provoking situations. OCD thus involves attempted avoidance of tricky situations (which, after a while, can certainly reduce a sufferer's pleasure in living), and the urge to perform various rituals when avoidance of feared situations is not possible. The elements of a CBT approach tackle the various aspects of this dilemma: a) *exposure* to the situations which trigger obsessional thoughts and compulsive responses, b) *prevention of any neutralising or avoidance* behaviours (no rituals and no running away), and c) *cognitive restructuring* to modify the inflated sense of personal responsibility for what might happen if rituals are not performed. As we shall see with Lisa, it is difficult to continue with the behavioural aspects of CBT (exposure plus response prevention) unless we can find a powerful cognitive challenge to the irrational belief that one is personally responsible for what might happen to others (Salkovskis, 1999).

### Snapshots from Therapy

Lisa and her mother are sitting comfortably in the therapy room, ready for their first session. How shall I work with them, so as to take into account all the issues I have discussed above? We know that a CBT approach would begin with a behaviour analysis of the problem at hand. This assessment phase could be difficult for Lisa if she and her mother enter therapy with what White and Epston refer to as a 'problem-saturated story' (White & Epston, 1990). From a socially sanctioned perspective, children are often seen by their parents to be the 'cause' of the 'problem', or simply as the problem itself. We may wish to consider the narrative approach of 'externalising the problem' as a playful way of removing the burden of the problem from Lisa's shoulders. The 'problem chapters' of the story could hopefully be set alongside (and later replaced with) new chapters that draw on Lisa's strengths to find solutions.

A CBT approach would also seek to uncover the belief system which maintains the need to perform the rituals even though the original event which produced anxiety is long past. Such a belief, as I mentioned above, may take the form: 'If I don't continue to perform all the rituals when I get the urge to do so, something terrible will happen to a member of my family'. Such beliefs often have a sting in the tail, which makes it difficult for the therapist to say, 'Lisa, just stop the rituals for a couple of days and you will see that your fears were groundless because nothing terrible has happened'. Lisa would not fall for that one, because she has counter-logic ready: 'But the tragedy may not happen for several months, and I couldn't take the chance for that long'. So what we also need in our CBT approach is a powerful counter to Lisa's belief system. CBT has ways of achieving

this, but what happens if Lisa is not all that suited to CBT staples such as keeping diary entries for thought monitoring (so she can become more aware of the thoughts which drive her actions) and use of the downward arrow technique (which aims to look below surface thoughts to find the more elusive belief systems lying hidden beneath)? This requires a degree of cognitive maturity (formal operational thought) which Lisa may not yet possess. Once again, a narrative approach may provide an alternative.

The pivotal aspect of our CBT approach is exposure plus response prevention. We want Lisa to maintain her normal life, without avoiding situations where the urge to perform rituals is strong. We want to expose her to those situations while instructing her to refuse entirely to perform any rituals (response prevention). That's a nice behavioural task, and we don't need a narrative alternative this time. Sometimes, though, we will want to make exposure easier to manage by beginning with short exposure periods which the child can sustain and gradually increasing the time required (graded approach).

Our first session is important. It's the assessment phase and we want to establish problem definition, working relationship, goal setting, and perspective change as early as possible. We are starting our behaviour analysis, but Lisa and her mother are burdened by the problem. We want to relieve that pressure, and we want to use Lisa's own resources and energy as much as possible.

The narrative approach of externalising the problem is a way of 'learning about the enemy' which reduces its power. Lisa is invited to help us achieve this by conjuring up the problem in many and varied forms (e.g. using drawings and clay models, and giving them names). We soon have illustrations and descriptions of the various rituals, which become personalised as members of the 'Ritual Family'. For the purpose of therapy, they exist separately from Lisa, and so are no longer 'her' problem. She finds that naming each

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ritual according to its particular action provides an easy way to identify and remember them. We can see them before us, occupying their own (lengthy) sofa in the therapy room. Balance is next to Angle, and they are looking at Touch and Neck further along. We have figured out their identities, and we know their moves!

Integrating an externalising approach with the behaviour analysis component of CBT has assisted our shared

understanding of the OCD and helps chart the way forward. Now we can actually see 'the problem' in front of us. Lisa has been an essential member of the therapeutic team. We can establish goals pretty clearly once we know the Ritual Family's secrets. We will vanquish them all, but we can focus on each one in turn. We know where to start, because we can see their relative strengths and weaknesses. Lisa and her mum are suddenly confident that change is possible because the problem has been described in much more precise detail, and Lisa's burden has been lifted. She is clearer now about the importance of exposure and response prevention, because we can visualise their use with each member of the Ritual Family, and she has discovered the progress she has already made in limiting and outsmarting some of the family members. (She has already limited, of necessity, the balancing ritual which requires her to touch the other arm of a chair (for example) if she accidentally

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touches one (12); then she has to reverse that sequence to balance it (12/21); and then she has to balance all of that (12/21, 12/21), and all that has gone before (12/21, 12/21; 12/21, 12/21), and so on). Lisa also knows the underlying belief system which impels the rituals (as part of our endeavour to explain and demystify OCD), and our initial attempts to challenge it have exposed its sting in the tail.

It takes time to run down all these pesky members of the Ritual Family, and some prove stubborn. Lisa eventually overcomes the need to touch each item of clothing twice to the floor before she can put it on in the morning. She doesn't need to align her body with lines and angles in the room any more. OCD is often about control in some form, and Lisa was using some control of her own to fight back. One of the tougher rituals to shift was the neck turn when going through two doorways at home which were screened with vertical plastic strips. It was a simple movement, which may have developed into a motoric habit. We were able to encourage Lisa's father to fit the two open doorways with proper doors, and the neck ritual soon faded away. This was a therapeutic bonus for Lisa's mother, who had long campaigned for this task to receive priority!

The key to complete success in overcoming the rituals and keeping them at bay was going to be our finding an effective counter to the belief system. We decided to use a 'storying' approach because story telling was more suited to Lisa's cognitive style than was CBT in more structured form. Beginning with simple tales of life at home and at

school, it was my job to shape the narrative in ways which might uncover a powerful belief to counter the thought of catastrophe. Towards the end of our conversation, Lisa stated that she liked to be in control of her life, and added upon reflection that she would hate to control anyone else's life. It is important that the therapist remains awake and alert when such a critical moment arrives!

I pointed out to Lisa that decisions to perform or prevent rituals could potentially have life or death consequences for her family, if the underlying belief was true. This sounded to me as if she had absolute control over her parents. At this point, Lisa sat bolt upright in her chair and declared with some vehemence that she was not going to be in control of anyone else's life but her own. She suddenly gained the energy and the determination to drive out the remaining rituals. The end was near for these intrusive habits.

### Outcome

We reached this point in about six sessions (at approximately fortnightly intervals, a frequency which I find acceptable but which is dictated somewhat by my travelling schedule), with Lisa's Mum able to say that she could no longer detect any ritualistic behaviour in her daughter. Lisa admitted to the occasional head swing but we decided this habit now seemed independent of any anxiety or urges. We would arrange a follow up session in about three months.

I eventually received a phone call from Lisa's mother saying that she might need to bring Lisa back for further sessions. There had been another significant family upset and rituals had returned. There were some new ones and some old favourites. I asked Lisa's Mum to remind Lisa of our sessions, and of the strategies she had learnt. Could she treat her own condition this time around?

A later phone call revealed that the crisis had passed and that Lisa had been successful in getting rid of the new set of rituals. She was decidedly proud of herself, and she knew that she could now be her own therapist if ever the need arose. This seemed like an ideal outcome after seven sessions of what I came to call narrative behaviour therapy. Our integrated approach, which Lisa was confident in using, had been as successful as the gold standard CBT treatment (Franklin & Foa, 1998), and perhaps it was even better because it relieved her burden early on and fit her own style like a glove.

### Coda

I titled my paper 'Narrative Behaviour Therapy' to reflect my CBT background. It could as easily have been called 'Behaviour Narrative Therapy' if I had been intent on integrating some behavioural approaches with a primarily narrative orientation. In my work with the several children represented by Lisa's story, my approach has been that of a CBT practitioner who has introduced narrative elements where these seemed to help overcome client resistance or facilitate a sense of understanding and self-control. There are

of course other models of therapy which can be utilised in an integrative approach. I also wanted to check that the resultant hybrid was as effective as could be expected from available outcome research. We often need to fashion our treatments to suit unique circumstances, and I would like to encourage other practitioners to examine their integrative practices against treatments validated by outcome studies.

### Endnotes

1. The original version of this article was presented as a paper at the Australian Association for Cognitive Behaviour Therapy (AACBT) conference held in Sydney at the start of September 2001. An expanded (but again unwritten) version was then presented at a meeting of Southern CAMHS country (rural) therapists in the Adelaide Hills near the end of October 2001.
2. Robin Wileman's interview with Kim Halford will appear in this Journal later this year.

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