DRYING UP THE BEDWETTING: RETELLING OF A NARRATIVE JOURNEY

by

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DECLARATION

I, the undersigned, hereby declare that the work contained in this assignment is my own original work and had not previously in its entirety or in part been submitted at any other university for a degree.

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Signature **Date**

SUMMARY

As a research-therapist-in-training I sought to document a young boys story of his struggle with enuresis. The purpose of the study was to explore the use of the narrative metaphor with this young boy who took a stand against enuresis after numerous attempts to resolve it. Enuresis is a medical diagnostic term and I attempted to seek alternatives to the diagnosis and treatment of what is sometimes viewed as pathology. I undertook to find an answer to the research curiosity: How could the narrative metaphor be used in working against the bedwetting?

The narrative approach was utilized to guide the research journey in order to facilitate the client's preferred, alternative story of his life. I was interested in highlighting an alternative story to the diagnosis and treatment of enuresis as pathology.

Looking at the positivist views on enuresis I became particularly interested how the narrative metaphor could be used against enuresis. I used the guidelines and questions suggested by Michael White's work (1995:201) on narrative therapy and bedwetting to strengthen Michael's voice. White described ways of externalising the problem and mapping the influence of the problem.

Key concepts used during the research journey were: terms adopted from narrative therapy, enuresis and postmodernism.

OPSOMMING

Synde 'n navorsingsterapeut wat besig is met opleiding het ek probeer om 'n jong seun se verhaal van sy stryd met enurese te dokumenteer. Die doel van die studie is om die gebruik van die narratiewe metafoor saam met hierdie seun, wat 'n standpunt teen enurese ingeneem het ná vele pogings om dit te oorkom, te ondersoek. Enurese is 'n mediese diagnostiese term. Ek het probeer om alternatiewe vir die diagnose en die behandeling van iets wat partykeer as 'n patologie gesien word, te soek. Ek het onderneem om antwoorde te vind vir die navorsingsvraag "Hoe kan die narratiewe metafoor gebruik word teen bedwatering?"

Die narratiewe benadering is gebruik om die navorsingsreis te lei, om sodoende die kliënt se verkose, alternatiewe lewensverhaal te vergemaklik. Ek wou fokus op 'n alternatiewe storie as teenvoeter vir die diagnose en behandeling van enurese as patologie.

Positivistiese sienings van enurese het my belangstelling in wyses waarop die narratiewe metafoor teen enurese gebruik kan word, geprikkel. Ek het die voorgestelde riglyne en vrae oor narratiewe terapie en enurese in Michael White se werk (1995:201) gebruik om die seun se stem te versterk. White beskryf wyses waarop die probleem ge-eksternaliseer kan word, asook maniere waarop die invloede van die probleem gekarteer kan word.

Sleutelkonsepte wat ek tydens die navorsingsreis gebruik het sluit in terminologie wat ontleen is aan narratiewe terapie, aan enurese en aan post-modernisme.

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CHAPTER 1

PAVING THE WAY FOR THE RESEARCH STORY

> *Narrative therapy seeks to be a respectful, non-blaming approach to counselling and community work, which centres people as the experts in their own lives. It views problems as separate from people and assumes that people have many skills, competencies, beliefs, values, commitments and abilities that will assist them to reduce the influence of the problems in their lives* (Freedman & Combs 2000).

1.1 INTRODUCTION

The journey of discovering preferred ways of being, awakened my curiosity to an ethical way of practicing therapy as a therapist in training. I would like to draw on the metaphor of a journey used by White (2002) to make meaning of my experience as research therapist in training. White (2002:12) explains that in using this I could be "transported to other places in life in which I might become other than who I was". I continued my journey as therapist in training with this metaphor as a map to take me "to unscheduled destinations via routes previously uncharted" (White 2002:13). Although it seemed like a daunting task of not knowing where I was going, I had the support I needed from my supervisor, colleagues and family as route markers along the way to continue even through challenging times.

This journey was undertaken by a young boy, Michael, aged 14 and me. His mother brought him to the Unit of Educational Psychology because of her concerns regarding Michael's relationship with bed-wetting. Michael's mother had shared the many attempts that had been made to find a solution to the bed-wetting, but to no avail. Enuresis is a medical diagnostic term. The main challenge I was faced with on this journey was to seek other possible ways of approaching the diagnosis and treatment of what is commonly viewed as pathology. My re-telling of this story will attempt to illuminate the process of applying narrative principles in the re-authoring of Michael's life by facilitating his preferred stories as it relate to the problem.

1.2 MAPPING THE DIRECTION FOR THE JOURNEY

1.2.1 Introduction

The purpose of the study was to explore the use of a narrative approach to therapy by means of a detailed case study within a participatory action research design. I believe that the narrative metaphor was a respectful way of working with this young boy who was able to take a stand against bedwetting, despite numerous setbacks over the years.

During the extensive search for an alternative way of approaching enuresis, I came across the article by Michael White (1984) where encopresis is externalised and renamed "Sneaky Poo". White (1984:116) explains that the behavioural and psychodynamic explanation of encopresis had left him rather "puzzled". This resonated very strongly with me and with my client. I chose not to allow perspectives of pathology dominate my thinking. I was encouraged by the words of Freeman, Epston and Lobovits (1997:104) that a therapist should not become "overwhelmed, no matter how dire the problem". I hoped that during the research journey I would find out what was needed to assist Michael in finding his voice. I became curious as to how I could use Michael White's work to provide route markers on my journey as research-therapist-in-training.

As Freeman, Epston and Lobovits (1997:9) point out, "[t]he language that we use when speaking about young people has certain effects". To say that Michael was enuretic "is to imply something about his identity" (Freeman, Epston & Lobovits 1997:9). White (1995:22) suggests that "clients come to believe that the problem speaks of their identity".

The label given to Michael by many professionals, his parents, his family, and even himself was that of enuresis. Instead of going along with this internalised description of Michael's problem, I was hoping that in collaboration with Michael and his family we could "bring forth" (see Freedman & Combs 1996:16) an externalised definition of the problem. Having established that enuresis was plaguing him, I was interested to hear the history of the problem, to hear the threads of the alternative ways of being that Michael and his family believed in, and thickening the alternative story by focussing on the unique outcomes.

During our initial discussion, it seemed to me that enuresis had attempted to shape Michael's understanding of who he was and how he was to live his life. It seemed to

me that enuresis had played a role in almost all the different areas of his life. When Michael's mother referred to him as enuretic, the language used implied a fixed description of who he was. White (1995:30) emphasises that "[w]e have to be very sensitive to the issue of language. Words are so important. In so many ways, words are the world". This in effect emphasizes the significance of language to "… constitute meaning to experience and lives and reality" (Kotzé & Kotzé 1997:6). Language is seen as "constituting our world and beliefs. It is in language that societies construct their views of reality" (Freedman & Combs 1996:28).

White (in Freedman & Combs 1996:39) claims that people come to therapy when dominant narratives are keeping them from living out their preferred narratives.

Narrative therapy would postulate that my client had to develop a preferred story about himself and his reactions to bed-wetting.

1.2.2 Significance of the study

The traditional counselling approach to bedwetting is to "provide support to the child and parents, give information on causes and physiology of the bladder, to promote independence by giving the child responsibility and to develop rapport with the child and the parent" (Schaefer 1997).

The traditional psychotherapeutic approach to bedwetting (enuresis) has been a domain of "dominant knowledge's" (White and Epson, 1990:18) whereby the therapist performs the therapeutic sessions from a position of exclusive knowledge and power. The narrative approach of Michael White and David Epston suggests that solutions are to be found in the lives and the relationships of the clients, and should not be solely based on the therapist's specialist know-how. According to Morgan (2000:10), narrative therapists are interested in joining their clients to discover the stories they have about their lives.

My approach as therapist was to facilitate the re-authoring of problematic aspects of Michael's life according to himself and others close to him. I chose to place the problem outside of Michael, instead of locating it as part of his identity, which would only reinforce the idea that he was the problem. To counter the diagnosis of enuresis, that was talking him into the idea of being a failure, I invited him to personify the problem, to give it a name and to have conversations about how the bedwetting was affecting his life. White (2001:3) demonstrates that one of the primary achievements

of externalising conversations is that "we can unpack thin conclusions that people have about their own and about each other's identity".

In my journey with my client, I strove to stand with him in a place where his story could be reframed. I held the hope that Michael would be able to reclaim agency over his own life.

1.2.3 Research curiosity

The research question is as follows:

How could the narrative metaphor be used in working against the bedwetting?

As I continued on the research journey, I also embarked on answering the following questions:

- Did the search for an alternative story enable Michael to take a stand against the dominant discourse concerning enuresis? If so, in what ways?
- What ways of collaboration were used that engaged both the researcher and the participants in this therapeutic process?
- How did using the narrative approach to therapy influence me as researcher/therapist-in-training?

1.2.4 A research approach

I chose to conduct a qualitative research study, because qualitative research assumes that there are multiple realities, "that the world is not an objective thing, but a function of personal interaction and perception" (Merriam 1991:17). The qualitative approach enabled me to co-construct new realities in a collaborative process with the participant of the study. I use the term qualitative within a postmodern framework in which "knowledge is inherently contextual, local and pluralistic" Viljoen (2001).

Denzin and Lincoln (1994:4) accurately describe my position as co-researcher and travelling companion on this qualitative research journey:

> "Qualitative researchers stress the socially constructed nature of reality, the intimate relationship between the researcher and what is studied, and the situational constraints that shape inquiry. Such researchers emphasise the value laden nature of inquiry".

Throughout this journey, I attempted to explore ways in which we could emphasise Michael's preferred identity conclusions about himself that could stand against enuresis. The description of this journey forms one of the markers on the map.

1.2.4.1 Data production techniques

"Qualitative researchers operate under the assumption that reality is socially constructed, complex and ever changing" (Glesne & Peshkin, 1992 in Leedy, 1997:107). Leedy (1997:107) contends that the qualitative researcher is normally seen as the "research instrument" because of his or her 'personal' participation in the environment where the research takes place.

The following practices were used during our conversations as way of documenting the research:

- Audio and visual recordings were made of the conversations that I had with Michael. (The term *conversations* is used as an alternative to *interviews*) since I was interested in learning about Michael's experiences, through attentive listening, curious questioning and reflection.) I also took notes. The recordings were later transcribed.
- A detailed case study of the therapeutic process with Michael was undertaken. The process will be described.
- Written documents such as therapeutic letters and certificates that recognised and celebrated Michael's stand against the bedwetting were produced.
- A literature review that describes and compares narrative therapy and the traditional counselling approach to bedwetting was conducted.
- Interviews with the family in the form of an outsider-witness group who witnessed the re-authoring of Michael's story were also undertaken.

1.2.4.2 Data analysis

Two processes proceeded simultaneously in an interwoven way namely the therapeutic journey as well as the research process. In qualitative research "the investigator usually works with a wealth of rich descriptive data, collected through participatory observation, in-depth interviewing …" (Mouton 2001:108). Michael and I had many conversations during our journey. I conducted these conversations by

following some of the narrative practices (which will be discussed in chapter 2). Most of our conversations were tape and video recorded. I made use of practices such as reviewing recorded transcripts and reflecting on the conversations and the research journey as a whole.

According to Freedman and Combs (1996:21) while modernist thinkers tend to be concerned with facts and rules, postmodern thinkers are concerned with meaning. Positioning myself within a postmodern worldview I realized that language plays an important role in the therapeutic setting. Michael White (1995:30) is of the opinion that "(w)e have to very sensitive to the issue of language. Words are so important. In so many ways words are the world". The use of language has contributed to the understanding of meaning - making of Michael's preferred identity. During the research Michael was invited to be an active participant in the journey.

As Babbie and Mouton (2001:283) note, thick descriptions are constructed from multiple sources of evidence. Within a narrative approach however, I had to be cautious in my methods of analysing the very personal data of my client. In my tentative stance towards trying to make meaning of the process, I engaged in frequent self-reflection by writing down my own experiences after a session and discussing the process during supervision. I also engaged Michael in the data analysis process, by inviting him to participate in describing his experiences of the therapeutic journey and making his own meaning of our discussions. I also made use of letters as a reflection of our conversations.

1.2.4.3 Trustworthiness of the research

Botha (1998:93) claims that the "term validity is slippery because it is a term from the modernistic paradigm that has the inclination to singular and universal truth". It was not my aim to look for a method of inquiry that would ensure the validity of the findings of this research. Instead, during this research journey, I considered ways of producing data that are ethical and trustworthy:

- My own influence on the research journey. Heshusius (1994:16) suggests that participatory consciousness is the awareness of a deeper level of kinship between the knower and the known. An inner desire to let go of perceived boundaries that constitute self and other - must be present before a participatory mode of consciousness can be present. In view of this, it is my intention to

reflect on my research question of how the narrative approach has influenced me as a research-therapist in training in Chapter 5.

The criteria to assess the trustworthiness of qualitative research as suggested by Kincheloe and McLaren (cited in Kotze 2000:177) were used during the research journey:

- Qualitative researchers do not believe that research descriptions can portray "reality" accurately. They reward credibility only when constructions are plausible to those who constructed them - the participants.
- Qualitative researchers question external validity, arguing that this traditionalist concept of external validation is too simplistic. Instead, Piaget's notion of accommodation seems more appropriate in this context, as it asserts that humans reshape cognitive structures to accommodate unique aspects of what they perceive in new contexts.
- Qualitative researchers advocate catalytic validity, which points to the degree research moves those it studies to understand the world and the way it is shaped in order to transform it. The research should display the reality-altering impact of the inquiry process, so that those under study will gain self-understanding and direction. I continually searched with Michael for means of deconstructing and reconstructing his reality. I resonate with the words of Hoffman (1997:11) that "in therapy, we listen to a story and then we collaborate with the persons we are seeing to invent other stories or other meanings for the stories that are told". Michael's reflection on the therapeutic process is documented in Chapter 4.

1.2.5 Participatory action research

A participatory action research design gave me the methods to explore Michael's story. I was interested in how I could join Michael in his telling of the problem and the options available to us for re-authoring his stand against the bedwetting.

Wadsworth (1998:16) considers that "participatory action research involves all relevant parties in actively examining together current action and the drive behind such a research is our need to know in order to bring change". Seymour-Rolls and Hughes (1995) further suggest that participatory action research "is a method of research where creating a positive social change is the predominant driving force".

On my journey, I employed "re-authoring conversations" within a narrative framework. Carey and Russel (2003:60) explain that "the practice of re-authoring is based on the assumption that no one story can possibly encapsulate the totality of a client's experience. Re-authoring conversations involve the co-authoring of story lines that will assist in addressing whatever predicaments have brought someone into counselling".

Sax (2002) takes the view that "the narrative practice of re-authoring conversations is well suited to action orientated research as it explores the stories that constitute people's lives in terms of both action and consciousness". Furthermore, she suggests that "the interplay between action and meaning allows people to intentionally explore and develop new and preferred ways of being and thinking that have an influence on the lives and relationships, it also provides the reflective space to step back and query into the meaning that informs particular actions".

1.3 ETHICS

1.3.1 Introduction

Snyman and Fasser (2004:75) argue that the "ethics and ethical code of conduct in the healing professions are now more important than ever and that the role of postmodern psychotherapists is far more complex than that of their modern counterparts".

Throughout this journey, it was the narrative approach to conversations and the social-constructionist view that guided the therapeutic process in an ethical way. Freedman and Combs (1996:16) explain that the main premise of social constructionism is as follows:

> "… the beliefs, values, institutions, customs, labels, laws, divisions of labour, and the like that make up our social realities are constructed by the members of a culture as they interact with one another from generation to generation and day to day. That is, societies construct the "lenses" through which their members interpret the world. The realities that each of us takes for granted are the realities that our societies have surrounded us with since birth. These realities provide the beliefs, practices, words, and experiences from which we make up our lives, or as we would say in postmodernist jargon, constitute selves".

Social constructionism guided my involvement in the research process as therapist in training. In this way, it invited me to try to understand and also challenge Michael's taken-for-granted narrative. Freedman and Combs (1996:265), suggest that, "in the

post-modern world, ethics focus on particular people in particular experiences and that in the modernist world ethical rules were enforced in a top-down way". Thus, in contrast to knowing what is best for my client, I preferred to focus on his own lived experiences in addressing the problem. It was in this way that Michael was "given a voice" and this played a part in the ethical approach to research.

1.3.2 Situating myself in the research process

I was assigned as a MEd Psychology student to do therapy with Michael who was referred to the Unit for Educational Psychology. The position that I held throughout this journey is one of a researcher/therapist-in-training. I engaged with Michael from a "not-knowing position", "where the client is the expert". This position has created the space for a respectful approach to Michael and his experiences of the problem. Taking a narrative stance, I moved away from the expert position and Michael became the expert on his own life. Michael became a participant in the research process. It involved "not asking questions from a position of pre-understanding and not asking questions to which I want particular answers" (Freedman & Combs 1996:44).

Frank (in Scrimgeour 2002:32) argues that "a story needs a listener and stories are not material to be analysed; they are relationships to be entered into, relationships are sacred, therefore, listening to stories is an ethical act". As therapist, I positioned myself as co-explorer of Michael's story in exploring new understandings that spoke differently about the problem than the "label" of enuresis. Bird (1994:44) describes professional talk "as the interpretation of the dialogue by the therapist". I applied the following guidelines given by Bird (1994:45) to protect me as research-therapist-in-training from participating in professional talk:

- Never write in secret when using clinical examples for an article, ask the client's permission, show the finished, completed article to the client, and ask for feedback. (Michael and his family gave written consent to conduct this research and to publish the results of the re-telling (see Appendix A)).
- Do not disregard "disrespectful" thoughts, e.g. this person is not working hard enough or "is resistant to my ideas". (Self-reflection became part of my therapeutic process. I became critical of my own use of language during

therapeutic discussions to establish a more equal power relation between researcher and researched).

1.3.3 Positioning myself as co-author

I made use of a "participatory mode of consciousness" which was respectful to Michael's way of being, resulting in conversations that transpire (with) him and not (about) him. According to Heshusius (1994:16), a "participatory mode of consciousness" suggests that the client's story will be honoured and respected with him being the expert of his own life. Kotzé (in Scrimgeour 2002:33) suggests that understandings, which are co-created in this way, are called "co-searching for new knowledges". Therefore, my research includes both Michael and me as co-authors of alternative stories, preferred knowledge and practices (White 1991:37). I agree with Morkel (2002) that "the way of being with others does not allow much space for evaluative seeing, but it is through asking yourself '[c]ould I imagine such a life for myself?' that you move into a state of merging, a state of consciousness". For a research-therapist-in-training, it was this way of being that "opened up a mode of access that was not there before" (Heshusius cited in Morkel 2002:20).

1.4 THEORETICAL FRAMEWORK OF THE STUDY

1.4.1 Introduction

There are diverse ways to conceptualise the process of knowing in therapy.

1.4.2 Post-modernist discourse

Narrative therapy transpires from the milieu of post-modern thought. According to Freedman and Combs (1996:22), post-modern ideology has four essential beliefs. They are:

1. Realities are socially constructed;
2. Realities are constituted through language;
3. Realities are organized and maintained through narrative;
4. There are no essential truths.

As research/therapist-in-training, these beliefs offer useful ideas about how power, knowledge, and truth are negotiated in therapy and research.

According to Hansen (2004:4), "postmodernism is a complex philosophical movement that has challenged the basic tenets of modernism". Consequently, contends that "in the postmodern thesis, observers create realities; with its various constructivist and social constructionist strains (and) it seems to be a sensible proposition that would lead counsellors to appreciate the unique realities of individuals and groups" (Hansen, 2004:7).

Anderson and Goolishian (in Viljoen 2001) found that the postmodern ideas challenge the traditional modernist relationship between the therapist and client, where the therapist is expected to cure or "fix" the problem experienced by the client, with expert knowledge. White (2000:9), on the other hand, emphasises that "(a) postmodern therapist enters each therapeutic conversation with a not-knowing approach curious about the client's own knowledge's". He further suggests that the postmodern therapist respect the client, as the expert of his/her own life story. Other postmodern theorists, Anderson and Goolishian (1988), Gergen (1985), Gergen and Kaye (1992) and Hoffman (1992 in Viljoen, 2001), view all forms of knowledge and ideas as evolving through language and taking shape in the realm of the "common world" and "within a common dance". Freedman and Combs (1996:21) provide yet another important perspective when they describe postmodernism as follows: "(p)ostmodernists believe that there are limits on the ability of human beings to measure and describe the universe in any precise, absolute, and universally applicable way." They are, thus, interested in meanings rather than in facts and rules. In accordance with a postmodernist perspective, I used a narrative approach that is concerned with finding different meanings by the retelling of the client's preferred stories. In postmodernism, the fundamental belief is that knowledge is achieved through experience and through social interaction.

1.4.3 Social constructionism

Social constructionism has implications for the therapeutic process. The aim of my conversations with Michael was not to uncover truths about him, but rather to co-construct meaning where he was given the opportunity to tell his story and I collaborated with him in re-authoring his story. In doing so, I was guided by Freedman and Combs (1996:33) who argue that in "a narrative social constructionist worldview we cannot objectively know reality, all we can do is interpret experience, no interpretation is true".

Sinaikin (2004:105) argues that the "Diagnostic and Statistical Manual of Mental Disorders TR (1994) (DSM TR-IV) model is not about true or false, it is the story we tell our clients about their problems". He contends that the DSM-IV-TR model "puts the psychologist into a position of absolute control, dictating a model of disease and wellness to passive, non-participatory patients". In the conversations that I had with Michael, therefore, it was important that his voice be heard and that I not elicit a history of the diagnosis of enuresis. In collaboration with Michael, we selected a narrative that maximised his sense of authorship and empowerment while at the same time minimising any sense of biological defect and helplessness. As research-therapist-in-training, it was the curiosity and the not-knowing that opened up the spaces to instil a sense of agency in this young boy. The diagnostic label of enuresis is reductionist and enuresis was threatening to do some serious harm in Michael's life. He needed to hear an alternative preferred version of his story.

The social constructionist would, therefore postulate that the self is understood as a social construct through language. Griffith and Griffith (2002:33) highlight the importance that the "language, ideas and traditions brought to the therapy by clients are honoured". In my journey with Michael, he was invited to be an active participant in the research journey. As Freedman and Combs (1996:34) suggest, "[s]elves are socially constructed through language and maintained through narrative". Sinaikin (2004) considers that "the psychiatric profession embraces and gives unbridled support to the hegemony of DSM-IV-TR and the labels and narratives as truths ..., social constructionism questions the usefulness of labels and the domination of the DSM-IV-TR". I preferred to think that a label was not the only way to conceptualise Michael's problem, instead I was interested in looking at alternative ways of understanding Michael's relationship with enuresis and the implications of this relationship for him.

1.5 APPROACHES TO CONVERSATION

1.5.1 Introduction

In the narrative way of working, the theory holds the belief that it is possible to question the taken-for-granted truths and discourses that can captivate a client's identity within dominant cultural stories about ways of living and being. This can be done by means of a process of deconstruction. According to Freedman and Combs,

(1996:57) deconstruction refers to "the process of unpacking". Through the deconstructing process, problems become entities that are separate from people and create the space for people to name their skills, competencies, beliefs, values, commitments and abilities that will assist them to reduce the influence of problems in their lives (Morgan 2000:2).

I decided to make use of narrative therapy practices because of their commitment to finding other approaches to the diagnosis and treatment of problems that are commonly viewed as pathology. In the following section, I will discuss the aspects of narrative therapy practices and sand tray techniques that I incorporated into my way of collaborating with Michael.

1.5.2 Curiosity about narrative therapy

The narrative therapist understands that lives are lived through stories. The view in narrative therapy that your client in therapy is guided through a process that allows him to recognize that his life consists of many stories and that he is the author of those stories resonated with me. Narrative therapy has been described as "re-authoring" or "re-storying practices" (Morgan 2000:5). She further suggests, "[f]or a narrative therapist, stories consist of events, linked in a sequence, across time and according to a plot". The narrative is a thread that weaves the events together, forming a story. Freedman and Combs (1996:16) describe narrative therapists as "being interested in working with people to bring forth stories that do not support or sustain problems". As people begin to live out the alternative stories, they further new possibilities for relationships and new futures.

The stories that our clients give to us as therapists are mostly problem-saturated. It is within a narrative approach that the preferred story becomes the alternative one. The new or alternative story liberates the client from the chains of the problem.

1.5.2.1 Externalising conversations

An important practice of the narrative approach is the externalising of the problem. It was this idea that stood out for me in familiarising myself with narrative therapy. It deeply challenged my thinking in my journey with Michael. I fully concur with White's (2001:2) that externalising conversations can be very helpful in "the unpacking of some of the negative identity conclusions that people bring with them into therapy". The narrative practice of externalising problems encourages clients to

personify and objectify the problems that they experience as oppressive (White & Epston 1990:38). This is based on the belief that "the problem is the problem; the person is not the problem" (Morgan 2000:17).

Particular emphasis is placed on how a problem affects a person's view of him/herself and of their relationships to others (White 1991:29). When a problem is externalised, the attitude of the young client in therapy has the space to shift. Freeman, Epston and Lobovits (1997:9) argue that "when children realize that the problem, instead of them, is going to be put on the spot they enthusiastically join in conversation". In this way, the focus in therapy would be on values, hopes, and preferences in relation to the problem rather than on pathology.

In externalisation conversations with Michael, enuresis was renamed "Sneakers". Examples of externalisation conversations are "What did you do to outsmart Sneakers?" and "What personal strengths did you use?" This is done through unpacking and taking a curious but critical look at the meaning of the problem or incident.

1.5.2.2 Deconstruction

White (1992:109) explains that "deconstruction has to do with procedures that challenge 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 a client's lives".

I was interested in discovering, acknowledging and taking apart the beliefs of the broader culture in which my client lived, that was serving to assist the problem story (Morgan 2000:45). In this sense, deconstruction offered me a way of coming to a closer understanding of my client's life story.

1.5.2.3 The client as the expert

I attempted not to pathologize and label my client, but to take up a "not knowing" position. Anderson and Goolishian (in Scrimgeour 2002:26) found that this approach is one where the therapist asks questions from a "not knowing" approach, not from preconceived ideas and wanting particular answers, but always moving from a "not yet known" position. This stance does not mean that I was only a passive listener; I was an active participant in therapy without attempting to dominate or impose my

own meaning on our conversations (Freedman & Combs 1996:44). At a workshop in Somerset West in the Western Cape, Michael White cautioned that the concept of "not knowing" could be misinterpreted as *not knowing*. He explained that we are only "not knowing" in the sense that we do not assume to know what would work for other people, but that narrative therapists are interested in wanting to know more about the client's experience. The "not knowing" position encouraged me to be curious and not to see myself as the expert, but rather to see Michael as the expert in his own life.

The implications of a "not knowing position" exclude the so-called expert advice that I may have about bedwetting like cognitive behaviour therapy and the bell and pad method. The question here is not whether other therapeutic methods are effective or not, but rather which way of approaching the problem would my client prefer? I did it in such a way that I honoured the expertise of my client and found out what worked for him. Examples of the questions during conversations that are conducted from a non-expert, not knowing approach may include "How do you prefer to talk about the bedwetting? or "What word would you like to use for the bedwetting?"

1.5.2.4 Discovering unique outcomes

When the problem becomes "disempowered" as people separate from the dominant problem-saturated stories that constitute their lives, "it becomes more possible for them to orient themselves to aspects of their experiences that contradict these knowledges" (White, 1992:127).

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Michael White (1992) refers to these contradictions as "unique outcomes". Freedman and Combs (1996:67) suggest, "unique outcomes are experiences that would not be predicted by the problem-saturated plot or narrative" that has governed the client's life. It may be a plan, action, thought, desire, or dream. It could be ability or a commitment made to anything that the problem dislikes (Morgan 2000:52). Examples of questions include "I was wondering how you outsmarted Sneakers?" and "Are there times that Sneakers did not visit so often at night and what did you do?"

1.5.2.5 Reflecting team

> "When persons are established as consultants, to others, and to the therapist, they experience themselves as more of an authority on their own lives, their problems, and their solutions to these problems". (Epston & White 1992:17)

During our journey, I asked Michael if he would like to share his story with members of his family. He enthusiastically invited his two brothers, sister, and mother to witness his victory over "Sneakers". They were invited first to listen to an interview, and later to be interviewed about what they had learnt from listening to Michael's stories. This is a process in which everybody is invited to participate in re-authoring a client's life. Everybody was changed through the co-construction of new and special knowledge's. I found that this process can bring hope, support and joy into the therapeutic process with children.

1.5.2.6 Therapeutic documents

Epston (1998:95) describes how he applied the opportunity for "expanding the conversation" through the practice of letter writing, thus enabling "the therapist and client to take the therapeutic conversation further by noticing what was discussed in the session, writing further thoughts, questions and in doing so expanding the conversation". The words in the letter do not fade and disappear the way conversation does, they ensure through time and space, bearing witness to the work of therapy and immortalising it" (Epston 1998:95).

In Chapter 2, there is a description of some of the different therapeutic documents that I used in my journey with Michael.

1.5.2.7 Sand play in a narrative context

According to Freeman, Epston and Lobovits (1997:163), there are numerous ways to approach sand play in a narrative context. It can offer the client an opportunity to build a problem-saturated world, to map the influence of the problem or to build the alternative story. Following this suggestion, as the conversations with Michael progressed, I invited him to build a series of trays depicting the problem-saturated story. He also constructed an alternative story and explored the steps taken forward in the journey with the obstacles he encountered along the way.

1.6 LOOKING AT ENURESIS

Enuresis seems to be one of the most common problems that are experienced by children. El-Radhi and Board (2003:440) found that nocturnal enuresis is a chronic childhood complaint, which affects 60 million people worldwide and over half a million children in the UK.

According to the DSM IV-TR (1994), the prevalence of enuresis is between 5% and 10% among 5 year olds, between 3% and 5% among 10 year olds and around 1% among individuals age, 15 years and older.

Nocturnal enuresis is defined as the involuntary passage of urine during sleep, in a child aged 5 years or older, in the absence of any congenital or acquired defects of the nervous or renal system (Cronjé 2004:439).

The word is derived from the Greek term "I make water". A variety of factors can contribute to the development of nocturnal enuresis; genetic factors and stressful early life events seem to be the most notable. Most children will eventually outgrow their enuresis but this may take several years, and thus treatment is indicated for children who are adversely affected by the wetting (Cronjé 2004:439).

Scheaffer (1997) proposes a list of the traditional treatment approaches to enuresis:

- Bell and pad conditioning method - enuresis alarms
- Drug treatment
- Psychodynamic therapeutic approach
- Dry bed training
- Star charts and behaviour modification
- Counselling approach
- Hypnosis

In Chapter 2, I explore the ideas surrounding enuresis and look at the factors that have been identified as having a causative role in bedwetting.

1.7 ON A THERAPEUTIC JOURNEY WITH MY CLIENT

This section provides an outline of the research journey.

The duration of the sessions spanned over two months and there were five sessions of, on average, fifty minutes each, at weekly intervals.

During my initial session with Michael, I invited him to tell me about his relationship with enuresis. He shared how it was dominating his life and how much he wanted to change the negative identity of incompetence and low self-esteem that came with enuresis. In the following session, we deconstructed the enuresis and I introduced the narrative practice of externalising the problem. I did this in an effort to help Michael to conceptualise the problem and guided him to visualize the problem as something

that resides separate from him. The next two sessions were a continuation of the deconstruction process but during these sessions, we started exploring exceptions to the dominant story and our conversations focussed on identifying unique outcomes or times when Michael was able to resist the influence of Sneakers. As Michael's preferred story started to emerge, I collaborated with Michael to find ways to hold on to his new preferred way of being. A way of thickening the alternative story was to find witnesses that could bear witness to the change. Our sessions ended with a celebratory ceremony in which Michael invited his family who stood with him against his battle with Sneakers.

1.8 OUTLINE OF THE RESEARCH JOURNEY

In **Chapter 1**, I provided an outline and discussion of the steps on the research journey which resulted from my curiosity about narrative research. **Chapter 2** addresses some dominant premises of narrative therapy and discourses on enuresis. The process of deconstructing these discourses can empower and re-author the dominant story of my client's life. In **Chapter 3,** I explain the research design and methodology that will form the broad conceptual context of my study. **Chapter 4** retells the actual therapeutic process of this journey. **Chapter 5** summarises my reflections and experiences of a narrative approach in my journey as research-therapist-in-training on how I dealt with bedwetting.

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1.9 CONCLUSION

In this chapter, I have explored the rationale of the study. The research problem, the concepts, and terms used were also discussed. The research design and methodology were discussed briefly.

In **Chapter 2,** I explore the dominant premises of a narrative approach and give an overview of the positivist views on enuresis.

CHAPTER 2

REVIEW OF LITERATURE

2.1 INTRODUCTION

The emphasis in this section is on Michael White and David Epston's work, which forms the foundation of the narrative therapy approach and therefore of this research. I have selected only the key terms and concepts that assisted me in the steps that I took during this journey.

As therapist and researcher, I have come to realise that each question I reflect on enables me to create another step in my journey as narrative therapist. I have had many therapeutic paths to choose from since I started my training. I travelled along one path for a time and then changed to another. "There is no right way to go - merely possible directions to choose from" (Morgan, 2000:3). This is the premise that I as therapist and researcher worked from to give my client as many directions as possible - to open up possibilities for him. Michael played an important role in mapping the direction of the journey. There is a saying that: "A journey of a thousand miles begins with one small step". I have taken that first step. In my training as Educational Psychologist, I was introduced to narrative therapy by Elize Morkel. I learned about postmodernism, which fascinated me from the beginning and presented a different perspective. The narrative approach was based on the assumption that people are the experts in their own lives and view problems separate from people (Morgan 2000:2). It was this first step in my conversations with Michael that "took me to destinations that I could not have predicted, by routes not previously mapped (White 2002:12). Narrative therapy unlocked new ways for me of being in the world in my journey as a therapist-in training.

2.2 MODERN DISCOURSES SURROUNDING ENURESIS

When I was informed that I would be working with a young man who had been struggling with the diagnosis of enuresis since birth, I started reading up on the topic. I encountered various research journals, books and internet resources which defined enuresis according to a standard description and ways of intervention. The positivistic

discourses about enuresis left me with very little in the way of an alternative to approaching Michael and I almost felt as stuck as the set prognosis for this problem. The availability of a diagnosis tempted me to conclude that Michael's problem was common, well-known, well-understood and treatable.

Gergen (1996:3) suggests that implicit in the DSM-IV-TR is the "assumption that psychotherapy is a relationship between an expert who has knowledge and a non-expert who needs help". Gergen (1996) furthermore supports this idea by saying that the "process of consulting the expert for help and obtaining an official diagnostic label for the problem suggests to clients how they ought to change their behaviour, emotional state or biology to get well".

Michael and his mother came for their first visit already strongly influenced by the language of the DSM-IV model, as I was. The medical profession had given him the label of enuresis and that is how his mother referred to the problem during the intake interview.

Sinaikin (2004:104) suggests that "the DSM psychiatry is derived from and legitimized by the scientific method, a perspective that is grounded in the positivistic traditions". He further says that an alternative model to the medical model is social constructionism. Within social constructionism, the self is understood as a social construct. Sinaikin (2004:104) notes that

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> "the words that we use to create frameworks for understanding have tangible consequences because the description we have of life is not reflections or representations of life".

Enuresis is a medical diagnostic term, and the way in which the language is used in speaking with and about young people has certain effects. When his mother described Michael as a child with enuresis, it seemed to me that the language implied something about his identity. It suggested a child who would suffer from low self-esteem and incompetence.

Although the designation of specific labels to an individual, such as "enuretic" may be seen as hampering the discussion, Michael White (1995) believes that these descriptions can be languaged in such as way to enable the client to take a stand against the problem and "empower" themselves. Michael's sense of self was formed around a label "Enuresis". Parents and family responded to him based on their

understanding of how a person with enuresis should be handled. As a therapist, I attempted to explore alternative ways of approaching the dominant description of enuresis.

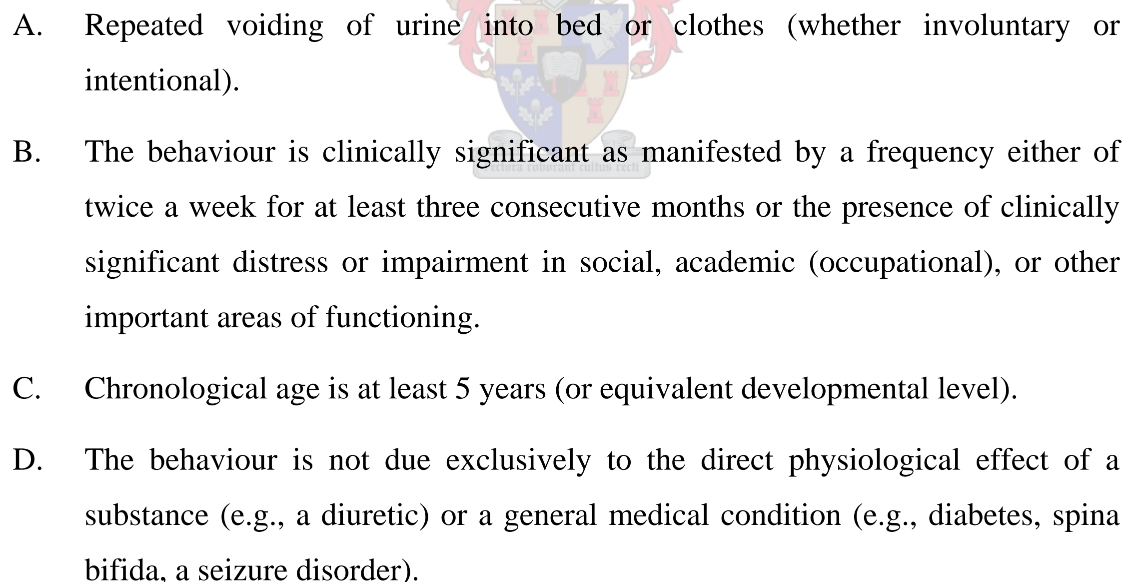
2.3 ENURESIS

Cronjé (2004:439) notes that bedwetting is a common problem. He found that 15% of 5-year olds wet their beds more than three times a week, 7% of 10-year olds and 1% of 15-year olds wet their beds. Schaefer (1979) suggests that the word enuresis was originally derived from the Greek term, which means, "I make water".

2.3.1 Definition of enuresis

The DSM-IV-TR (1994) defines enuresis as "the repeated voiding of urine during the day or at night into bed or clothes". Most health practitioners accept and apply the diagnostic criteria used and described in the DSM-IV without further questioning its usefulness.

The following criteria for the diagnosis of enuresis are specified in the DSM-IV-TR (1994:121):



A. Repeated voiding of urine into bed or clothes (whether involuntary or intentional).

B. The behaviour is clinically significant as manifested by a frequency either of twice a week for at least three consecutive months or the presence of clinically significant distress or impairment in social, academic (occupational), or other important areas of functioning.

C. Chronological age is at least 5 years (or equivalent developmental level).

D. The behaviour is not due exclusively to the direct physiological effect of a substance (e.g., a diuretic) or a general medical condition (e.g., diabetes, spina bifida, a seizure disorder).

There are two dual groupings for enuresis: Primary-Secondary and Nocturnal-Diurnal (Kronenberger & Meyer 2001:127). Firstly, the situation in which the wetting occurs during the night or at night may be one of the subtypes. Nocturnal enuresis refers to the passing of urine only at night time when the child is asleep. According to Kronenberger and Meyer (2001:127) nocturnal enuresis is much more common than diurnal enuresis. Diurnal enuresis refers to the daytime voiding or the passage of urine

during waking hours. Diurnal enuresis is often considered by the parents as more intentional than nocturnal enuresis and may involve power struggles between the parent and the child (Kronenberger & Meyer 2001:127). A combination of the two subtypes mentioned above (nocturnal and diurnal enuresis) may also be present (DSM-IV-TR 1994:119).

Secondly, two different kinds of enuresis may be identified. The term primary enuresis is used to refer to a child with enuresis who has never had bladder control before (Kronenberger & Meyer 2001:127). Secondary enuresis describes a child who had bladder control at one time before regressing to enuretic behaviour (Kronenberger & Meyer 2001:127).

According to Mash and Wolfe (2002:334), teasing, name-calling, and social stigmatisation are common peer reactions to this problem. Therefore, even though enuresis is a physical condition it is often associated with psychological distress.

2.3.2 Etiology

Scharf *et al*. (in Kronenberger & Meyer 2001:128) indicate that the causes of enuresis seem to be multifactoral and several potential etiological factors have been suggested for enuresis: medical problems, sleep disorders, bladder capacity, genetics and psychological factors.

According to Cronjé (2004:443), the most common effect of bedwetting is benign enuresis that is caused by a combination of an inadequate arousal response to bladder fullness and an inadequate increase in nocturnal antidiuretic hormone (ADH) production and small bladder capacity. Mash and Wolfe (2003:334) explain that ADH is a hormone that helps concentrate urine during sleep hours, meaning that the urine contains less water and is therefore of decreased volume. It seems that "some children with enuresis do not show the normal increase in ADH during sleep" (Mash & Wolfe, 2003:334).

Sadock and Sadock (2003:1256) contend that physiological factors are likely to play a major role in most cases of enuresis. Furthermore, they note that a child's risk for enuresis has been found to be more than seven times greater if the father is enuretic. "There is a strong proposal of a genetic component and much can be accounted for by tolerance for enuresis in some families and by other psychosocial factors" (Sadock &

Sadock 2003:1256). According to El-Radhi and Board (2003:442), if both parents used to wet the bed, their child has a 75% chance of wetting the bed.

Psychological factors are often seen as etiologically responsible for enuresis. Psychodynamic theorists tend to view enuresis as a result of unresolved conflict between a child and his parents and other significant people in his life (Terblanche 1995:9). The prevalence of secondary enuresis may develop as a regressive response to stress. It further seems that factors ranging from permissive or restrictive toilet-training experience to emotional problems to faulty learning could influence the problem (Kronenberger & Meyer 2001:129).

Some theorists view sleep disorders such as deep sleep, narcolepsy and sleep apnea as an important factor in nocturnal enuresis according to Scharf *et al*. (in Kronenberger & Meyer 2001:129). It seems that though enuresis occurs in any sleep stage, it is unrelated to factors such as depth of sleep and dreams.

As El-Radhi and Board (2003:442) point out, children with nocturnal enuresis often have bladder muscle instability. They suggest that bedwetting "occurs when the volume of urine produced exceeds the functional bladder capacity and the child fails to wake up to void".

Butler and Holland (in El-Radhi & Board 2003:442) describe a three-system model for nocturnal enuresis. The model depicts that enuresis is caused by a difficulty in one or more of the following systems:

- Bladder instability or reduced functional bladder capacity.
- Nocturnal polyuria or low nocturnal vasopressin capacity. The antidiuretic hormone arginine vasopressin (AVP) results in increased urine concentration and reduced output (El-Radhi & Board 2003:442).
- Lack of arousal from sleep.

2.3.3 Clinical assessment

El-Radhi and Board (2003:442) suggest that a comprehensive assessment will help determine the underlying cause of children's bedwetting and at the same time identify the problem the child is struggling with. It is important to take a detailed history that includes the family history of bedwetting, the type of enuresis (primary or secondary) and the psychological aspects of the child. Cronjé (2004:440) suggests that one should

enquire about the previous periods of dryness and about previous medication and treatment. According to Kronenberger and Meyer (2001:129) physical causes, functional bladder capacity, sleep disturbance, renal disorders and neurological should be carefully evaluated before proceeding to a psychological assessment of enuresis.

In the narrative approach however, it is about "mapping the influence of the problem" that could help persons identify the problem's sphere of influence in the behavioural, emotional and physical domains (White & Epston 1990:42). In my journey with Michael I invited him to tell me about the influence that Sneakers had on his life and his relationships with members of his family. According to (White & Epston 1990:45) the identification of the problem makes unique outcomes possible.

2.3.4 Treatment

Children with enuresis and their parents feel helpless. Therefore treatment that is applied in a successful manner will always improve the psychological and emotional aspects of the children with enuresis (El-Radhi & Board 2003:443).

Sadock and Sadock (2003:1257) state that behavioural and pharmacological interventions are among the treatment modalities that have been successfully used for enuresis. They argue that classical conditioning with the bell and pad apparatus is generally the most effective treatment for enuresis.

Behavioural interventions have been consistently used for children with enuresis. This kind of intervention has been researched repeatedly. Werry (in Terblanche 1995:15) states that it is currently regarded as the most popular and effective aid in behavioural treatment for nocturnal enuresis. According to Kronenberger and Meyer (2001:133) literature reviews indicates that the urine alarm cures enuresis in 62-75% of cases but that the relapse rate is 25-41%. Other behavioural treatments are positive practice, intake schedule, reinforcement for dryness, retention control training, avoidance contingency, over learning, cleanliness training, waking schedule and stop/start training (Kronenberger & Meyer 2001:132).

The pharmacological treatment can be divided into three categories focussing on three separate organ systems according to Djurhuus *et al*. (in Terblanche 1995:15):

- Focus on the nervous system and the sleeping pattern by using imipramine (Tofranil), amphetamine and diazepam;

- Focus on the bladder by using parasympatholytic drugs;
- Focus on the kidney (diuresis) by using desmopressin.

Other psychotherapeutic interventions include hypnosis and play therapy that are used occasionally for enuresis. Psychotherapy is indicated in cases where there are other psychopathologies in addition to enuresis (Kronenberger & Meyer 2001:140).

2.4 NARRATIVE PRACTICES, TERMS AND CONCEPTS

Narrative therapy was developed by Michael White and David Epston (White & Epston (1990); White (1995), White (2000) and White (2002). Its central idea is that people are the experts in their own lives and it views problems as separate from people. "Narrative therapy embraces ways of understanding the stories of people's lives, and ways of re-authoring these stories in collaboration with the therapist". According to White and Epston (1990) a problem is something you have, not something you are. The therapist within narrative therapy explores with the client a narrative of events that focuses on problems and possible alternatives. In order to re-author a person's life, the therapist unpacks the dominant problem-saturated story of the person while at the same time exploring alternative stories that became "subjugated" (White & Epston 1990:26).

Eva-Maria Gortner (2001:1) emphasises that in therapy the "client and the therapist create meaning with each other in a language system". Gortner (2001:1) proposes that the therapist within narrative therapy address three sets of factors: deconstructing the sense people make of their lives, the language practices they use and the power relationships in which they find themselves.

According to White (1999:7), "many practices of narrative therapy assist people to break from the identity claims that are associated with the problem saturated accounts of their lives" and help them to re-author their preferred selves which were marginalized by the dominant story.

In narrative therapy, problems are regarded as arising from and being maintained by oppressive stories, which dominate the person's life. White and Epston (1990) argue, "narrative therapy is not defined by its techniques, but by a belief system and that, it is as much a philosophy as a form of therapy". The objective in therapy is to collaborate

with the client in developing alternative narratives that are more empowering and satisfying and to provide hope for the future.

Freedman and Combs (1996:44) suggest that "when we meet people for the first time we want to understand the meaning of the stories for them". Therefore, the position as therapist would not be "listening for the chief complaints: not gathering the pertinent-to-us-as-experts bits of diagnostic information interspersed in their stories ... not listening for surface hints about what the core problem really is ..." (Freedman & Combs 1996:44). Narrative therapy also maintains "[a] not knowing stance" which is based on the idea that therapists have knowledge of the therapeutic process, but not the content or meaning of people's lives.

A narrative therapist must take an ethical stance in relation to the therapeutic process. The ethical stance can be expressed, as "[t]he problem is the problem, the person is not the problem" (Morgan, 2000:129). This has numerous implications for the client. In this case, the stories that the client offered were problem-saturated and his perception was clouded by his dominant problem-story. Michael experienced guilt and shame when he came for therapy because everyone acted in accordance to the problem-saturated story of enuresis.

Foucault (in Freedman & Combs 1996:37) maintains that language is an instrument of power. Within the post modernist discourse, his/her self-narratives reflect a person's identity. "These self-narratives constitute a person's identity and that self-narratives are not a function of the self, but of social interaction with other people" Gergen (in Botha 1998:100). In an attempt to make sense of their lives, people story their lives. White and Epston (1990:10) suggest that, "this is done by arranging their experiences of events in sequences across times in such a way as to arrive at a coherent account of themselves and the world around them". This account is referred to as a story or self-narrative. According to Kotzé (1994:48), these narratives of self constitute a person's life and relationships. Freedman and Combs (1996:34) conclude "that there is no such thing as an essential self". Selves "are socially constructed through language and maintained in narrative. We think of a self not as a construct inside an individual, but as a process or activity that occurs in the space between people".

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2.4.1 The externalising conversations

One of the first things that a narrative therapist is interested in doing is to separate the person's identity from the problem (Morgan 2000:17). By supporting a client to see problems as separate from themselves, "externalising conversations allow for explorations of the relationship between the person and the problem" (Morgan 2000:28).

There are many ways of understanding externalising, but perhaps it is best summed up in the phrase, "the person is not the problem, the problem is the problem" (Morgan, 2000:129). Externalising locates problems not within individuals, but as products of culture, history and language. Problems are understood to have been socially constructed and created over time. Therefore narrative therapists are interested in ways to determine, acknowledge and deconstruct the beliefs, ideas and practices of the broader culture a client lives in, ideas that strengthen problem discourses.

The practice of externalisation, which separates clients from problems, is a playful way to motivate children to face and reduce difficulties. The method of externalising the problem is "an approach that encourages clients to objectify and sometimes personify the problems, which removes them from their problems that are considered inherent and fixed" (White & Epson, 1990:38).

According to Freeman, Epston and Lobovits (1997:8), "in a family, blame and shame about a problem tend to have a silencing and immobilizing effect". When the problem is separated from the person in an externalising conversation the client is relieved of the pressure of blame and defensiveness. In therapy, Michael was no longer defined as inherently being the problem, but someone who could have a relationship with the externalised problem "Sneakers".

Externalising conversations 'de-centre' the problem in people's lives. This means that space is created between people and whatever is troubling them. Where an internalising use of language convinces a person that he/she is 'worthless', externalising conversations create the space for understanding that there is a history to the problem and the chance to reclaim their life from its effects (Carey & Russel 2002).

White and Epston (1990:39) propose that externalising conversations:

1. Decrease unproductive conflict between persons, including those disputes over who is responsible for the problem;
2. Undermine the sense of failure that has developed for many persons in response to the continuing existence of the problem despite their attempts to resolve it;
3. Pave the way for persons to cooperate with each other, to unite in a struggle against the problem, and to escape its influence in their lives and relationships;
4. Open up new possibilities for persons to take action to retrieve their lives and relationships from the problem and its influence;
5. Free a client to take a lighter more effective, and less stressed approach to "deadly serious" problems;
6. Present options for dialogue, rather than monologue, about the problem.

Externalising language is one of the ways in which problems can be separated from people and situated in the broader cultural context of lived experience. If one perceives oneself as the problem, or if one's relationship is the problem, then there is not much that a person can do - except maybe to act against him/herself. Externalisation makes it possible for clients to experience an identity that is distinct or separate from the problem (White 1995:23).

Externalising conversations with children offer the option of positioning themselves differently in relation to their problems, by interpreting problems as external rather than internal. When the problem is defined as internal to the child, the family members are usually affected and often feel overwhelmed and defeated (White, 1995:38). Externalising conversations are inclined to "create a lighter atmosphere wherein children are invited to be inventive in dealing with their problem, instead of being so immobilized by blame and guilt or shame that their parents are required to carry the full burden of problem-solving" (Freeman, Epston & Lobovits, 1997:8) as happened with Michael and his family.

The aim of externalising conversations was to help Michael shake loose the fixed identity and problematic description of an established identity and to draw attention to the qualities which were previously not clearly noticeable.

Examples of externalising conversations are discussed in **Chapter 4.**

2.4.2 Relative influence questioning

In narrative therapy, the therapist invites the clients to externalise the problem by asking relative influence questions. The client is firstly asked about the influence the problem has on the client's life and relationships. Secondly, the client is encouraged to reflect his/her influence on the existence of the problem (White & Epston, 1990:42). According to Freedman and Combs (1996:66), these two sets of questions establish that "rather than being the problem; the person has a relationship with the problem". In establishing the client's influence on the problem, the unique outcomes are established. In my conversations with Michael, I made use of relative influence questions to map the influence of enuresis on his life and relationships. Relative influence questioning created the space for Michael to firstly "become aware and to describe his relationship with the problem" and secondly to take himself out of "a world of problems that was intrinsic" to him. This allowed Michael not to view himself as the "problem", but as an individual that has a relationship with the problem. This is a practice that is empowering to the client and that contributes to an experience of agency. Michael White and David Epston (1990:16) described personal agency as the client's ability to shape his/her own life and experience and the capacity to bring about preferred outcomes. I concur with De Vries (2004:33) that personal agency escalates when the client becomes aware of their abilities to take a stand against the problem and to reclaim their lives from the influence of the problem. Carr (1998:492) find that "relative influence questions allow clients to construct unique outcomes which are the seeds for from which lives may be re-authored". More possibilities were opened up for Michael that could possibly lead to the alternative story.

2.4.3 Deconstruction of problem saturated stories

Narrative therapy can provide an opportunity to take apart or unpack discourses and reveals their impact on a person's life (Winslade & Monk 1999:26). Viljoen (2001) suggests that to deconstruct is not to undo or to destroy but to gently take apart and expose that which has been invisible to the naked eye. Freedman and Combs (1996:67) speak of the unique outcomes being "experiences that would not be predicted by the plot of the problem-saturated narrative but once the landscape of the problem has been broadened by mapping its effects on the lives and relationships of the people involved there can be many openings in which the unique outcomes can

surface". Once the problem has been broadened through deconstructive questions, looking at the where and how the problem has taken control over the individual's life, exceptions to the problem's influences can be explored. Freedman and Combs (1996:68), say that unique outcomes are the doorways to alternative stories.

Freedman and Combs (1996:125) propose a list of ways in which we can co-construct the unique outcomes if you do not observe the openings or sparkling events, the experiences that lie outside the problem-saturated story-by asking:

1. Questions about unique experience that have occurred;
2. Questions about unique outcomes in the realm of imagination through hypothetical experience questions;
3. Questions that ask about different points of view; and
4. Future orientated questions.

Michael White (1992:121) explains his account of deconstruction in the following words:

> "According to my rather loose definition, deconstruction has to do with procedures that subvert taken-for-granted-realities and practices; those so-called "truths" that are split off from the condition and context of their production, those embodied ways of speaking that hide their biases and prejudices and those familiar practices of self and of relationship that are subjugating person's lives. Many of the methods of deconstruction render strange these familiar and everyday taken for granted realities and practices by objectifying them. In this sense, the methods of deconstruction are methods that "exoticize the domestic". Referring to Bourdieu (1988), White explained that "exoticizing the domestic" through a familiar and taken for granted world facilitates the reappropiation of the self. This in essence is suggesting that through the objectification of a familiar world, we might become more 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" (White 1992:121).

2.4.4 Unique outcomes

Throughout the process of deconstruction, the therapist is on the look out for unique outcomes or those preferred ways of being that are neglected and un-storied (White & Epston 1990). White (1992:127) mentions that it is imperative to remember that the clients that consult us do not necessarily see the possible unique outcomes that are identified by the therapist as important. It is therefore vital that a possible unique

outcome must qualify for one in the eyes of the person to whose life the events relate. According to Carr (1998:492), unique outcomes "include exceptions to the routine pattern within which some aspect of the problem normally occurs. The therapist asks clients about particular instances in which the client avoids being oppressed by the problem or prevented the problem from having a major negative influence on their lives". He further suggests that "once the unique outcomes have been identified, these events may be incorporated into a story and the plot thickened by mapping them with landscape of action questions and landscape of identity questions. *Landscape of action* questions aim to plot the sequence of events as they were seen by the client and others". These questions encourage the "person to identify the history of the unique outcomes by locating them by within particular sequences of events that unfold through time" (White 1992:128).

Landscape of identity questions encourages a client to reflect on the meaning of the unique outcomes identified through the landscape of action questions. *Landscape of identity* questions assist the clients to emphasize their preferred beliefs and intentions, various relationships and personal qualities that might have been marginalized by the problem saturated story of their lives.

2.4.5 Re-authoring

According to White (1991:31), this process of landscaping of action and identity is called "re-authoring". In order to help the client to re-author his/her own life, the alternative stories are emphasized in order to increase the constitutive effects of these in the client's life, and to marginalize the dominant problem discourse.

Botha (1998:109) says that narrative therapy "never follows a "flop proof" recipe, instead it is a way of thinking about how people language their problems and how they deconstruct these linguistic constructions".

2.4.6 Sand play in a narrative context

Freeman, Epston and Lobovits (1997:163) suggest that there are "several ways to approach sand play in a narrative context". They further suggest that the child can be asked to create a problem-saturated sand tray during a therapeutic discussion. The following questions that can be asked after the child has built the sand tray:

- What does the world of the problem look like?

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- Is there a figure that reminds you of the problem?
- How does it live?
- Who are the problems cronies?
- What supports the problem?

(Freeman, Epston & Lobovits 1997:163).

> "A sand play world can be used to map the influence of the problem: Would you like to show me how the problem takes over? Elements of change can be introduced by creating a sand tray and this can be viewed as the "transition tray". When the child is ready to visualize/envisage a new story the alternative story can be built in the sand tray. In each session, a sandtray can be used to indicate the progress or to explore any setbacks. Photographs of the sand trays can be used to portray narrative change over sessions." (Freeman, Epston & Lobovits 1997:164)

Examples of narrative sand trays are discussed in Chapter 4.

2.4.7 The outsider witness group

In narrative practices, the use of outsider witnesses is a therapeutic practice and a key aspect within the therapeutic process. One of the central underpinnings of narrative practice is that our identities are formed in relationship with others. Carey and Russell (2003:4) suggest that "an outsider witness is an invited audience to a therapy conversation - a third party who is invited to listen to and acknowledge the preferred stories and identity claims of the client's existing community - family, friends and may represent the reflecting team". White (1995:179) argues that "the process is quite different from pointing out positives, but focuses rather on acknowledging the clients' experience of the dilemmas that they have faced and of the struggles that they have engaged in over their efforts to change what they wanted to change in their lives".

Carey and Russell (2003:15) emphasise that an outsider-witness practice facilitates the process of making a link between the happenings in the therapy room and the rest of the client's life. This has enabled Michael to experience himself and his "preferred identity claims as part of a community of acknowledgement" (Carey & Russell 2003:5).

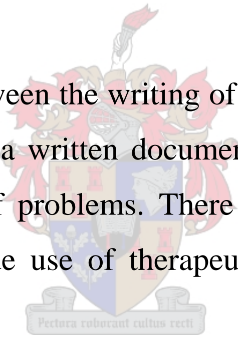
As a final step in Michael's journey, we discussed the idea of inviting his family into our final session as witnesses. The rationale was to witness the new narrative of

Michael and then to retell what they had heard in ways that would contribute to a rich description of alternative stories of his life (Morgan 2000:126).

The outsider witness group was engaged in a process that had four stages, the definitional ceremony. According to Carey and Russell (2003:6), Michael White employed the term definitional ceremony to his work in therapy and began to focus on the role of outsider witnesses in authenticating people's identity claims". In the first stage, Michael and I had conversations while the outsider witnesses (his family) listened. We then swapped places and the outsider witnesses had an opportunity to talk with each other about what it meant to hear Michael and my conversations. We then swapped places again and I asked Michael about his experience of listening to his family. In the last part, an opportunity was given to everyone to reflect on the process.

The process is further discussed in Chapter 4.

2.4.8 Therapeutic documents



There is a strong association between the writing of documents and narrative therapy. Morgan (2000:86) suggests that a written document often assists people to reclaim their lives from the influence of problems. There are many ways of documenting therapeutic conversations. I made use of therapeutic letters and certificates in my sessions with Michael.

Epston (in Freedman & Combs 1996:194) illustrates the meaning of therapeutic letters when he says:

> "... Words in a letter don't fade and disappear the way conversation does; they endure through time and space, bearing witness to the work of therapy and immortalizing it".

According to Freedman and Combs (1996:208) " therapeutic letters not only thicken the story and help the people one works with to stay immersed in it, but also involve the therapist in co-authoring. Letters serve three main purposes:

1. To summarize and recap meetings;

2. To extend ideas or stories that were initiated in therapy conversation;

3. To include people who didn't attend a meeting.

(Freedman & Combs 1996:210)

Morgan (2000:90) proposes that certificates can be drawn up and signed to commemorate significant events and turning points. Certificates help to celebrate the new story that emerges and to commemorate how the client has managed to overcome the problem to regain their life for its influence.

2.4.9 The role of the therapist and the process of narrative therapy

Gortner (2001) mentioned that "the process of therapy is a therapeutic conversation, a dialogue and that the main purpose is to co-develop preferred narratives for the client". The therapist takes up a "not knowing" attitude and asks conversational questions. The therapeutic process of re-authoring of personal narratives changes lives, problems and identities because personal narratives are constitutive of identity (Gortner 2001). The therapist implements a collaborative co-authoring consultative position. I adopted the social constructionist position in therapy by asking myself the following questions suggested by Freedman and Combs (1996:40) during therapy:

1. Am I being caught up in pathologizing or normative thinking? Are we collaboratively defining problems based on what is problematic in the person's experience? Am I staying away from "expert" hypothesis or theories?
2. Am I focussing on meaning instead of "facts"?
3. What are the stories that support this person's problems? Are there dominant stories that are oppressing or limiting this client's life? What marginalized stories am I hearing?
4. Whose language is being privileged here? Am I trying to accept and understand this person's linguistic descriptions?
5. Am I listening to understand how this person's experiential reality has been socially constructed?

(Freedman & Combs 1996:40)

White (2002:6) emphasises that it is the aim of the therapist to take up a "decentred and influential position" by building a scaffold through questions and reflections that makes it possible for people to:

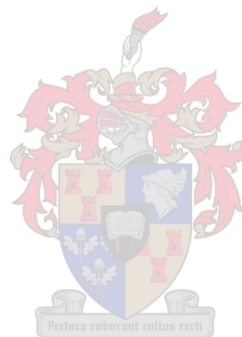
- more richly describe the alternative stories in their lives;
- step into and to explore some of the neglected territories of their lives; and

- become more significantly acquainted with the knowledge's and skills of their lives.

As the therapist, I positioned myself as collaborator in Michael's journey by building the scaffold through being curious about his journey.

2.5 CONCLUSION

In this chapter, I reviewed the traditional positivist views on enuresis. I have put together a review of literature on narrative therapy as I understand and used the constructs. The narrative approach presents themes of liberation in the therapeutic context that will be explored further in Chapter 4.



CHAPTER 3

RESEARCH DESIGN AND METHODOLOGY

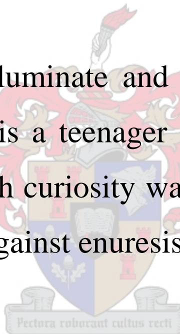
3.1 INTRODUCTION

In Chapter 1, I discussed the reasons why this study compels a qualitative methodology. The research design, ethical aspects and methods for data collection techniques have also been mentioned. Now I am going to discuss the research method in more detail.

3.2 RESEARCH STRATEGY

3.2.1 Goals of the research

The purpose of the study is to illuminate and explore working within a narrative metaphor. The client in this case is a teenager who has a history of bedwetting as indicated in Chapter 1. My research curiosity was guided by the question of how the narrative metaphor could be used against enuresis.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3.2.2 The research design

3.2.2.1 Introduction

In this study, I have chosen to use a postmodern framework. Freedman and Combs (1996:21) describe postmodernists as those who "believe that there are limits on the ability of human beings to measure and describe the universe in any precise, absolute, and universally applicable way". They are thus interested in meanings rather than facts and rules. I was also interested in exploring alternative meanings that stood against the bedwetting.

Hansen (2004:131) indicates that there are various ways to conceptualise the process of knowing as it applies to the counselling situation. For the greater part of the twentieth century, counselling was rooted in a modernistic epistemology. Modernism when applied to the counselling situation means that the counsellors can objectively observe clients and accurately come to know particular truths about them.

Hansen (2004:131) proposes the following list of the basic modernistic assumptions regarding client-counsellor communication:

- Clients are able to make accurate attributions about what they are experiencing.
- After clients identify internal experiences, these experiences can be communicated to the counsellor through the vehicle of language.
- After attending to their client's language, counsellors can gain an accurate understanding of the experiences their clients are attempting to convey.
- Once the experience is understood, the counsellor can draw on universal laws of human functioning, in the form of a counselling theory, to impart a corrective or healing intervention.
- Clients, like all people, have a relatively stable psychological core personality. Therefore, healing changes made to the cliental psychology of clients during counselling will generalize to situations outside of counselling.

The postmodern movement criticises the epistemological practice of modernistic psychology according to Gergen (in Botha 1998:56). Botha (1998:56) claims the criticism is "due to a basic incompatibility between the fundamental assumptions of the epistemologies of postmodernistic psychological research and modernistic psychological research". Bosch (in Nieuwmeyer 2002:9) gives an example of this in arguing that modernists are concerned with facts while postmodernists are looking for meaning.

According to Nieywmeyer (2002:9) in a postmodern practice, language makes up our world and beliefs. Freedman and Combs (1996:28) emphasise that language is an interactive process and through language, people together construct knowledge to arrive at meaning and create a new reality. Nieywmeyer (2002:9) suggests that during this process "language gives people agency because they can change the way they speak and the way they do things".

An important aspect of the postmodern discourse is the epistemological view that there are no essential truths and that realities are socially constructed (Freedman & Combs 1996:33). The view that there "are no essential truths" implies that "we can't objectively know reality, but that there are many possibilities how any given experience may be interpreted, but that no interpretation is really true" (Freedman &

Combs 1996:33). Zuber-Skerrit (1996:168) elaborates further by saying that knowledge is viewed as being contextual in its scope and interpretation. Social construction theory forms part of the postmodern paradigm. Botha (1998:68) describes social constructionism as "a position which regards the development of knowledge as a social phenomenon and holds that cognition can only evolve within linguistic interaction".

Social constructionism forms an integral part of this study. The aim of the therapy process is not to uncover objective truths about my client, but to co-construct a system of meaning and retell his story through a collaborative process, thus thickening the alternative or rather the preferred narrative.

3.2.2.2 Qualitative design

I chose to conduct a qualitative research study, because it is based on the assumptions that there are multiple realities, that the world is not an objective interpretation, but a function of personal interaction and perception (Merriam 1991:17). Furthermore, I preferred a qualitative research study, because the aim of my study is not to quantify data, but to co-construct new realities in a collaborative process with the other participant in the study. Qualitative research is a field of inquiry in its own right. It cuts across disciplines, fields and subject matter (Denzen & Lincoln 1994:1).

As Denzin and Lincoln (1994:2) indicate, "qualitative research is multimethod in focus, involving an interpretative, naturalistic approach to its subject matter". This means that qualitative researchers study phenomena in their natural settings, attempting to make sense of, or, interpret phenomena in terms of meaning people bring to them. Furthermore, I use the term qualitative research in a postmodern context, where "knowledge is inherently contextual, local and pluralistic" (Denzin & Lincoln 1994:2).

Using a narrative approach within a postmodern framework would assume that Michael could develop a story about himself and his reaction to the problem-saturated story, based on his own contextual and local experiences.

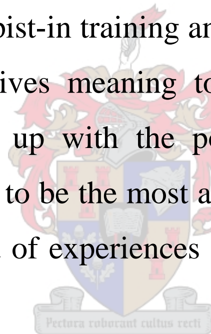
Mason (1996:5) gives a few guidelines on qualitative research:

- Qualitative research should be systematically and rigorously conducted. It is however important to think, plan and act in systematic ways, but the research

process should however not be a rigid or structured approach. Qualitative research should be strategically conducted, yet flexible and contextual. Mason (1996:5) explains that "essentially this means that qualitative researchers should make decisions on the basis not only of a sound research strategy, but also of sensitivity to the changing contexts and situations in which the research takes place".

- Qualitative research should involve critical self-scrutiny by the researcher or active reflexivity. It implies that researchers should take stock of their actions and their role in the research process. In this study, reflection on each session is very important. I made use of videotaping each session to help me summarise and reflect on the process evolving, with permission from my client.
- Qualitative research should be conducted as an ethical practice in its political context. The therapy took place at the Unit for Educational Psychology at the University of Stellenbosch.

As researcher, I was also a therapist-in training and a participant. As both a researcher and therapist, the participant gives meaning to the process. It is thus an active participatory process that links up with the postmodern discourse. A qualitative approach for this research seems to be the most appropriate method in order to obtain a holistic picture from the world of experiences of the participant and to allow for a collaborative participation.



3.2.2.3 Characteristics of a qualitative design

> "Qualitative research is a highly subjective phenomenon in need of interpreting rather than measuring. Beliefs rather than facts form the basis of perception. Research is exploratory, inductive and emphasizes processes rather than ends". (Merriam 1996:17)

Merriam (1996:17) also emphasises these characteristics of qualitative research:

- Firstly, qualitative research is primarily concerned with process rather than outcomes or products. (In this study, Michael participated in the process of therapy for 50 minutes once a week for five consecutive weeks.).
- Secondly, qualitative research is interested in meaning. How people make sense of their lives, what they experience, how they interpret these experiences, how they structure their social worlds. (During this journey it was the sharing of meaning-

making experiences between Michael and me) which enabled a co-authorship of a preferred story.).

- Thirdly, the importance of the researcher in a qualitative case study cannot be overemphasized. The researcher is the primary instrument for data collection and analysis. The researcher as instrument is responsive to the context and sensitivity plays an important role. (My role as researcher necessitated an ethical, reflective approach to our journey.).

3.2.2.4 Participatory action research

Smith (1997:187) describes participatory action research (PAR) as "a thoughtful reflection on reality" and the focus is on possibilities for change. McTaggart (1997:26) also describes "some kind of improvement or change" as an outflow of PAR.

As researcher, I was made aware by the narrative approach I followed of the power/knowledge imbalance between myself as therapist/researcher and my client. I therefore aimed to use the practices of transparency and accountability to open a way for "co-search" as described by David Epston (1998:133). Participatory action research gave me the framework and guidelines to approach our "co-search" as a way of empowering Michael in taking a stand against Sneakers (bedwetting).

According to Elden and Chisholm (in Bray, Lee, Smith & Yorks, 2000:35), "in co-participation the members of the research process must learn how to make sense of their own data in terms of their own language and in relation to their own perception and values". It seems that Elden and Chisholm's way of approaching participatory action research makes use of a social constructionist view of reality, enabling people to "envision a preferred future and organising effectively to achieve it" (Bray *et al.*, 2000:35).

Within a narrative approach, PAR supported my tentative, respectful and collaborative approach to explore new ways of meaning-making with Michael.

3.2.2.5 Participants

The participant, Michael, was a 14-year-old English-speaking learner. He was referred to the Unit for Educational Psychology for therapeutic guidance, and I was

assigned to engage in therapeutic conversations with him as part of the practical training during my MEd Psychology year.

3.2.2.6 Data collection techniques

Terre Blanche and Durrheim (1999:153) argue that "a document carries meaning independently of what its author's intentions were: it is simply a point of intersection for social meaning (or discourses) and is no more distant from what 'really happened' or what somebody 'really felt' than an interview". This is in line with Morgan (2000:99) that "there are different ways of documenting therapeutic conversations and that these documents do not only have value in meaning making process, but they also serve as steps the client has taken during therapy".

The following practices were used during the interviews as ways of documenting the research:

Video and audio recordings and transcriptions

The conversations that I had with Michael and with his family were recorded and later transcribed. Breakwell *et al*. (2000:233) suggests that one advantage of a video-recording is that it can be viewed several times making analysis more reliable. Michael and his parents gave me permission to take notes and to have the sessions recorded. The video recordings were used during supervision sessions. Transcribing each conversation from the recordings helped me to record the themes relating to the unique outcomes and the particular phrases that Michael used to describe the alternative story. Morgan (2000:96) contends that "most narrative therapists would consider these tapes to be the property of the family and would clearly discuss the purposes of such recordings at the outset". I explained that he was welcome to read my notes and watch the video recordings should he want to. I wanted my co-searcher to be actively involved in the research journey.

Photographs

According to Merriam (2002:13) written, oral, visual or cultural artefacts are various forms of documents that open up new possibilities for understanding and constructing meaning. A series of photographs were taken of Michael's sand trays. These photographs were used as resources in the documentation and further exploration of Michael's alternative story (Morgan 2000:99).

Letters

I used letters as a reflection of our conversations. The letters that I wrote were also used to provide a summary of the conversations we had shared. I have made use of the notes that I made during our conversations and the recordings to write the letters that included the exact phrasing of the conversation. In this way, Michael could suggest any deletions or additions to the letter.

Conversations with a narrative approach

According to Norum (2001:3), "the researcher and the storyteller must work together closely to come to a shared understanding of the narrators story". Michael and I had many conversations and most of these conversations were recorded and transcribed. Drewer and Winslade (1997:39) contend that "conversations is a very good metaphor for the social process of meaning-making, as it has the right pattern of to-ing and fro-ing. It focuses our attention on the interactions between people rather than on the intrapersonal dynamics of the individual".

As a research-therapist-in training I continually searched with Michael for means of deconstructing and reconstructing his reality. I conducted the conversations by following some of the following narrative practices:

1. Listening to the problem-saturated story without getting stuck;
2. Naming and externalising the problem;
3. Detecting clues of competence or the discovery of the unique outcomes;
4. Assembling the Alternative Story;
5. Documenting the evidence.

(Workshop notes: Dr Celene Hunter 2000)

Reflections

Apart from the taping of sessions and my field notes of observations, I recorded my reflection on the research process and discussed it during supervision sessions. It was easier to communicate my experience as research-therapist-in-training to my supervisor when it was written down.

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3.2.2.7 Data analysis

Terre Blanche and Durrheim (1999:152) argue that "the social constructionist is opposed to imposing preconceived categories and measuring instruments on the research". They also argue that "the meaning is not only constructed by the researcher, but also by the participant and the larger social system" (Terre Blanche & Durrheim (1999:153). I concur with Terre Blanche and Durrheim (1999:153) and therefore had to take account of these aspects when analysing the conversations with my client.

According to Mouton (2000:151) the data analysis in participatory action research is viewed as a collaborative effort between the researcher and the participants". This supports the social constructionist view of the construction of knowledge where "rather than commence with individual subjectivity and work deductively toward an account of human understanding through language, we may begin our analysis at the level of human relationship as it generates both language and understanding" according to Gergen (1994:264). Within the narrative approach Michael was invited to tell his story and we collaboratively wanted to explore his experiences. According to Clandenin and Connely (2000:140) "we run the risk of rupturing what makes them stories" when we follow the dictates of a particular method and turn stories into concepts, theories or social facts. It was therefore important for me to stay with Michael's story, to be respectful in coming to understand his storied experience in analysing his very personal story.

Thus, the process of analysing the data collected was a "co-search" of meaning in which Michael, his family and my supervisor and I participated. We made use of the methods of discussion, reflection and the reading of letters summarising certain conversations. Tentative questioning regarding Michael's experiences of the problem and asking him how he saw the process develop guided my interpretation of the process.

Two processes were planned to proceed simultaneously in an interwoven way, namely the therapeutic journey as well as the research process. While travelling with Michael on the journey, different sources of data were collected as part of the research process. This data was analysed and from there the chronological story (as found in Chapter 4) evolved.

I used summary formats to reflect on our discussions. Tentative interpretations were developed from the data recorded. These enabled me to refer to the broader theory of narrative practice. Michael and I reviewed what was said by reflecting on the meaning of the spoken words through the use of narrative letters (See Addendum C).

Michael's problem-saturated story, the externalising of the problem, clues of competence or the unique outcomes as well as the assembling of the alternative stories of his life as they emerged along the journey were highlighted in the data (See Addendum D for an example).

Interpretations were developed from the processed and analysed data and reference was made to the broader theory and literature. I also made use of self-reflective comments to assist me in highlighting the difficulties that I experienced when working with the narrative approach.

3.2.2.7.1 Trustworthiness of the research

Botha (1998:94) explains that the trustworthiness of the research "cannot be established by an individual researcher, it is the task of the researcher and the participants to establish through ongoing dialogue and mutual trust". The research procedure of my conversations with Michael through attentive listening, curious questioning was a way to establish accountability and trustworthiness of this research.

Another way in which an attempt was made that contributed to the trustworthiness of the research was to make my notes available to Michael at any time. The narrative letters that I wrote also aimed at inviting Michael to reflect and to comment on what was said and written down. By using his suggestions Michael was co-constructing the research and contributing to some research documentation.

Guba and Lincoln (1989:326) explain that in qualitative research, "the audit trail includes recorded materials such as cassette tapes, interview transcripts, interview guides, lists of interviewees, lists of categories and hypotheses the researcher used while analysing the data and notes about research procedures". Making use of audio and visual recordings that were then transcribed ensured dependability of the research. Confirmability is concerned "with establishing the fact that the data and the interpretations of an inquiry were not merely figments of the inquirer's imagination" (Lincoln & Guba 1985:362). Triangulation was included in my research-journey to ensure more trustworthy results. I attempted to use different means and sources of

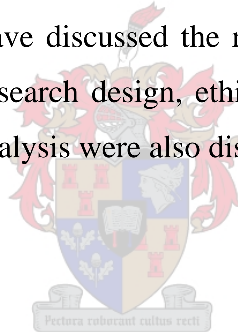
gathering data to gain a fuller perspective including conversations, field notes, video-and-audio recordings, photographs and reflections.

Michael and I could listen to the tape recordings of our sessions or he could read the transcriptions if he wanted to. In addition, I continually reflected on our conversations. I wrote some of my reflections down, but most often they were discussed during supervision.

To establish credibility I also made use of "peer debriefing" as suggested by Lincoln and Guba (1985:301) "a process of allowing a peer who is professional outside the context and who has some general understanding of the study, to listen to the researcher's ideas". Communicating my experiences to my colleagues and supervisor formed an integral part of the trustworthiness of the research.

3.3 CONCLUSION

In this chapter, I have explored the background for the choice of a qualitative research design. Within this context, I have discussed the reasons why this study compels a qualitative methodology. The research design, ethical aspects and methods for data collection techniques and data analysis were also discussed.



CHAPTER 4

DESCRIBING THE THERAPEUTIC PROCESS

4.1 INTRODUCTION

In this chapter, I will relate the journey Michael and I took together. Within the context of the therapeutic conversation, Michael and I met for five sessions. One of our sessions was cancelled due to transport problems as it was a long distance to travel to the university. The referral that I received about Michael reads as follows: "*Michael has ongoing problems with bedwetting; numerous attempts have been made to stop enuresis*".

Michael came for therapy with his mother seeking help for the bedwetting. Michael's mother had initiated the therapy when she called the Unit explaining that her son has a problem with bedwetting.

4.2 MEETING MICHAEL

Michael was a dark haired teenager who did not engage in dialogue with me in the first session, but responded, after long pauses, to the questions that I tentatively put to him. Michael arrived for the first session not knowing why he had to come and see me. After I had introduced myself, I asked Michael whether he knew why he had to see me. Often children are not told why they have to meet with a therapist. I believed that Michael's voice should be heard and it was important as a collaborative therapist to develop a sense of agency within Michael as "someone who is able to speak with authority" (Davies 1991:51).

He appeared to be very anxious, looked uneasy, worried, and nervous and throughout our conversation, he kept his eyes on the ground and whispered almost too softly to be heard. He indicated to me that all he knew was that he was coming for an assessment. I explained I was there to talk to him to see if we could "outsmart" whatever was bothering him (White & Epston 1990:46). When I asked him if it was OK to have conversations with me, he nodded in a hesitant way. On enquiring if I could take

notes during our conversations, he nodded again. I explained that he was welcome to ask any questions and to indicate to me if he was uncomfortable with anything. This was in line with what Freeman, Epston and Lobovits (1997:36) suggest that ongoing permission allows a young client to experience a voice in "co-building" a new story.

As the conversation continued, I slowly began to get to know Michael as an individual separate from the problem and as the "expert in his own life" (Dickerson & Zimmerman 1993:229). We had a conversation about things in general and about his school that he was attending. He told me that he liked playing rugby, soccer, music and that he attended drama classes at school. He liked high school, as it was his first year at high school and he experienced it as different from primary school.

During our conversations, Michael drew me a picture of himself. He drew himself as an actor. This is how Michael drew a picture of himself becoming an actor.

Friedman (1993:191) describes art therapy in the following words:

> "Art therapy evolved with the medical model of psychotherapeutic treatment. There has been a tendency for the therapist to use artwork as a diagnostic, interpretive, or rehabilitative tool. There is an important distinction to make between expert interpretive understandings of the symbols produced in creative activity and our current emphasis on the performative aspects. Expressive arts therapy, as it has been evolving, calls for an atmosphere of mutual respect for each client's unique experience and expression, a non-judgemental attitude with regard to productions, and a facilitative intent rather than a critical or interpretive approach to working with a client's creative expression."

I tried to acknowledge Michael's drawing in terms of his meaning-making experiences, rather than privileging the dominant discourses surrounding drawings. Freeman, Epston and Lobovits (1997:160) are of the opinion that there are more ways to communicate than communicating verbally.

4.3 THE BEDWETTING HAS ITS SAY

Michael's mother joined us later in conversation. When I asked her why she had brought him for therapy, she indicated that it was for the bedwetting.

Therapist: *What is your main reason for bringing Michael to the Unit?*

Mrs J: *The bedwetting is the main reason why he is here. The reason why I brought him was to get to the root of the problem, why he is still bedwetting".*

> "Parents and caregivers often try every thing they can think of, including turning to various experts" (Kotzé 2000:119).

I collaborated with Michael and his mother to "generate experience of preferred realities rather than to gather information" about the history of the bedwetting. Freedman and Combs (1996:113) make the point that "as narrative therapists we think about questions to generate experience rather than to gather information". My goal in our conversations was to find out as much as possible about the bedwetting or in other words to map the influence of the problem (White & Epston 1990:42) in Michael's life and in his family's life.

Dickerson and Zimmerman (1993:229) suggest that "[t]his is an important step in understanding the family members as clients separate from the problem and as the

experts in their own lives. Some of their competencies, preferences, and important relationships are also established. Then the descriptions of the problem by those involved are examined in an attempt to appreciate their understanding of the problem".

Michael's mother presented the following problem-saturated description of the bedwetting. Michael had a very long history of bedwetting, which had resisted all attempts to solve it, including therapy and medication. She indicated that he had used Tofrinol to stop the bedwetting, and that he had received treatment from the behaviour clinic for 8 months, but had never been dry. At this stage, I turned to Michael and asked him if it was okay if I asked his mother these questions. He just shrugged his shoulders. Her mother explained that the psychologist and doctors had said that "[t]here is nothing that they can do to help". The voice of the health practitioners working within a medical model resonated with all the internalised voices telling Michael that he was worthless. This was the thin description of Michael's identity. She indicated that she and her husband had been experiencing marital problems when Michael was in pre-school and she did not know if this could be the cause of the bedwetting. She further explained that the bedwetting was a family problem, his father had had the problem, and her younger son had enuresis.

After the problem was described, I suggested the following question:

Therapist: *Would it be okay with both of you if I talked about the problem in a way that separates it from Michael? Can we give the bedwetting a name seeing that it has been so sneaky?*

Michael: (In a faint voice)

Sneakers

The goal was to name and objectify the problem, rather than to define it as enuresis. Externalising conversations could give Michael an opportunity to move the focus from the dominant saturated story in which he regarded himself as someone who had enuresis. A more positive attitude to himself was created to break the guilt and shame he felt because of the bedwetting, which was robbing him of energy.

4.4 THE BEDWETTING'S VOICE IN MICHAEL'S LIFE

Through our externalising conversation, Michael and I discovered that Sneakers had an influence in various dimensions of his life:

- The bedwetting caused embarrassment, low self-esteem, and isolated him from his friends.
- It inhibited him from participating at school.
- It prevented him from using public transport, as Sneakers scared him into thinking that he would have an accident.
- Sneakers overwhelmed everyone in the house with the constant washing of sheets.
- Sneakers affected relationships between Michael and his brothers and sisters.
- Sneakers used humiliation and embarrassment to try to take a hold on Michael's life.
- Sneakers attempted to steal Michael's feelings of self worth, strength and confidence.

I asked Michael whether Sneakers was trying to convince him of the kind of person he was. Michael indicated that Sneakers was causing embarrassment and convincing him he was useless. I reflected on my attempt to develop some kind of understanding for how difficult the situation was for him. The embarrassment and feelings of uselessness represented a "dominant plot" on his life and was influential in shaping his life (White 1995:202).

Pectora roborant cultus recti

4.5 THE FAMILY'S RELATIONSHIP WITH THE BEDWETTING

I was curious about some of the discourses that influenced the way in which Michael and the family experienced enuresis. Nelson (in Kotzé, 2000:22) suggests that "deconstruction entails a critical operation in which taken for granted notions are questioned or disrupted to make more visible alternative ideas and stories". It operates to "undo these taken for granted ideas, but not to destroy them". I could explore how the discourse of enuresis had shaped Michael and his family's thinking on identity.

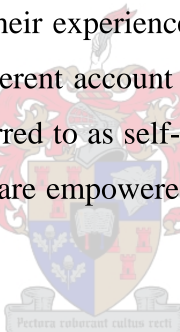
Michael's mother told me that she had tried everything, including turning to experts to solve the bedwetting problem. Gergen *et al*. (1996) mentions that the availability of a

diagnosis may suggest that the client's problem is common, well known, well understood and treatable. The process of consulting the expert for help and obtaining an official diagnostic label for the problem suggests to clients how they ought to change their behaviour, emotional state, or biology to get well.

Narrative therapy takes up the story metaphor to question those "taken for granted realities and practices that shape and sometimes restrict our lives" (White 1991:121). In this instance, the taken for granted practices had influenced the way in which the family members made sense of Sneakers. They felt that it was a family problem.

It was a relief for me to leave this dominant specialist-client relationship and join with Michael in a more egalitarian relationship that characterises the "reflecting processes" where the client and therapist talk together and work together as equally important partners (Anderson 1993:306).

According to White and Epston (1990:10), "… in striving to make sense of life, clients face the task of arranging their experiences of events in sequence across time in such a way as to arrive at a coherent account of themselves and the world around them ...". This account can be referred to as self-narrative "[t]hrough the meaning we ascribe to these self narratives we are empowered to perform our stories through our knowledge".



4.6 EXPOSING SNEAKERS

During our second therapeutic conversation, the goal was to establish a space where he could experience Sneakers as separate from him. I approached our conversation in this way, so that the problem no longer spoke of Michael's identity, and so Michael could start taking action against Sneakers.

Freeman, Epston and Lobovits (1997:160) make the point that "from the time the child walks into the room, nonverbal clues may suggest to the therapist a move into other realms of communication". Michael looked uncomfortable talking to me about the bedwetting and he was very shy. I wondered about the discomfort that Michael was experiencing. He indicated that Sneakers made him nervous all the time and thrived on tension. I realized that this was one of Sneakers tricks, to immobilize Michael with tension in the therapy room. I invited the following conversation:

M: *Sneakers makes me nervous, when I am at school or at Madressa I am scared that he will come.*

G: *Can you tell me a little more about what happens when Sneakers wants to interfere and make you nervous?*

M: *The other day at Madressa, Sneakers embarrassed me, I left and went home to relax in my room.*

G: *So Sneakers brings embarrassment along, but you mention that you went home to relax, do you always do this when Sneakers tries to interfere in your life?*

M: *Yes it takes the stress away.*

G: *What do you exactly do M?*

M: *I lie on my bed and imagine me being an actor on television one day.*

G: *Have there been times before that you did not allow Sneakers to get the better of you?*

M: *Yes, when I am in the drama at school?*

G: *How did you do that?*

M: *I love acting, I like being on the stage, So here I always try my best not to have … I mean Sneakers come out.*

G: *So what does that say about you when you are trying so hard to keep Sneakers away?*

M: *I don't know, maybe that I don't always allow Sneakers to ruin my day.*

We continued our conversation and I initiated change by introducing a warm-up exercise in which he was able to experience a relaxed atmosphere in the room and feel accepted. Afterwards I suggested to Michael that he did this type of exercise when Sneakers was making him nervous.

As our conversation progressed, I then suggested that we use the sand tray to help Michael in depicting what the world of the problem looked like. Michael could select from the array of miniature figures on the shelf to build his sand tray. I gave him the space to build his sand tray in silence with baroque music in the background. I hoped

that the sand tray could be used to unfold Michael's story, moving from the problem-saturated tray into the alternative story. I encouraged Michael to reflect on the stories he built. I asked him if he would mind sharing his story with me. He entitled the story "At war with Sneakers".

This was the Michael's first sandtray:

Michael's story of his sand tray was as follows:

> "These are two different countries at war, the people are fighting against each other, and they are ready for the battle. The king needs to be protected; the helicopter will come to rescue the king. There is a boat with divers and they are there to save the people. On this side is the zoo, they are also protecting the people. I am Zeus in the picture in charge of the people."

The rest of my second session was shaped by an externalising conversation. White and Epston (1990:39) argue that externalising conversations are the means for paving "the way for clients to cooperate with each other, to unite in a struggle against the problem, and to escape the influence in their lives and relationships".

I asked Michael how Sneakers's voice affected his life and relationships. Michael described the effect of Sneakers on his life and identity as follows: "It makes me feel bad about myself; I feel like a failure, I can't do what I want to, because I am scared

that he is going to come, I can't go to sleep at my friends place, because it is embarrassing". White (1989:34) argue that externalizing "counteracts the effects of labelling". I discovered in my conversation with Michael that Sneakers was affecting every area of Michael's life, his family, his friends and school life.

I was curious about what Sneakers looked like. I asked Michael to describe what Sneakers looked like by drawing a picture of him. This could support Michael to recognize that he was more than the identified problem and guide him to visualize Sneakers as an entity that existed outside himself. This is how Michael depicted Sneakers:

A further way to separate the problem from Michael was by making use of a balloon. I suggested to Michael that he choose any colour balloon and think of a message that we could write on it. Michael decided on "Sneakers get out of my life". Michael decided that he would set the balloon free on his way home.

Externalising the problem gave Michael the opportunity to move his focus from the dominant saturated story of regarding himself as "incompetent" to someone who was able to stand up to the challenges of Sneakers.

4.7 LISTING SNEAKERS TRICKS

I engaged in an investigation into the tricks and tactics of Sneakers by asking many questions. Michael highlighted the following as Sneakers's tricks:

- Sneakers was able to fool Michael by pretending Michael did not need to urinate and then suddenly he would appear.
- Sneakers always seemed to have a new plan up his sleeve.
- It was hard to predict what Sneakers would do.
- Sneakers would disappear for a while and then surprise Michael when he least expected it.

As we discussed Sneakers's tricks and tactics, the problem started to develop its own "persona" (Morgan 2000:26). I wanted to know how Sneakers operated and to help Michael explore all the aspects of the problem.

4.8 THE PREFERRED NARRATIVE

In our first two sessions, there were a number of themes that Michael identified as problematic to him including the embarrassment, lack of confidence, low self-esteem, and humiliation. We explored the effects of these dominant plots on Michael's life. The effects were not only traced in Michael's life, but also in the lives of his family. During the third session, I hoped to probe for the unique outcomes that could stand in contrast to Sneakers. I made use of letter writing to highlight the unique outcomes during our conversations. This was in line with Morgan (2000:110) who notes that letter writing plays a part in thickening the alternative. I hoped that by documenting the unique outcomes it will help Michael to "stay more connected" to the preferred narrative.

Morgan (2000:104) contend that "letters that summarise a conversation and contain some further questions also assist people to stay connected to the emerging alternative story that is co-authored in narrative meetings. When people are more connected to the preferred stories of their lives, they are more likely to continue to be able to get free from the influence of the problem".

The following letter was written to Michael as an introduction to our third session:

22 October 2003

Dear Michael

I thought that I would write you this letter after we met Wednesday because there are so many things you told me that caught my attention and that I have since been curious about.

You told me about Sneakers tricks. One of his tricks was that he pretended as if he was far away and that he surprised you. You have also said that Sneakers has a different plan everyday. Michael you have also told me that Sneakers came to visit you twice last week and that it was the day before you came to see me. I wonder how Sneakers feels now that you know what his tricks are. I was wondering what it has been like for you to outsmart Sneakers for five days. What personal strengths or qualities did you use? I was also wondering if Sneakers knew what you were up to. If he was, what do you think his reaction would be? What did you do to outsmart Sneakers in this way?

I was also curious about what happened to the balloon with the message that you put on it: Sneakers get out of my life. I was wondering what happened to it and how you set Sneakers free on your way home.

Michael, there are many questions in this letter. Maybe we can talk about them today.

Regards,

Gweneth

I read the letter, paragraph by paragraph to Michael, creating opportunities for discussion. Numerous unique outcomes appeared in our conversation that contradicted the problematic story.

Michael mentioned that the fact that managing to outsmart Sneakers on several occasions, made him feel in control. In the past Sneakers had come to visit every night, but for the past three weeks he had come only once a week. I agree with White (1995:202) that "in working to find contradictions to the dominant plot, rather than seeking contradictions to the problem a broad field of enquiry will open up". In taking this route in our journey Michael, his family and I discovered "an abundance of contradictions to the dominant plot" of worthlessness (White 1995:202).

Another unique outcome was Michael's full participation in our therapeutic discussions after experiencing a lot of failure with medication and health professionals. He mentioned that he was a competent actor in the school drama group and an excellent rugby player. Some of the statements that Michael made while I was reading him the letter implied other openings for a preferred story and these created possibilities for beginning a re-authoring conversation.

The statements that Michael made were inconsistent with the problem-saturated story.

- I am the boss and I am in charge.
- I can outsmart Sneakers and I am cleverer than he is.
- I know his tricks now so he will be gone one of these days.
- I want to be an actor one day.
- My marks at school are improving and I am more confident in class.

I wanted to know what steps he had taken. I was curious to see how these actions reflected what he wanted for his life and what they said about his personal qualities. These steps reflected a not-giving-up spirit, perseverance and courage. His family members confirmed this later in the reflecting team. When Michael indicated that he was determined to get Sneakers out of his life, his voice was full of pride as he experienced this victory as a sparkling moment.

Through identifying the unique outcomes and using the landscape of action and landscape of identity questions, we were able to explore Michael's hopes, dreams intentions, strengths, and beliefs.

Michael's story of being the boss, being brave, showing perseverance, and being in charge overshadowed the story of incompetence and low self-esteem. Michael and I then decided to invite an outsider witness group into our discussion, to offer some of their reflections to the alternative story and new identity claims Michael preferred to relate with.

Michael shared with me that Sneakers did not have fun anymore and that life must be boring for him. He indicated that Sneakers was confused. Michael excitedly related that it was 'amazing' to outsmart Sneakers. He enthusiastically told me that he had set the balloon free as they drove home and he hoped that someone would get hold of Sneakers and give him a smack.

We continued to explore the theme of taking control of the situation by employing a future visualisation technique "for within narrative organisation of meaning, the past and the future inform the present to create a unitary meaning" (Yule 1993:45). It was an attempt to provide hope and assist in "making the leap from possibility to probability and later to actuality" (Yule 1993:45). A similar technique was used later in our conversations when I asked what Michael would do if he were asked to give advice to a 14 year-old on strategies to deal with the bedwetting on the internet.

Pectora roborant cultus recti

I asked Michael to imagine the following while he was sitting in the chair:

> "You have now learned how to outsmart Sneakers. You have learned this trick very quickly, and you can use it to have dry beds every night. The reason Sneakers sometimes visits you are because he still tries to trick you especially if you do not wake up at night when you need to urinate. I would like you to do this trick every night before you go to bed and tell yourself the following things. When I need to urinate, I will wake up all by myself, go to the bathroom all by myself, I will urinate in the toilet and return to my dry bed. When I wake up, my bed will be dry and I will be very happy because I have outsmarted Sneakers. After you have finished telling yourself these things, imagine the feeling you have when you wake up and you bed is dry. It is a comfortable feeling".

The rationale was to empower Michael to take control of his own life and to experience feelings of success.

4.9 IT IS A MATTER OF TIME

I asked Michael if he could build another story in the sand tray depicting what he was experiencing in his life at that moment. He titled his tray "My house".

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First Michael chose Zeus, whom he had had in the previous tray and he put him in the far left corner. He built his house, his garage with three trucks and his garden in the tray. His cat and teddy bear was also part of the scene. He placed a watch on the side of the tray and said that it was only a matter of time before he would have outsmarted Sneakers.

4.10 MICHAEL BECOMES THE CONSULTANT

As Michael's story of victory and new direction over Sneakers emerged, I wanted to assist him in thickening out this new story that stood in contrast to the dominant story of worthlessness that has been shaping his life up to the present.

I shared the following letter that I had found on the internet with Michael:

Bed-wetting

I have been working with a 14-year-old youth for over a year now. He has many presenting problems but one of the issues we are trying to help him get control over is bed-wetting. This youth wets the bed on a nightly basis. We have tried various medications to combat this as well as limiting water intake past 8:00 pm at night and waking him up at night and waking him up at night to go to the washroom.

The youth is generally responsible for his actions and does his own sheets on a daily basis however often gets into conflict because he cannot keep up with the amount of sheets he has to wash and other residents get on his case because they have only one day a week to wash and this resident often takes over their slots in the washer.

If anyone has any experience with strategies to deal with enuresis, please drop me a line.

One interesting fact in this is the resident does not have a bed-wetting problem when he is on home visits away from the treatment centre.

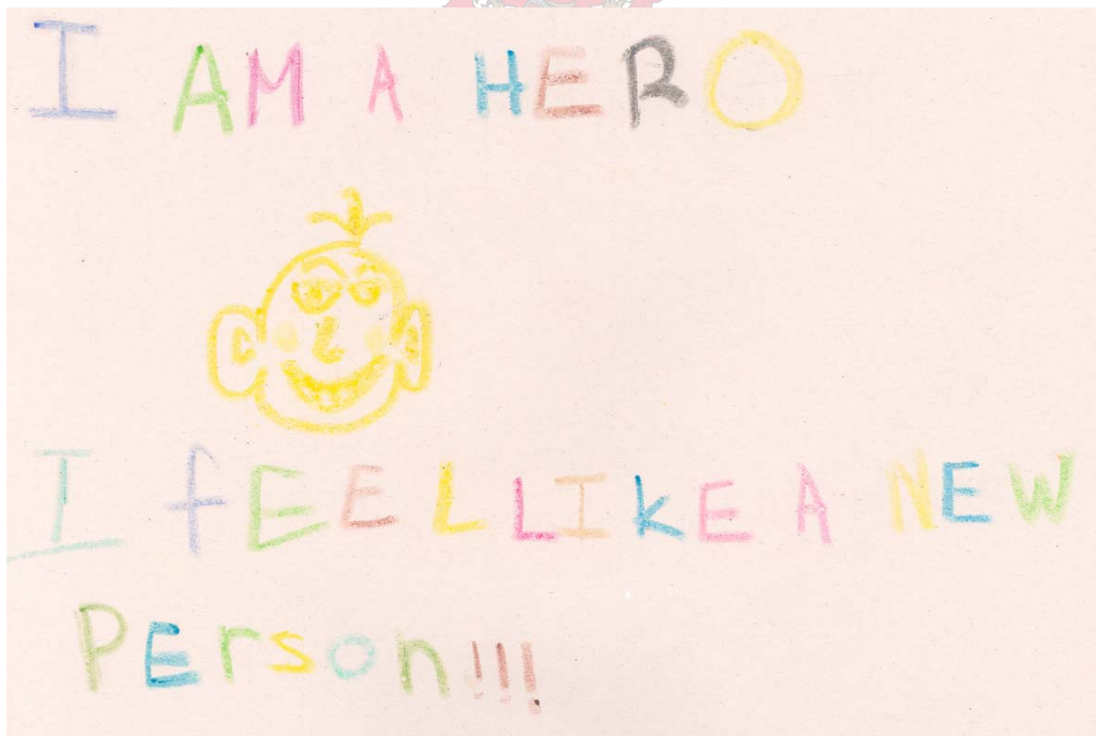
Thanks

Neil Hosler

Michael and I discussed this person's experiences mentioned in the letter. We reflected on his own journey and getting to know Sneakers. Michael responded to the letter in the following ways:

- You have to speak to the problem by giving it a name, I named the bedwetting Sneakers.
- I told him I am the boss and know his tricks.
- I told him that I am in control of him.
- If Sneakers comes to visit once or twice it is okay, because it is not failure, it is taking control of the situation.
- If I could do it, so can you.
- Do not give up hope, you will outsmart Sneakers.

Michael wanted to portray his victory over Sneakers. He drew this drawing to celebrate his achievement.



Michael and I wrote the following document during the session. The document was entitled "Michael's steps against Sneakers" and it described his alternative story. I used the example in Morgan (2000:89) to guide Michael in the drawing up of this document.

Michael's steps against Sneakers

- I have decided that I want him out of my life.
- I have discovered that Sneakers is a liar.
- I have to remember that I have managed to successfully outsmart Sneakers 12 out of 14 days.
- I know that I am the boss of Sneakers and that I am in control.
- I am not Sneakers slave anymore.
- Knowing all about Sneaker's tricks
  - He pretends to be far away as if he is not coming.
  - He always has a plan.
  - He tries to surprise me.
- Knowing about all these things, I can get Sneakers out of my life by:
  - Going to the bathroom before I go to bed.
  - Getting up at night when I need to go to the bathroom.
  - Watching out for Sneakers while I am playing.

Michael embarked on his journey by reading the document every night to himself. I contacted Michael 12 months after his celebratory document about the steps he had taken. He told me that he was still reading his document and indicated that it had worked for him. I agree with White (1995) when he reflects on the effectiveness of a document. He suggests that "it worked because it engaged … in a consultation of his

own knowledgeableness, and it served to elevate one of the counter-plots" of Michael's life-worthlessness.

4.11 I HAVE TAKEN BACK WHAT HE HAS STOLEN FROM ME

Michael announced his stand against Sneakers by naming his final tray that he built "I have taken back what Sneakers has stolen from me".

Pectora roborant cultus recti

Michael indicated to me in the first session that he liked music and I thought that it would be encouraging to play him the song of R. Kelly "I believe I can fly".

4.12 TEAMING UP AGAINST SNEAKERS: A CELEBRATION CEREMONY

I was interested in opening a conversation with people whom Michael identified with. We had talked about an "outsider witness" team to assist him in redefining his identity - people who would stand with him and support him against Sneakers. He named his mother, father, two brothers, and sister as members of his team.

Because it is difficult to keep an identity claim in isolation, we were looking for witnesses that could help him to acknowledge his identity, and share his story about what was important to him.

The purpose was to give voice to the new story "I have taken back my life from Sneakers" to which others could bear witness. Until a month ago, Michael's story of his identity had been one where incompetence, low self-esteem, and isolation had the upper hand. I explained to Michael that I would ask a few questions and his family would talk about what it meant for them to have witnessed Michael's actions in performing his preferred story.

According to his mother, they had tried everything to overcome the bedwetting, but nothing had helped. However, the alternative story that we were bringing to light was that Michael was determined to overcome the bedwetting and to take charge of his life. Michael took his first step in reclaiming his identity in the last session. When I asked him if he would like to invite anyone along to our conversations to witness the new story of his identity, he was very keen and chose to invite his mother, brother, and sister.

At the beginning of the meeting, Michael's mother explained their various attempts to outsmart Sneakers, none of which had helped. The meeting gave Michael's mother the opportunity to affirm that Michael's "self-esteem and entrepreneurship was rising". In Michael's words it provided him with the opportunity to become the boss and champion in his life".

Michael's sister shared with us the differences she had witnessed in Michael. "He could do anything that he wanted to do, he was brave and had perseverance." She further indicated that she was proud of him and that she could see the difference in his

marks at school. The family acknowledged how Michael had moved them through his determined actions. The conversation with Michael and his family was an important step in the re-authoring of Michael's identity.

When Michael was given an opportunity to reflect on his family's reflections on the comments, he said he felt more confident about himself. He spoke about the breakthrough in outsmarting Sneakers in the previous session. Michael thought that Sneakers was using shyness to convince him that he could not speak to people. Sneakers was also convincing him that "I am not good enough to do anything around the school and house, Sneakers comes and ruins my day". Michael further said that since he had befriended Sneakers and knew what his tricks were he could withstand its influence on his life. We spoke about Michael's dream: becoming an actor. He was thrilled to speak about his dream and passion. The response of the family helped to strengthen the alternative story for Michael.

The team focused on respectful listening and this allowed Michael to introduce his new identity and to open doors for him. Michael reflected at the end of the session on the experience of being listened to. It made him realise that his family believed in him and that enabled him to escape from the voice of labels and judgements. I am hopeful that Michael will fulfil his dream of becoming an actor one day. I also know that his family has continued their support of Michael in keeping Sneakers in his place.

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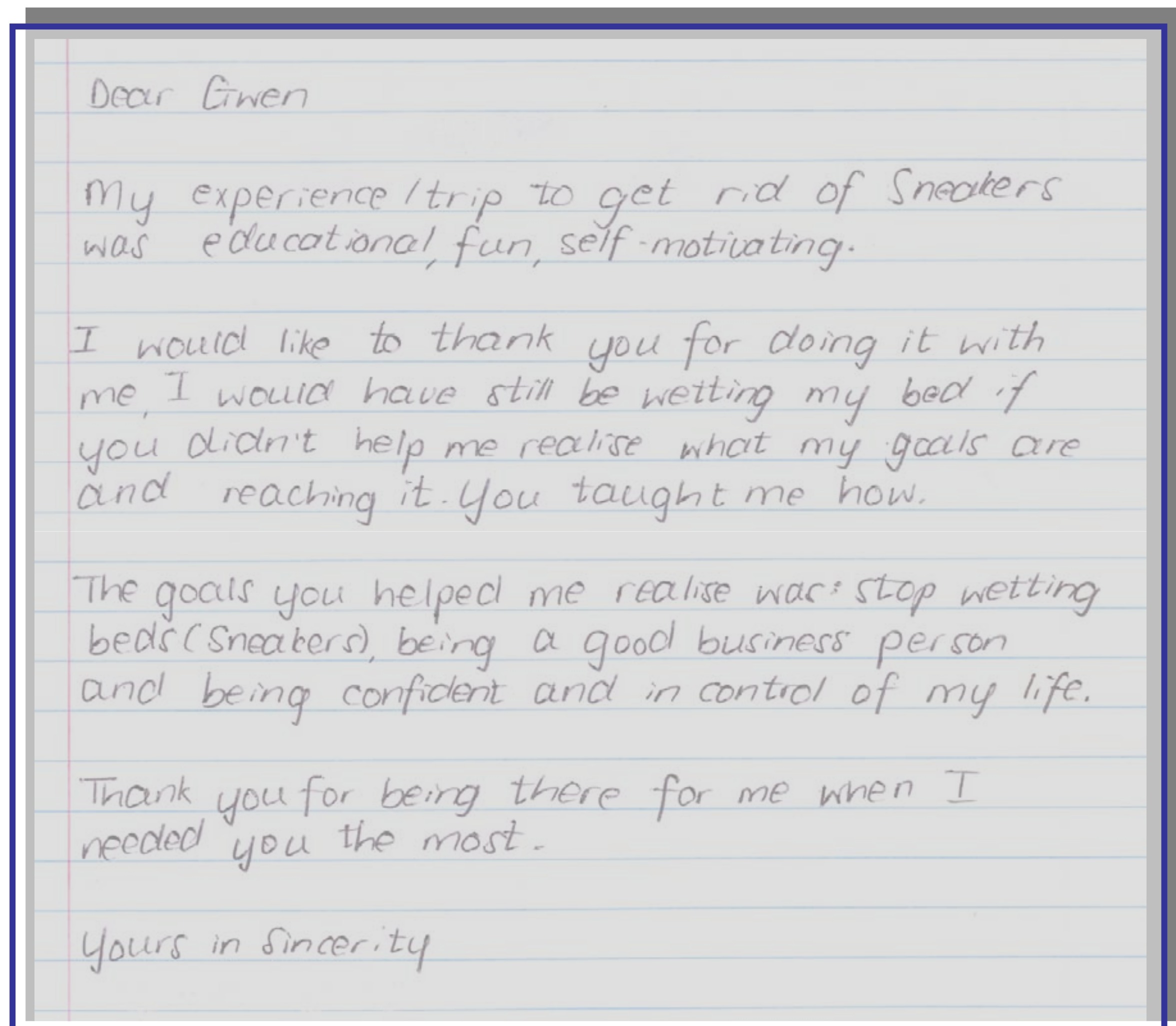
Michael's brother said, "If he comes back he must be notified that I am a rugby player and I like tackling, so he better watch it". I was moved when Michael's mother said, "No matter if Sneakers come back, I still love you, so with Sneakers out of the way we have more room for everything else." This last session encapsulated the heart of narrative therapy for me: "our identities are formed in relationship with others" (Carey & Russell 2003:15).

Michael was awarded a certificate of significant achievement for "Outsmarting Sneakers". Michael beamed with pride when I handed him the certificate and he smiled. This has been a journey of perseverance and determination for Michael.

4.13 A YEAR LATER

I do not claim any rights for the change in Michael's life; I believe that Michael took charge of Sneakers and made the change happen in his life story. After 1 year I

contacted Michael to enquire after his wellbeing and whether Sneakers was still lurking somewhere in the background. This is what he wrote to me:



Dear Gwen

My experience / trip to get rid of Sneakers was educational, fun, self-motivating.

I would like to thank you for doing it with me, I would have still be wetting my bed if you didn't help me realise what my goals are and reaching it. You taught me how.

The goals you helped me realise was: stop wetting beds (Sneakers), being a good business person and being confident and in control of my life.

Thank you for being there for me when I needed you the most.

Yours in Sincerity

4.14 CONCLUSION

Reflecting on this chapter, I realise that my journey with Michael was an amazing experience as research-therapist-in-training. The alternative story that was born out of the externalisation process was one of Michael's inner strengths that he discovered within himself, a new identity separate from Sneakers. In the final session, Michael told me that Sneakers did not visit him any longer, as "he knew what Sneakers's tricks were now". A year later Michael still travels his journey without Sneakers accompanying him on his road. I concur with White and Epston (1990:16) that "as persons become separated from the problem stories, they are able to experience a capacity to intervene into their own lives and relationships".

Chapter 5 will complete the research journey as I reflect on the therapeutic process.

CHAPTER 5

REFLECTIONS OF MY JOURNEY

5.1 INTRODUCTION

In this chapter, I reflect on the journey relating to a therapeutic process within a narrative framework. The aim of the research was to have a look at how the narrative metaphor could be used in working against bedwetting, guided by the research questions that surfaced as I was on my research journey set out in Chapter One.

I would like to use the metaphor of the Polaroid used by Ann Lamott (in Human 2003:40). She contends that writing a first draft, or doing research, in my context:

> "is very much like watching a Polaroid develop. You can't - and in fact you're not supposed to know exactly what the picture is going to look like until it has finished developing. First you just point at what has your attention and take the picture … maybe your Polaroid was supposed to be a picture of that boy standing against the fence, and you didn't notice until the last minute that a family was standing a few feet away from him … Then the film emerges from the camera with a grayish green murkiness that gradually become clearer and clearer, and finally you see the husband and wife holding their baby with two children standing beside them. And at first it all seems very sweet, but then the shadows begin to appear".

I would like to think that I adopted this metaphor as a narrative researcher in training to enable me to be patient, curious, and wait for the plot to develop. As I positioned myself within the narrative framework, I was patient, interested and curious to see the picture of Michael's story develop. Michael made me realize that as a therapist, major interventions are not always necessary in people's lives, one should rather as Human (2003:55) suggests, "bring the untold stories in peoples lives to the fore".

I reflected on the words of Anderson (1993:305) that "therapy is not a technique; it is a way for the therapist to engage in personal relationships". As a collaborative therapist, I wanted to create a space in therapy and in the words of Weingarten (2000) to be a "fellow traveller" to listen, build a relationship, and participate in conversations that privileged Michael's voice. Reflecting on my journey with Michael

I was transported to "think beyond what I routinely think and to question what I took for granted" (White 2002).

5.2 REFLECTING ON THE RESEARCH CURIOSITY QUESTIONS

I would like to reflect on the questions I asked in Chapter 1. Reaching conclusions sound so final and I therefore choose not to reach a conclusion, because in the words of Julian Muller (2001:13) "Research creates its own story with new possibilities. Therefore, narrative research doesn't end with a conclusion, but with an open ending, which hopefully would stimulate a new story and new research". According to Reinharz (1992:194), "learning should occur on three levels in any research project: the levels of person, problems and method. The benefits for me as a research-therapist-in training was enriching and life altering. My position as a future therapist have been greatly influenced by participating in and witnessing of a narrative approach.

The research questions were:

How could the narrative metaphor be used in working against the bedwetting?

As I continued on the research journey, I also embarked on answering the following questions:

- Did the search for an alternative story enable Michael to take a stand against the dominant discourse concerning enuresis? If so, in what ways?
- What ways of collaboration were used that engaged both the researcher and the participants in this therapeutic process?
- How did using the narrative approach to therapy influence me as researcher/therapist-in-training?

5.2.1 How could the narrative metaphor be used in working against the bedwetting?

The journey Michael and I experienced together, gave us both the opportunity to be "transported to other places in life in which (we) must become other than who (we) (were)" (White 2002:12).

Michael's sense of despair was tangible during our first session in the therapy room. On reflection, I wondered about Michael's internalised sense of self. Michael had been overwhelmed with the problem of enuresis since he was a young boy and that it

had had an influence on the shaping of his identity. In my conversation with Michael's mother, she came to the conclusion that "there was never a time that he was ever dry and that he does not want to go out because he is wet all the time". These taken for granted ideas became internalised and was part of his framework for making sense of his life.

The narrative metaphor allowed me as therapist not to feel pressurised into solving the problem, but to honour Michael's abilities to develop solutions with me and expand on his own ways of understanding himself. Michael's story about his identity had been one where shame, embarrassment, worthlessness, and incompetence had the upper hand, but the narrative metaphor created the space for the emergence of an alternative story. "For too long he (Sneakers) has ruined my life. It is now over. He has embarrassed me enough," said Michael. Our journey of exploring alternative identity conclusions lead to descriptions of courage, competence, and perseverance. To me Michael's story highlighted the potential of the externalising conversations, because it had enabled him to break from the negative identity conclusions and paved the way for his preferred narrative.

Set within a postmodern framework, a narrative approach allowed me as therapist/researcher and my client to move beyond the confines of one dominant discourse and allowed us to exercise choice in the position we preferred to take in relation to the problem of enuresis. Davies (1991:46) describes this positioning as an opportunity to claim a form of agency:

> "The speaking/writing subject can move within and between discourses, can see precisely how they subject him/her, can use terms of one discourse to counteract, modify, refuse or go beyond the other, both in terms of her/his own experienced subjectivity and in the way in which she/he chooses to speak in relation to the subjectivities of others".

The social constructionist discourse maintains that knowledge is socially constructed through language (Gergen 1985:270). The therapeutic relationship I entered into with Michael was based on the premise that all knowledge is socially constructed and that reality is constituted through language. In my own exploration of using a narrative approach, I was challenged not to be complacent in my own "expert" know-how of approaching a problem such as enuresis. I attempted to enter into a collaborative, participative process with Michael. I made use of tentative questioning and respectful

listening instead of offering advice, interpreting actions, or prescribing plans of action.

A narrative approach enabled me to use language in such a way to open up and explore new ways of talking with Michael about his experiences of bedwetting. As Michael and I started exploring alternative ways of making meaning of bedwetting, I put into practice the narrative slogan that "the person is not the problem, the problem is the problem" (White in Friedman, Epston & Lobovits 1997:8).

This narrative approach to externalising a problem seemed to give Michael the space to stand away from previous descriptions of his identity that he was not comfortable with. I reflect on the empowering use of the narrative metaphor for Michael in the next question.

I maintained an attitude of curiosity, which guided the questions I asked. My remaining curious and maintaining a not-knowing position placed Michael in a position of expertise and at the same time helped me to enter into and gain an understanding of his experience. I found that taking a curious position, asking questions instead of making statements, encouraged Michael to participate in the conversations. I hoped to get to know more about Michael as a person than just the bedwetting. Within a narrative approach, there is the social constructionist view that every person has multiple stories about themselves. A problem-saturated story tends to be a very thin description of a person's identity. Morgan (2000:15) encourages careful questioning in the interests of arriving at "a rich description involv[ing] the articulation in fine detail of the storylines of a person's life".

When I reflected on the fact that Michael had been to various therapists and that I was curious as to why he was still willing to see another therapist, he noticed his own determination to overcome the bedwetting. This form of tentative questioning and holding on to the hope of a preferred story enabled both of us to tell a much richer, alternative story.

Therapeutic letters were very useful as summaries of our conversations. I found that the letters also served as a forum for reflection on Michael's alternative story of hope. The letters enabled us to develop and keep alive the threads of Michael's preferred identity story during the conversations, and the letters became a link between the therapeutic sessions. According to Michael White (White & Epston 1990:126) "It is

our contention that narrativising letters more accurately display the 'work' than professional accounting methods".

Narrative Therapy emphasises the practices of accountability and transparency during therapeutic discussions. This ethical position made me aware of the therapist-client power relation. I attempted to incorporate this into my actions with Michael, by continuously asking for Michael's opinion and experiences on the direction that our conversations were going. Through making my therapeutic notes available to him and writing down that what Michael wanted to be documented also contributed to a more equal power sharing relationship.

I agree with White (1995:168) when he says:

> "I have an ethical commitment to bring forth the extent to which the process of therapy is a two-way process and to try to find ways of identifying, acknowledging, and articulating the extent to which the therapeutic interactions are actually shaping of the work itself, and also shaping of my life more generally in positive ways".

I experienced a more relaxed, collaborative atmosphere in my therapeutic conversations with Michael. The pressure to be the "specialist" and do everything correctly according to a formula was lessened by the acknowledgement of my own shortcomings and the guidance of Michael and my supervisor. Their participation, reflective conversations with me and my own tentative stance in my approach to this process gave me a measure of accountability with which to proceed in our journey.

5.2.2 Did the search for an alternative story enable Michael to take a stand against the dominant discourse concerning enuresis? If so, in what ways?

Making use of a narrative approach in constructing an alternative story enabled both Michael and me to look beyond the problem saturated story and to challenge the taken-for-granted realities that faced Michael in his struggle to gain agency over his own life.

The process of creating an alternative story did not happen overnight, but required careful and tentative questioning by me as therapist. In accordance with Morgan's (2000:14) description of the process of weaving an alternative story together, "the therapist is interested to seek out, and create in conversations, stories of identity that will assist people to break from the influence of the problems they are facing".

For Michael, an exploration of the alternative stories of his life created space for change. Through our discussions, alternative stories concerning enuresis (Sneakers) and ways in which Michael could manage Sneaker's tricks enabled him to take a stand against the problem. Michael could use this newfound space to voice his own opinion and create a sense of agency over his own body and life.

The narrative metaphor also gave me as therapist the space to avoid the pressure of trying to find solutions to the diagnosis of enuresis. It further enabled me to take a stand against the modernist discourse. According to Anderson and Goolishian (in Viljoen 2001) the postmodern ideas challenge the traditional modernist relationship between the therapist and the client where the therapist is expected to "fix" the problem experienced by the client with expert knowledge. Positioning myself within the postmodern worldview has allowed me to join Michael to discover his alternative story and to facilitate the re-authoring of the problematic aspects of his life according to himself. The postmodern worldview has also allowed me not to pathologize, and not to label, but to explore alternative ways of approaching the dominant description of enuresis. Instead, the use of alternative ways of meaning making enabled Michael to participate with me in bringing forth "rich and thick descriptions" (Morgan 2000:15) of alternative stories that stood outside problem stories. The narrative metaphor has liberated Michael from the oppressive and dominant narrative.

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Although Michael walked into the room during our first session with his head down and avoiding eye contact, my use of less blaming languaging surrounding the history of the enuresis enabled him the opportunity to voice his own opinion. Through an externalising conversation regarding the influence of bedwetting on Michael's life, he could separate the problem's voice from his own.

Through voicing his own experiences regarding Sneakers, Michael was able to expose the problem and its tricks. In reflecting during our conversation on the problem's effects on Michael's identity, he started mentioning experiences of "failure", "incompetence", "embarrassment" and "worthlessness". This thin description of Michael's person according to the problem was however challenged over time.

Freedman and Combs (1996:16) argue that within new stories, people can live out new self-images, new possibilities for relationship and new futures. The narrative metaphor allowed Michael to see his life in a different light, re-authoring his life.

I attempted to explore and identify unique outcomes of Michael's life that could stand in contrast to the problem-saturated story. In my decision to make use of a narrative letter I hoped to document Sneaker's tricks discussed during our first two conversations and create an opportunity for further discussion on incidents that stood in contrast to the problem story.

Michael felt empowered by the externalising of the problem and was able to distance himself from Sneakers for the first time. Michael's ability to start controlling the bedwetting created feelings of "control" and being a hero. I was surprised how quickly Michael engaged in conversation using the externalised description of the bedwetting namely Sneakers. Sneakers became a real entity that Michael drew and depicted in a sand tray on numerous occasions (See photographs). According to Friedman, Epston and Lobovits (1997:16) "having laid the problem out visually the child may find it easier to describe its effects".

Michael and I slowly started exploring the thin strands of alternative ways to describe Michael as a person. Michael described himself as a hero during the time that Sneakers made fewer and fewer visits. Thus a narrative approach gave Michael the option of choosing not to stand by the dominant description of himself as a "failure" but to weave together a preferred way of viewing and experiencing himself as a "hero" in overcoming the problem.

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Michael was enabled to claim agency over his own body and life. A hero is usually someone who is not just brave enough to face a problem and challenge it, but helps others in need. Michael White (White & Epston 1990:82) describes the effect of personal agency as "the narrative mode which locates a person as a protagonist or participant in his or her world … and thus in the shaping of their lives and relationships".

In searching for ways in which Michael and I could further enrich his newly discovered knowledge over Sneakers and share his experiences with others, I stumbled upon the letter on the internet from another therapist asking guidance in supporting a boy struggling with enuresis. The knowledge Michael was able to share in a letter written to the therapist, validated Michael's own struggle and success in challenging Sneakers. Michael White (Epston & White 1990:31) describes this

process of "the identification of and provision of the space for the performance of these knowledges as a central focus of the therapeutic endeavour".

In making use of a narrative approach Michael was able to take a stand against the descriptions of the problem, claim agency over his own body and life and thus co-author alternative stories of experiencing and knowing himself.

5.2.3 What ways of collaboration were used that engaged both the researcher and the participants in this therapeutic research process?

I found the qualitative research paradigm in a post-modern context useful in the process of describing the journey Michael and I undertook together. The qualitative paradigm provided me as researcher/therapist-in-training and Michael as participant to share and explore his personal ways of making meaning of his life's story. Denzin and Lincoln (1994:4) emphasise the "intimate relationship between the researcher and what (whom) is studied". I do not believe that Michael and I would have been able to collaborate as closely as we did, if the research approach had not allowed for "participation", "in-depth conversations" and a "wealth of rich descriptive data" (Mouton 1996:169).

I found that certain ways of doing within a narrative approach to therapy were closely related to some of the characteristics of a qualitative research framework as mentioned in Chapter 3. Mason (1996:5) points out that the research process should not be rigid or too structured in its approach. Flexibility and being contextual were two important aspects within the researcher's approach to the subject (person) according to Mason. By using Michael White's (2002) metaphor of a journey, I also tried to describe the therapeutic process not as a set structure of objectives to be reached but an exploration of "subjugated knowledges" that needed to be rediscovered through therapeutic discussion (Epston & White 1990:25). Some roads could be dead ends, other a cul-de-sac that bring you right back to where you started. Yet, the flexibility within our therapeutic discussions allowed movement to take place and for Michael to take up an alternative position to bedwetting than before.

The curious questioning I used temporarily scaffolded the direction of our conversations, but we were able to shift direction or stumble upon new found unique outcomes at any time. This required a respectful and tentative stance towards Michael and his own contributions to a collaborative research process.

Mason (1996:5) describes the necessity of a "critical self-scrutiny by the researcher" or "active reflexivity" to make meaning of their own actions, motives, use of questions and the role they play within the process. A narrative approach also draws attention to the political context within which therapists operate. To avoid the misuse or abuse of the position of power/knowledge that a therapist "endowed" with through the professional disciplines discourse, Michael White (1990:29) encourages "conditions that encourage us to critique our own practices to identify more readily the effects, dangers and limitations of our ideas and own practices". These approaches to reflexive practice link up with Participatory Action research in its emphasis in cyclic reflexivity. According to Grundy in Seymore-Rolls (2004:2) "reflection in PAR is that moment where the research participants examine and construct then evaluate and reconstruct their concerns".

Through means of therapeutic discussion, the writing of letters, supervision, transparent questioning to Michael about his own experiences of the process allowed a form of collaboration in constituting new knowledges surrounding a youth's experiences of enuresis and being able to claim a form of agency.

Lastly Mason (1996:5) focuses on the ethical practice of the research conducted and points out the political context of all research. As mentioned previously, a narrative approach to therapy constitutes ethical practice for therapists and researcher. An ethical way of working for me was an important and challenging aspect of this research. Epston and White assert that "since we are caught up in a web or net of power/knowledge, it is not possible to act apart from this domain and we are simultaneously undergoing the effects of power and exercising this relation to others" (1990:22).

Johnella Bird (2001:10) indicates that in exposing the power relations, "we can research the effect of the silence, the difficulty, the sense of being overwhelmed, challenging the panic that comes with expectations and the critical ideas that act to silence". As Bird mentions, this exposure of the power relation between me as therapist and Michael as client allowed us the opportunity to explore his own contextual experiences of enuresis in his life. Thus I as therapist/researcher stood in a relational position within the process, which Bird describes as "a relational form of consciousness". It allowed collaboration by a particular way of engaging in and with

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language, not only in my therapeutic discussions with Michael, but also in writing up our journey as a research thesis.

5.2.4 How did using the narrative approach to therapy influence me as researcher/therapist-in-training?

When I committed myself to walking this journey with Michael using a narrative approach to therapy, I was not sure where it might lead me. Looking back on the thorough training we as a group received from Elize Morkel, I was very grateful for the emphasis Elize placed on the principle of ethical practice. An ethical way of being required reflecting on my own experiences relating to the therapist-client relationship, the concept of confidentiality and what it entails to *being ethical* as a therapist (Kotzé 2000).

The narrative way of meaning making in the world, based on postmodern, social constructionist views opened my eyes to the multiple interpretations of life experiences. It forced me to not only tolerate but respect other ways of being in the world that differed from my own. The concept of shared meaning making lessened the pressure on me as a student/therapist in training/researcher to "recreate the wheel" from scratch. Instead just focusing on how to be a good therapist, which techniques to use or how to implement them, a narrative approach required a shift from me as therapist.

While attending a Michael White workshop in August 2004 in Somerset West, Western Cape, he drew my attention to the various positions a therapist can take in relation to therapeutic conversations. According to White (2002:6) "the intention of the therapist is to take up a decentred and influential posture". His words made me aware of my tendency to want to give advice and fix the problem for the client as I had done as a teacher in the past. A narrative approach challenged me to make a fundamental shift. Thus Michael's personal story and his own skills and knowledges took priority during our discussions. This enabled Michael to have "primary ownership" over his own life story (White 2002:6).

A narrative approach emphasises a decentred yet influential posture. It challenged me in my use of language, phrasing of questions and through reflection to be able to build a "scaffold" that would make it possible for Michael to more richly describe the alternative story of his life as a hero. I found the new use of languaging difficult at first and unnatural at times during our second session. Making use of a kind of

"roadmap" of the different techniques used in narrative therapy I was able to put the basic scaffolding in place to guide my discussions and questions. Michael's spontaneity and humour could be used to set the tone and make the whole "serious" problem of enuresis a playful approach to Sneakers. Freedman and Combs (1997:277) describe the influential power of language "by instead of inviting them (clients) to become further immersed and isolated in their problems, we seek to join them in their experience of the world".

Johnella Bird (2001:13) emphasises the political implication of taking an ethical position in therapy and making use of the process of exposing and negotiating meaning through discussion. She claims that, "[a]cknowledging the political implications of therapy enable us to both render ourselves available to ongoing critique of the certainties we hold while finding strategies to engage enthusiastically with the relationship between knowing and not knowing" (Bird 2001:13).

During my first session with Michael, I attempted to be transparent, open, and inquisitive and to invite Michael into the therapeutic discussion. This felt strange to me at first, because of the traditional modernist discourse that I was exposed to until then. A discourse of keeping the therapeutic process a secret, not allowing the client into your specialised know-how and keeping a professional distance. The effect of such an approach to therapy is described by Bird (2001:8) as negative "[a]s this position does harm by confirming universal psychological truths which relegate those people to the margins to both professional inadequacy and madness".

As I have mentioned earlier, I preferred to attempt to do "No Harm" (Bird 2001) by not using therapy as a technique, "but a way to engage in client relationships" (Friedman 1993:303). As the first session progressed and Michael and I played around with various ways of making meaning of his experiences of enuresis, I experienced relief at not being the "expert". Within this more equal power-sharing position we were both able to share and participate collaboratively.

By engaging in constant therapeutic discussion, not only with my client but also with fellow therapists-in-training and my supervisors I was taught the importance of reflection. I could learn from others, discuss with others, differ from others and constantly adapt my own understanding of experiences in my life.

A narrative approach places a lot of emphasis on the shared meaning-making process of therapeutic discussion. As White (1995:23) puts it, "Externalising conversations opens up new possibilities for action, in the evolution of these conversations, persons continue to revise their relationship with their problems". I experienced the creation of a safe space for both Michael and myself to be able to look at the problem from a distance.

Through our discussion of the problem as a separate entity, new ways of talking and thinking about enuresis emerged from our conversations. It opened my eyes to the various alternatives available to us in language in describing a situation, an experience, a problem. It enabled me to critically reflect on the use of diagnostic labels within my own practice as therapist-in-training, as well as the effects it had on children whom I taught in an earlier part of my career as a teacher.

It reminded me again of Morkel's (2002:20) description of a state of merging, when through my discussions with Michael I reflected on how such a life of living with a label would have been for me. Heshusius (Morkel 2002:20) describes this merging as "participatory consciousness" which opened up various alternative routes for Michael and I to discover, that wasn't there before.

5.3 LIMITATIONS OF THE JOURNEY

Reflecting on our journey, I would have preferred more time to 'thicken' Michael's alternative story even further. The importance of "spreading the news" of Michael's triumph over Sneakers is based on a poststructuralist understanding of identity as something that is not innate and fixed, but constantly in development and under negotiation (Epston in Kotzé & Kotzé 2001:125). However, the outsider witness session, where Michael's family members acted as an audience to his performance of his new story, did light the way to a new understanding of Michael's identity. Part of the limitation is that as research-therapist, I was in training and experimenting with the narrative approach and consequently this process described may be used as a basis, rather than a proto-type, for further work in this area. Conducting therapy-as-research was extremely challenging for me. A final limitation of this study can be attributed to the data analysis constraints imposed by a qualitative research paradigm. Although the qualitative ways of working fitted within the narrative approach, I had to stay with the story and be respectful in analysing the data of the conversations in

using content analysis and not to reduce it to content and then analyse the content. I resonate with the words of Freedman and Combs (1996:44) when they describe their understanding of how to listen to stories by saying: "When we meet people for the first time, we want to understand the meaning of their stories for them. This means turning our backs on 'expert' filters: not listening for chief complaints; not 'gathering' the pertinent-to-us-as-experts bits of diagnostic information interspersed in their stories". We should instead listen "with focussed attention" to the stories of our participants and try to understand from "their perspective and in their language the experience they share with us (Freedman & Combs 1996:44).

5.4 THE JOURNEY CONTINUES

In reflecting on this journey, I am reminded of the debilitating effect of labelling and its effects on the lives of young people. My conversations with Michael resulted in me asking myself the question: How can I as future therapist play a role to try and ensure that young people are not marginalized and labelled? The power of a narrative approach speaks to me as it assists, according to Michael White (1995:197), "the therapist to break from the discourses of pathology and the formal systems of analysis that are so marginalizing and objectifying of people". As future therapist this has engendered a great mindfulness of questioning the taken for granted aspects in children's lives. The collaborative approach offered Michael the opportunity to understand himself differently from the interpretation that was imposed on him by the medical model.

Besley (2002:128) states that narrative therapy has "started to turn the gaze (Foucault's terminology for objectification) back on itself and to decentre the therapist so the client is at the centre of their own therapy". He further suggests that "narrative therapists do not present themselves as distant, objectively neutral experts who diagnose problems and prescribe solutions and treatments, but as curious, interested and partial participants in the client's story". The narrative approach allowed me to enter my therapeutic work with Michael as "a fallible human being, rather that as (an) expert" (Freedman & Combs, 1996:275).

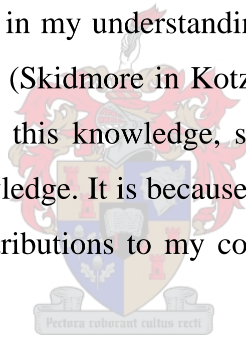
As therapist, I am aware that the future challenges are attitude changes in a medical and modernistic approach to bedwetting. I hope for transformation to a therapeutic approach which honours a person's personal stories rather than focusing on pathology.

The narrative approach gave me the space to position myself not only as a therapist who solely focuses on diagnosis, but rather leave space for the story of Michael's life to evolve.

I agree with Morkel (2002:20) that "it is impossible to engage in a participatory process without becoming involved and being changed as researcher". In my journey alongside Michael, I felt privileged and can only thank him for allowing me to journey with him. The personal gift that I received was the way my thinking was influenced. Michael also helped me to be in touch with a "way of knowing" that changed my life.

In celebrating the changes that have already taken place in Michael's life, the handing over of the certificate testified to his "hero status" in not only overcoming Sneakers, but also in his new found knowledge that he was able to share with others.

And the story continues. Not only for Michael, but also for me. Carrying this story with me, the changes it wrought in my understanding of myself as a person and as a therapist, is a "way of knowing" (Skidmore in Kotzé & Kotzé 2001:160). It requires an ethical way of working with this knowledge, sharing it with others and always reflecting on my use of the knowledge. It is because of this way of understanding that I am grateful for Michael's contributions to my collaborative study and my way of doing therapy.



> "In a mutually influential therapy process in which change is a natural consequence of dialogue, a therapist, like a client, will be subject to change. It seems illogical to presume otherwise, to think that we could be involved in a transformative process and not be transformed ourselves" (Anderson in Kotzé & Kotzé 2001:160).

Thank you Michael for the preferred identities where you and I travelled to. I carry with me the invaluable knowledge and experience that we shared on this journey.

REFERENCES

American Psychiatric Association. 1994. **Diagnostic and statistical manual of mental disorders (DSM-IV-TR).** Washington: APA.

Andersen, T. 1993. See and hear and be seen and heard. In: Friedman, S. (ed.) **The new language of change. Constructive collaboration in psychotherapy.** New York: Guilford. (pp. 303-323)

Babbi, E. & Mouton, J. 2001. **The practice of social research**. Cape Town: Oxford University Press.

Besley, A.C. 2002. Foucault and the turn to narrative therapy. *British Journal of Guidance and Counselling*, 30(2):125-143.

Bird, J. 1994. **Talking amongst ourselves.** Adelaide: Dulwich Centre Publications.

Bird, J. 2001. To do no harm. Key note address given by Johnella Bird at the inaugural Pan Pacific Family Therapy Congress. 4-7 September 2001.

Botha, A. 1998. Pastoral therapy and extra marital affairs: A narrative approach. Pretoria: UNISA (M thesis).

Breakwell, G.M., Hanmmond, S. & Fife-Schaw, C. 2000. **Research Methods in Psychology**. London: Sage.

Carey, M. & Russell, R. 2002. Externalising - commonly asked questions. *International Journal of Narrative Therapy and Community Work*, 2:76-85.

Carey, M. & Russell, R. 2003. Outsider witness practices: Some answers to commonly asked questions. *International Journal of Narrative Therapy and Community Work,* 1:3-16.

Carey, M. & Russell, R. 2003. Re-Authoring: Some answers to commonly asked questions. *International Journal of Narrative Therapy and Community Work.* 3:60-71.

Carr, A. 1998. Michael White's narrative therapy: *Contemporary Family Therapy*, 20(4):485-503.

Clandinin, D.J. & Connely, F.M. (2000). **Narrative Inquiry. Experience and story in Qualitative Research.** San Francisco: Jossey-Bass Publishers.

Cronjé, J.C. 2004. Management of bedwetting in children. CME, 22(8):439-475.

Davies, B. 1991. The concept of agency. A feminist poststructualist analysis. *Social Analysis, Special issue on Postmodern Critical Theorising*, 30:42-53.

De Vries, C. 2004. Narratives of a family living with HIV/AIDS and a researcher's alternative story. Stellenbosch: University of Stellenbosch. (Thesis: MEdPsych).

Denzin, N.K. & Lincoln, Y.S. 1994. **Handbook of qualitative research.** Thousand Oaks: Sage.

Dickerson, V.C. & Zimmerman, J.L. 1993. A narrative approach to families and adolescents. In: Friedman, S. (ed.). **The new language of change. Constructive collaboration in psychotherapy.** New York: Guilford.

Drewery, W., Winslade, J. & Monk, G. 2000. Resisting the dominating story: Toward a deeper understanding of narrative therapy. In: Neimeyer, R.A. & Raskin, J.D. (eds.). **Constructions of Disorder: Meaning–making frameworks for psychotherapy.** California: Jossey-Bass Inc.

Drewery, W., Winslade, J. 1997. The theoretical Story of Narrative Therapy. In: Monk, G., Winslade, J., Crocket, K. & Epston, D. **Narrative Therapy in Practice**, 32-52. California: Jossey-Bass Inc.

Durrheim, K. & Terre Blanche, M. (1999). **Research in practice: Applied methods for the social sciences**. Cape Town: UCT Press.

El-Radhi, A.S. & Board, C. 2003. Providing adequate treatment for children with nocturnal enuresis. *British Journal of Community Nursing*, 8(10):440-446.

Pectora roborant cultus recti

Epston, D. & White, M. 1992. **Experience, contradiction, narrative and imagination: Selected papers of David Epston and Michael White 1989-1991.** Adelaide: Dulwich Centre Publications.

Epston, D. 1998. **Catching up with David Epston: A collective of narrative practice-based papers.** South Australia: Dulwich Centre Publications.

Freedman, J. & Combs, G. 1996. **Narrative therapy: The social construction of preferred realities.** New York: Norton.

Freedman, J. & Combs, G. 2000. Workshop presented at South African Association for marital and Family Therapy, Gauteng-branch, Johannesburg.

Freeman, J.C., Epston, D. & Lobovits, D. 1997. **Playful approaches to serious problems: Narrative therapy with children and their families.** New York: W.W. Norton.

Friedman, S. (ed.). 1993. **The new language of change. Constructive collaboration in psychotherapy.** New York: Guilford.

Gergen, K., Hoffman, L. & Anderson, H. 1996. Is diagnosis a disaster? A constructivist trialogue. Internet: http://www.swarhmore.edu/

Gergen, K.J. 1985. The Social Constructionist Movement in Modern Psychology. *American Psychologist*, 30(3):266-275.

Gergen, K.J. 1994. **Realities and relationships: soundings in social construction**. Massachusetts: Harvard University Press.

Gortner, E.M. 2001. *Narrative Therapy: The Collaborative Language System Approach.* (Internet)

Griffith, J.L. & Griffith, M.E. 2002. **Encountering the sacred in psychotherapy. How to talk to people about their spiritual lives.** New York: The Guilford Press.

Grimbeek, M.E. 1998. Korttermynterapie met getraumatiseerde kleuters. Johannesburg: Randse Afrikaanse Universiteit. (M Thesis)

Hansen, J.T. 2004. Thoughts on knowing: Epistemic implications of counseling practice. *Journal of Counseling and Development*, 82(2):131-138.

Heshusius, L. 1994. Freeing ourselves from objectivity: Managing subjectivity or turning towards a participatory consciousness. *Theory into Practice*, 34(2):117-123.

Hoffman, L. 1997. **Foreword in Conversation, Language, and possibilities. A Postmodern Approach to Therapy**. New York: Basic Books.

Human, L. 2003. Fiction writing as metaphor for research: A narrative approach. *Practical Theology in South Africa*, 18(3):41-60.

Hunter, C. 2000. Workshop notes on doing narrative counselling: One step at a time.

Kotzé, E. & Kotzé, D.J. 1997. Social construction as a postmodern discourse: An epistemology for conversational therapeutic practice. *Acta Theologica*, 17(1):27-50.

Kotzé, E. 1994. The social construction of a family therapy training programme. Johannesburg: Rand Afrikaans University. (Dissertation: D.Phil)

Kotzé, E. 2000. **A chorus of voices. Weaving life's narratives in therapy and training.** Pretoria: Ethics Alive.

Kronenberger, W.G. & Meyer, R.G. 2001. **The child clinician's handbook** (2nd Edition). Boston: Allyn and Bacon.

Leedy, P.D. 1997. **Practical Research: Planning and Design**. New Jersey: Macmillan Publishing Company.

Lever, H. & Gmeiner, A. 2000. Families leaving family therapy after one or two sessions: A multiple descriptive case study. *Contemporary Family Therapy: An International Journal,* 22(1):39-65.

Pectora roborant cultus recti

Mash, E.J. & Wolfe, D.A. 2002. **Abnormal child psychology** (2nd Edition). Belmont CA: Wadsworth Press.

Mason, J. 1996. **Qualitative researching**. London: Sage.

McTaggart, R. 1997. Guiding principles for participatory action research, in McTaggart, R (ed), *Participatory action research: International contexts and consequences*, 25-44. Albany: State University of New York Press.

Merriam, S.B. & Associates. 2002. **Qualitative research in practice.** San Francisco: Jossey-Bass.

Merriam, S.B. 1991. **Case study research in education: A qualitative approach.** San Francisco: Jossey-Bass.

Monk, G. 2003. Sociopolitical activist or conversational partner. Internet: www:http//Foucault.info/ weblog/000045.html. (August 15, 2004)

Morgan, A. 2000. **What is narrative therapy - An easy to read introduction.** Adelaide: Dulwich Centre.

Morkel, E. 2002. When narratives create community: Standing with children against stealing. Pretoria: University of South Africa. (Thesis: MTh.)

Mouton, J. 1996. **Understanding social research.** Pretoria: Van Schaik.

Mouton, J. 2001. **How to succeed in your master's & doctoral studies**. Pretoria: Van Schaik.

Muller, J. van Deventer, W & Human, L. 2001. Fiction writing as metaphor for research: a Narrative Approach. http:www.julianmuller.co/za/narrative%20 research.htm.

Muller, J.C. 2003. Unheard stories of people infected and affected by HIV/AIDS about care and the lack of care: the research story of the project. *Practical Theology in South Africa*, 18(3):1-20.

Nieuwmeyer, S.M. 2002. Woman storying HIV/AIDS in community. Pretoria: University of South Africa. (Thesis: MTh)

Norum, K. 2001. Hearing Voices: All of them. www.julianmuller.co/za/ narrative%20research.htm.

O'Connor, K.C. 2004. Research as therapy: Measuring effectiveness of men against violence workshops. www:http//www.cs.usyd.edu.au. (August 23, 2004)

Patton, MQ (1987). **How to use qualitative methods in evaluation.** Newbury Park, California: Sage Publications

Reinharz, S. 1992. **Feminist methods in social research**. New York: Oxford University Press. 197.

Sadock, B.J. & Sadock, V.A. 2003. **Kaplan & Sadock's synopsis of psychiatry** (9th Edition). Philadelphia: Lippencot Williams & Wilkins.

Sax, M. 2002. Finding common ground between human service seekers, providers, a reauthoring conversations approach. A dissertation by M.F. Sax. Internet: http://www.narrativeapproaches.com/narrative%20papers%20folder/sax.htm

Schaefer, C.E. 1979. **Childhood enuresis and encopresis: Causes and therapy.** New York: Van Nostrand Reinhold Company.

Scrimgeour, E. 2002. Honouring sacred spaces: Voicing stories of terminal illness. Pretoria: University of South Africa. (M thesis)

Seymour-Rolls, K. & Hughes, I. Action research electronic reader: Participatory action research: Getting the job done. http//www.scu.edu.au/schools/gcm/ar/arr/arrow/rseymour.html (August 23, 2004)

Sinaikin, M.D. 2004. How I learned to stop worrying and love the DSM. *Psychiatric Times,* 103-105. (February)

Pectora roborant cultus recti

Smith, SE, 1997. Deepening participatory action research in Smith, SE, Willms, DG, Johnson, NA (eds) 1997. *Nurtured by knowledge: learning to do participatory action research*. New York: Apex Press.

Snyman, S. & Fasser, R. 2004. Thoughts on Ethics, psychotherapy and postmodernism. *South African Journal of Psychology*, 34(1):72-83.

Terblanche, L. 1995. Enuresis and encopresis: An epidemiological study in the Rocklands community. Bloemfontein: University of the Orange Free State. (M thesis)

Viljoen, J. 2001. Deconstructing secondary Trauma and Racism at a South African Police Service Station. Pretoria: University of South Africa. (Thesis: MTh.)

Wadsworth, Y. 1998. What is participatory action research? Action research: International, Paper 2. Internet: http//www.scu.edu.au/schools/gcm/ar/ari/p-ywadsworth98. html. (May 16, 2004)

Weingarten, K. 2000. Witnessing, Wonder and hope. *Family Process*, 39(4):389-402.

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

White, M. 1984. Pseudo-encopresis: From avalanche to victory, from vicious to virtuous cycles. Family systems Medicine, Vol.2 No.2. Adelaide, Australia: Dulwich Centre Publications.

White, M. 1989. Saying Hullo again: The incorporation of the lost relationship in the resolution of grief. Dulwich Centre Publications (ed), Selected Papers, 29-36. Adelaide: Dulwich Centre Publications.

White, M. 1991. Deconstruction and therapy. Dulwich Centre Newsletter, 3:21-40.

White, M. 1992. Deconstruction and therapy. In: Epston, D. & White, M. **Experience, contradiction, narrative and imagination**. Adelaide: Dulwich Centre publications.

Pectora roborant cultus recti

White, M. 1995. **Re-authoring lives: Interviews and essays**. Adelaide: Dulwich Centre Publications.

White, M. 1995. Reflecting teamwork as definitional ceremony. In: White, M. **Re-authoring lives: Interviews and essays.** Adelaide: Dulwich Centre Publications.

White, M. 2000. Reflections on narrative practice: Interview & Essays. South Australia: Dulwich Centre Publications.

White, M. 2001. Narrative practice and the unpacking of identity conclusions. Internet: http://www.dulwichcentre.com.au

White, M. 2002. Journey metaphors. *The International Journal of Narrative Therapy and Community Work,* 4.

White, M. 2002. Workshop notes. Internet: www.dulwichcentre.com.au.

Winslade, J. & Monk, G. 1999. **Narrative counselling in schools: Powerful and brief.** London: Sage.

Yule, H. 1993. Narrative therapy in the South African context: A case study. University of Cape Town, Cape Town. (M Thesis)

Zimmerman, J.L. & Dickerson, V.C. 1996. **If problems talked: Narrative therapy in action.** New York: Guilford Press.

Zuber-Skerrit, O. 1996. **New Directions in Action Research**. London: Falmer Press.

Pectora roborant cultus recti

CONSENT FORM FOR THE RELEASE OF INFORMATION BY PARTICIPATING MEMBERS

I hereby give my permission for information concerning myself to be used in the written report of the project and in the publication. I understand that my confidentiality will be preserved throughout the study. I also understand that any information that may lead to my identification will not be used or included in the project report or publication.

I prefer the following name (either own or pseudonym) be used in the research report or any other publication resulting from the project.

Name to be used ....

....	....
(Signature of participant)	Date
....	....
(Signature of parents)	Date
....	....
(Signature of witness)	Date

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MAGTIGINGSVORM

Ondergetekende ________________________________ kliënt/vader/moeder/voog **(onderstreep waar van toepassing)** gee toestemming aan die **EENHEID VIR OPVOEDKUNDIGE SIELKUNDE** van die **UNIVERSITEIT VAN STELLENBOSCH** om:

1. inligting aangaande myself of kind van relevante persone of instansies te verkry

   ____
   HANDTEKENING

2. indien nodig, te observeer, video- of klankopnames van die verloop van die ondersoek/hulpverlening te maak. Sodanige opnames word streng vertroulik en anoniem hanteer;

   ____
   HANDTEKENING

3. verkreë inligting (wat anoniem en streng vertroulik hanteer sal word) vir navorsingsdoeleindes te gebruik ten einde die diens te verbeter tot voordeel van toekomstige kliënte.

   ____
   HANDTEKENING

4. 'n geskrewe verslag van die volledige assessering deur die Eenheid vir Opvoedkundige Sielkunde ten opsigte van myself of my kind beskikbaar te stel aan:

   - sy/haar huidige en/of voornemende skool en/of ander instansie **JA/NEE**

   Naam van skool/instituut: ______________ **Naam van skoolhoof:** ______________

   - myself, die ondergetekende **JA/NEE**
   - die volgende persone (bv. arbeidsterapeut): ____________________

____
HANDTEKENING

___/___/_____
DATUM

____
GETUIE

Eenheid vir Opvoedkundige Sielkunde • Unit for Educational Psychology
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TRANSCRIPTIONS OF SESSION 5

EXAMPLE OF TRANSCRIPTION

SESSION 5 DAY/DATE	**VERBATIM MATERIAL CLIENT AND THERAPIST**	
12/11/2003	G:	Hello Michael, how are you today?
	M:	Fine
15h00-16h00	G:	Today we have invited your family to be part of our session. This is our last session today; I wrote you a message on the board.
	G:	This is how our session for today will progress:
		First, the two of us are going to talk, but before I do that, I want you to give me permission to the detail of our conversation.
		First, the 2 of us are going to talk, then they will listen to us, then we will switch place and they will then speak to each other on what they have heard us speak about, then all of us will talk together. There are 4 stages; It is saying what you have heard. Who did you invite to join us today M?
	M:	My sister, Nicky, My mother and my brother, Brandon
	G:	Are all of them familiar with Sneakers?
	M:	Yes
	G:	So may I speak about Sneakers?
	M:	Yes
	G:	So we can tell them about Sneakers, I first want to consult with you and then, tell them about Sneakers tricks, tell them about Michaels plan, OK, and then How you gave advice on the internet. Is it Okay if we discuss that with them?
	M:	Yes
	G:	And maybe why it is important for you to Outsmart Sneakers, Is that Okay, Do you give me permission to discuss that with them?
	M:	Yes
	G:	We will then have a ceremony at the end of the day, are you fine with that?
	M:	Yes
	G:	Thank you for coming, we had a good time together, If you want to come back next year your mom can make an appointment with the secretary.
	M:	Ok
	G:	Last week was such a tremendous session when you told me "I flew away from Sneakers, Do you see yourself as the winner?
	M:	Yes

	G:	How often did Sneakers visit this week?
	M:	He did not come this week.
	G:	That is fantastic! So for the first time you have outsmarted him, What do think has enabled you to give his final blow?
	M:	Last week I took everything back that he has stolen from me.
	G:	So was it our session of last week?
	M:	Yes
	G:	So you spoke continuously to him, not forgetting his plan.
	M:	I watched out for him especially last night, because I know he like surprising me before I come to you.
	G:	Yes that is part of his plan, So you know his tricks now, No wonder you look so self-assured today that is great M. I am thrilled.
	G:	Let us just move the chairs so we can get everyone in. I need to check the camera and get your family.
		M's family enters with G – the little brother is also part of the reflecting team.
	G:	Maybe we can get the little one some toys, Come boy here we have some things for you to play with.
	G:	You all may have a seat.
	G:	Firstly I would like to welcome you to this session, it is really an important session for Michael, as you all know Michael have been coming here for the past 5 weeks and we have quite a victory and we would like people that are important to him to share this victory with him and that is why he have decided to invite you along today.
	G:	I am going to explain the format of the session, we are on video today, is that ok with everyone?
	Mrs J:	It is fine
	G:	And what about you Nicky and Brandon?
	Nicky:	No problem.
	Brandon:	The same here.
	G:	We do use this information for research purposes.
	G:	I must truly tell you that I am very proud of Michael, He has made a lot of progress, as you know Mrs J you have walked a long journey with Michael and this really is big for him. What we are going to do today is that on the board I would just like to say congratulations to Michael.
	G:	Michael and I are going to talk for the following five minutes while you listen, our time is a bit short today, but there are just a few things that he has given me permission to discuss with you, because whatever we discuss is confidential.
	G:	After that, you will change places and you will discuss what you have heard we say.
		I put a few points are on the board, so when the two of us talk look at what you have heard, what did it say about Michael's purposes, his hopes dreams and commitments, so what ever we have talked about you can say what have connected with you as a brother, mother and sister?
	G:	Okay

	G:	Then we are going back then Michael and I will say what we have heard you speak about and at the end, all of us will talk together, but I will go through the process with you, you do not have to worry.
	G:	Just relax and sit back, May I get all the names; It is Nicky, Brandon, mom, and the little boy – What is your name?
	Little boy:	Peter
	G:	Welcome here today Peter, Are you Okay today, do you know where you are today?
	Omar:	No
	G:	In Stellenbosch
	G:	It is very far from Belhar,
	Omar:	I came with the bakkie
	G:	You are a clever little boy; I think you must go to school.
	Omar:	No
	G:	Is it too nice at home, I think that mother spoils you.
	G:	M we are going to start now, you know the past sessions we spoke about Sneakers, Do you maybe want to tell them who Sneakers is and why did you name him Sneakers?
	M:	I named him Sneakers because he sneaks around, do you understand what I am saying.
	G:	I want you to speak to me, make as if they are not there. Ok M we have spoken about Sneakers tricks, do you maybe want to tell them about Sneakers tricks?
	G:	What does he do Michael?
	M:	He makes as if he is not coming and then he comes, he surprises me.
	G:	Do you maybe want to tell me how you outsmarted Sneakers, What did you do?
	G:	Your score last week was 24 out 28 and Sneakers only scored 4 out of 28. So you won him, what did you do, Michael?
	M:	I told myself that I am the boss, I am the man.
	G:	Did you here that, I think you should really speak a little bit louder.
	M:	I told myself that I am the boss and not Sneakers.
	G:	What did this say about you Michael?
	M:	That I did not allow Sneakers to dictate to me, For too long he has ruined my life. It is over now. He has embarrassed me enough.
	G:	What did you do, How did you manage it?
	M:	By believing that I can do it, I went to the toilet at night and did not drink such a lot before I went to bed.
	G:	You also gave someone advice on the internet, tell me how did that make you feel about that, giving advice to someone with a similar problem.
	M:	I felt like I am a champion.
	G:	You felt like a champion, Michael why was important for you to outsmart S?
	M:	Every time that S come I feel dirty in the morning,

	G:	What about yourself?
	G:	I can remember in the first session you said that you want to get rid of him, so that means that it is a decision that made for yourself.
	M:	Yes
	G:	What did you learn and what was powerful for you, How did you do it right to outsmart this guy? When did you have a victory over Sneakers?
	M:	Last week
	G:	What happened last week that was significant?
	M:	The part that I said I flew away from him.
	G:	Did you think about the session when you left and what did you think about?
	M:	I thought to myself on my way home that I am free, free from Sneakers and all the thing that he caused in my life.
	G:	So the victory came in last week's session, Do you think that your team can help you? And if what can they do?
	M:	Wake me up at night.
	G:	Is it supporting you Michael?
	M:	Yes, but they need to remember that I am in charge.
	G:	Now we are going to give the team a chance to say what you have heard.
		The Family switches places with G and M
	G:	I will make notes as you talk, so the 3 of you will talk with each other.
	Brandon:	They actually talked about Sneakers and how Michael wants to get rid of the problem.
	Nicky:	He also asked us to wake him up at night,
	Mrs J:	I must say that Michael feels very good when Sneakers did not come. I have seen a definite change in him in the mornings.
	Brandon:	I think it is even better if Sneakers do not come because it leaves my room smelly.
	Nicky:	And in the morning I am not late anymore , so if Sneakers don't come I am not late for school
	Mrs J:	I think he is finally coming over Sneakers now.
	Nicky:	Yes, I think it is a good victory, he said that he is the boss now and that he is rid of Sneakers.
	Mrs J:	Yes
	Mrs J:	I think one of his main dreams and hopes are to overcome Sneakers.
	Nicky:	I think it is high time now, because he is in Std 6. This thing has caused a lot of embarrassment.
	Mrs J:	With Allah's help, yes he will overcome Sneakers.
	Brandon:	I will try to wake him up to go to the bathroom.
	Nicky:	I will wake him up at night.
	G:	maybe you can just elaborate on Michael's dreams, What does it say about Michael?
	Nicky:	Michael was always like that, He could do anything that he wanted to do, if he really wants to do it he can, he will come

over it.

Brandon: He was always shy at times to talk about this Sneakers business, but I think that he is showing that he is overcoming it now.

Mrs J: I think his self –esteem is rising too, and his entrepreneurship his also increasing. His entrepreneurship is also working out better for him.

Nicky: Yes

G: Is there anything else that you want to discuss?

Nicky: I am Proud of you man!

Mrs J: He actually loves coming here every week.

Brandon: I hope he makes a success of this Sneakers, get rid of it finally.

Mrs J: I think he will, because the time that he through the balloon out of the bakkie he said I want to get rid of you. Just go! Just go!

Mrs J: Sneakers is gone, I know it.

G: Is that it, anything else.

G: Maybe we can just switch again.

G: M this people said such a lot of things now, I do not know if I can remember everything

M: Must I say what they have said?

G: What did you hear here today Michael? What stood out for you? What message came out very strong?

M: Brandon said that I use to be shy, but now I show that I want to get rid of Sneakers.

G: Anything else, Nicky said something very powerful that I can remember, What stood out for you that Nicky said?

G: She said that you were brave and that you could do it if you wanted to, Do you agree with her? And what did your mother say?

M: She said that my self-esteem was rising.

G: It is so amazing that she mentions it, because right at the beginning the first session we spoke about this low self-esteem affects your life. The word self –esteem. It seems to be that the gain was enormous for you Michael, not only is Sneakers out of the way, but you are more confident and your entrepreneurship is rising.

G: I would like to say that when I saw you coming in today, I could see a confident young man, you exuberated self-confidence. When you came for the first session you did not want to be here or look me in the eye, you sat like this, but now you are up with these nice sunglasses, looking confidently at me, and that speaks of competence.

G: How are they going to support you, both of them will try and wake you, Nicky will not be late any longer, your mother said that it is a great victory, She mentioned that you wanted to celebrate this, but unfortunately you are fasting, but maybe after the fasting.

Mrs J: Inshalah

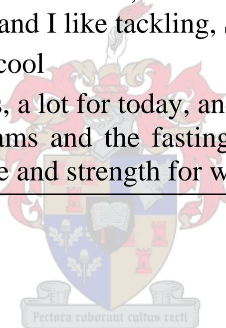
G: And the entrepreneurship is working out for you.

G: And you love coming here that was a nice compliment to me.

G: You know what struck a chord to me was when your mother

		said that you let Sneakers out of the bakkie, and that you really want him out of your life. That's speaks of determination. I think that we really have a success story here wherever they get your e-mail that they will be able to use your advice.
	G:	I will send you a copy of the e-mail that I send to you. Now all of us are going to speak together. We are going to wrap it up. Mrs J how do you feel about everything at this stage?
	Mrs J:	I think it is very good seeing that we have done everything from year to year day to day, I think it is very good we have tried everything, medication just nothing seemed to help, and this is like really is getting to an end now.
	G:	The victory is there, I explained to him that Sneakers may still try his tricks, and if he gets it right sometimes it is not failure, He has a plan, We know that on the day before he comes to me Sneakers visits him. But he knows Sneakers tricks, we made a little card the last time and I asked him to put it up on his wall, so that can always be aware of Sneakers tricks.
	G:	Nicky is there anything that you want to say.
	G:	What grade are you in?
	A:	Grade 11
	G:	You are almost in matric, I am sure you cannot wait.
	Mrs J:	Inshalah.
	Nicky:	Well his marks at school is rising, he use to get 4and 5 out of 10, but now it is 8 and 9 and it is rising.
	G:	It is amazing Nicky, You can see the change at school and at home.
	A:	We have a better connection with each other now.
	G:	Both of you have a better relationship now.
	Brandon:	All that I can say is that we share a room together and in the morning my mother screams *"Het jy al weer in die kooi gepee"* So, the scream is annoying, But I am surprised Sneakers did not come like he use to come. So no more screaming from my mother in the morning.
	G:	So you could also see the difference here.
	Brandon:	Normally he lies till late in his bed, But now he is up and about earlier, I am actually glad for that,
	G:	So you say that all of you will be able to support him in this. But on the other hand Sneakers might sneak back, but I know that Michael have a team to help him keep Sneakers away now, You are on his team now to help him, Sneakers will know that are 3 plus Peter to watch out for him, Okay.
	G:	At this stage we are going to have a ceremony, I have something that I would like to hand over to Michael.
	G:	M, you may rise to the occasion, I have a certificate here for you and it says it is a certificate of significant achievement awarded to Michael for Outsmarting Sneakers, I would like to congratulate you, It was not me, I did not use a magic wand, It was what you did in the session when you came to me, So congratulations.
	G:	You have 3 people on your team to help you. They are there to support you. Congratulations, May I congratulate you.

	M:	Yes
	G:	Don't we get applause here.
	G:	Mrs J if Michael wants to come back you can phone the secretary we are closing down, feel free to come back if you need to. This was very short; I think we did what we had to.
		Last week was amazing; it is about taking control of Sneakers I would like to honour you as a family for supporting Michael in his journey with Sneakers. Thank you, I was moved by our session here today and I am hopeful for the future because I have learned here today that families still support each other.
	G:	Anything that you want to tell your team, Michael?
	M:	You are my team and I am the boss.
	G:	Thank you for coming and the sacrifice that you have made, We are a team now.
	Mrs J:	Thank you for your time and patience
	G:	Thank you Michael, This is closure for us we worked for 5 sessions every Wednesday. Good Luck for the exams.
	Mrs J:	I just want to say to Michael that it does not matter if Sneakers comes; I still love him and allot. So now, with Sneakers out of the way, There are more room for everything else.
	Brandon:	If he comes back, he must just be notified that I am a rugby player and I like tackling, So he must watch it.
	G:	That's cool
	G:	Thanks, a lot for today, and I really appreciate it, good luck with the exams and the fasting, I admire you, because it speaks of courage and strength for what you believe in.



EXAMPLE OF RECORD OF STORIES AND MEANINGS

STORIES	MEANINGS IN STORIES
Problem-saturated story	Labelling
Externalising of the problem	Incompetence
Unique outcomes	Embarrassment
Preferred alternative story	Low self-esteem
	Anger
	Frustration
	Inferiority
	In control
	Shame
	Despair
	Worthlessness
	Courage
	Competence
	Perseverance
	Hope
	Blame
	Confidence
	Determination
	Brave
	Self-esteem
	The bedwetting
	Dreams and hopes

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