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BRIEF REPORT

A Pilot Examination of the Use of Narrative Therapy With Individuals Diagnosed With PTSD

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Narrative therapy is a postmodern, collaborative therapy approach based on the elaboration of personal narratives for lived experiences. Many aspects of narrative therapy suggest it may have great potential for helping people who are negatively affected by traumatic experiences, including those diagnosed with posttraumatic stress disorder (PTSD). The potential notwithstanding, narrative therapy is relatively untested in any population, and has yet to receive empirical support for treatment among survivors of trauma. A pilot investigation of the use of narrative therapy with 14 veterans with a diagnosis of PTSD (11 treatment completers) is described. Participants completed structured diagnostic interviews and self-report assessments of symptoms prior to and following 11 to 12 sessions of narrative therapy. After treatment, 3 of 11 treatment completers no longer met criteria for PTSD and 7 of 11 had clinically significant decreases in PTSD symptoms as measured by the Clinician Administered PTSD Scale. Pre- to posttreatment effect sizes on outcomes ranged from 0.57 to 0.88. These preliminary results, in conjunction with low rates of treatment dropout (21.4%) and a high level of reported satisfaction with the treatment, suggest that further study of narrative therapy is warranted as a potential alternative to existing treatments for PTSD.

Narrative therapy refers to a set of techniques developed using the ideas of Michael White and David Epston (White & Epston, 1990) that has been proposed as a treatment approach for working with survivors of trauma (e.g., White, 2004, 2005). These approaches were recently synthesized in a treatment manual that organizes therapy for trauma survivors around nine core principles (Stillman, 2010). Narrative therapy is a postmodern, flexible, and individualized approach, but it does contain specific principles for practice that may be amenable to consistent training, application, and evaluation.

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In narrative therapy, interpersonally constructed narratives (defined as a series of events organized in sequence over time according to a plot or theme; White & Epston, 1990) are viewed as the central mechanism for interpreting, experiencing, and interacting with the world. Trauma is seen as leading to narratives that are overly negative, threatening, and isolated from a person's wider set of past and current experiences (i.e., focused on trauma-related themes and events to the exclusion of all else), thus leading to distress and, among other things, symptoms of posttraumatic stress disorder (PTSD). Narrative therapy provides collaborative conversations between the therapist and client that explicate trauma-influenced narratives, examine alternative means (i.e., narratives) of interpreting past and present events that are less likely to lead to distress and impairment, and encourage experiences and actions that are consistent with these newer narratives and inconsistent with the trauma-influenced narratives.

In each session, clients may choose to focus on discussions of (a) aspects of the client's life that stand in contrast to, or opposed to, traumatic events and their effects; (b) the effects of trauma on the client's life and the client's responses to such effects; or (c) the traumatic events themselves. Therapy sessions are guided by the nine core principles of narrative therapy

(Stillman, 2010) which include (a) repositioning (identifying and developing events, people, and initiatives in a client's life that are outside of the effects of the trauma), (b) intentionality (examining and developing personal values, decisions, and initiatives), (c) identity proclamation (examining trauma and alternative narratives from an interpersonal context), (d) position of the interviewer (viewing the client as the expert in their own life and experiences, viewing the therapist as a collaborator but not leader or director), (e) personal agency (identifying and respecting explicit decisions made by the client in all contexts), (f) externalization (viewing problems as explicitly outside of the person confronted by them, as a means of enhancing agency, exploration, and action), (g) absent but implicit (examining contexts for decisions and judgments, such as reasons that events are judged as unacceptable or painful), (h) narrative metaphor (viewing all experience as interpreted through narrative, and examining such narratives throughout the conversation), and (i) deconstruction (critically examining the origins and influences of problem-dominated narratives from personal and cultural perspectives).

Current treatment approaches for PTSD have been shown to be very efficacious, but have not been found to be universally effective or acceptable (Bradley, Green, Russ, Dutra, & Westen, 2005). If narrative therapy can be shown to improve PTSD symptoms, it may offer a useful alternative to existing well-established trauma-focused interventions. In the present study, we conducted a pilot investigation of narrative therapy as a treatment for PTSD using a pre- and posttreatment design among a group of veterans seeking treatment for chronic PTSD in an outpatient hospital setting.

Method

Participants and Procedure

Participants were referred for a treatment study from the outpatient mental health service of a large Veterans Affairs Medical Center and were required to have a diagnosis of PTSD, be stable on any psychiatric medications for 3 months, and not have active psychosis or mania, high levels of risk for suicide or violence, or active substance dependence. Due to hospital rules regarding evidence-based treatments, all referrals had been offered, and refused, a course of either prolonged exposure or cognitive processing therapy prior to their referral to this study. Of 19 referrals, 4 did not pass chart review (based on recent medication change, elevated risk for suicide, or psychotic symptoms), 1 did not have PTSD based on structured clinical interview, and 14 met criteria for inclusion and were enrolled. Of the 14 participants, 3 were African American and the remaining 11 were Caucasian; 5 were married, 2 remarried, 5 divorced, and 2 single. Ten participants had served during the Vietnam era, 2 during the recent wars in Iraq or Afghanistan, and 2 during the Gulf war. Ages ranged from 23 to 66 years, with a mean age of 55.21 years ($SD = 13.75$). On the Clinician Administered PTSD Scale (CAPS; Blake et al., 1995), all but one participant reported combat trauma; two also reported trauma involving motor vehicle accidents, two reported childhood abuse, three reported assaults occurring outside of the military, and two reported natural disasters. Every participant reported at least one traumatic event occurring in the military. All participants provided informed consent as stipulated by the Minneapolis VA Healthcare System Institutional Review Board.

Four clinicians were recruited from mental health staff at the Minneapolis VA Medical Center Mental Health Service and included two doctoral-level licensed psychologists with 10 or more years of clinical experience each and two licensed independent social workers with 3 or more years of experience each. Therapists were trained by the second author (JS) over 6 days and biweekly supervision was provided. Treatment consisted of 12 sessions of narrative therapy of 1-hour duration over the course of approximately 3 months (one client chose to end treatment after 11 sessions due to life circumstances). Typically, sessions were weekly, but in one case sessions occurred on an average of every other week due to limitations in the client's schedule (in this case, treatment occurred over the course of 6 months). All sessions were videotaped and a random 10-minute segment of each session was coded using the Narrative Therapy Adherence Rating Scale (Stillman, 2010) by two master's-level raters who were trained by JS.

Independent evaluations were completed using the CAPS to establish eligibility and obtain indices of symptom severity before and after therapy by two master's-level project assistants who were trained in the instrument by the first author (CE). Efforts were made to schedule posttherapy evaluations within 4 weeks of termination of therapy, and evaluations took place between 6 and 57 days following the final session (all but two were completed within 21 days; $Mdn = 16.5$). In addition to clinical interviews, participants completed self-report measures of functioning (PTSD Checklist-Military Version, Weathers, Litz, Herman, Huska, & Keane, 1993; Beck Depression Inventory-II, Beck, Steer, & Brown, 1996) pre- and posttreatment as well as the Client Evaluation of Services Scale (Nguyen, Attkisson, & Stegner, 1983) posttreatment.

Measures

The CAPS (Blake et al., 1995) was the primary outcome measure, and the means for establishing a PTSD diagnosis according to the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., *DSM-IV*; American Psychiatric Association, 1994) for inclusion in this study. The CAPS has established reliability and validity and provides both a diagnostic classification for PTSD (based on the 1 frequency/2 severity scoring rule) and a total severity score ranging from 0 to 136 based on a semistructured clinical interview. Interrater reliability, based on independent ratings of a random set of 8 of the total of 25 videotaped CAPS interviews in the study, was found to be high (intraclass correlation coefficient [*ICC*] = .98, .97 for frequency and intensity ratings, respectively).

The PTSD Checklist-Military Version (PCL-M; Weathers, Litz, Herman, Huska, & Keane, 1993) is a self-report measure of PTSD symptoms that provides a symptom severity score ranging from 17 to 85 based on ratings for each of the 17 symptoms of PTSD. Internal consistency for the measure was high in the study sample ($\alpha = .89$).

The Beck Depression Inventory-II (BDI-II; Beck, Steer, & Brown, 1996) is a widely used self-report measure of depressive symptoms that provides a total score reflecting level of depression ranging from 0 to 63 (study sample $\alpha = .93$).

The Client Evaluation of Services Scale (Nguyen, Attkisson, & Stegner, 1983) is a widely used measure of satisfaction with well-established reliability and validity data. It has eight items and scores range from 8 to 32 with higher scores indicating more satisfaction (study sample $\alpha = .84$).

The Narrative Therapy Adherence Ratings Scale (Stillman, 2010), developed for this study, is an observer rating system for evaluating the presence of techniques that are consistent or inconsistent with narrative therapy. Coders observed 10-minute segments of each therapy session. For each segment, the presence of techniques consistent with each of the nine specific principles was rated on a scale of 0 = *not present* to 3 = *present throughout the segment*. The scale provides descriptions and sample techniques for each principle. Four summary categories were separately rated on the same 0–3 scale: Narrative Metaphor, Positioning (including Position of the Interviewer, Externalization, and Personal Agency), Subordinate Story Development (including Repositioning, Absent but Implicit, and Intentionality), and Deconstruction (including Identity Proclamation and Deconstruction). In addition, raters coded the presence of narrative therapy–inconsistent behavior, coded as the converse of each principle (descriptions and examples were again provided for each). For example, an overly directive stance on the part of the therapist would result in a higher score on Position of the Interviewer–inconsistent behaviors. Narrative therapy–inconsistent ratings were again made with a score of 0 = *not present* to 3 = *present throughout the segment*. As not all principles are relevant for every segment of a therapy session, it was expected that some principles would be rated higher than others, but that all would be present at least part of the time, and that narrative therapy–inconsistent behaviors would be very rare. The *ICC* for evaluating interrater reliability for the adherence scale, as assessed in a subset of 13 session ratings that were double-coded, was .69.

Data Analysis

Therapist adherence was examined with mean values for the Narrative Therapy Adherence Rating Scale. Acceptability of therapy was examined with rates of treatment dropout and mean scores on the Client Evaluation of Services Scale. Pre- to post-therapy changes in PTSD and depressive symptoms were explored with within-group *t* tests, using Cohen's *d* as a measure of effect size.

Results

Mean adherence ratings on the Narrative Therapy Adherence Rating Scale across sessions and clients were calculated for all four therapists. Ratings on the broad summary categories ranged from 2.31 to 3.00 for use of the Narrative Metaphor ($M = 2.79$, $SD = 0.56$), 1.77 to 2.74 for Positioning ($M = 2.25$, $SD = 0.86$), 0.69 to 1.27 for Subordinate Story Development ($M = 1.15$, $SD = 0.67$), and 0.42 to 1.25 for Deconstruction ($M = 1.03$, $SD = 0.80$). Ratings of principle–inconsistent interactions across all principles were low, and were at 0 for all principles except Position of the Interviewer ($M = 0.11$, $SD = 0.37$) and Personal Agency ($M = 0.01$, $SD = 0.10$).

Acceptability of the therapy was assessed through examination of retention in the treatment and responses to questionnaires assessing treatment satisfaction. Rates of dropout were low (three cases of 14 who initiated care) and at 21.4% were comparable to those seen in other treatment studies for PTSD (Imel, Laska, Jakupcak, & Simpson, 2013). Scores on the Client Evaluation of Services Scale, measuring therapy satisfaction, ranged from 23 to 32 with a mean score of 26.82 ($SD = 2.93$). This value compares favorably to values reported in large outpatient treatment samples (e.g., Loh et al., 2007; Nguyen et al., 1983).

There was a statistically significant mean reduction in total CAPS symptom severity scores from a pretreatment mean of 76.27 to a posttreatment mean of 57.82. This change of 18.45 represents a 24.2% reduction in mean symptoms, $t(10) = 3.43$, $p = .006$, $d = 0.88$, representing a large effect size. Prior studies (e.g., Schnurr et al., 2003) have established that a drop of 10–12 points is a clinically significant reduction of symptoms on the CAPS. Based on this criterion, seven of 11 treatment completers (three of whom no longer met criteria for PTSD) exhibited a clinically significant drop in PTSD symptoms. There were also statistically significant reductions in PCL scores, from 69.64 ($SD = 9.86$) to 63.11 ($SD = 12.38$) $M_{\Delta} = 6.53$, $t(10) = 2.58$, $p = .027$, $d = 0.58$, a medium size effect and 9.4% overall reduction. There was also reduction in BDI-II scores, from 36.09 ($SD = 13.49$) to 27.50 ($SD = 12.42$) $M_{\Delta} = 8.59$, $t(10) = 4.27$, $p = .002$, $d = 0.66$, a medium size effect and 23.8% overall reduction.

Discussion

Narrative therapy is a therapeutic approach that appears to have potential as a brief treatment for those confronted by the negative effects of trauma. Narrative therapy is flexible, client-centered, active, and dedicated to developing those aspects of client's identities and lives that are separate from their past experiences and the problems that they currently face. This study is intended as a first step in empirically evaluating narrative therapy.

Results from this pilot study are promising, in that they demonstrate changes from before to after treatment on measures of PTSD symptoms that are clinically significant in seven

out of 11 treatment completers. Mean levels on the posttreatment PCL and BDI as well as the fact that only three participants no longer met criteria for PTSD suggests that several treatment completers, though improved, still showed ongoing symptoms of PTSD. Acceptability of the treatment is suggested by high rates of satisfaction and retention rates that were comparable with other therapeutic approaches in this area (Imel et al., 2013). The pre- to posttreatment effect size on the CAPS ($d = 0.88$) was comparable to effect sizes for other clinical trials with this population. Bradley and colleagues (2005) conducted a meta-analysis of treatment outcome studies for PTSD and reported a mean effect size of 0.81 from pre- to posttreatment in combat trauma samples receiving treatment for PTSD.

One distinctive feature of narrative therapy when working with negative effects of trauma is the lack of a requirement for recounting the traumatic event (i.e., exposure to trauma memories). Although narrative therapy does offer guidelines for how to usefully engage a client in a discussion of specific traumatic events if the client is willing to do so, it does not mandate that this take place at any given point in the therapy, or at all. It is interesting to note, however, that although few participants chose to discuss their traumatic events with the focus, intensity, and frequency of other structured trauma-focused treatment approaches, all of the participants did disclose traumatic events in at least one session. Study therapists reported that clients chose to discuss traumatic events between one and eight sessions, typically for 10–20 minutes per session. Ongoing evaluation of more rigorous trials is needed to evaluate what role these varying levels of exposure may play in predicting treatment outcomes. The fact that participants in the present study had refused well-established empirically supported treatments for PTSD prior to enrolling suggests that narrative therapy may, if it is shown to have efficacy in more extensive trials, provide an alternative treatment for those who struggle to engage in current state-of-the-science treatments.

Further work utilizing randomized assignment to comparison groups will be needed before efficacy can be evaluated, as the current design does not allow the conclusion that observed change is due specifically to narrative therapy as opposed to general therapy factors or even the passage of time. Results cannot be generalized beyond the distinct population of veteran participants seen in the current study. Additional information on outcomes and predictors, including especially comorbidity with other disorders, is needed. Further evaluation of narrative therapy will also require a more reliable means of evaluating therapist adherence, as the reliability of the present iteration of the Narrative Therapy Adherence Rating Scale was only modest. This pilot study did not investigate long-term retention of treatment gains (e.g., from 3- or 6-month follow-up evaluations) and this remains another important question for future work.

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