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Brief Report

A Preliminary Report on the Use of the Narrative Approach for Childhood Mental Health Problems

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ABSTRACT
Aim: To examine the feasibility of using the narrative approach for managing childhood mental health problems. **Methods:** The sample consisted of 10 children aged 9-12 years, who were rated as having problems on the Strengths and Difficulties Questionnaire (Teacher version), of which 5 were in the experimental and 5 in the control group. The experimental group received a 10-session package based on the narrative approach. Both groups were assessed using the Strengths and Difficulties Questionnaire, Pictorial Instrument for Children and Adolescents, Children's Global Assessment Scale and an open interview pre and post therapy. **Results:** A reduction in the problem behaviors of the children was noted, both on teacher and self-report and an improvement in global functioning occurred. **Conclusions:** Narrative approach may add to the armamentarium to manage childhood mental health problem.
Keywords: Narrative approach, childhood problems

INTRODUCTION
Psychological problems are highly prevalent in children in the school setting, and they have significant implications for the children's everyday and long-term functioning. A broad spectrum of problems might be of concern to students, ranging from mild difficulties in adjusting to a new school to serious psychiatric/ developmental disorders. The problem category most frequently cited by schools, for both boys and girls across all school levels is 'social, interpersonal, or family problems.' The second and third most frequent problems for boys are aggression or disruptive behavior; and for girls, anxiety and adjustment issues.[1] The prevalence rates of behavior and emotional problems in Indian school settings vary between 10.5% to 50.6%.[2-4]

Narrative therapy seeks to be a respectful, non-blaming approach to intervention, which centres people as the experts in their own lives. It views problems as separate from people and assumes people have many skills, competencies, beliefs, values, commitments and abilities that will assist them to reduce the influence of problems in their lives.[5] Narrative therapy is sometimes known as involving 're-authoring' or 're-storying' conversations.[6] Playful approaches in narrative therapy direct the focus away from the child as a problem and onto the child-problem relationship. Children's sense of effectiveness as agents of change clearly increases when they experiment with possibilities in relationship to a problem[5].

The narrative has often been used to understand the child's internal world;[7] however, narrative therapy itself is a relatively recently researched form of therapy.[5,8] The extant research which has mainly used a case-based approach looks into the methods,

targeted domains, the developmental fit of the therapy demands, and the utility of narrative therapy in managing clinical conditions. Validity of the narrative metaphor is suggested by studies conducted on other forms of psychotherapy.[9,10] The investigator has not come across any studies using this approach in the Indian setting. The current pilot study was conducted to evaluate the feasibility of carrying out a narrative based intervention in the school setting.

METHOD

Sample: The study was conducted in the Kannada medium section of a government aided coeducation school catering to the lower socioeconomic strata. The Strengths and Difficulties Questionnaire (SDQ) - Teacher's Version[11] was administered to 70 randomly selected children in the school and children in the borderline or case categories were considered for inclusion. Children with mental retardation or chronic physical illnesses; those on medication or psychological interventions for mental conditions; and those from single parent families or orphanages were excluded from the study. Among children meeting the selection criteria, the 10 with the highest scores on SDQ were assigned to the experimental or control groups (5 children each). These children were aged between 9 and 12 years and were studying in classes 4 to 7.

Assessment: Pre-assessment measures included a semi-structured interview with the parent to obtain demographic and background details; the child's account of the problems with Pictorial Instrument for Children and Adolescents (PICA)[12] and a clinical interview; and the clinician's rating on the Children's Global Assessment Scale[13]. Additionally, the children in the experimental group were administered the Self-interview[14] to assess their self-concept. The PICA is a semi-structured interview with 137 pictures. The content of each picture is simple, schematic and neutral and refers to a single DSM-III-R criterion. The pictures encompass emotions, behavior, thought content and thought process. The study-specific interview was designed to elicit information about the nature and magnitude of the problem, the extent of interference caused by it in everyday activities, and the child's reactions to and efforts at coping with the problem. The assessments with the children were conducted in the local language. The Self-interview is designed to reflect the child's own representation of himself/herself. Post intervention assessment included the SDQ teacher's version, PICA, the study-specific interview for children and the CGAS.

Description of narrative therapy: The narrative therapy was based on the narrative approach described by White and Epston[15], who emphasized externalization, acknowledgement of a new self-description and reauthoring a new narrative; and Wiest et al[10] who emphasized externalization, influencing questions, art and play metaphors and written texts. These approaches was augmented by methods described by other authors;[5,8,16-19] in particular cultural and developmental issues in narrative methods were incorporated.[17,18] These concepts were introduced to the child through the use of dolls, puppets, art work, drama, stories and letters. Art and play metaphors were used depending on the child's developmental stage as well as their individual preference. Influencing questions were used to strengthen the non dominant story. Writing was used either in the form of letters or stories for all children, as articulation of all the components of the story sequentially served to bring up issues which were otherwise untouched and to crystallize the alternative narrative for the child. The initial phase of therapy (sessions1-3) focused on clarifying the nature of the problem,

externalizing it as an entity separate from the child and preparing the child to make an effort to overcome it. The mid phase of therapy (sessions 4-7) focused on actually confronting the problem and evolving means of coping with it. The final phase (sessions 8-10) focused on reiterating the gains made and means of overcoming the problem in future. Identified children with problems who were not provided narrative therapy, were seen briefly or referred to other services as per individual requirement. The intervention was provided to the children in the experimental group individually over 10 sessions held at weekly intervals by the investigator.

RESULTS

The pre and post assessment scores (Table 1) indicates that there was a decline in teacher-reported problems in all cases in the experimental group. The child's own rating of the intensity of the problem had also come down in 4 cases and competence to deal with it has increased in all cases. The global functioning of the child as rated by the clinician had improved in 4 cases. The control group did not evidence similar changes.

Table 1: Comparison of pre- and post-therapy scores of the experimental and control group children

		Child 1		Child 2		Child 3		Child 4		Child 5	
		Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Experimental group	SDQ (T)	18	8	21	12	19	8	24	15	23	11
	PICA	209	45	116	12	44	33	94	99	97	28
	Competence	2	7	1	6	3	6	5	8	2	7
	CGAS	62	78	68	76	72	82	60	60	68	76
Control group	SDQ (T)	22	21	23	23	18	17	20	20	23	24
	PICA	68	70	61	60	50	48	87	85	35	35
	Competence	3	3	4	4	2	3	2	2	4	4
	CGAS	68	66	71	72	66	69	65	66	72	74

DISCUSSION

Earlier studies show that the prevalence of mental health problems in normal school going population is high and they affect children's everyday functioning. However, indicators of difficulties in adjustment can easily be overlooked as normal problems of school going children. These behavioral and emotional indicators of mental problems can be identified by teachers through use of brief screening instruments. The present study indicates that narrative therapy can be usefully employed in school going children before they require clinical attention. The approach strengthens the child's own resources in dealing with the normative stress of development. This has important implications for schools, particularly those catering to children from deprived backgrounds with limited access to mental health professionals.

The results of this pilot study seems to be in line with the core belief of narrative therapy that people have the skills and competencies to reduce the impact of the problem on their lives. Given the importance of stories in the Indian cultural context and folklore, the narrative in this study appears to have served both an educative function as well as an opportunity to try out alternatives in the safe confines of the child's own imagination. Miller et al have emphasized the role of culture in determining the function served by the narrative in any population.[17] The narrative approach also involves 'restorying' conversations which is developmentally appropriate for children.

In conclusion, the results of this pilot study suggest that narrative approach may be useful for addressing the mental health needs of the school going population. Further

studies on larger samples are however necessary to substantiate the efficacy of the narrative approach for childhood problems in the Indian setting. Qualitative analysis along with case descriptions would be useful to understand the approach better.

REFERENCES

1. Teich JL, Robinson G, Weist MD. What kinds of mental health services do public schools in the United States provide? Adv School Mental Health Prom 2007; 1:13-22.
2. Dalal M, Kapur M, Subbakrishna D. Prevalence and pattern of psychological disturbance in school going adolescent girls. Indian J Clin Psychol 1990; 17:83-88.
3. Sarkar A. Prevalence and pattern of psychological disturbance in 8-11 year old school going children. Unpublished M.Phil dissertation. Bangalore: Bangalore University; 1999.
4. Shenoy J, Kapur M, Kalaiperumal VG. Psychological disturbance among 5-8 year old school going children – A study from India. Soc Psychol Psychiatr Epidemiol 1998; 33:66-73.
5. Freeman J, Epston D, Lobovits D. Playful Approaches to Serious Problems. New York: WW Norton & Company; 1997.
6. Zimmerman JL, Dickerson VC. Using a narrative metaphor: implications for theory and clinical practice. Fam Process 1994; 33:233-245.
7. Wang Q, Leichtman D. Same beginnings, different stories: a comparison of American and Chinese children's narratives. Child Dev 2000; 71:1329-1346.
8. Smith C, Nylund D (Ed). Narrative Therapies with Children and Adolescents. New York: Guilford Press; 1997.
9. Lichenstein T, Baruch R. "I was born from the earth:" reconstructing the adoption self-narrative in the treatment of a preadolescent girl. Fam Society 1996; 77:90-97.
10. Wiest DJ, Wong EH, Brotherton S, Cervantes JM. Postmodern counseling: using narrative approaches in the school setting. Fam Ther 2001; 28:1-17.
11. Goodman R. The Strengths and Difficulties Questionnaire: A research note. J Child Psychol Psychiatry 1999; 38:581-586.
12. Ernst M, Cookus BA, Moravec BC. Pictorial Instrument for Children and Adolescents (PICA-III-R). J Am Acad Child Adolesc Psychiatry 2000; 39:94-99.
13. Shaffer D, Gould MS, Brasic J, Ambrosini P, Fisher P, Bird H, et al. A Children's Global Assessment Scale (CGAS). Arch Gen Psychiatry 1983; 40:1228-1231.
14. Cassidy J. Child-mother attachment and the self in six-year-olds. Child Dev 1988; 59:121-134.
15. White M, Epston D. Narrative Means to Therapeutic Ends. New York: Norton; 1990.
16. Weist MD, Murray M. Advancing school mental health promotion globally. Adv School Mental Health Prom 2007; 1: 2-12.
17. Miller PJ, Wiley AR, Fung H, Liang C. Personal storytelling as a medium of socialization in Chinese and American families. Child Dev 1997; 68:557-568.
18. Strand PS. Clinical theory and practice. Expanding narrative therapy. Fam Process 1997; 36:325-339.
19. Keeling ML, Bermudez L. Externalizing problems through art and writing: experience of process and helpfulness. J Marital Fam Ther 2006; 32:405-419.

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