



# Narrative practice and peer support

by Hamilton Kennedy



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## Abstract

In 2018, Hamilton was working in a youth psychiatric hospital as a peer-support worker and studying narrative therapy. Having initially trained in intentional peer support (IPS), Hamilton began to incorporate narrative ideas into their work. This paper offers an exploration and some stories of this process. It recounts the strengths and challenges of combining a peer approach with narrative practice. Combining narrative practice with a peer approach provided new opportunities for resisting totalising narratives of 'illness', working towards achieving meaningful lives, and reconnecting with people and relationships.

**Key words:** *intentional peer support; peer support; narrative practice; mental health*

Trying anything new in one's work can be challenging. But combining ideas from different fields can also be exciting. As a peer-support worker employing an intentional peer support (IPS) orientation (see Mead, 2014), I started learning about narrative therapy. I noticed many similarities and points of resonance between these two fields.

Intentional Peer Support is a way of thinking about and inviting transformative relationships. Practitioners learn to use relationships to see things from new angles, develop greater awareness of personal and relational patterns, and support and challenge each other in trying new things. (Intentional Peer Support, 2019)

In IPS, counselling relationships are viewed as partnerships. IPS examines our lives in the context of mutually accountable relationships and communities. IPS doesn't start with the assumption of a problem, but it promotes a trauma-informed way of relating.

In narrative therapy, I found a practice that

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 people have many skills, competencies, beliefs, values, commitments and abilities that will assist them to reduce the influence of problems in their lives. (Morgan, 2000, p. 2)

While this description of narrative practice resonated with my experience of working with IPS, I also discovered differences between these two approaches. For example, IPS can involve the intentional and therapeutic use of the practitioner's lived experiences. It emphasises 'co-creation' and 'co-learning' between therapist and consultee (Intentional Peer Support, 2019). This differs from the ideal relationship between therapist and consultee in narrative practice, which emphasises 'decentring' the therapist and eliciting the client's knowledge and experience (White, 2007, p. 39). Despite differences in practice, both approaches share similar ethical and theoretical underpinnings: the value of listening to a person's story and honouring a person's naming of experiences, challenging taken-for-granted assumptions about experiences, and a commitment to social justice.

In seeking to combine ideas from narrative practice and IPS, I found myself working in ways that were different to both. I was, however, encouraged by some stalwarts

of narrative therapy, David Denborough and Cheryl White, to keep this up. They suggested that I might use narrative practice in a ways that were different from how it had been practised in the past, and that I develop ways of working that are uniquely my own and specific to where I work, those I work with and who I am. I can only encourage others to do the same.

This paper is a conversation between narrative practice and IPS, focusing on what they might learn from each another and how they might enrich each other. The paper outlines specific practices that I have developed through engagement with these two sets of ideas and practices: re-authoring as a peer, honouring extraordinary lives and re-memembering together.

## *Re-authoring conversations as a peer*

I have worked with people while they are in a psychiatric hospital and following their discharge. Psychiatric hospitals can be deficit-based environments. I know this from my experience of having been an inpatient in them and from my work in them. Problems may assert a particularly intrusive presence when someone is receiving mental health treatment in a psychiatric hospital. However, there are still neglected stories of strengths and values that can be brought forward.

It has been exciting to begin engaging in re-authoring conversations in this work context. The people who I speak with are considered to have a 'mental illness'. I am their peer because I too am considered to have such an 'illness'. Typically, these illnesses are seen as existing within us. Together, we have a unique ability to question such dominant discourses about mental illness. Through re-authoring conversations, my peers and I can do away with single-storied accounts of our experiences and attempt to create multi-storied accounts that begin to capture the breadth of our lives. We are then able to question dominant discourses of mental illness 'recovery' and 'wellness'. In an environment that labels people unwell, I seek to uncover what is obscured by this label being applied or taken as a person's only story. I have, for example, been privileged to hear the story of a strong father, which had been obscured by the story of a traumatised refugee; the story of the beloved community figure, which had been obscured by the story of an unruly criminal.

As a peer to those in hospital, I am able to position myself as a particular kind of listener: one who is connected to the person at this moment in time through the shared experience of psychiatric hospitalisation, and often other shared experiences too. This positioning has afforded me a particular capacity to invite and to hear people's stories of the 'neglected but potentially significant events and experiences' of their lives (White, 2007, p. 61). My training in IPS developed my skill in 'listening for the untold story' (Mead, 2014, p. 36), a concept that resonates with narrative therapy's focus on the subjugated stories of people's lives. The IPS practice involves listening for assumptions made and finding out how the person has learnt to tell their story the way they have. Through doing so, counsellors abstain from 'problem-solving based on the "told" story' (Mead, 2014, p. 36). Through the peer-support model, those who I speak with and I can share special, resonant knowledge. I have been able to share that my experience of being storied as someone with mental illness, although this somewhat resonates with me, fails to take into account other aspects of me.

Many users of mental health services are very willing to engage in questioning of dominant discourses and to produce resonant stories of our experiences and problems. Some examples of this from my practice include finding that what was labelled psychosis, to the person was just 'the spirits who talk to me'. For another, what was labelled psychosis was, in fact, their place of 'sanctuary'. We were able to reach these conclusions together, in part by working in a way that could 'honor the diversity of our lives and the lives of others' and attempt to 'appreciate what special knowledge we may have gained in our lives from experiences of difference or even hardship' (Denborough, 2014, p. 148).

The mainstream discourse of mental health, although broadening, often still adheres to a dichotomy of sickness and wellness. Both IPS and narrative practice aim to transcend this. To escape this dichotomy, I have sought to distance myself from clinical language and posturing. I am less concerned with diagnosis or symptomatology and more interested in a person's account of their experience. A question I have asked people when the relationship has allowed is, 'Could you tell me a story about how you think you came to be here talking with me today?'

When ideas of someone being entirely sick or completely well are applied to me and those I work with, this fails to honour our diversity. As Chimamanda Adichie (2009) has noted, when we reduce people to a single story, we often view them with 'nothing

more than pity'. Similarly, if I am reduced to a single story – that of someone with recurrent experiences of mental illness – this story overshadows many of my achievements, values and aspirations. I have heard these single-storied accounts internalised in comments such as 'I don't have a personality, I have BPD [borderline personality disorder]', and in language that presents a diagnosis as someone's personhood: 'I'm depressed'; 'I'm bipolar'. My experience has been that an affinity with a diagnosis can sometimes prove important and meaning-making. However, it is still important to me to invite people to hold these diagnoses lightly. Although they may prove useful as a means to externalise a problem, over-reliance on a diagnosis as the explanation for experience does not reflect the richness of people's experiences. I seek to invite other narratives.

Together, we challenge dominant discourses and stories that are told about us. There are a few discourses that are particularly prevalent in mental health systems. One is that medication is necessary (perhaps even mandatory) for addressing mental health concerns. Another is that people need to have a sense of structure, routine and sets of 'normal' behaviours and activities. This is often interpreted as work and/or study. These are just polite versions of the way people denigrate those who don't work in paid roles by saying 'get a job'. I view this as one of the dangers of an increasingly neoliberal world, perhaps inherent to capitalism itself. Of course, this analysis may be too grand, an unrelatable product of my town worldview, if I were to explicitly present it to the people I work with. However, it is still important to me that discourses of capitalism be rendered visible, for example through working with people to find out how we arrived at the idea that we must learn or earn. IPS encourages the sharing of counsellors' worldviews with those they work with. As a result, I am made responsible for being open and honest about my disillusionment with traditional models of mental health support. I have found that this almost always resonates with those I talk to.

## Extraordinary lives

I have found it useful to engage in practices influenced by Denborough's ideas about 'questioning normality and escaping failure' (Denborough, 2014, p. 147). Denborough quotes White (2002, p. 33): 'never before has the sense of failure to be an adequate person be so freely available to people, and never before has it been so willingly and routinely dispensed'.

Many people have said to me, 'I am a failure' or 'I feel like a failure'. I also feel very much like a failure insofar as not having achieved many of the expectations placed upon me. However, there is at least some part of me that is buoyed by reading about how in failure, 'we will wander, improvise, fall short, and move in circles. We will lose our way, our cars, our agenda, and possibly our minds, but in losing, we will find another way of making meaning' (Halberstam, 2011, p. 25).

I have been able to use this lived experience of being a failure to invite a broadening of other people's experiences of failure. I have aimed to show and bring into our conversations that if we feel that we have failed in some area, this does not need to imply that we are not succeeding or thriving in other ways.

Denborough (2014) recounted his experience of a narrative gathering of people with 'mental health struggles'. A phrase they and I found particularly resonant was that 'these are not ordinary lives we are living' (2014, p. 163). This statement inspired me and invoked movement in my understanding of myself and those I work with. This, combined with accounts exploring what a person sees as constituting a 'life of honour' (Denborough, 2014, p. 159), allowed for new possibilities in my practice. Borrowing from this, I began to ask people how they came to know what they wanted for their life. If the person had identified that others' expectations of them did not fit well, I began to ask about the things they might look forward to, want to work towards or experience attraction to in the light of this.

My experience has been that those who undergo psychiatric hospitalisation are readily able to recognise that their lives are not ordinary and to enter into conversations about their lives and their aspirations for life.

Hamilton: You've spoken of not feeling able to continue studying at university this year. I too was unable to study for some time while I was in a psychiatric hospital. I know what it meant for me, and I would be happy to discuss it more with you, but could you tell me a bit about what not continuing with study means to you?

Jack: Yes. Well, my family has not been happy with me. They care about me and want the best for me, but they aren't stoked about me not going back to uni.

Hamilton: Is that an expectation they have of you?

Jack: Yeah, they think I should be studying and working towards getting a degree because they know I used to really want to be a paramedic.

Hamilton: You 'used to really want to be a paramedic' – what does that say about what you aspire for yourself now?

Jack: It's not that I don't want to do that. I want to help people. But, right now, I don't feel like I can get there. There's stuff I care more about.

Hamilton: Yeah. Would you tell me a bit about that?

Jack and I went on to discuss the things that Jack wanted to bring closer into his life. Loneliness had been all too present, and friends felt out of reach. Jack had also had some troubling experiences with 'visions', which had resulted in him being diagnosed with a psychiatric illness. We learnt that Jack's aspiration was to bring friends into his life, and that was what we worked towards. Inevitably, we confronted looming expectations of others. However, when we connected to Jack's expectations and aspirations for himself, the expectations of others held less power.

Another example of attempts to engage in re-authoring conversations with a young person involved separating the goals foisted upon her by clinical services from the goals that she had for her own life.

Pandora: [crying] They say I have to go to the gym and the cooking group today, but I don't want to. I just don't see the point.

Hamilton: Really? Why do you think that they have this plan for you?

Pandora: I don't know. They said I need to get ready for discharge, get some routine and start doing normal things again.

Hamilton: Does this fit with your expectations for discharge and the routine of your life outside of hospital?

Pandora: No. There's nothing normal about my life outside of hospital. I don't go to the gym. I don't even get out of bed most the time.



Hamilton: If these expectations aren't meeting your own, and you say there's nothing normal about your life outside of hospital, could I ask about the desires you do have for yourself?

Through this line of questioning, we were able to see that for Pandora, there was 'nothing normal' about her life, especially as it was underscored by the persistence of a problem that made it difficult for her to achieve the expectations of others. We learnt that, more than normality, Pandora desired to reconnect with the 'fun' that was once in her life. Working towards this fun had little to do with meeting the expectations of others. In fact, it involved shunning these in order to pursue her own desires for life.

## *Re-membering together*

A peer-support model may involve the sharing of personal experiences and vulnerability; sometimes this can make conversations more difficult for the worker. Conversations that involve re-membering can be hard for me within the IPS model. Re-membering involves a kind of recollection and reconsidering of relationships. This is similar to the idea of re-authoring but applies specifically to conversations about relationships (see Russell & Carey, 2004). A peer-support relationship makes peer workers vulnerable to being asked intimate questions about their lives and relationships. There are often discussions of bereavement, grief and saying 'hullo' again (White, 1988). These conversations have been difficult for me because I have experienced disenfranchised grief and loss in my life. This, however, has been a useful starting point. Perhaps it has even benefited my ability to engage in peer conversations about people who have died, or are no longer in our lives, and with whom we have had challenging relationships (Dulwich Centre, 2008, p. 70).

Many people I have talked to have had a family member who has died, and with whom they had a difficult relationship. I have also had this experience. Although in the past I avoided these conversations, I have learnt through reading and then practice that when we are able to reconnect with and reconsider those we have lost, we are able to become stronger (Wingard, 2001, p. 43). One such conversation remains foremost in my memory. It was with a young man whose uncle had passed away suddenly after a heart attack, just like mine had. Nervously, he spoke about hearing this person's voice. He had been told that this was psychosis. We immersed ourselves in conversation

about the idea of seeing ourselves through someone else's eyes (Wingard, Johnson & Drahm-Butler, 2014), and how this was similar to the experience of hearing the voice of someone talking about you. This was a little nerve wracking for us both, but we were able to see the power of re-membering. It allowed this person to derive more value and meaning from the experience of hearing voices.

Many people who have been diagnosed with a mental illness have confided to me a sense of loneliness and isolation. This can be particularly present in a hospital that services a very large area: the person is often hours away from where they usually reside. When it has been shared that a sense of loneliness or isolation is present, I attempt to keep this in my mind throughout the conversation. This is because it has proved useful, when people have explained a skill or problem they have, to then ask, 'who wouldn't be surprised that ...' or 'who knows that ...' This serves two purposes: it allows for a thickening of preferred storylines and it can contribute to creating a sense of support for a person, hopefully reducing the impact of the isolation.

Sometimes isolation proves powerful. In my experience, re-membering practices can contribute to providing richer stories but cannot serve as an 'antidote to isolation' (Russell & Carey, 2004, p. 54). Practices that invite characters, pets, people from the past or notable figures into a conversation sometimes serve to highlight a distinct lack of direct human relationships.

Given that I have embodied knowledge of the discomfort of this experience, I am uniquely positioned to develop new ways of asking these questions, ways that are sensitive to the significant isolation a person may experience. My best response to the unfortunate and occasionally re-isolating effects of re-membering questions has been to ask questions about a hypothetical future relationship. If we acknowledge the presence of isolation this can be a starting point for moving towards future relationships. An example of this was in a conversation with a young man who, through hardship, had become separated from his most meaningful relationship. It did not look like this was going to change anytime soon. He spoke of no longer being able to do things that he enjoyed and about what was now absent from his life. This provided an opportunity for us to talk about a future relationship and how we might want to work towards this. This process felt easy and made sense to us both. Through introducing a vulnerable but relatable peer approach, I have found that narrative practice could be strengthened.

## *They don't get it*

As has been the case for many others introducing narrative therapy to those who consult us, I have found that most people relate to the principles 'quite instantaneously' (White, 2004, p. 66). People are very willing to resist totalising narratives and discourses. This, combined with the kind of equality a peer model provides, enables us to challenge taken-for-granted knowledge, including about the 'self' and diagnoses, which has limited utility for making sense of people's experiences. Furthermore, instead of providing a complementary or alternative understanding of things, sometimes decrying supposedly objective understandings, such as those offered by psychiatry, can allow for a more significant understanding of skills, problems and events in our lives.

My peer-support work has been largely informed by principles of the consumer/survivor/ex-patients movement. This movement, as with many other broad civil rights movements, aims to question hegemony and challenge elitist discourse. The people who are currently in the mental health system are uniquely positioned to do this. A specific, although by no means isolated, example is a young person confiding to me that 'the doctors don't know shit'. We explored this more and found that, for this person, medical professionals had not been able to provide any useful interventions or explanations of his experience. If psychiatry is invested in providing a medical explanation of experience, then perhaps we are invested in exploring these experiences in ways that resonates with a particular person or group.

In my practice, the idea that there are 'no certainties about life or truths about human nature and identity' (White, 2004, p. 105) has been significant. This has enabled conversations with people about difficult topics, particularly suicide. I have found that overly simplistic explanations often are given about people who have tried to die. Stating that a person has a level of 'chronic suicidality' and this is to be expected, or that they have tried to die in the context of a relationship breakdown, actually tells us very little. As I assume no certainties or truths, I can bring an open heart and mind to conversations with people who have tried to die. When I am free from a specific agenda, I am better able to explore people's agency, desires and beliefs in relation to times they have tried to die. Using my peer-support skills here, I might also offer a small story about how I have also tried to die and the circumstances surrounding this. This can provide a

structure for people to share their experience in a way that allows us to discern what they value or hold dear.

Peer-support workers aim to emphasise and utilise the expertise of the individual we are talking to. However, much like in experiences of other types of talk-based support, when dealing with a difficult issue there can be an expectation that, as employees, we should know what to do and how to do it (Ncube, 2007). Conversely, what has sometimes been useful in my role is my lack of knowledge of traditional therapeutic modalities. I often do not know what to say or do. IPS principles remind me to be authentic and transparent about this. When I have been able to say, 'I just don't know' or 'I'm not sure what would be best from here', this has often created space for us to sit in the uncertainty of not knowing. It is in this space that a peer-support model encourages us to acknowledge where we are at and consider how we can move towards more desirable outcomes. This often has been stressful for me, and may be for others too. However, this is indicative of how seriously and genuinely we are invested in these conversations. When I am able to connect to the notion that it is okay to not know and to sit with uncertainty, it can create an acceptance of uncertainty in people's lives and also allow for us to move forward in our conversations.

## *How to work in a hopeful and supportive way when you are not feeling hopeful*

I have attempted to explore the potential benefits of using a lived experience of mental illness through working from a peer perspective in conjunction with narrative practice. However, in order to become stronger in my practice, it is important that I highlight some of the difficulties that I have experienced in working from a peer perspective influenced by narrative therapy.

Often, I do not feel very hopeful. I often struggle to see the value or meaning in anything. I know that I am not alone in this. These ideas are not always present with me, but when they are, they are extremely powerful. I also experience forms of madness, which are sometimes more prevalent than at other times. This can distort my ability to accurately interpret events, reality and people. Am I really the sort of person who should be involved in supporting other people who feel similarly? How can I support others

to remain hopeful and work towards overcoming problems if I am heavily influenced by the problems I experience and by my feelings of hopelessness?

With a peer orientation, my experiences are not sidelined, but rather brought to the fore as a tool for connection and learning. I have sincerely doubted my ability to work with people like myself. However, I believe that I can work in hopeful ways with people even if I am not necessarily hopeful for my own life. Madness can have a special ability to make me dislike myself, but it also creates a special sensitivity to the experiences of others, and accordingly I feel compelled to assist them. There is an unfortunate irony about this which is not lost on me and those like me. Other people have shared with me that they too have had similar feelings, which is why a few narrative skills, in particular, have served me well when hard times have presented themselves:

- asking people what they might say or might have said to someone who was experiencing something similar
- asking people what others might say about their experience, for example, 'what might your partner/mother say about this?'
- encouraging people to share their experiences with others.

### *How do you remain a peer when using skills designed for therapists?*

Peer work presents itself as creating a relationship dynamic in which both parties are equal and work in a mutual way. This is seen as being in contrast with traditional therapeutic relationships in which people are positioned as a service provider or a service user. However, sometimes peer work can replicate unjust power dynamics. Here is a short list of reasons that a peer-support worker may have power over a consultee:

- they are paid to be in the relationship
- in a hospital setting, they can end conversations when they like, unlike their 'peer', who may not feel comfortable to
- they voluntarily enter the setting where they meet, unlike their 'peer' who is most often there due to the enforcement of the state.

This is evidence that it is not a fundamentally equal relationship. However, this does not mean we cannot be peers if we have had shared experiences, such as hardship or hospitalisation.

The dynamic is further complicated when formal therapeutic knowledge is introduced. One of narrative therapy's strengths is its simplicity, but this does not take away from its formality. This has proved challenging as I have attempted to fit narrative maps and skills into environments in which people are involuntarily treated. This is particularly pertinent because peer support often can provide people with a space free from traditional ideas about treatment, recovery and mental health. Narrative skills have sometimes proved unhelpful to forming peer relationships. Ultimately, even though I have had traumatic life experiences, diagnoses of mental illness, and experience of psychiatric institutions and mental health services, I still hold a privileged position in which traditional therapist–client roles can be reproduced. Although this is not inherently bad, my economic and social privilege has left me in an awkward position.

These difficulties are not insurmountable. Many people have appreciated the opportunity to work with me, and together we have had great relationships that have been meaningful for us both. However, this has not been the case with everyone I have encountered in my work. One remedy has been inviting truly peer-led interactions: if someone expresses their frustration at a formal conversation we are having, I am led by this. Some people who are in the mental health system would prefer to have someone to talk to as a peer, rather than a counsellor. Although I am a peer in many cases, my theoretical knowledge and understanding of therapeutic modalities can prove a barrier to a peer relationship.

As I continue to straddle dual roles, as a person with lived experience of madness and a person working within the mental health system, I am developing my skills and creating a practice that is uniquely my own. Combining narrative practice with peer support has provided a unique perspective that has had benefits for all involved. It has enabled me to resist dominant narratives of 'illness' and 'sickness', assisted me and those I work with to move towards lives that are meaningful in ways we determine for ourselves, helped to softly reconnect us with people in our lives, and provided a truly novel way to get to know people and work with them. Ultimately in this relationship, I am not quite a therapist, not quite a peer to those I work with. I am a mad narrative practitioner, and that's okay with me.

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