

**Narrative Therapy & the Affective Turn: Clinical Practice/Part Two**

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**December, 2019**

**Abstract**

This is the second part of a two-part account of narrative therapy and the affective turn that explores specific clinical practices and strategies that can be employed using an affective-discursive framework when working with individuals, couples and families. Part One is published: Monk, G., & Zamani, N. (2019). Narrative therapy and the affective turn: Theoretical Concepts /Part One. *Journal of Systemic Therapies*. 38(2)1-19.

**Key words:** affect, affective turn, narrative therapy, embodiment, affective practice, affective-discursive practice

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In an article in *JST* on Narrative therapy and the affective turn: Part One (Monk & Zamani, 2019), the authors made a case for the embracing of an affective-discursive approach that could thread together the works of contemporary narrative therapy scholars and practitioners who are particularly interested in engaging with the body, neuroscience and affect in therapy. The authors made a case in Part One that some narrative therapist educators placed an over-reliance on text and talk and placed less value on engaging all channels of human experience, especially during the training of narrative therapists. Karl Tomm (2018), a central figure in the emergence of NT and the training of narrative therapists in North America since the 1980s, made an observation that sometimes narrative therapists need rescuing from the tendency to become “disembodied as they seek more and more rigor in articulating a preferred text of a person’s life stories” (p. xi-xii). He says, “For some time now, I have been concerned about how privileging the ‘story’ of people’s lives too strongly in Narrative work can have an inadvertent negative effect by separating persons from the bodies in which they live - and depend on- to generate those stories” (p. xii). The authors noticed how sometimes a “disembodied” text and talk emphasis in some narrative training contexts can occur and inadvertently contribute to a cartesian split of mind and body.

Yet, increasingly, many narrative therapists, galvanized by contemporary issues of social justice and neuroscience research, are providing a refreshing contribution to the application of Narrative Therapy (NT). Today, there is a growing number of scholars and practitioners of narrative work who are reinforcing the importance of going beyond text-based analogies. Some narrative practitioners, including these authors specifically address the issue of not separating text and talk from the body and affect, a practice that was never part of the origins of narrative work (Bird, 2004; Tomm, 2018; Zimmerman, 2018). Through the consideration of the contributions of the turn to affect, this article builds on the practice implications of White and Epston’s (1990) original intentions of narrative practice as an approach that is clearly in opposition to practices that separate mind, body, and affect.

In this article we seek to honor both the seminal writings of the founders of the work and their intentions, as well as attune to the value and contributions of contemporary applications of NT practice. We present the material in the articles Part One and Part Two on the basis that there is not

one true reading of how NT should evolve. We do believe in the value of attempting to find unifying connections between many of the contemporary practices and applications of NT and the inspirational contributions of the affective - discursive turn that have not been previously discussed in the NT literature. Connecting NT with new developments in affective and bodily responses is an effort to support an intentional and integrated body of work rather than an eclectic disconnected plethora of practices that lack clinical integrity. Our purpose in writing on NT and the Affective Turn is to continue to support the legacy, integrity and development of contemporary iterations of NT. Thus, in Part One the authors discussed the theoretical contributions of the affective-discursive turn and the role it plays in this endeavor. In this Part Two article, we showcase the practical implications of affective-discursive practice in NT.

### **Issues pertaining to the application of intentional affective and bodily practices in Narrative Therapy**

Our conversations with NT practitioners and our exploration of NT research for this article have demonstrated a surge in the use of affective practices, which have been thoroughly embraced by practitioners both new to the practice of NT or have been engaged in narrative work for many decades. We discovered after our Narrative therapy and the affective turn: Theoretical Concepts /Part One article was published in the *Journal of Systemic Therapies*. 38(2)1-19 in 2019, David Denborough, a close confidant of Michael White and in some ways a guardian of his legacy published a comprehensive article titled Narrative practice, neuroscience, bodies, emotions and the affective turn in the *International Journal of Narrative Therapy* 3(1) 13-53 during this same period. In this Denborough (2019) article he stated: In fact, at this time of the affective turn, I believe the field of narrative practice, as a form of poststructuralist practice, is a perfect site to bring together poststructuralist and discursive considerations and realms of affect and emotion (p.35).

As we stated in an Affective Turn: Part One article, our descriptions of the brain and neurological conditions can be situated within a broader constellation of human experience. Additionally, our discussion here is not to make claims about how NT is practiced across the globe but rather our focus is primarily on the broader pedagogical derivatives of NT that have formed around a disembodied and linguistically oriented practice (Zimmerman, 2018). These understandings

have been formed through our correspondence with NT colleagues in multiple locations and at NT conferences. Some examples include individuals participating in the Vancouver narrative community, the Vermont narrative community, and the San Diego narrative community.

In some interactions with NT practitioners and scholars, we have witnessed a casting of suspicion of some of the applications of contemporary affective elements of therapy and body work which are being integrated into new applications of NT. This criticism and suspicion appear to be fuelled in part by a concern that NT has always had a wholistic focus on human experience, which includes the embrace of affect and the body and text and talk. Thus, it is viewed by some that it is redundant or inconsequential to focus upon or address advances in the study of affect and the body experience as they are already integrated into the work of NT. We notice too from conversations and written commentary responding to early versions of this article that some narrative therapists believe that NT does not need to evolve as it is already a complete and finished product. Critics of the discussion of NT and the affective turn argue that the essence of narrative work is being changed to something else in these writings – perhaps a new type of therapy being proposed or critics suggest the connection of NT and the affective turn is not an evolution of NT. We do recognize the subjectivity involved with the discussion of what counts as an evolution of NT or a corruption of it. Rather than argue for NT's evolution or promise a new entity that shows NT influences, instead this article seeks to highlight the emergence of the affective turn within multiple theoretical and practice locations of NT and invites the reader to consider these new trends of embodied practices across various social locations and experiences. We want to underscore the importance of remaining cautious of certain modernist and positivist notions that can be inadvertently smuggled into narrative practice. We are optimistic that NT's history of resistance to taken-for-granted knowledges and its poststructuralist orientation creates context where neurobiological and technological advancements can be interwoven with NT in thoughtful and creative ways.

### **The Work of Narrative Therapists and their Turn to Affect: A brief history**

As discussed in Part One, NT reaches back to the connections to affect studies for more than three decades. Specifically, Deleuzian theories associated with the study of human affect have provided impetus for scholars in the social sciences and humanities to observe human behavior

beyond purely linguistic and discursive constructions and conventions. According to Cole (2009), Gilles Deleuze's work explored the centrality of the relationships between affect, language and power, and studied human affect as a line of force and intensity that is shaping of human action. Michael White, the cofounder of Narrative Therapy (NT), in the last few years before his death became an avid surveyor of the contributions of Gilles Deleuze and became inspired by the insights of this European philosopher. Deleuze and Guattari (1987), among others (for example, Massumi, 2015) became a force for disrupting the tendencies in the social sciences and humanities to fall prey to engaging complex human action into Cartesian categories of body, mind and affect. As Cvetkovich, (2012) remarked, "Deleuzian projects have also enabled a fuller vocabulary for accounts of sensory experience that have emerged from cultural studies of embodiment and the turn away from Cartesian splits between body and mind." (p.4).

White and Epston's interest in experiences outside of text and talk reach back more than three decades, Turner (1969), Geertz (1973), and Myerhoff (1982) were influential writers in the social sciences, that shaped the origins of NT emphasizing the critical role of human interaction shaped by the bodily performance of expression and meaning in people's lived experience. David Epston spoke of the significance of Griffith and Griffith's (1994) work and their connection between mind and body at the time of their workshops and writing delivered on narrative and the body.

More recently, there is an exciting body of therapeutic work published over the last two decades by NT practitioners that pay acute attention to the integration of affect, the body as experience, and the interactional effects of a socio-cultural and socio-political landscape, all critical elements that do not denigrate or diminish the established traditions of mainstream narrative practice. Narrative therapy practitioners such as Beaudoin & Zimmerman, (2011); Beaudoin, (2010, 2015, 2017); Beaudoin & Duvall, (2017); Bird (2004); Carey, (2017); Duvall and MacLennan, (2017); Ewing, Estes & Like, (2017); Hamkins, (2014); Rosen, (2018); Weingarten and Worthen (2017), Zimmerman, (2018) and Tomm (2018) have made a strong case for strengthening the practice of NT as it pertains to affect, language/culture and the body.

Drawing on Wetherell's (2013) reflections on the contributions of the affective turn in research, we have summarized some of the elements that often feature in discussions on the affective turn that may be applied to clinical practice within NT or alongside it:

1. The affective turn focuses on materiality (the body) and relationality as part of weaving together the cultural and the biological.
2. The affective turn acknowledges that there is more going on in human interaction that is beyond intellect, linguistic knowledge, and reason.
4. Affect works with palpable experiences that are not exclusively dependent on language structure, and discourse.
5. Some affect studies recognize the complex act of bodily action and emotion taking place at the same time (Wetherell, 2013).
6. Affective– discursive practice is a “joint, coordinated, relational activity in which affect and discourse twine together” (Wetherell, 2013 p. 359).

### **Getting Clear on What Affect and Affective Practice Means**

Many scholars (for example, Cvetkovich, 2012; Gould, 2010) provide different definitions from one another on the word and meaning of affect and make distinctions between affect and emotion. For example, Cvetkovich, (2012), draws a distinction between affect and emotion suggesting Deleuzian-inspired theorists describe affect as a “precognitive sensory experience” and emotions as “cultural constructs and conscious processes that emerge from them, such as anger, fear, or joy (p.4).” We prefer Cvetkovich's own definition in which she states, “I ... use affect in the generic sense rather than in the more strict Deleuzian sense, as a category that encompasses affect, emotion and feeling that includes impulses, desires and feelings, that get historically constructed in a range of ways (whether as distinct specific emotions or as a generic category often contrasted with reason) ...” We also draw on Wittgenstein and Gergen (2009) in their discussions on emotions, where emotions are experienced as cultural performances of affect, and situated within a relational context in which meaning is constructed (Mascolo, 2009). We use the terms affect and affective practices interchangeably, with “affect” representing an embodied experience that includes physiology, neurology and brain structures, discourse, and language resulting in a cultural expression that is often immediate. Affective practices are the actions and habits, shaped by discourse, that have developed over the course of our lives in response to our social, environmental, biological, and psychological contexts. For instance, a woman feeling fear, and the resulting identities and actions she may engage

in with fear's influence, around men after a history of suffering abuse at the hands of men could be considered an affective practice.

### **The Role of Neuroscience in Affective Practice**

Many NT authors now view the importance of working with the autonomic nervous system when clients are affected by strong negative stimuli evoking a fight/flight/freeze/appease reaction. Therapy practices are employed to help the regulate the autonomic nervous system (ANS) by offering attuned communication, emotional balancing, response flexibility, and fear modulation, and also paying attention to input from the embodied senses including the gut and heart (Beaudoin & Duvall, 2017).

According to Van der Kolk (1998), the linguistically-based system of memory goes "offline" during sustained levels of stress, which can be caused by a physical or psychological threat. Levels of cortisol are shown to increase as fear increases, which has effects on the language regions in the brain. The ANS creates a hyper-vigilant response to the sensory cues in the environment. The non-verbal systems (visual, auditory, olfactory, and kinesthetic) are activated, and our attention becomes selective. Of course, this all occurs within a highly complex system whose richness is lost in the attempts to language an immediate and fluid moment. Van der Kolk comments that we can be left with the remnants of the fear experience even once the threat is over, and, sometimes without accompanying language to speak to it. Further, according to Van Der Kolk (2015):

Even years later traumatized people often have enormous difficulty telling other people what has happened to them. Their bodies experience terror, rage, and helplessness, but these feelings are impossible to articulate... It is extremely difficult to organize one's traumatic experiences into a coherent account – a narrative with a beginning, a middle, and an end" (p. 43).

Thus, working with a client's story can be difficult when a client is overwhelmed by a fight/flight/freeze/appease reaction. When I worked with the Domestic Violence Response Team in San Diego, I (Navid) would be required to arrive on an active crime scene with police officers to support the identified victim of violence and offer crisis counselling and resources. These contexts highlighted the importance of attending to attuning practices, such as the tone of my voice, the tempo of my speaking, and mirroring affect and staying mindful of space, contributed to an environment that

supported a de-escalation in their physiology and a shifting of the client's perceptual field from fear to consideration. In this role, it was critical that clients had access to resources the next day, and I would often hear from the clients who might say to me "I don't remember anything that you said" given the context, but often would remember how it "felt" to speak with me.

Despite enthusiasm among some narratively-oriented scholars and practitioners regarding the confluence of postmodern oriented therapies and neuroscience, there is disquiet and concern among some narrative scholars about the role of neuroscience in influencing narrative therapy. Sacks (2010) reports that while developments in neuroscience are "exciting beyond measure" he warns of the danger of losing the "richness of the human context" (p. 8). Duvall and MacLennan (2017) comment that while the connection between psychotherapy and neurobiology promises new possibilities in therapy, we need to acknowledge that current practice is speculative and still evolving in both the scientific and social context. The danger is that narrative therapists could become so consumed by focusing on conceptualizations of brain structures and physiology that they are not paying attention to harmful macro-level or micro-level forces impacting communities, schools and families. Our hope is that combined with NT values and practices, practitioners can engage with neuroscience with critical intention.

### **Considering How the Attention to Affect Relates to Therapeutic Practice**

Therapists from most therapeutic traditions know the importance and influence of affect and the emotional connection between therapist and client. Griffith and Griffith (1994) comment that when human beings feel safe in their relationships and in their physical environment, we demonstrate an emotional posture of tranquillity. In a non-threatened body state, we are well placed to care for others and ourselves. Humans in a tranquil state are found to be loving, trusting, reflecting, and affirming. In a state of tranquillity, we are not focused on managing our external environment as we perceive there to be minimal threat. In this state, we pay attention to our relationships and can pay attention to an inner resonance. Griffith and Griffith refer to another emotional posture - "mobilizing for action" which occurs when the body is under threat and moves into a defend and attack posture which could include behaviours such as walling off, scorning, shaming, justifying, ignoring, and criticizing. These emotional postures, triggered by the body's mobilization system, are a self-



protective act that camouflage and obscure the unarticulated narrative. This explains why it is so difficult for some clients to open up and disclose things they haven't shared before. Griffith and Griffith note that the telling important narratives within an emotional posture of tranquillity facilitates meaningful interaction and progress. Within this conceptualization of therapist responsibility, there are therapeutic practices that can support this process.

Carey (2017), states that having an understanding of the work being conducted on the neurobiology of trauma has brought her attention to the importance of paying attention to the felt experiences of the body. In her writing, she makes a case for the inclusion of both positive and negative affect in narrative therapy and how necessary it is to build a bridge to new experience and the development of new and embodied memories. She recognizes that it is preferable to first pay attention to positive affect before exploring problem issues, because the body releases neurochemicals such as serotonin and dopamine which optimize learning.

Below, we have outlined some basic practice guidelines for creating a climate that allows for an affective-discursive NT practice. These are practices pooled from the emerging literature pertaining to the affective turn, as well as some practices we have developed in our work.

### **Attunement - Body Feeling and Noticing**

We have heard the question, "how does it help us to tease out feelings and emotion from the story when everything is connected?" Just as we pay attention to text and talk when studying the transcript in NT training, we argue there is value in explicitly tracking affect within a therapeutic conversation when teaching the practice of NT. The skilled Narrative therapist is of course simultaneously focusing on multiple channels of relational interaction - words, affect, and the body.

Tracking affective practices within therapy is not new. However, we want to underscore the point that the integration of textual channels in narrative work with a more deliberate attunement to the bodily channels has the potential for richer, more nuanced understandings of clients' lived experiences. Tomm (2018), for example, stated that it is preferable to pay attention to a possible inadvertent prioritization and focus on a mechanistic scaffolding of preferred story descriptions that has been prominent in some NT trainings in recent years. Bird (2004), suggests giving priority to the emotional quality of dialogue, especially as this is occurring in the present moment. Carey (2017) and

Zimmerman (2018) suggested that if the narratives shared by clients are disembodied and disconnected from the emotional state, therapists are unable to effectively re-story painful and difficult experiences. The new preferred story may be compelling, but the emotional problem story remains privileged because it stays embedded in the old neural pathways.

The close tracking of affective practices requires an emotional attunement with ourselves and with our clients. Bird (2004) states that the process of discovering client meaning in the present moment includes: “the attention to thoughts, feelings, sensations, visions, body responses, smells, the said, the partially said, the struggle for words, the emotional quality of the words spoken, the look, the presence, the absence and much more” (p.35). To fully engage a client who is experiencing strong emotion requires the skills of an empathic, attuned practitioner. Hamkins (2014) describes the role of a narrative practitioner who is paying attention to affect as demonstrating “emotional resonance” (p. 24).

As a psychiatrist, when I meet with patients, I try to attend carefully to the emotions that are arising in them and to the stream of emotions that are arising in me in resonance with them. What do I see and hear? What do I feel in my solar plexus, my chest, my face? Are tears rising in me, anger, fear, tenderness, playfulness, joy? When I can feel those feelings and observe that I am feeling those feelings, it is calming and clarifying to me, and, often, moving. ... I can convey my awareness and acceptance of those emotions to the patient in a myriad of ways, in my demeanor, the expression on my face, the tone of my voice, and in what I say. When I succeed in my emotional validation ... patients communicate by becoming more relaxed, more forthcoming, more self-accepting, and more hopeful... (p.27).

Hamkins (2014) states that when the therapist and client are emotionally attuned it makes it possible to speak about what is felt most intensely. Clients determine what stories can be safe to share with the therapist which facilitates the movement towards a posture of tranquillity.

Griffith and Griffith (1994) ask therapists to pay attention to bodily expressions and how they are affected from a political, economic, moral, religious, or cultural frame of reference. In paying attention to affect, they want to bring the body into the conversation so that it has a voice. Griffith and Griffith make the point that there are social practices that demand silencing of spontaneous bodily expression in order to preserve the status quo. Consider too the self-surveillance required and psychological distress experienced by a physically and sexually violated person needing to feign

agreeableness by altering their affect and bodily responses to diminish even further harm being done to them. The specific attention to affect only increases and enhances the therapeutic responses that can be made by practitioners in tracking how the body and emotion can simultaneously internalize the oppressive discourses of exclusion and personal failure. Wetherell (2012) argues that the study of the expressions of power is crucial in affect studies as the display of emotion is unevenly expressed in relationships of consequence. Attention to affect invites us to consider who is emotionally privileged and what does emotional privilege and emotional disadvantage look like. Additionally, we can analyse how affect enacts, reinforces, or disrupts human interaction.

Our bodies are performing in the face of external stimuli. Griffith and Griffith (1994) state that when the outward performance of a body is forbidden, human beings present a “somatized expression by the body” (p. 61). They suggest that forbidden outward expressions of the body can contribute to chronic somatic symptoms and other bodily manifestations of significant psychological distress. Griffith and Griffith argue that eating disorders, alcohol and substance abuse can become manifest when a young person is forbidden from showing outward bodily expression of internal distress in addition to being verbally silenced. This is exacerbated when containment of the body and voice occurs in the presence of sexual, physical, and emotional abuse in childhood. When a female client is feeling unsafe in a violent relationship with her husband, she is constantly managing bodily expression to not increase the potential future threat of violence. Griffith and Griffith ask, “When your stomach began hurting while talking to your husband, what would your stomach have said if it were to have a voice?” (p. 160).

Stories of hope and stories of despair exist within the fluidity of bodily interactions and narratives are created out of the living dance of bodily interactions. Hamkins (2014) reminds us that it is important to attune to feelings of joy as well as paying full attention to sorrow. This attunement and attention to affective practices can also support a therapists’ access to “reasonable hope,” where client and therapist can find access to future visions and hopes that are accessible from the current affective state (Weingarten, 2017).

### **Specific Practices of Attunement**

The process of attunement within the affective turn can be understood as staying “experience-near” to the client’s and the workings of various narratives as they are thickened. In engaging clients with specific questions that elicit descriptions of physiological states, and paying attention to our own bodies, therapists can engage in affective practices with clients that indicate safety in the relationship, and an interest and curiosity about their story.

Attunement and affective-discursive reflection include an attention to the positioning of our bodies in relation to our client's bodies, our tone of voice, volume, and speed in an intentional effort to invite a posture of tranquillity (Griffith & Griffith, 1994). This attention to affect is particularly relevant when the therapist holds an identity that can be understood contextually as one of privilege or within a history of oppression (such as a male therapist working with a female survivor of violence who suffered at the hands of men). For instance, in my work with survivors of intimate partner violence, I have found that sharing about my body’s responses to their stories can be a relational connection that may not have been experienced within other relationships, particularly if my client identifies as female (I identify and present as a cis-gendered male). For instance, while a client shares a story, they might see an expression of pain and compassion on my face, which I might accompany with a hand on my heart and a statement of, “your story is really moving to me.” This can be followed with a question of, “What did it take to strategize and survive this relationship?” This 5-second moment conveys multiple strong messages. When compacted with various social locations and contextual complexities, the messages can create an embodied experience of connection that supports the therapeutic endeavor. Of course, these types of interactions require the relational skills and intention to theory and practice to judge the appropriateness. Fortunately, this moment in NT is an opportunity to begin engaging with and developing practices that attend to these features of relationship.

One of the effects of this attention to attunement is in the pacing of stories. Often, whether it be inexperience or constraints of our time and environment, stories can be rushed to get to the “whole story,” which often means a linguistically-based understanding. Deliberateness with pacing, voice tone, silence and closer proximity to the client can provoke a deepening of the sharing, as well as

continuing a conversation a little bit longer or shutting the line of inquiry down quickly as the client is signalling they are not wanting to go there. Therapists have to be acutely aware when the social courtesies demonstrated by clients and family members are surpassed to reveal definite signs of alarm setting in motion the flight, fight or appease responses. These signs of alarm are expressed in shifts in body state— a change to rapid or shallow breathing, closed off rigid body posture, tight lips, frequent swallowing, tightness or loudness of voice, showing hesitation during speech, or showing an averting gaze.

### **Affective Work Beyond Talk Therapy**

#### **Non-Western healing focusing on affect and the body**

Some communally oriented cultural communities have a long cultural legacy in which the non-conscious, embodiment, and the non-verbal realms of existence are prized (Denborough, 2010, 2019; Karageorgiou, 2016; polanco, 2010). For example, in Maori culture, the recognition of mauri (the ‘life force’) and whatumanawa (which refers to open and healthy expressions of emotion) are two fundamental elements in the Te Wheke Maori holistic health model articulated by Rose Pere (NiaNia, Bush & Epston, 2017). Indigenous understandings of affect are profound and wide ranging and well beyond the scope of this paper but are deserving of independent examination (Dog, & Erdoes, 1996; Duran, 2006; Durie, 2001; Incayawar, Wintrob, Bouchard, & Bartocci, 2009; Kim & Kwok, 1999; Waldegrave, Tamasese, Tuhaka, & Campbell, 2003).

Engaging with the body carries an anti-colonialist spirit that attends to the histories of healing within communities which dominant Western health and medical practices may ignore. By asking about music, art, dance, and other embodied rituals of engaging with experience, NT practitioners can honor and mine these traditions as processes supporting healing and the therapeutic endeavor. The notion that the body is to be ignored carries a Western, colonial tradition bred by Enlightenment ideals of reason and a Cartesian separation of mind and body (Monk & Zamani, 2019).

#### **Therapeutic non-verbal practices combined with Narrative Therapy**

Narrative therapy combined with Eye Movement Desensitization and Reprocessing (EMDR) (Rosen, 2018; Zimmerman, 2018), Narradrama (Dunne, 2017) and Mindfulness (Zimmerman, 2018) are important practices that support the development of preferred emotional states and preferred

identity stories that work beyond talk therapy. In this next section we briefly review two widely known mental health practices – EMDR and Mindfulness and how they are used alongside NT.

### *EMDR & Narrative Therapy*

Siegel (2010) suggests we have two forms of awareness. One form is what we are most familiar with in NT, which is the narrative form where our awareness constructs stimuli within a narrative display. The other form of awareness that has been relatively ignored in many trainings on NT and are what might be described as implicit memories that are embedded in the body but are not integrated into any autobiographical story form. These memories, if traumatic, are tied to particular physiologies, affective practices, and muscle memory that the brain tries to dampen, shut down or block to protect itself from the pain and flood of the toxic chemical overload. This unprocessed “internal” emotional energy is body-based and can be disconnected from any cognitive and overt meaning-making process.

Narrative therapists Lynne Rosen and Jeff Zimmerman have adapted the techniques of EMDR (Shapiro, 2013) and integrated them with the practice of NT. EMDR focuses upon this second form of awareness described by Siegel (2010). The technique addresses the adaptive information processing of perceptions of events stored in memory networks that are problematic when triggered by particular contextual situations or lived events. They can be physical sensations, affective responses stored in isolation from a grounded autobiographical narrative, or the flooding of particular thoughts as they are shaped by their associated physiology and the discourses they are embedded within. When triggered by an experience, the neural pathways light up as though these affective sensations are happening in the present moment. Francis Shapiro (2014) stated that when a person is experiencing intense distress, they are often unable to link these traumatic events to anything adaptive and the source of the traumatic event may no longer be connected to its source. EMDR is largely a non-verbal technique that can help the person engage in adaptive responses to the trauma(s) as the rapid eye movements somehow engage the implicit memory system but in an entirely different way than the contextual triggers which essentially resurrect the unprocessed dysregulated responses. EMDR can work with the unprocessed memories and, with applications of NT, engage with the emotions in a spontaneously new way.

In alignment with Michael White's (2007) scaffolding for therapeutic conversations to traverse gaps in what is known to what is possible to know, Lynne Rosen (L. Rosen, personal communication, May 8, 2018) moves between the landscapes of linear and nonlinear work, weaving together practices from EMDR therapy and Somatic-oriented therapies in conjunction with NT practices. Rosen states that when working with the non-linear elements of therapy, interventions become more fluid or what she would describe as a "poetic" weaving together of sensations, cognitions, affect and dreams to expand the dimensions of what is therapeutically possible. Rosen slows therapy using somatic practices (e.g. EMDR) when clients want to rapidly turn away from distressing sensations – especially with those clients who only have kinaesthetic and implicit memories. She centralizes the client's experiences, conducts co-research together and instead re-orientes to the client's inner experience. Rosen acutely attends to the body's rhythms, noticing bodily nuances that are windows into accessing the underlying relational stories which must first be engaged with nonverbally, then enacted, and finally storied. She states, "I listen to how clients tell stories, as some tell a trauma story more as a chronicle or fact, but it is devoid of a language of inner life, or 'felt' experience" (L. Rosen, personal communication, May 8, 2018). She conducts complex and nuanced visualization techniques which help clients redress events from the past to restore the person's moral imagination. Rosen describes the outcome of the process:

"I have witnessed clients repopulate identities with real and imagined allies, deconstruct so-called "truths" about deficit-based identities, connect with a sense of compassion for their multiple selves over time, and enact responses in the imagination for how one wished things had gone, creating a vision in accordance with what one gives value to...With child-like creativity—responsibility for abuse is assigned where it belongs, and preferred solutions and subordinate stories emerge. This sense of "aliveness" and agency creates new possibilities for relating" (L. Rosen, personal communication, May 8, 2018).

The spirit of White and Epston's work is apparent in the descriptions used by narrative therapists engaging in these practices, as evidenced by Rosen's descriptions above. White's work regarding the "absent but implicit" can be situated within these contemporary practices (Carey, 2009, 2017).

### *Mindfulness*

A meditation practice that is thousands of years old developed within a Buddhist context has become enormously influential in the delivery of contemporary mental health interventions.

Popularized by American meditation practitioners such as Jon Kabat-Zinn (2003) and become widely known as a practice called mindfulness is combined with other theoretical and practice approaches to assist people with serious mental health challenges. According to Percy (personal communication, April 8, 2019), the word 'mindfulness' was originally derived from the Pali language word *sati* translated by Thomas Rhys Davids, a British Civil Servant, over 100 years ago. Mindful practices in psychotherapy are being increasingly incorporated into poststructural family therapy. Marie-Nathalie Beaudoin (Beaudoin & Duvall, 2017) has written widely on the applications of mindfulness and engaging directly with bodily responses when working with clients using NT. Jeff Zimmerman's (2018) also indicates applications of mindful meditation and NT. This work clearly draws upon the turn to affect and neuroscience and combining discursive approaches to therapy – an affective-discursive practice. The practices that accompany mindfulness meditation focus the narrative therapist tracking the clients affective and embodied responses to mental health challenges. Zimmerman makes the point that “mindful meditation serves as the ultimate experience of deconstruction because while participating in it you are noticing what is affecting the interaction and how the interaction is unfolding” (p. 83-84). When engaging in the listening to problem-saturated stories or focusing on unique outcome moments Zimmerman will have clients breathe with mindful body awareness and be able to use the body as a resource to explore how and where the problem is situated in the body. Slowing down the process of therapeutic engagement using the breath in NT supports space to scaffold lived experiences that will enhance alternative narrative development.

Percy (2008) proposed that incorporating mindfulness with NT helps challenge the exclusive preferences given to the linguistic emphases in therapy. He stated, “incorporating mindfulness [with NT] provides a different and direct way of relating to bodily sensations and the immediacy of emotional and mental states” (p. 363).

*Working with Affect in the realm of the absent but implicit*

Working with the “absent but implicit” is an important notion to NT (White, 2000). It is an effort to “double-listen” to and begin to draw out the multiple preferred lived experiences lying outside of the dominant problem discourses fortified within the person's cultural context. NT therapists can track the “absent but implicit” as it relates to the affective practices that are shaped by a



client's social location. For instance, expressions of pain as it relates to exploring meaning making systems relayed through conversation can be brought into the foreground and privileged in their considerations. Thus, a thickening of a client's story through the integration of affective experiences can be achieved with the linguistic rendering of a narrative.

Carey (2017) describes the "absent but implicit" approach within affective practices as an attempt by the therapist to identify and inquire further about what the emotional pain implies in the client's life. For instance, feelings such as fear, and anxiety may start to be seen as an act of protest to what was done to the client and strong affect can be understood as an active stand against violation. Further, Carey proposes the following questions to highlight skills and values: "How is it possible for you to take this action of protesting something that is not ok? How are you able to continue to refuse to go along with what was done to you?" (Carey, 2017, p. 47). The path to developing new and embodied memories can be constructed from questions such as "What are the tears a response to? What are you refusing to go along with? What was going on in this situation that was not ok with you?" (p. 45) This type of questioning is a way to get to what people value and collect information in a manner of obtaining double storied testimonies. This line of questioning not only thickens a problem-saturated story but can begin to connect a client to an identity of activism, or protest: one that harbors agency versus subjugation.

This practice requires clinicians going beyond simple observations and connecting emotions to stories. Carey (2017) points out seeing the tears as an *effect of* contributes to the construction of being helpless and failing to prevent or to get away from the perpetrator. Coming to see that the pain and tears are an active *response to* what was going on not only makes sense of the pain, but also provides an opening to holding strongly to significant and precious understandings of life and of having taken action in accord with these understandings and principles.

### **Affective Integration and Identity States**

The use of scaffolding is a concomitant practice of integrating the linguistic narrative and the affective practices a narrative holds. When narrative therapists do not over rely on purely linguistic and textual domains, they can deliberately track clients' bodily connection to their story to encourage a thicker understanding of their relationship with their stories.

Ewing, Estes and Like (2017) focus on the weaving back and forth across multiple landscapes of thinking, feeling, and body, making for a more congruent performative response. They contextualize therapy to connect sociocultural discourses with physiology and to the landscape of action and identity. They associate and evaluate any physiological sensations that are related to new interpretations or actions. Therapists are invited to notice heart rate, muscle tension, feelings in stomach, and other bodily sensations and the physiological landscape is mapped. New neural connections are strengthened through repetition, or a “looping back” through stories, over extended periods of time. Neural associations between preferred physiological sensations and preferred states of identity can be created and strengthened. As a client continues to learn and integrate new experiences into a preferred story and identity state, the “looping back” practice integrates these learnings in an embodied way, in an effort to substantiate the initiatives the client is preferring (Ewing, Estes & Like, 2017). Repeated new experiences can be disruptive to biased perception/action loops built into problem-saturated stories.

The “statement of position map” offers a helpful foundation in which questions about affect and physiology can be situated (White, 2007). As a client shares a story, questions that invite the noticing and naming of a physiological state, followed by an exploration of the effects of this state can allow for a thicker development of an embodied narrative. Thus, as a client shares a story that harbors fear or worry, a NT attending to the affective-discursive elements can explore the ways that fear or worry may present themselves in physiological states, and how this affects meaning-making.

### **Body and feeling strengthening in the richer telling and performing**

#### *Insider witness approaches*

While the integration of art and story-telling is an ancient practice across communities, the affective turn within the 21<sup>st</sup> century marks an intentional appreciation in Western healing communities for the effects of story-telling in an embodied, extralinguistic manner. There are various approaches and methods to this, and the values around flexibility, adaptability, and cautiousness of assuming and assigning value, NT practice fits well and supports these extra-linguistic practices. Carlson and Epston (2017) use insider witnessing practices to incorporate information that is not just textually storied, but also embodied. Insider witnessing includes the amplification of bodily noticing

as a story teller is performing and enacting the client's resiliency narrative. This performative work anchors the preferred emerging identity in the body and in the emotional channel. The more robust felt experience, the more likely for the performance to be a remembered experience. Heightened attention and access to what is deeply known beyond words can fuel movement and progression. In the witnessing, audience members are invited to suspend their disbelief, and the audience members often find themselves relating to the characters in the performance in ways that bring forth genuine expressions of compassion, care, anger, sadness, and affiliation.

*Internalizing before externalizing*

We agree with Zimmerman (2018) when he states that affect must be "internalized" before it can be effectively externalized. For example, for a client to fully experience the negative effects of the externalized problem, the client can benefit from connecting to affect as well as a cognitive intellectualized description. To bring awareness to the felt sensations of the problem the client should experience an embodied understanding of the externalized problem which provides a more potent naming of the problem saturated story for the client to take a stand against. As clients name and identify emotions, we suggest that the emotional experience is connected to the physiological and affective experiences in the body. Anchoring affect as an internalizing move before externalizing might look something like – Where is the sadness in your body? How is the pain showing up? Zimmerman speaks of empty stories that are comprised of detailed descriptions but are devoid of any affective content. Similar to Griffith and Griffith's work (1994) Zimmerman speaks of the value of asking 'body questions' when little emotion is displayed. Narrative descriptions disconnected from affect limit the therapeutic value in both challenging problem saturated narratives or co-constructing preferred narratives. Zimmerman proposes 'thickening attunement - strategies that evoke affect before verbal narratives are concretized. In Zimmerman's book, *Neuro-narrative Therapy*, he lays out highly detailed specific approaches that invoke client affect.

*Affect-infused unique outcome work*

Another critical piece in strengthening preferred neural networks and weakening non-preferred, negative neural networks is attending to 'affect-infused' experiences within *unique outcome* moments (Beaudoin & Zimmerman, 2011). Unique outcome moments are the source of the

construction of alternative preferred narratives. However, unique outcomes, when disembodied from an affective-infused anchoring, can be rendered meaningless or unnoticed because of the pervasiveness of the problem saturated story. Noticing, attending to, and re-experiencing *unique outcome* moments also helps strengthen preferred neural pathways (Beaudoin & Zimmerman, 2011; Ewing, Estes & Like, 2017). For instance, inviting a client who has been subjugated to intimate partner violence to be attentive to their bodies when ‘fear’ is not present can allow for a more accessible recognition of the unique outcomes as they occur. This can allow for a storying that privileges the preferred moments and experiences. Attending to ‘affect-infused’ *unique outcome* moments in therapeutic conversations, as well as just talking about these experiences, makes the preferred state more accessible to clients in different contexts in the future (Beaudoin & Zimmerman, 2011).

### Case Study

This case study is a representation of my work with a couple in a private practice setting and reflects some of the narrative practices that have emerged in attending to the affective-discursive turn discussed in this article. All identifying information has been scrubbed to protect client confidentiality.

### Contextual Information

My work with David and Diedre began when they sought my services due to my background in domestic violence work. They are a cis-gendered couple in a heterosexual, monogamous relationship. They have three children together. They identify as middle-class, educated, and able-bodied. David is a European-American and Diedre is an African-American. They had experienced some tension building in their relationship for a couple years, but it had come to a boiling point when Diedre had physically attacked David and the police arrived. David was very cautious in how the narrative of abuse was constructed, as he had some history with therapists insisting that he must have contributed to the violence somehow due to his “maleness” and dominant gendered discourse in domestic violence epistemology.

David described the couples counselling endeavour as a “last ditch effort”, stating that he was “not comfortable” around Diedre but acknowledged that they parent “well together”. Diedre shared

that she is “afraid to not find a way through this”, and that despite everything that had happened, she still “loves him”. The following sections focus on particular practices that were utilized in various conversations throughout the time in which I met with Diedre and David, which spans approximately 2 years.

*Tracking embodied preferences and values*

A collective goal between the three of us (Diedre, David, and myself) was to eliminate the prospect of a return of violence to the couple’s relationship. At the start of every session I would position myself as a representative of the public to their private experiences with violence and invite each of them to describe the presence of violence since we had last met (Gray, 2006; White, 2009; Knudson-Martin et al., 2015). This constructed an entry point for our conversations that privileged safety and acknowledged the proximity of violence to the relationship. When I first began to speak with David about his history with violence in the context of his relationship with Diedre, I visually observed his posture stiffening. I paused the conversation and invited him to “describe what you are noticing in your body right now.” David shared that he felt his “heart pounding, thoughts racing, and [his] breathing heavy”. I asked him if he was familiar with these bodily reactions, to which he responded, “yes”. I asked him what he would call this body response, which he named, “anxiety”. I invited him to describe how he made sense of the presence of “anxiety” in the context of our conversation thus far. David shared that it was a feeling that was with him since he’s had to “sit with Diedre” since the violent event that brought them to counseling. He further contextualized “anxiety” within a relational experience, where he would be alert and “hyper-aware” to particular words and phrasings that would be interpreted as a “scrubbing” or skirting of accountability to past violent behaviors.

After this conversation with David, I turned to Diedre to see how her body was responding to the emergence of some the incidents and reactions discussed. Diedre shared that she had a bodily reaction of “palms sweaty” and feeling “shaky”. She shared that she had been familiar with these experiences in the past as they would sometimes lead to “panic attacks”, which was an experience she had come to manage more effectively recently with the help of individual counseling. In response to questions contextualizing her bodily response, Diedre shared that this physiology was related to

thinking about the relationship with David ending, and how her identity had come to be known in the context of their relationship – as a “violent” and “unsafe” person. I noticed my own bodily responses begin to react to Diedre as she shared her sense of vulnerability around identity. My voice tone softened, and I slowed the pace of my questions and responses. My hope here was to temporarily maintain a body state that was open, soft, vulnerable and present, with an effort to create space for a broader contextualization of identity. Here, I was able to ask about how Diedre understood David’s relationship with violence in their relationship, maintaining the affective posture and tone described earlier. Diedre shared that it made her really “sad and scared”, and that she had not been “attentive nor kind” in her “love for him”. She stated that she is “working on that” and that she “want[s] both of [them]” to be apart from violence. I turned to David after this discussion to check in with his affective state and body responses. Using a similar bodily “statement of position map”, David stated that his “breathing is slower”, his “heart has slowed down”, and that his “thoughts are not racing”. I asked him what he would call his body responses now, which he responded to as, “attentive”. I asked him to share what was giving space for “attentive” to be present, to which he shared that Diedre’s “reflections are fair” and “true”. The context made explicit by offering language to affective states allowed for “truth” to resonate between both partners. It allowed him to say something that she had not heard explicitly prior, that “[he] need[s] a reason to go back that’s not just the kids”. These interactions create a framework in which a “reasonable hope” can be accessed from an affective-discursive framework; a context where the potential for movement is both heard and felt (Weingarten, 2010).

#### *Unique Outcomes and Sustaining Preferred Identity States*

One important quality that emerges in these practices is the experiential learning of the couple in understanding their partner’s actions and behaviors is arising from complex and fluid identity states, rather than from problematic “personalities”. In my work with Diedre and David, this proved to be important as both knew each other to be great parents and, at times, “good” partners, but this knowing had been obscured by rising tensions and heated arguments accompanied by violence. Further, these identity states were intentionally woven into broader political discourses, such as the

difficulty David had had in accessing a conversation that made space for his experience as a male subjected to violence by a female partner.

In one conversation that emerged after approximately working four months together, David and Diedre arrived in my office and David promptly shared that he had “anxiety” with him again. Given past conversations, “anxiety” had been contextualized to be connected to his attention and weariness of violence. David began to share of an “incident of verbal abuse and physical bullying”, a conversation about violence that Diedre appeared to be reacting to differently. David finished his story of the event by sharing that he “saw [the violence] coming”, noticing the affective precursors (as discussed in counseling) in her body and the ways her eyes were “dark and grey”, stating that her “physiology seemed tense”.

I turned my attention to Diedre, as I was unclear about what was going on for her during this conversation. Diedre shared that she “regretted [the violence]” and as it began to occur she noticed that her “body had taken control”. A unique moment had occurred in their fight that was unfamiliar in comparison to their new recollections; a moment where they both noticed a “runaway” physiology that they impeded the flow of. Historically, David would get physically cornered and prompted by Diedre to continue a fight, Diedre supported David in what they had to come to name as his “right to retreat”. This was housed in a shared value of “shielding kids from marital conflict”. They described how an attention to their bodies had given access to a moment where they could connect with a preferred way of being in conflict. To be clear, these were practices that they had come to name and lean on, not a set of “coping strategies” taught by the therapist.

As this conversation continued between the three of us, I continually utilized the statement of position map for tracking physiology and identity states, and a “looping back” through the preferred reactions (Ewing, Estes & Like, 2017). As our time continued together, named identity states and relational motifs were referred back to and thickened, continually exploring the ways that these values, physiologies, associated identities, and habits interplayed in the immediacy of a moment.

#### *Taking Relational Ownership*

By the end of our time together, Diedre and David still had contexts in their relationship that invited tension. However, David shared that they “speak very differently” about their problems and

had taken on some challenges of his own to further their relationship. David shared that he was interested in “figuring out a way to be direct and succinct without being harsh” and noticing that tone and timing affected what he used to consider as “matter of fact” statements. Diedre had come to describe her violence as “transgressions” that she was not interested in “covering up”, but also not interested in them being the “limits of what’s normal”. They had created a practice of attunement with each other, where they would actively listen closely and ask about physiology and “what is possible” to talk about. They shared that this helped them “keep check on anger” and “focus on the future”. Their “ups and downs” are situated within a more fluid and complex territory, where caution is taken around identity conclusions and totalizing statements.

### Conclusion

NT moved the field forward in the 1980s during the period of the ‘discursive turn’ by inviting new considerations into the relationship between the therapist and client, noting the critical importance of the socio-political context in problem creation, and the emphasis on language and metaphor as a primary vehicle for change. In both Part One and Part Two, we have argued for more invigorated attention to the interconnections and intersections of both the cultural and physiological landscapes of human action. More intentionality to embodied experiences can further the existing NT techniques that prioritize social justice issues and render visible the ways that our political landscapes are mapped onto our bodies. We believe that the recognition and re-emphasis of the affective-discursive dimensions further supports NT trainings that can position NT to better respond to the 21<sup>st</sup>-century landscape.

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