

***Case Study 1: An Evidence-Based Practice Review Report***

***Theme: School (setting) Based Interventions for Children and Young People with Special Educational Needs (SEN)***

***Can Narrative Therapy be an Effective School Based Intervention for Children and Young People with Special Educational Needs?***

**Summary**

Narrative therapy is a form of psychotherapy. It is a strength-based process that enables people to identify difficulties within the dominant stories created from their life experiences. Dominant stories are explored, and exceptions, personal values, skills and knowledge are noted and built upon, to enable a person to reconstruct a new and empowering story in which the difficulties are diminished and skills developed to manage future behaviour.

This systematic literature review examines the evidence base for narrative therapy interventions delivered in school settings. The review found promising evidence in all studies that narrative therapy can be effective in reducing problematic behaviours in children and young people with a range of special educational needs. Future research should address the limitations highlighted by this review.

## **1. Introduction**

*What is narrative therapy?*

Based on family therapy, White and Epston (1990) developed narrative therapy as a strength based, non-pathologising, culturally sensitive, and collaborative framework to assist people in identifying the values, skills and knowledge they possess to effectively manage difficult problems (Beaudoin, Moersch & Evare, 2016; Gilling, 2016). In narrative therapy, problems are not viewed as within-person, and individuals are viewed as the experts, who possess the resources and strength to support their own development in managing change and solving future problems (Lambie & Milsom, 2010). Experiences that begin in early childhood, through interactions at school, with family members and the community, influence the formation of identity (Winsdale & Monk, 2007) and provide stories that give meaning to a person's life and a foundation to interpret future experiences (White & Epston, 1990, p. 10). These narratives can have positive or negative influences on behaviour and impact on the way people navigate their lives (Kamali & Looyeh, 2013). Negative perceptions of an experience are often emphasised, which can produce a self-defeating, self-concept that maintains the problem (Richert, 2006). Narrative therapy helps to highlight events that have not been integrated into a personal narrative. In narrative therapy, stories of difficult experiences are reframed to construct new alternatives to personal narratives (Freedman & Combs, 1996).

Narrative therapy consists of the following components designed to empower the client to change the perception of the problem behaviour (White & Epston, 1990):

- Characterising the influence of the problem
- Externalising
- Identifying exceptions and unique outcomes
- Re-authoring a preferred story
- Inviting witnesses to experience the new story
- Committed action

Developmentally appropriate questions are asked to help the individual identify and understand the problem and its impact on their life and relationships. The prevailing story is deconstructed to support the identification of strengths and begin the process of externalising the problem (Lambie & Milsom, 2010). Exceptions are prioritised to identify positives that can be incorporated into the new narrative. Individuals are encouraged to externalise and objectify the problem, a key component in narrative therapy (Freedman & Combs, 1996). This step limits self-blame and instead emphasises that the problem is created in social and cultural contexts separate from the person, rather than viewed as an individual deficit (Semmler & Williams, 2000). Similar to solution focused therapy (de Shazer, 1985), unique outcomes to the problem behaviour are identified, explored and given meaning and individual strengths, successes and skills are emphasised as resources to support change. An alternative story reflecting

new preferences, values and identities is constructed from this process (White, 2000).

Preferred stories are designed to empower the individual to reflect differently on the thought, intent and values that might have been underlying the problem and to reconstruct a more preferable personal narrative (Gilling, 2016). Future actions are considered to establish and integrate the preferred story by helping the individual to identify other people to experience and support the new narrative (Lambie & Milsom, 2010). Narrative therapy provides a framework for exploring damaging stories of self by conceptualising narratives that empower self-efficacy (Freeman & Combs, 1996).

In the school environment, students are often described or identified as being different from the norm, *e.g.* 'gifted and talented' or 'underachieving' (Winslade & Monk, 2007), which may be reinforced by adults to become the dominant story. These stories often lead to social, emotional and mental health issues, such as anxiety and depression, especially when a person is faced with challenging situations, without effective skills to navigate them successfully. By isolating the problem, reframing experiences and envisioning a new narrative, people have an improved ability to solve future problems (Etchison & Kleist, 2000).

The process of narrative therapy practice can be effectively modified for individual or group sessions, and for the age range of the participants. German (2013) utilised the 'Tree of Life' intervention based in narrative

therapy theory with a class of Year 5 pupils to challenge racism and enhance self-esteem and cultural understanding. Narrative therapy techniques may include the use of puppets with primary school students to help them understand and externalise problems (Eppler, Olsen & Hidano, 2009), or incorporate play therapy techniques into the process (Looyeh, Kamali & Shafieian, 2012). Like cognitive behaviour therapy, narrative therapy addresses deep-seated and damaging personal beliefs to alter negative perspectives. Narrative therapy has been used to identify potential solutions to discrete actions, such as helping children with ADHD to learn not to interrupt conversations (Kamali & Looyeh, 2013).

### *Psychological Theory*

Narrative therapy is grounded in social constructionist theory that suggests realities and knowledge are jointly constructed through social processes influenced by history and context (Lambie & Milsom, 2010). Knowledge and realities are shared and maintained through language and interactions with others, and are reflective of social beliefs that over time, create a sense of identity and personal narrative (Bruner, 1990). Interpretations of reality are developed into stories that give a frame of reference to understand experiences (Etchison & Kleist, 2000).

Narrative therapy principles have been influenced by Foucault (1973), who suggested that “theories about identity have been accepted as a set of normalising truths which have the power to shape our lives and relationships”

(German, 2013, p.77). Dominant discourses constructed through experiences become the truth that people measure themselves against (German 2013). As such, the meanings around a negative dominant self-concept can be revised and reframed through language to provide new empowering narratives.

Moreover, narrative therapy process is described as a scaffolded conversation map (White, 2007), based on Vygotsky's Zone of Proximal Development. Questioning from the therapist allows the individual to explore previously unknown facets of themselves from experiences, enabling the development of alternative views to construct a preferred story, where the problem is non-existent.

#### *Importance to EP practice*

With changes to the Special Educational Needs Code of Practice (Department for Education; Department of Health, 2014) to include young people up to 25 years old, and the increased focus on mental health and wellbeing in education (Department for Education Green Paper, 2017), the role of Educational Psychologists (EP) has broadened. In addition to supporting cognition and learning, EPs are increasingly required to deliver therapeutic interventions at different levels, targeting a range of social, emotional, and behavioural needs (MacKay, 2007). The unique role of the EP and their access to educational contexts, make them well placed to deliver these interventions in school.

Children with disabilities and disorders are often stigmatised or labelled as being different to others and difficult for teachers and family, leading to a dysfunctional and unhealthy narrative (Kendall, Hatton, Beckett, & Leo, 2003). Accordingly, these conditions often define the student, and strengths, skills and resources inherent in the student are overlooked (Gilling, 2016). Schools are one aspect of the community in which identity is developed and narratives emerge, and thus can provide a context for acknowledgment and consolidation of preferred stories (German, 2013).

#### *Rationale for review*

A review by Farrell et al. (2006), explored the role of the EP, and found that the delivery and support for therapeutic interventions was a growing area concern and need for schools and parents. Increasingly, EP services often overlap the responsibilities of clinical and counselling psychologists due to changes in Children's Services, and the Every Child Matters legislation (DfES, 2004). Many EPs currently have significant counselling and therapeutic skills in a range of therapeutic approaches and can incorporate these skills to support vulnerable children and young people, and systemically to support others to deliver programmes, such as school staff who work with children on a daily basis (MacKay, 2007).

EP practice has begun to incorporate narrative therapy into practice, as it provides a powerful and effective approach to working with children and young people in a range of settings (German, 2013). By placing the individual in a position of agency and control, the EP can collaborate with a young

person in realising alternative pathways and possibilities (Hobbs et al., 2012, p. 44). EPs can use narrative therapy as a medium for positive change to enable students to envision and embrace a new perspective, build resilience and coping strategies, to enable effective management of future behaviour.

Several studies have explored the effectiveness of narrative therapy on measures such as: helping a student transition from an alternative school setting to mainstream (Haskins, Johnson, Grimes, Moore, & Norris-Brown, 2016); stealing behaviours (Seymour & Epston, 1989); social and emotional skill development (Beaudoin et al., 2016); and helping children of parents with affective disorders (Focht & Beardslee, 1996). However, there is a limited research base in the UK, and an increased focus on Educational Psychologists delivering evidence based therapeutic interventions.

Therefore, the question addressed in this review is:

Can Narrative Therapy be an effective school-based intervention for children and young people with a range of special educational needs?

## **2. Critical Review of the Evidence Base**

### *Literature search*

A literature search was conducted in December 2017 and January 2018 using six electronic databases: PsychINFO, ERIC (EBSCO), SCOPUS, Web of Science, MEDLINE and Science Direct. The search terms were entered into the databases centred on 'narrative therapy intervention' and combined with 'school' to focus the search (Table 1). The keywords were amended according to search criteria for some of the databases due to the accessibility

and availability of studies in each database and to filter narrative interventions that were not therapeutic.

Table 1

*Search terms*

Database	Search Terms
PsychINFO ERIC (EBSCO) Web of Science SCOPUS MEDLINE	Narrative therapy intervention AND school
	Narrative therapy AND school
Science Direct	“narrative therapy” AND school

The search generated 444 results across the six databases. Sixteen studies were excluded because of duplication. A title screening excluded 395 studies and 14 studies were excluded after an abstract screening. The full text of nineteen studies were reviewed and thirteen were eliminated using the inclusion and exclusion criteria (Table 2). A distinction was made between including studies using ‘narrative therapy intervention’ and not including ‘narrative intervention’ because narrative therapy follows a specific six stage process. There are several studies that employ narrative interventions, but these are primarily story-based and focus on developing language and literacy skills. A further search was conducted using the Educational Psychology in Practice journals and one paper was identified. Six studies were selected for data synthesis. Figure 1 shows the search process and a list of excluded studies with rationale is provided in Appendix A. Included studies are outlined in Table 3 and detailed in Appendix C.

Table 2

*Inclusion and exclusion criteria*

	Inclusion criteria	Exclusion criteria	Justification
1. Type of publication	The study must appear in a peer reviewed journal	The study does not in a peer reviewed journal	Peer reviewed journals ensure quality assurance of the study
2. Language	Studies written in English	Studies not written in English	Reviewer is not able to translate studies not written in English.
3. Setting	Primary and secondary schools; special schools; preschool	Not in a school i.e. an after school club, nursery or university	To consider the implication of the intervention on students in a school setting
4. Intervention	Narrative therapy	Not narrative therapy eg 'narrative intervention,' 'narrative skills,' 'story telling' or 'narrative instruction'	To ensure the effects were from a narrative therapy intervention and not a narrative intervention which can take many forms
5. Type of design	Group based or single case study design	Not a group based or single case study design	The review compared the effectiveness of the intervention whether with one subject or between or within participants
6. Participants	Participants are of school age with special educational needs	Participants are not of school age and do not have special educational needs	To consider the effectiveness of the intervention on statutory school aged children with SEN
7. Measures	The study must have pre and post intervention data	The study does not have pre and post intervention data	The use of objective and quantitative measurements to obtain data was warranted to effectively evaluate the intervention.

Figure 1

Flow diagram of study selection process

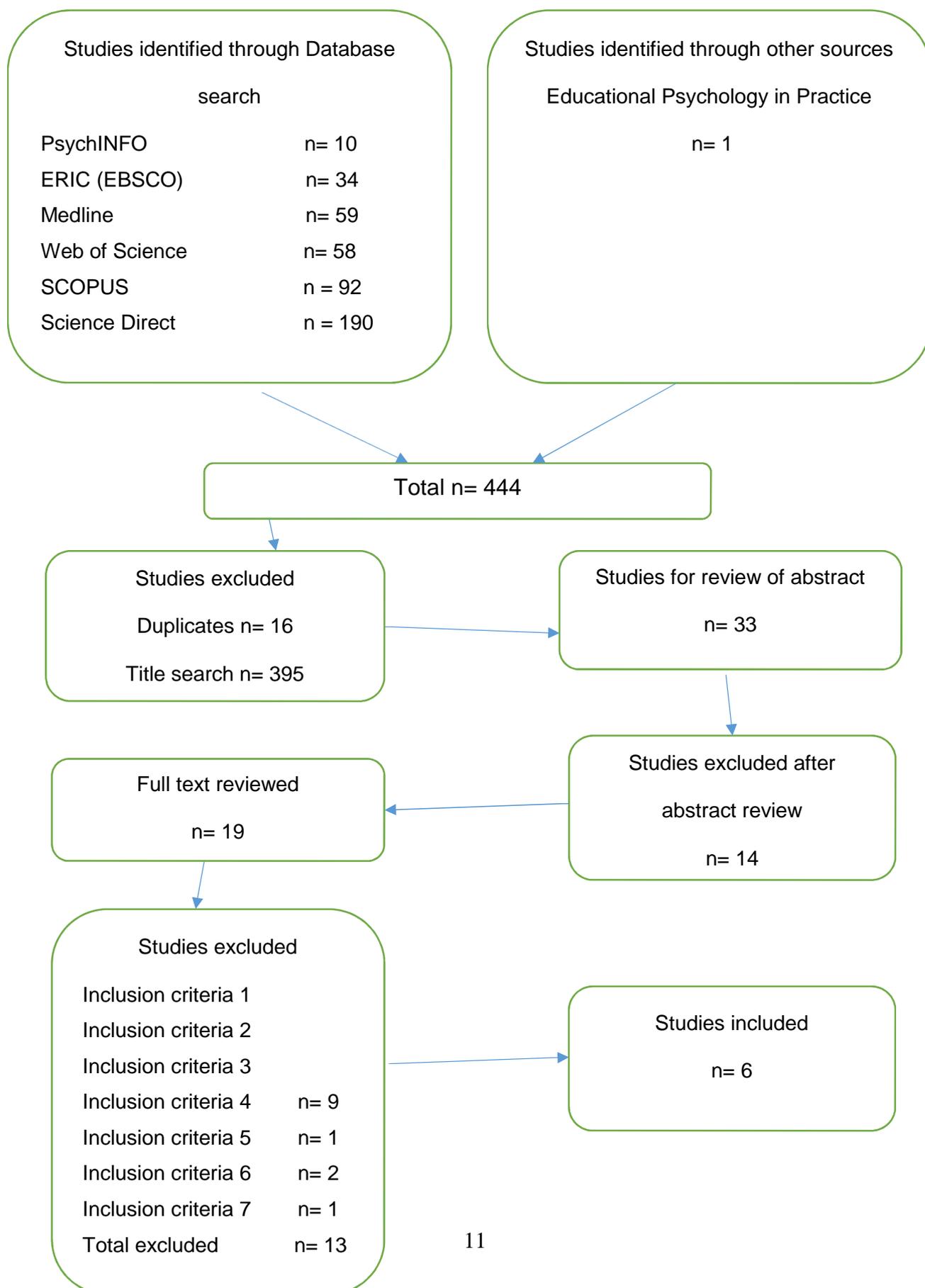


Table 3

*Selected studies for inclusion in review*

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Included Studies	
1.	Cashin, A., Browne, G., Bradbury, J. & Mulder, A. (2013). The Effectiveness of Narrative Therapy With Young People With Autism. <i>Journal of Child and Adolescent Psychiatric Nursing</i> . 26, pp. 32-41.
2.	Rahmani, P. & Moheb, N. (2010). The effectiveness of clay therapy and narrative therapy on anxiety of pre-school children: a comparative study. <i>Procedia- Social and Behavioural Sciences</i> . 5, pp. 23-27.
3.	Looyeh, M., Kamali, K., Ghasemi, M. & Tonawanik, P. (2014). Treating social phobia in children through group narrative therapy. <i>The Arts in Psychotherapy</i> . 41, pp. 16-20.
4.	Rahmani, P. (2011). The efficacy of narrative therapy and storytelling in reducing reading errors of dyslexic children. <i>Procedia-Social and Behavioural Sciences</i> . 29, pp. 780-785.
5.	Looyeh, M., Kamali, K. & Shafieian, R. (2012). An Exploratory Study of the Effectiveness of Group Narrative Therapy on the School Behaviour of Girls with Attention-Deficit/Hyperactivity Symptoms. <i>Archives of Psychiatric Nursing</i> , Vol. 26, No. 5, pp. 404-410.
6.	Hannen, E. & Woods, K. (2012). Narrative therapy with an adolescent who self-cuts: a case example. <i>Educational Psychology in Practice</i> . Vol. 28, No. 2, pp. 187-214.

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*Weighting of studies*

The six studies selected for review were evaluated according to the Weight of Evidence framework (Gough, 2007). The framework outlines guidelines to assess the methodological quality and relevance of each study in addressing their appropriateness to the research question. Three scores in the three areas are weighted, combined and averaged to determine an overall WoE D score (Table 4).

The group design studies (studies 1-5) were evaluated for WoE A using the Procedural and Coding Manual for Review of Evidence-Based Interventions by Kratochwill (2003), which was amended to include evaluation of Measurement, Comparison Group, Appropriate Statistical Analysis, Implementation Fidelity and Site Implementation. The single case design (Hannen & Woods, 2012) was coded using the Quality Indicators: Within Single-Subject Research by Horner et al. (2005). For the total WoE A for both coding protocols, the scores were combined and averaged for an overall WoE A score. The WoE framework criteria for WoE A (Methodological Quality), WoE B (Relevance of Design) and WoE C (Relevance of Topic) is provided in Appendix B and examples of the coding protocols are found in Appendix D. Table 5 provides the overall WoE scores in each area for the six studies under review (WoE D).

Table 4

*Framework for Weight of Evidence (Gough, 2007)*

Weight of evidence A	Weight of evidence B	Weight of evidence C	Weight of evidence D
Non review specific judgement about the type of research evidence	Appropriateness of the evidence to answer the review question	Relevance of the focus of evidence to the review question	The three sets of judgements (A,B &C) are combined for an overall assessment
<i>(Methodological Quality)</i>	<i>(Methodological Relevance)</i>	<i>(Topic Relevance)</i>	<i>(Overall Weight of Evidence)</i>

Table 5

WoE D gives the score that indicates the extent to which the study meets the requirements of the review question. The scores for each dimension (WoE A, WoE B, and WoE C) are combined and then averaged to form the WoE D score.

*Overall weight of evidence ratings (WoE D)*

Study	Weight of Evidence A	Weight of Evidence B	Weight of Evidence C	Weight of Evidence D
Cashin et al. (2013)	Medium 1.8	Low 1	Medium 2	Medium 1.6
Rahmani & Moheb (2010)	Medium 2	Medium 2	Medium 2	Medium 2
Looyeh et al. (2014)	Medium 2.2	High 3	Medium 2	Medium 2.4
Rahmani (2011)	Medium 1.8	Medium 2	Low 1	Medium 1.6
Looyeh et al. (2012)	Medium 2	High 3	Medium 2	Medium 2.3
Hannen & Woods (2012)	Medium 1.8	Low 1	High 3	Medium 1.9

Note: Where weak = 0, low = <1.4, medium = 1.5-2.4 and high =>2.4

### **3. Characteristics of included studies**

#### *Key Participants*

The selected studies were published between 2010 and 2014 and conducted in Australia (Cashin, Browne, Bradbury & Mulder, 2013), Iran (Rahmani & Moheb, 2010; Looyeh, Kamali, Ghasemi & Tonawanik, 2014; Rahmani, 2011; Looyeh et al., 2012) and the UK (Hannen & Woods, 2012). Both Iran and Australia, follow a western style education system largely similar to the UK in terms of the curriculum, and therefore, any minor differences in the educational system was not considered to impact on the WoE for this review. In total 109 participants were included, with sample sizes ranging from a case study (Hannen & Woods, 2012) to thirty participants (Rahmani, 2011; Rahmani & Moheb, 2010) and with ages ranging from 6-16 years. Looyeh et al., (2012) and Hannen and Woods (2012) had female participants (n=15), while Looyeh et al. (2014) and Cashin et al. (2013) had male participants (n=34). Both the Rahmani (2011) and Rahmani and Moheb (2010) studies did not report gender differences (n=30 for both studies). Participants were chosen due to having special educational needs ranging from dyslexia (Rahmani, 2011); to autism (Cashin et al., 2013); anxiety (Rahmani & Moheb, 2010); social phobia (Looyeh et al., 2014); self-harm tendencies (Hannen & Woods, 2012) and attention-deficit/hyperactivity symptoms (ADHD; Looyeh et al., 2012).

Participants were recruited from a selected preschool (Rahmani & Moheb, 2010), primary or elementary schools (Looyeh et al., 2013; Rahmani, 2011) and a secondary school referral from the SENCo (Hannen & Woods, 2012). Participants in the Looyeh et al. (2012) study were selected from consecutive

referrals by school districts to a psychological services centre. Cashin et al. (2013) used a convenience sample to recruit participants by the distribution of flyers around the local area.

Qualifying criteria included that participants a) did not have prior history of treatment for their difficulty, b) met the Children Symptom Inventory (CSI) symptoms cut off score for a potential diagnosis or c) had a confirmed clinical diagnosis of their difficulty (Looyeh et al., 2013; Looyeh et al., 2014).

Rahmani (2011) used the Dyslexia checklist (Micheli, 2006) to identify participants (Cronbach's  $\alpha=0.82$ ). Cashin et al. (2013) included criteria that participants could not have a comorbid condition. All studies took place in mainstream educational settings apart from the Cashin et al. (2013) study that took place in a university clinic. This study was included in the review due to its relevance to the review question and setting was taken into consideration for WoE A.

### *Study design*

Five of the studies used a quantitative approach, with Hannen and Woods (2012) using a mixed methods design. Four studies used an experimental design where all participants undertook testing at baseline and post intervention (Rahmani, 2011; Rahmani & Moheb, 2010; Cashin et al., 2012; Hannen & Woods, 2012) or baseline, post intervention and follow up (Looyeh et al., 2014; Looyeh et al. 2012). The studies that included follow up were rated higher for WoE B because of the importance of monitoring the long-term impact of the intervention. The studies that employed improved

controls, such as a wait list control group, and random allocation were given a higher rating for WoE B (Looyeh et al., 2014 and Looyeh et al., 2012).

Rahmani, (2011) and Rahmani & Moheb, (2010), randomly assigned participants and did not employ intervention control groups.

Cashin et al. (2013) employed a quasi-experimental within-participants design with no control group and therefore was given a Low (1) rating for WoE B. Hannen and Woods (2012) was a single case design and was given an overall WoE B rating of Low (1) because it did not have a control group nor random allocation.

#### *Narrative therapy interventions*

The interventions in the six studies were based on narrative therapy techniques but varied in their content and implementation. Two studies (Looyeh et al., 2014 & Looyeh et al. 2012) used narrative therapy techniques that were adopted from play therapy activities by Kaduson and Shaefer (1998), and modified for the presenting problem of participants. These consisted of 5-6 activities that were used in several sessions with different stories modified to target distinct symptoms, behaviours and outcomes. Both of these studies received a higher rating for implementation and fidelity in WoE A as they employed narrative therapy techniques that were sufficiently manualised and adapted for the study. Narrative therapy groups received 14 x 90 minute sessions over 7 weeks (Looyeh et al., 2014) and 12 x 1 hour sessions over 6 weeks (Looyeh et al., 2012) and were delivered by a therapist and school psychologist respectively.

The narrative therapy sessions in the Cashin et al. (2012) study were delivered by a qualified mental health nurse practitioner and consisted of 5 x 1 hour sessions over 10 weeks. Narrative therapy principles were modified for the thinking style of the participant group by including social stories as part of the intervention (Cashin et al., 2008) and a protocol for the intervention was provided, which was reflected in WoE A ratings.

Rahmani and Moheb (2010) followed a narrative therapy programme based on play therapy techniques (Kaduson & Schaefer, 1998) and therapeutic metaphors (Mills & Crowley, 1986) adapted to the age level of the participants (preschool). This study ran for 10 X 1 hour sessions over 5 weeks. The intervention was delivered effectively (25 X 45 minute sessions over 5 months) in Rahmani (2011), but the intervention was not described in sufficient detail to ensure fidelity or adaption of the narrative therapy process and this was reflected in the ratings for WoE C.

The Hannen and Woods (2012) study received a higher rating for WoE C due to the intervention being delivered by an educational psychologist (EP) over 6 weeks (1 X 1 hour session each week) after attending a six day Level One training course in narrative therapy based on White's (2007) Maps of Narrative Practices. The EP received monthly group supervision with an Association of Family Therapy accredited supervisor.

*Measures*

All studies used appropriate measures for the presenting problem. Rahmani and Moheb (2010) and Looyeh et al. (2012) used the Children Symptom Inventory 4 (CSI-4; Gadow & Sprafkin, 2004) to measure anxiety and ADHD symptoms respectively. The reliability of the CSI-4 in test-retest is between 0.46 to 0.87 and internal consistency is between 0.74 to 0.94, therefore, criterion validity is considered acceptable (Rahmani & Moheb, 2010).

Rahmani (2011) used multiple methods but only the Diagnostic Reading Test (reliability in test-retest ranges from 0.68 to 0.96) to measure reading errors, was deemed appropriate to include for this review. Looyeh et al. (2014) collected data using the CSI-4 to measure social phobia, from both parent and teacher.

Cashin et al. (2013) used multiple methods and sources to evaluate a range of psychological and biological measures associated with autism, including the Strengths and Difficulties Questionnaire (Parent version) and self-report measures The Kessler-10 (Kessler et al., 2003) for depression and anxiety, and the Beck Hopelessness Scale (Beck et al., 1974), to measure future expectations. The K-10 has strong reliability (Cronbach's  $\alpha = 0.93$ ) and the Beck Hopelessness scale has high internal consistency for dichotomous scales (Kuder-Richardson-20 coefficient of 0.93). Cashin et al. (2013) also collected the salivary cortisol: DHEA (dehydroepiandrosterone, an adrenal gland hormone) ratio at two time points, although the results were not included in this review.

Hannen and Woods (2012) collected data from the Beck Youth Inventory II (BYI-II: Beck & Beck, 2005); Resiliency Scales for Children and Adolescents (RSCA: Prince-Embury, 2008); Relative Influence Questions (White & Epston, 1990), Narrative Assessment Interview (Hardtke & Angus, 2004); parental reports and a range of therapeutic documents to measure self-harm tendencies and mental health. The study only reported the BYI-II and RSCA baseline and post intervention data and were considered for this review.

### *Outcomes*

All of the studies reported reductions in presenting symptoms in the intervention group. Rahmani (2011) reported effect sizes, but these were recalculated using the Pretest-Posttest Control Group calculation (Morris, 2007) and two studies (Rahmani & Moheb, 2010; Looyeh et al., 2014) provided enough data to calculate effect sizes. Effect sizes for group studies were calculated by dividing the mean pre-post difference in control and intervention groups by the pooled pre-test standard deviation. Looyeh et al. (2012) reported a Cohen's  $d$  effect size. For Cashin et al. (2013), the within-person change effect size was reported and this was recalculated for consistency. Cohen's  $d$  criteria (1988) was used to interpret effect sizes of 0.2 as small, 0.5 as medium and over 0.8 as large.

Four studies reported large effect sizes. Rahmani and Moheb (2010) reported an effect size of  $d = -3.17$  for the impact of narrative therapy on anxiety; Looyeh et al. (2012) reported large effect sizes at both post intervention ( $d = 0.93$ ) and follow up ( $d = 0.74$ ) for improvement in change in

ADHD/ADD/HD symptom scores. A significant decrease in reading errors was reported by Rahmani (2011),  $d= 1.69$  after intervention. Effect sizes increased for social phobia in Looyeh et al., (2014) between post intervention and follow up for both parent ( $d= -4.06$  v  $-4.52$ ) and teacher ( $d= -2.92$  v  $3.46$ ), which may indicate additional improvements after delay.

The SDQ: Total Difficulties parent report in Cashin et al. (2013), showed a medium effect size ( $d=0.57$ ) of the reduction in stress related problems in children with autism, however, the subtests Emotional Symptoms Scale and Peer Problems Scale reported large effect sizes,  $d=.75$  and  $d= .72$  respectively. The remaining subtests reported small effect sizes; Conduct Problems ( $d= -0.13$ ), Hyperactivity ( $d= 0.18$ ), and Pro-social ( $d= -.40$ ).

Because of the small n design, a post hoc power analysis (Wilcoxon signed rank test), using a change of 3 points in the SDQ:Total Difficulties, found that a clinical trial would require 63 participants in each group for 80% power to find a significant change at  $p<.05$  level. A reduction in distress levels (Kessler-10) was statistically significant ( $p=.017$ ) and showed a large effect size ( $d= 1.03$ ) compared to the Beck Hopelessness Scale, which reported a medium effect size ( $d=.37$ ) for a reduction in negative expectations.

Hannen and Woods (2012) did not provide enough data to calculate effect sizes. However, results from the BSCI-Y subtest of the BYI-II showed an improvement in self-concept and the BDBI-Y subtest reported a reduction in disruptive behaviour post intervention for self-harming behaviours. The RSCA scores show improvements in mastery, resilience and emotional

reactivity. However, no improvement was shown in the anxiety, depression  
anger subtests (BYI-II). The effect sizes for each study are presented in  
Table 6.

Table 6

*Effect sizes*

Study	Participants	Comparison	Outcome Measure	Effect size	Descriptor	WoE D
Cashin et al. (2013)	N=10	Within participants Baseline/post interventions	SDQ Total Difficulties	$d= 0.57$	Medium	Medium 1.6
			Emotional Symptoms Scale	$d= 0.75$	Large	
			Conduct Problems	$d= -0.13$	Small	
			Hyperactivity	$d= 0.18$	Small	
			Prosocial	$d= -.40$	Small	
Kessler-10	$d=1.03$	Large				
Beck Hopelessness Scale	$d=.37$	Small				
Rahmani & Moheb (2010)	N=30	Baseline/post intervention	Children Symptom Inventory 4 (CSI-4)	$d= -3.17$	Large	Medium 2
Looyeh et al. (2014)	N=24	Baseline/post Baseline/follow up	Children Symptom Inventory 4 (CSI-4)-Parent	$d= -4.06$ $d= -4.52$	Large Large	Medium 2.4
		Baseline/post Baseline/follow up	Children Symptom Inventory 4 (CSI-4) Teacher	$d= -2.92$ $d= -3.46$	Large Large	
Rahmani (2011)	N=30	Baseline/post	Diagnostic Reading Test	$d= 1.69$	Large	Medium 1.6
Looyeh et al. (2012)	N=14	Baseline/post Baseline/follow up	Children Symptom Inventory 4 (CSI-4)	$d= 0.93$ $d= 0.74$	Large Large	Medium 2.3
Hannen & Woods (2012)	N=1	There was not enough information to calculate	Beck Youth Inventory Resiliency Scales for Children and Adolescents	No effect sizes were reported		Medium 2

Effect size descriptors for  $d$  (Cohen, 1988) are: small,  $d=0.2$ , medium,  $d=0.5$  and large,  $d=0.8$

#### **4. Conclusions and Recommendations**

The purpose of this review was to explore the effectiveness of narrative therapy for children and young people with a range of special educational needs. This review evaluated six studies and all showed promising results in reducing: anxiety; self-harm tendencies; social phobia; ADHD tendencies; emotional symptoms associated with autism; and reading errors of dyslexic children. Medium and Large effect sizes were found in the studies with the highest WoE (Rahmani & Moheb, 2010; Looyeh et al., 2014; Hannen & Woods, 2012; Rahmani, 2011; Looyeh et al., 2012). Cashin et al. (2012) used a within-participants design, which makes it more difficult to determine if the results were due to the intervention or other factors. The largest effect sizes were found in children with social phobia (Looyeh et al., 2014). This study included multiple reporting methods (parent and teacher) and examined longer term aspects of the intervention, showing improvements post intervention and after 30 days. These results indicate that preferred stories constructed through narrative therapy can be adopted and strengthened over time. Homework was required between sessions in several studies, including keeping a diary of feelings and thoughts, and this may have impacted on reinforcing techniques learned during sessions.

##### *Limitations*

There are several limitations to the studies in this review. Although the studies included in this review were conducted in countries with Western-style educational systems, due to the population and small sample sizes, it can be argued that it is difficult to generalise the findings to the U.K.

Additionally, the CSI-4 assessment was norm-based on U.S. populations, which may differ from Iranian counterparts. Apart from Hannen and Woods (2012), the researchers did not engage in supervision, and training in narrative therapy was not addressed. This may have affected potential objectivity and reliability of the findings.

Implementation of narrative therapy varied greatly amongst the studies, through content and length of sessions, ranging from 5 weeks to 5 months. The narrative therapy procedure was modified for the age of the participants in Rahmani (2011), and did not include key components such as externalising the problem. However, the intervention ran the longest and showed large effect sizes for reducing reading errors. Although group narrative therapy incorporated components of play therapy (Looyeh et al., 2012; Looyeh et al., 2014), which were modified for the presenting problem, this approach demonstrated an effective way for participants to engage with the intervention.

#### *Areas for future research*

Current literature demonstrates that narrative therapy is a useful and effective intervention that EPs, and schools, can employ to empower children and young people to change their self-concept and develop greater self-esteem. Future areas of research should focus on building the evidence base within the U.K. This would include additional research on the effects of narrative therapy on specific areas of cognition and learning, and mental health and behaviour and with larger populations. Because narrative therapy

is grounded in constructivist approaches, additional research, using qualitative designs, would enable a richer understanding of the meanings people give to experiences.

## 5. References

- Beaudoin, MN., Moersch, M. & Evare, B. (2016). The Effectiveness of Narrative Therapy with Children's Social and Emotional Development: An Empirical Study of 813 Problem-Solving Stories. *Journal of Systemic Therapies*, Vol. 35, no. 3, pp. 42-59.
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## 6. Appendix A

### *Excluded studies*

Reference	Criteria for exclusion
Beaudoin, M-N., Moersch, M., Evare, B. (2016) The Effectiveness of Narrative Therapy with Children's Social and Emotional Skill Development: An Empirical Study of 813 Problem-Solving Stories. <i>Journal of Systemic Therapies</i> , Vol. 35, no. 3, pp. 42-59.	Criteria 6. Not special educational needs
Davies, P., Shanks, B., Davies, K. (2004) Improving narrative skills in young children with delayed language development. <i>Educational Review</i> , 56:3, pp. 271-286.	Criteria 4. Not narrative therapy
Dodd, J., Ocampo, A., Kennedy, K. (2011) Perspective Taking Through Narratives: An Intervention for Students with ASD. <i>Communication Disorders Quarterly</i> , 33(1), pp. 23-33	Criteria 4. Not narrative therapy
German, M. (2013) Developing our cultural strengths: Using the 'Tree of Life' strength-based narrative therapy intervention in schools, to enhance self-esteem, cultural understanding and to challenge racism. <i>Educational and Child Psychology</i> , Vol. 30 No. 4, pp. 75-99.	Criteria 6. Not Special Educational Needs
Gillam, S., Olszewski, A., Fargo, J., Gillam, R. (2014). Classroom Based Narrative and Vocabulary Instruction: Results of an Early Stage, Non-randomized Comparison Study. <i>Language, Speech and Hearing Services in School</i> , Vol. 45, pp. 204-219	Criteria 4. Not narrative therapy
Gilling, J. (2016). What can narrative therapy bring to our Understanding and practice around mental health and behaviour? Constructing preferred stories in the classroom. <i>Educational and Child Psychology</i> , Vol. 33, no. 4, pp. 80-94	Criteria 7. No pre/post measures
Green, L., Klecan-Aker, J. (2012) Teaching story grammar components to increase oral narrative ability: A group intervention study. <i>Child Language Teaching and Therapy</i> , 28(3), pp. 263-276.	Criteria 4. Not narrative therapy
Hoffman, L. (2009) Narrative Language Intervention Intensity and Dosage, Telling the Whole Story. <i>Top Language Disorders</i> , Vol. 29, no. 4, pp. 329-343.	Criteria 4. Not narrative therapy
Kamali, K., Looyeh, M. (2013) Narrative Intervention: A School-Based Counselling Strategy for Students with Attention Deficit/Hyperactivity Disorder. <i>Intervention in School and Clinic</i> 48(5) pp. 307-312	Criteria 7. No pre/post measures

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<p>Lambie, G., Milsom, A. (2010) A Narrative Approach to Supporting Students Diagnosed with Learning Disabilities. <i>Journal of Counselling and Development</i>, 88:2, pp.196-203</p>	<p>Criteria 7. No pre/post measures</p>
<p>Peterson, D. (2011) A Systematic Review of Narrative-based Language Intervention with Children Who Have a Language Impairment. <i>Communication Disorders Quarterly</i>, 32(4), pp. 207-220.</p>	<p>Criteria 4. Not narrative therapy</p>
<p>Ritter, M., Saxon, T. (2011) Classroom-based phonological Sensitivity Intervention (PSI) Using a Narrative Platform: An Experimental Study of First Graders at Risk for a Reading Disability. <i>Communication Disorders Quarterly</i>, 33(1) pp. 3-12</p>	<p>Criteria 4. Not narrative therapy</p>
<p>Soto, G., Solomon-Rice, P., Caputo, M. (2009) Enhancing the personal narrative skills of elementary school-aged students who use AAC: The effectiveness of personal narrative intervention. <i>Journal of Communication Disorders</i>, 42, pp. 43-57.</p>	<p>Criteria 4. not narrative therapy</p>

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## 7. Appendix B: Weight of Evidence Framework

### Group Studies

Weight of Evidence A is a non-specific review judgement (Gough, 2007). The APA Task Force Review Coding Protocol (Kratochwill et al., 2003) for group studies was used to evaluate studies 1-5 in this review. The protocol was adapted for this review by including only pertinent sections. The rationale for these amendments are as follows:

Table 7

#### *Amendments to WoE A Protocol*

Sections removed	Rationale for removal
1.B7-B8	Only quantitative studies were included in this review
C. Primary/secondary Outcomes	Outcomes are addressed separately in the effect size table
D. Educational/Clinical significance	Only narrative therapy interventions were included in this review
G. Replication	There was no replication of studies
I. Follow Up assessment	Only two studies reported follow up assessments

## A. Quality of Methodology

### *Weighting and criteria for Measurement (A)*

Weighting	Description
High (3)	Needs at least 3 out of 4: <ul style="list-style-type: none"><li>- Reported reliability of .85 or above for all primary outcomes relevant to the review question or used well referenced measures</li><li>- Data was collected using multiple methods</li><li>- Data was collected from multiple sources</li><li>- Reported validity for all measures used or use a well referenced standardised or norm-referenced measure</li></ul>
Medium (2)	Needs 2: <ul style="list-style-type: none"><li>- Reported reliability of 0.85 for some primary outcomes or used well-referenced measures</li><li>- Data was collected from multiple methods and/or sources. (The above criteria must be met for 75% of primary outcomes).</li><li>- Reported validity for all measures used or use a well referenced standardised or norm-referenced measure</li></ul>
Low (1)	Needs at least 1: <ul style="list-style-type: none"><li>- Reported reliability of .50 or above for some primary outcomes or used well-referenced measures.</li><li>- Only one data source or method was used</li><li>- Validity is not reported</li></ul>
No Evidence (0)	There is not enough evidence to rate this measure

*Weighting and criteria for Comparison Group (B)*

Weighting	Description
High (3)	<ul style="list-style-type: none"><li>- Includes a control group</li><li>- Confidence in rating the type of comparison group is strong</li><li>- Demonstrated group equivalence by random assignment</li><li>- Evidence of equivalent mortality and low attrition</li></ul>
Medium (2)	<ul style="list-style-type: none"><li>- Used a 'no intervention' group</li><li>- Confidence in rating the type of comparison group is Moderate</li><li>- Demonstrated group equivalence through random assignment or post hoc tests</li><li>- Evidence of equivalent mortality and low attrition</li></ul>
Low (1)	<ul style="list-style-type: none"><li>- Does not include a control group</li><li>- Confidence in rating the type of comparison group is low</li><li>- There is no evidence of random assignment</li><li>- There is no reference to equivalent mortality</li></ul>

*Weighting and criteria for Statistical Analysis (C)*

Weighting	Description
High (3)	Demonstrated all of these: <ul style="list-style-type: none"><li>- Conducted an appropriate analysis</li><li>- Controlled for family-wise error (when appropriate)</li><li>- Effect sizes were reported for all primary measures</li><li>- Had a sufficiently large sample size</li><li>- Conducted pre/post measures</li></ul>
Medium (2)	Demonstrated 2 of these: <ul style="list-style-type: none"><li>- Conducted an appropriate analysis</li><li>- Provided enough information for some effect sizes to be calculated</li><li>- Had a sufficiently large sample size</li><li>- Conducted pre/post measures</li></ul>
Low (1)	Demonstrated 1 of these: <ul style="list-style-type: none"><li>- Conducted an appropriate analysis</li><li>- Provided enough information for some effect sizes to be calculated</li><li>- Had a sufficiently large sample size</li><li>- Conducted pre/post measures</li></ul>
No evidence (0)	There is not enough evidence to rate this measure

*Weighting and Criteria for Implementation and Fidelity (F)*

Weighting	Description
High (3)	Demonstrated strong evidence of acceptable adherence plus at least 2 of these: <ul style="list-style-type: none"><li>- On/going supervision/consultation, coding sessions or audio/video tapes</li><li>- The use of a manual through information provided to the implementers using either (1) written materials involving detailed accounts of the exact procedures and the sequence in which they are to be used or (2) a formal training session that includes a detailed account of the exact procedures and the sequence in which they are to be used.</li><li>- If the intervention is to be administered in “sessions” or “lessons” then this information must be provided on a session to sessions/lesson to lessons basis.</li><li>- If adaptation occurs to fit varying contexts, there is a description of the procedure for adaptation.</li></ul>
Medium (2)	Demonstrated evidence of adherence and at least one of these: <ul style="list-style-type: none"><li>- Ongoing supervision/consultation, coding sessions or audio/video tapes</li><li>- The use of a manual through information provided to the implementers using either: (1) written materials involving an overview of broad principles and a description of the intervention phases or (2) a formal or informal training session involving an overview of broad principles and a description of the intervention phases</li></ul>
Low (1)	Demonstrated evidence of acceptable adherence measured through at least one of the above criteria or use of a manual.
No evidence (0)	Reflects that nothing was done to ensure implementation fidelity or evidence indicated unacceptable adherence

*Weighting and criteria for Site Implementation (H)*

Weighting	Description
High (3)	Study must have been conducted in a public school or an alternative school
Medium (2)	Study must have been conducted in a private, charter or university affiliated school setting
Low (1)	Intervention was not implemented in a school setting but could be implemented with little modification
No evidence (0)	Intervention not implemented within a school context and would require major modifications to do so.

Table 8

*Overall weighting for Weight of Evidence A*

Study	A	B	C	F	H	Overall WoE A
Cashin et al. (2013)	High 3	Low 1	Medium 2	Medium 2	Low 1	Medium 1.8
Rahmani & Moheb (2010)	Low 1	Medium 2	Medium 2	Medium 2	High 3	Medium 2
Looyeh et al. (2014)	Medium 2	Medium 2	Medium 2	Medium 2	High 3	Medium 2.2
Rahmani (2011)	Medium 2	Medium 2	Medium 2	Weak 0	High 3	Medium 1.8
Looyeh et al. (2012)	Low 1	Medium 2	Medium 2	Medium 2	High 3	Medium 2

Note: Where weak = 0, low = <1.4, medium = 1.5-2.4 and high =>2.4

For the single case study (Hannen & Woods, 2012), the Horner et al. (2005) coding protocol was used. The following table states the level of rating required for each of the criteria within the protocol.

*Weighting and criteria for single case design*

Rating	Description
High (3)-all met Medium (2) -2 met Low (1)-1 met 0 (not enough information to rate)	<p>Description of Participants and Settings</p> <ul style="list-style-type: none"> <li>- Participants are described with sufficient detail to allow others to select individuals with similar characteristics (eg. Age, gender, disability, diagnosis)</li> <li>- The process for selecting participants is described with replicable precision</li> <li>- Critical features of the physical setting are described with sufficient precision to allow replication</li> </ul>
High (3)-all met Medium (2) -3/4 met Low (1)-2 met 0 (not enough information to rate)	<p>Dependent variable</p> <ul style="list-style-type: none"> <li>- Dependent variables are described with operational precision</li> <li>- Each dependent variable is measured with a procedure that generates a quantifiable index</li> <li>- Measurement of the dependent variable is valid and described with replicable precision.</li> <li>- Dependent variables are measured repeatedly over time</li> <li>- Data are collected on the reliability or inter-observer agreement associated with each dependent variable, and IOA levels meet minimal standards (eg IOA=80%, Kappa=60%)</li> </ul>
High (3)-all met Medium (2) -2 met Low (1)-1 met 0 (not enough information to rate)	<p>Independent variable</p> <ul style="list-style-type: none"> <li>- Independent variable is described with replicable precision</li> <li>- Independent variable is systematically manipulated and under the control of the experimenter</li> <li>- Overt measurement of the fidelity of implementation for the independent variable is highly describable</li> </ul>
High (3)-both met Medium (2) -1 met Low (1)-0 met 0 (not enough information to rate)	<p>Baseline</p> <ul style="list-style-type: none"> <li>- The baseline phase provides repeated measurements of a dependent variable and establishes a pattern of responding that can be used to predict the pattern of future performance if introduction or manipulation of the independent variable did not occur.</li> <li>- Baseline conditions are describes with replicable precision</li> </ul>
High (3)-all met Medium (2) -2 met Low (1)-1 met 0 (not enough information to rate)	<p>Experimental control/internal validity</p> <ul style="list-style-type: none"> <li>- The design provides at least three demonstrations of experimental effect at three different point in time</li> <li>- The design controls for common threats to internal validity (eg permits elimination of rival hypotheses)</li> <li>- The results document a pattern that demonstrates experimental control</li> </ul>

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<p>High (3)-both met  Medium (2) -1 met  Low (1)-0 met  0 (not enough information to rate)</p>	<p>External validity</p> <ul style="list-style-type: none"> <li>- Experimental effects are replicated across participants, settings or materials to establish external validity</li> <li>- Selection and attribution biases (eg the selection of only certain participants, or the publication of only successful examples) are minimised</li> </ul>
<p>High (3)-all met  Medium (2) -3/4 met  Low (1)-2/4 met  0 (not enough information to rate)</p>	<p>Social validity</p> <ul style="list-style-type: none"> <li>- The dependent variable is socially important</li> <li>- The magnitude of change in the dependent variable resulting from the intervention is socially important</li> <li>- Implementation of the independent variable is practical and cost effective</li> <li>- Social validity is enhanced by implementation of the independent variable over extended time periods, by typical intervention agents in typical physical and social contexts</li> </ul>

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*Overall weighting for WoE A for single case design*

Description	Hannen & Woods (2012)
Participants and setting	High 3
Independent variable	Medium 2
Dependent variable	Medium 2
Baseline	High 3
Experimental control/Internal validity	Low 1
External validity	Weak 0
Social validity	Medium 2
Total WoE A	Medium 1.8

Note: Where weak = 0, low = <1.4, medium = 1.5-2.4 and high =>2.4

## B. Relevance of Methodology

Weight of Evidence B was determined by review-specific criteria relating to methodological relevance.

### *Weighting criteria for WoE B for group studies*

Weighting	Description
High (3)	<ul style="list-style-type: none"><li>- The study includes an active control group eg waitlist group</li><li>- Participants are randomly assigned to the conditions</li><li>- Group equivalency must be established</li><li>- The study reported pre, post and maintenance scores of the outcome measures for all groups</li></ul>
Medium (2)	<ul style="list-style-type: none"><li>- The study includes a control group</li><li>- Participants are randomly assigned to the conditions</li><li>- The study must report pre and post scores of the outcome measures and for all groups.</li></ul>
Low (1)	<ul style="list-style-type: none"><li>- There is no control group</li><li>- Participants are not randomly assigned to the conditions</li><li>- The study must report appropriate measures to assess the effectiveness of the intervention</li></ul>

### *For single case design (Horner et al., 2005)*

Weighting	Description
High (3)	<ul style="list-style-type: none"><li>• Use of a multiple baseline design or included at three attempts to demonstrate intervention effect</li><li>• Included generalisation and maintenance phase with at least three data points for each phase.</li></ul>
Medium (2)	<ul style="list-style-type: none"><li>• Detail three attempts to demonstrate intervention effect</li><li>• Either generalisation or maintenance phase with at least three data points for each phase.</li></ul>
Low (1)	<ul style="list-style-type: none"><li>• May not have demonstrated intervention effect three times</li><li>• Generalisation or maintenance data may not be included, or may be less than three data points</li></ul>

Table 9

*Overall weighting for WoE B*

Study	Weight of Evidence B
Cashin et al., (2013)	Low 1
Rahmani & Moheb (2010)	Medium 2
Looyeh et al. (2014)	High 3
Rahmani (2011)	Medium 2
Looyeh et al. (2012)	High 3
Hannen & Woods (2012)	Low 1

### C. Topic Relevance

Weight of Evidence C was determined by review specific criteria relating to topic relevance.

#### *Weighting and criteria for WoE C*

Weighting	Description
High (3)	Must include the following: <ul style="list-style-type: none"><li>- All components of the intervention are evident</li><li>- Presenting problems of the participants explained fully and appropriate for study</li><li>- Intervention was planned to improve psychological and/or learning issues</li><li>- Intervention was delivered by a qualified counsellor and/or EP who had supervision</li><li>- The intervention was documented in sufficient detail to ensure replicability</li><li>- More than one method of data collection was recorded</li></ul>
Medium (2)	Must include the following: <ul style="list-style-type: none"><li>- Some of the components of the intervention are evident</li><li>- Presenting problems explained fully and appropriate for study</li><li>- Intervention was planned to address psychological and/or learning issues</li><li>- Intervention was delivered by a qualified and trained counsellor /teacher</li><li>- The intervention was explained clearly</li><li>- At least one method of data collection was recorded</li></ul>
Low (1)	Needs at least 2 of 4: <ul style="list-style-type: none"><li>- One component of the intervention is evident</li><li>- The intervention was delivered by a trained counsellor/teacher</li><li>- The intervention was explained</li><li>- One method of data collection was included</li></ul>

Table 10

*Overall weighting for WoE C*

Study	Weight of Evidence C
Cashin et al. (2013)	Medium 2
Rahmani & Moheb (2010)	Medium 2
Looyeh et al. (2014)	Medium 2
Rahmani (2011)	Low 1
Looyeh et al. (2011)	Medium 2
Hannen & Woods (2012)	High 3

Note: Where weak = <1.4, low = <1.4, medium = 1.5-2.4 and high =>2.4

Table 11

WoE D gives the score that indicates the extent to which the study meets the requirements of the review question. The scores for each dimension (WoE A, WoE B, and WoE C) are combined and then averaged to form the WoE D score.

*Overall weight of evidence ratings (WoE D)*

Study	Weight of Evidence A	Weight of Evidence B	Weight of Evidence C	Weight of Evidence D
Cashin et al. (2013)	Medium 1.8	Low 1	Medium 2	Medium 1.6
Rahmani & Moheb (2010)	Medium 2	Medium 2	Medium 2	Medium 2
Looyeh et al. (2014)	Medium 2.2	High 3	Medium 2	Medium 2.4
Rahmani (2011)	Medium 1.8	Medium 2	Low 1	Medium 1.6
Looyeh et al. (2012)	Medium 2	High 3	Medium 2	Medium 2.3
Hannen & Woods (2012)	Medium 1.8	Low 1	High 3	Medium 1.9

Note: Where weak = <1.4, low = <1.4, medium = 1.5-2.4 and high =>2.4

## 9. Appendix C

### *Mapping the field*

Study	Participants	Intervention	Design	Measures	Outcomes
Cashin, Browne, Bradbury & Mulder (2013)	<p>Convenience sample of 10 young people (m=9, f=1) diagnosed with autism recruited via flyers. Criteria included a diagnosis of autistic disorder or Asperger's disorder. Participants were excluded if they had a comorbid intellectual disability. Two participants were from the same family.</p> <p>Age range: 10-16 years old</p> <p>Attrition: Female withdrew after premeasures and 2 sessions. These results were not included in the final analysis. Mean age range of remaining participants=</p> <p>Mean age of remaining participants =13.78.</p>	<p>5 sessions of narrative therapy intervention.</p> <p>Frequency: 1 hour session every 2 weeks over a 9 week period. The intervention was conducted by a mental health nurse at a university health centre.</p> <p>Aim: a reduction in stress related problems in young people with autism.</p>	Quasi-experimental; within participants, single sample, unblended intervention study with a pre/post test design.	<p>Primary measure was the Total Difficulties Score form the Parent version of the Strengths and difficulties Questionnaire (SDQ). The five subscales of the SDQ were assessed separately. Secondary measure used the Kessler-10 Scale of Psychological Distress (K-10); Beck Hopelessness Scale; salivary Cortisol:DHEA ratio.</p>	<p>There was a 3 point reduction in the baseline scores for the Total Difficulties Score on the SDQ after intervention but did not achieve statistical significance (p=0.150). The Emotional Symptoms Scale on the SDQ showed the strongest difference pre/post intervention and non-significant scores reported on the Conduct Problem and Hyperactivity Scale. Improved behaviour was noted by parents on the Prosocial and Peer Problems Scales.</p>

Study	Participants	Intervention	Design	Measures	Outcome
Rahmani & Moheb (2010)	30 kindergarten children chosen due to having anxiety disorders according to the CSI-4  Age range: all were 6 years old	A 5 week narrative therapy or clay therapy intervention  Aim: a reduction in anxiety levels  Frequency: 10 sessions of 60 minutes each	Pre-test/post-test with control group design. Children randomly assigned to clay therapy (n=10), narrative therapy (n=10) or control group (n=10).	Children were measured using the Child Symptom Inventory 4 (CSI-4) which measures behavioural disorders. The Parent Checklist screens for 15 emotional and behavioural disorders.	Both experimental groups showed a decrease in anxiety levels. There was an increase in anxiety levels in the control group.

Study	Participants	Intervention	Design	Measures	Outcome
Looyeh, Kamali, Ghasemi & Tonawanik (2014)	24 males with a diagnosis of social phobia drawn from 648 4 <sup>th</sup> grade students in 8 elementary boys schools from across 4 geographic regions. The Children Symptom Inventory checklist-4 (CSI-4) determined the inclusion criteria.	7 week narrative therapy intervention.  Aim: to reduce symptoms of social phobia  Frequency: 14 sessions of 90 minutes each delivered 2X each week. The sessions were conducted in a school room. The intervention was adapted from 5 play therapy activities compiled by Kaduson & Shaefer (1998). Participants kept a diary of thoughts, feelings and events to share.	Pre and Post test design with random allocation to treatment (n=12) group or placed on a wait list control group (n=12). Follow up data was collected 1 week and 30 days after intervention.	Children Symptoms Inventory checklist (CSI-4) was used to screen pre/post intervention. The study used the Farsi language version validated for implantation in Iran. The CSI-4 was used by teachers and parents to rate symptoms.	Results indicate a significant difference in symptom scores between the intervention and control group as reported by parents and teachers, indicating a reduction in symptoms over time. Reductions were shown 1 week after intervention and sustained 30 days after intervention. The wait list control group showed no change in symptoms over time.

Study	Participants	Intervention	Design	Measures	Outcome
Rahmani (2011)	30 children identified as dyslexic using the Dyslexia checklist (Micheli, 2006) to prescreen.	<p>A five month narrative therapy intervention</p> <p>Aim: a reduction in reading errors</p> <p>Frequency: 25 sessions lasting 45 minutes of individual story telling therapy with a counsellor using a felt board.</p>	Pre-test/Post-test with control group. Random allocation to treatment (n=15) or control (n=15) group.	Weschler Intelligence Scale for Children, 3 <sup>rd</sup> ed. (WISC-III-R); Diagnostic Reading test; Dyslexia checklist	Results show a 60% reduction in reading errors in the narrative therapy group as compared to the control group.

Study	Participants	Intervention	Design	Measures	Outcome
Looyeh, Kamali & Shafieian (2012)	<p>14 girls selected from consecutive referrals to a psychological service centre by school districts in Iran. Criteria included no prior treatment of ADHD; met the Children Symptom Inventory (CSI) cut off score for diagnosis of ADHD; had a confirmed diagnosis of ADHD.</p> <p>Age range: 9-11 years old</p>	<p>A 6 week narrative therapy intervention delivered twice weekly by a school psychologist.</p> <p>Aim: to improve behaviour</p> <p>The intervention included 6 group activities adapted from play therapy activities compiled by Kaduson &amp; Shaefer (1998). The stories were repeated in more than one session and directed at different symptoms, behaviours and outcomes. The sessions were conducted after hours in a school setting.</p>	<p>Experimental design. Students randomly assigned to 2 intervention groups (n=3 and n=4) or control group (n=7). A wait list control group was used. Pre/post data was recorded.</p>	<p>Children's Symptom Inventory (CSI-4) behaviour ratings by teachers provided pre and post intervention scores 1 week and 30 days following completion of therapy.</p>	<p>The combined intervention group showed a significant reduction in symptom scores 1 week and 30 days after completion of intervention. Participants in the wait list group showed no significant change in symptom scores.</p>

Study	Participants	Intervention	Design	Measures	Outcomes
Hannen & Woods (2012)	<p>A female in Year 8 identified as 'self-cutter' by the SENCO at the mainstream secondary school.</p> <p>Age: 12 years old</p>	<p>6 sessions of narrative therapy of one hour in length. Sessions were held in school at weekly intervals outside the school holidays.</p> <p>Aim: to examine a self-account of a adolescent who self-cuts as it emerged through narrative therapy.</p> <p>Sessions were conducted by an Educational Psychologist who had Level One training and on-going Supervision provided by the Association of Family Therapy.</p>	A mixed methods evaluative case study.	<p>A parental interview; pre/post tests using Beck Youth inventory (BYI-II) and Resiliency Scales for Children and Adolescents (RSCA); Relative Influence Questions (RIQ); Narrative Assessment Interview (NAI); various therapeutic documents; Post intervention Likhert Scale; Reflective diary used by EP.</p>	<p>Quantitative and qualitative data suggest that emotional wellbeing, resilience and behaviour improved over the intervention period. The BYI-II did not indicate improvements. Post interview the subject showed improvements in happiness levels and was no longer cutting and less consumed by anger. Parent and teacher reports indicate an improvement in behaviour.</p>

## 10. Appendix D: Coding Protocols

[Adapted from Task Force on Evidence-Based Interventions in School Psychology, American Psychology Association, Kratochwill, T.R. (2003)]

### Coding Protocol

Name of Coder: \_\_\_\_\_

Date: \_\_16/01/2018\_\_\_\_\_

Full Study Reference in proper format: **Cashin, A., Browne, G., Bradbury, J. & Mulder, A. (2013). The Effectiveness of Narrative Therapy With Young People With Autism. *Journal of Child and Adolescent Psychiatric Nursing*, 26, pp. 32-4**

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Intervention Name (description of study): \_\_\_\_\_ Narrative Therapy\_\_

Study ID Number: \_\_\_\_\_ 1 \_\_\_\_\_

- Type of Publication:  
 Book/Monograph  
 **Journal Article**  
 Book Chapter  
 Other (specify):

#### 1. General Characteristics

##### A. General Design Characteristics

A1. Random assignment designs (if random assignment design, select one of the following)

- Completely randomized design  
 Randomized block design (between participants, e.g., matched classrooms)  
 Randomized block design (within participants)  
 Randomized hierarchical design (nested treatments)

A2. Nonrandomized designs (if non-random assignment design, select one of the following)

- Nonrandomized design  
 Nonrandomized block design (between participants)  
 **Nonrandomized block design (within participants)**  
 Nonrandomized hierarchical design  
 **Optional coding for Quasi-experimental designs**

*The One-Group Pretest-Posttest Design*  
O1 X O2

A3. Overall confidence of judgment on how participants were assigned (select one of the following)

- Very low (little basis)  
 Low (guess)  
 Moderate (weak inference)  
 High (strong inference)

Very high (explicitly stated)

N/A

Unknown/unable to code

## B. Participants

Total size of sample (start of study):   10  

Intervention group sample size:   10  

Control group sample size:   0  

## C. Type of Program

Universal prevention program

Selective prevention program

Targeted prevention program

Intervention/Treatment

Unknown

## D. Stage of Program

Model/demonstration programs

Early stage programs

Established/institutionalized programs

Unknown

## E. Concurrent or Historical Intervention Exposure

Current exposure

Prior exposure

Unknown

## 2. Key Features for Coding Studies and Rating Level of Evidence/Support

(Rating Scale: 3= Strong Evidence, 2=Promising Evidence, 1=Weak Evidence, 0=No Evidence)

### A. Measurement (Estimating the quality of the measures used to establish effects)

A1 The use of the outcome measures produce reliable scores for the majority of the primary outcomes

Yes

No

Unknown/unable to code

A2 Multi-method (at least two assessment methods used)

Yes

No

N/A

Unknown/unable to code

A3 Multi-source (at least two sources used self-reports, teachers etc.)

Yes

No

- N/A
- Unknown/unable to code

A4 Validity of measures reported (well-known or standardized or norm-referenced are considered good, consider any cultural considerations)

- Yes validated with specific target group
- In part, validated for general population only
- No
- Unknown/unable to code

**Overall Rating for measurement\_3\_\_\_**

**3= Strong Evidence 2=Promising Evidence 1=Weak Evidence 0=No Evidence**

**B. Comparison Group**

B1 Type of Comparison Group (Select one of the following)

- Typical intervention (typical intervention for that setting, without additions that make up the intervention being evaluated)
- Attention placebo
- Intervention element placebo
- Alternative intervention
- Pharmacotherapy
- No intervention
- Wait list/delayed intervention
- Minimal contact
- Unable to identify type of comparison

B2 Overall confidence of judgment on type of comparison group

- Very low (little basis)
- Low (guess)
- Moderate (weak inference)
- High (strong inference)
- Very high (explicitly stated)
- Unable to identify comparison group

B3 Counterbalancing of change agent (participants who receive intervention from a single therapist/teacher etc were counter-balanced across intervention)

- By change agent
- Statistical (analyse includes a test for intervention)
- Other
- Not reported/None

B4 Group equivalence established (select one of the following)

- Random assignment
- Posthoc matched set
- Statistical matching
- Post hoc test for group equivalence

B5 Equivalent mortality

- Low attrition (less than 20 % for post)
  - Low attrition (less than 30% for follow-up)
  - Intent to intervene analysis carried out?
- Findings\_\_\_\_\_

**Overall rating for Comparison group**   0    
**3= Strong Evidence 2=Promising Evidence    1=Weak Evidence    0=No Evidence**

**C. Appropriate Statistical Analysis**

**Analysis 1**\_\_\_\_\_Wilcoxon signed-rank test \_\_\_\_\_

- Appropriate unit of analysis
- Familywise/experimenter wise error rate controlled when applicable
- Sufficiently large N

**Overall rating for Statistical Analysis**   1    
**3= Strong Evidence 2=Promising Evidence    1=Weak Evidence    0=No Evidence**

**F. Implementation Fidelity**

F1. Evidence of Acceptable Adherence (answer F1.1 through F1.3)

- F1.1  Ongoing supervision/consultation
- F1.2  Coding intervention sessions/lessons or procedures
- F1.3  Audio/video tape implementation (select F1.3.1 or F1.3.2):
  - F1.3.1  Entire intervention
  - F1.3.2  Part of intervention

F2. Manualization (select all that apply)

- F2.1  Written material involving a detailed account of the exact procedures and the sequence in which they are to be used
- F2.2  Formal training session that includes a detailed account of the exact procedures and the sequence in which they are to be used
- F2.3  Written material involving an overview of broad principles and a description of the intervention phases
- F2.4  Formal or informal training session involving an overview of broad principles and a description of the intervention phases

F3. Adaptation procedures are specified (select one)  yes  no  unknown

**Rating for Implementation Fidelity** (select 0, 1, 2, or 3):  3  2  1  0

**H. Site of Implementation**

H1. School (if school is the site, select one of the following options)

*Can Narrative Therapy be an effective school-based intervention for children and young people with a range of special educational needs?*

- H1.1  Public
- H1.2  Private
- H1.3  Charter
- H1.4  University Affiliated
- H1.5  Alternative
- H1.6  Not specified/unknown

H2. Non School Site (if it is a non school site, select one of the following options)

- H2.1  Home
- H2.2  University Clinic
- H2.3  Summer Program
- H2.4  Outpatient Hospital
- H2.5  Partial inpatient/day Intervention Program
- H2.6  Inpatient Hospital
- H2.7  Private Practice
- H2.8  Mental Health Center
- H2.9  Residential Treatment Facility
- H2.10  Other (specify): \_\_\_\_\_
- H2.11  Unknown/insufficient information provided

**Rating for Site of Implementation** (select 0, 1, 2, or 3):  3  2  1  0

### Summary of Evidence

Indicator	Overall evidence rating 0-3	Description of evidence Strong Promising Weak No/limited evidence  Or Descriptive ratings
<b>General Characteristics</b>		
Design		Quasi-experimental
Type of programme		Selective Preventative
Stage of programme		Early stage programme
Concurrent/ historical intervention exposure		Not known
<b>Key features</b>		
Measurement	3	High
Comparison group	0	Weak
Appropriate Statistical Analysis	1	Low
Implementation and Fidelity	2	Medium
Site Implementation	1	Low

**Quality Indicators: Within Single-Subject Research (Horner 2005)**

Name of coder:

Date: 18/01/2018

Study number: 6

Full study: **Hannen, E. and Woods, K. (2012) Narrative therapy with an adolescent who self cuts: a case example. *Educational Psychology in Practice*, 28:2, 187-214**

**Description of Participants and Setting**

	Yes	No
<ul style="list-style-type: none"> <li>Participants are described with sufficient detail to allow others to select individuals with similar characteristics (eg age, gender, disability, diagnosis)</li> </ul>	Yes	
<ul style="list-style-type: none"> <li>The process for selecting participants is described with replicable precision.</li> </ul>	Yes	
<ul style="list-style-type: none"> <li>Critical features of the physical setting are described with sufficient precision to allow replication</li> </ul>	Yes	

**Dependent variable**

	Yes	No
<ul style="list-style-type: none"> <li>Dependent variables are described with operational precision.</li> </ul>	Yes	
<ul style="list-style-type: none"> <li>Each dependent variable is measured with a procedure that generates a quantifiable index</li> </ul>	Yes	
<ul style="list-style-type: none"> <li>Measurement of the dependent variable is valid and described with replicable precision</li> </ul>	Yes	
<ul style="list-style-type: none"> <li>Dependent variable are measured repeatedly over time</li> </ul>	Yes	
<ul style="list-style-type: none"> <li>Data are collected on the reliability or interobserver agreement associated with each dependent variable, and IOA levels meet minimal standards (eg IOA=80%; Kappa=60%)</li> </ul>		No

**Independent variable**

	Yes	No
<ul style="list-style-type: none"> <li>Independent variable is described with replicable precision</li> </ul>	Yes	
<ul style="list-style-type: none"> <li>Independent variable is systematically manipulated and under the control of the experimenter</li> </ul>	Yes	
<ul style="list-style-type: none"> <li>Overt measure of the fidelity of implementation for the independent variable is highly desirable</li> </ul>		No

**Baseline**

	Yes	No
<ul style="list-style-type: none"> <li>The majority of single-subject research studies will include a baseline phase that provides repeated measurement of a dependent variable and establishes a pattern of responding that can be used to predict the pattern of future performance, if introduction or manipulation of the independent variable did not occur.</li> </ul>	Yes	
<ul style="list-style-type: none"> <li>Baseline conditions are described with replicable precision.</li> </ul>	Yes	

### Experimental control/Internal validity

	Yes	No
• The design provides at least three demonstrations of experimental effect at three different points in time		No
• The design controls for common threats to internal validity (eg permits elimination of rival hypotheses)		No
• The results document a pattern that demonstrates experimental control	Yes	

### External Validity

	Yes	No
• Experimental effects are replicated across participants, settings or materials to establish external validity.		No

### Social Validity

	Yes	No
• The dependent variable is socially important	Yes	
• The magnitude of change in the dependent variable resulting from the intervention is socially important		No
• Implementation if the independent variable is practical and cost effective	Yes	
• Social validity is enhanced by implementation of the independent variable over extended time periods, by typical intervention agents, in typical physical and social contexts.	Yes	