These notes are a starting point for me to begin a conversation about a more deliberate and intentional attention to feeling, emotion and the body in narrative therapy. I am defining affect simply as the “experience of feeling.” It can include every aspect of emotion, physical reverberation, snarls, blushes, tears, sobs, levels of arousal, and dynamic changes in patterns of neural activity. Attention to affect requires us to come to terms with the body. Affective practice according to Wetherell (2012) is the attention to the non-conscious aspect of human behavior which can shape habits within deeply embedded relational patterns. Margaret Wetherell’s (2012) analysis of the “affective turn” draws upon the writings of Ahmed (2014), Massumi (2002), Sedgwick (2003), Stewart (2007), and White, (1993).

As humans we are sometimes unaware our bodily responses until after they have occurred. For narrative therapists this is, I think, a relatively new area of inquiry even though narrative practice engages emotion and the body. The affective turn is a deliberate attention to human action that is occurring that is unaddressed by exclusive attention to text and talk. Sometimes it is human action that is initially beyond conscious awareness. Sharp bursts of affect invoke an action-oriented body. Affect constitutes a strong push to fight, flee, freeze, to appease - to do something. In the face of conflictual interactions between persons the body feels threat. One body is wanting robust intensity, displaying a harsh voice tone, the eyes drilling in, a furrowed brow, the body moves close demanding engagement. The other body is burdened, experiences a sense of tiredness, a heaviness, an overwhelming desire to sleep. In the next round of interaction one body is withdrawing, turning away, blank looking, and hunching over. Affect scholars such as Siegel, 2012 emphasize the automaticity of the involuntary nature of bodily and physiological reactions. We are familiar with the physiological mechanisms of how the central nervous system (CNS) produces chemical transmitters that connect neural circuits that fire rapidly conveying information to the body. In an
affective response, the body pumps out somatic actions and gestures. Initiated by the autonomic nervous system (ANS), there are changes in heart and breathing rate, blood flow variations, muscles moving in involuntarily ways producing facial frowning, wrinkling, twisting, and smiling.

Cromby refers to three distinct approaches to the affective turn that is being discussed in the social sciences in the last two decades.

1. Tompkin’s affect theory emphasize the way affect flows in “complex recursive circuits and feedback loops both within and between individuals (Cromby, 2015 p.5)

2. Drawing on the discipline of psychoanalysis affect is a primary human process that registers “seething, motives, nameless compulsions and unspeakable desires of the unconscious, the operations of which are forever threatening to be known directly and so must always be diluted or disguised before they enter awareness” (p.5)

3. Deleuze and Guattari have written the most influential work on the affective turn interpreted by Massumi (2002). “Affect is pre-personal, before experience, and consisting of unqualified intensities that constitute and precede the sociolinguistic” (p.5). From this framework affect is a motivating force of becoming. “the ceaseless process of restless change that characterizes life itself.”

Scholars focused on the Affective Turn can find poststructural discourse explanations somewhat limited in explaining action. However, Wetherell (2012) argues that the organization and interpretation of body possibilities is always culturally embedded and any embrace of a simplistic categorization of basic human emotions misrepresents the complex investigation of the affective turn.

We are understandably preoccupied with text and talk in therapy given the influence of literary theory and the discursive or linguistic turn (Rorty, 1967; Potter & Wetherell, 1987). When we teach narrative therapy there is a tendency to privilege text and transcript and at times, we can become less interested in viewing videotapes that show us what is going on with our bodies and voice tone and the presentation of affect. I have heard critics new to narrative therapy say that narrative work is too cerebral, too cognitively focused, and demonstrates an exaggerated interest in words and thoughts
and neglects what people are experiencing in their bodies and their emotions. Experienced practitioners of narrative therapy know this criticism to be inaccurate. We know the practice of narrative therapy can be thoroughly captivating of a person’s entire human experience. Yet, narrative therapists have not traditionally emphasized the value of engagement with affect and bodily experience. This is beginning to change. There is now an eager exploration of neurobiology and bodily experience in narrative work. Beaudoin and Duvall’s (2017) edited book Collaborative Therapy and Neurobiology is a great example of this emerging exploration. Increasingly, leaders in narrative work are bringing forward the importance of our bodies and our emotions and their connection to narrative practice. Lynne Rosen, Maggie Carey & SuEllen Hamkin’s (2016) conversations captured by Peggy Sax titled Bridging Neurobiology, the body and Narrative Practice (https://www.youtube.com/watch?v=H3FD8ULVpfE&feature=youtu.be) is further evidence of attention to the affective turn. These emerging initiatives are, I believe, worthy of attention and I look forward to discussing the therapeutic implications of these ideas with other narrative therapy practitioners.


