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Jenessa Margaret Radocchio
The Revaluation of Pathology:
Narrative, Nietzsche, and the
Emergence of the Storied Body

ABSTRACT

This research project is a theoretical inquiry into the connections and significations between philosophy and contemporary clinical practice. It is hypothesized that postmodernism has a direct and meaningful impact on the work of clinical social workers and mental health professionals generally. For a more manageable study and to make the topic more accessible to the reader, one type of philosophy (postmodernism) was chosen to be analyzed, along with its clinical counterpart (narrative therapy). To ground the study, Nietzschean ideology and narrative therapy were analyzed and discussed through the lens of self-mutilation.

It was found that many significant connections exist between Nietzsche's ideas and narrative therapy in general, suggesting that philosophy, as a discourse that concerns itself with the human experience, has a vital and sizeable influence on contemporary clinical practice. The implications of the study are that, taking postmodern ideology to its logical ends would mean the dissolution of the ideas of both normalcy and deviance in clinical practice, subsequently serving to de-pathologize the phenomenon of self-mutilation and redefine it as a storying or narrating of one's experience and identity on the body.

THE REVALUATION OF PATHOLOGY:
NARRATIVE, NIETZSCHE,
AND THE
EMERGENCE OF THE STORIED BODY

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

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2007

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CHAPTER I

INTRODUCTION

Philosophy as a discipline concerns itself with ideas regarding the most basic and primordial condition of human beings. Rather than a set of claims, philosophy is a method of inquiry that is (ideally) based on reason, critique, and rigorous investigation. Insofar as any type of change—whether it be individual, social, or institutional—begins at the level of ideas, philosophy and the philosophic process of inquiry can be seen as a necessary vehicle for individual and cultural change. Unfortunately, the effect of the ideas engendered from any particular philosophical movement may take years, if not decades to find their way into general social consciousness. This could be why philosophy has traditionally been seen as being removed from the reality of people’s everyday lives, and one of the least useful of all the academic disciplines. That philosophy is relegated to the ivory tower of the academy, neither influencing, nor being influenced by, the reality of people’s everyday lives, is a position that this paper will seek to challenge.

Perhaps no other occupation is as invested in people and their communities, cultures, and relationships than is social work. Dichotomies are constructed between clinical social work and social action, theory and practice, yet ultimately it is impossible to divorce the two. Theory and ideas permeate and serve as the foundation for all the work that is done with our clients. It is somewhat startling, then, that there is not more direct contact and exchange between philosophical theories about the individual, culture,

truth, and language—and clinical practice generally. This is not to say that philosophy as an academic discipline is completely divorced from the realm of social work and clinical practice; however, the practice of clinical social work could greatly benefit from more intensive study and use of the philosophical theories that have, either directly or indirectly, impacted the way we see the world. This paper is an attempt to examine the impact that philosophy—specifically postmodern ideology—has had on contemporary clinical practice.

Clearly, the above topic is not a simple endeavor. To enhance accessibility of this topic for the reader, one philosopher was chosen along with a clinical treatment modality with which the philosopher's theory may be compared. For the purposes of this paper, the treatment modality of narrative therapy will be considered through the lens of the philosophy of Friedrich Nietzsche. The choices of narrative therapy and Nietzschean ideology were not made capriciously, though at first glance the ideas may seem disparate. First, as Nietzsche has been dubbed by some as the grandfather of postmodernism, his philosophy was chosen because it represents, essentially, the beginning of a radical and important shift in philosophy away from rationalism and the perceived centrality of the ego towards a view of reality that includes a multiplicity of truths that are constructed based on a myriad of socio-cultural and political factors. This paradigm shift, of course, did not happen instantly. Indeed, it did not even happen in Nietzsche's lifetime. He was chosen for this paper, however, due to his status as a precursor to the postmodern movement. Further, the mental health treatment modality of narrative therapy was chosen because it is the treatment modality that is the closest to postmodern ideology.

That is, narrative therapy is the only contemporary treatment modality that expressly uses the postmodern perspective in its work with clients.

In order to more fully explore the ways in which Nietzsche and narrative therapy may be connected, the clinical phenomenon of self-mutilation will be used as the stage upon which the two theories will be compared. As both a social and clinical issue, self-mutilation is a complex phenomenon, having gone through many different incarnations and, subsequently, pathologies. More specifically, self-mutilation has existed in many different forms since biblical times, and has been viewed, diagnosed and, eventually, treated in many different ways over time. The enigmatic and persistent nature of self-mutilation, coupled with the fact that it is an act that is rooted in and negotiates both social and psychological issues, makes it a very suitable clinical subject through which narrative therapy and Nietzschean ideology may be studied.

Once self-mutilation was chosen, the problem of nomenclature presented itself – how to adequately name the phenomenon so that it may be spoken about? Self-mutilation has been defined as everything from clipping fingernails and cutting hair (Menninger; 1938), to lacerating the skin with sharp objects, amputation of a limb, eating disorders, and eye enucleation (Favazza; 1996, Walsh & Rosen; 1988). Further, are cultural and historical accounts of what is considered in contemporary terms self-mutilation (Shamans, Christian ascetics, carnival workers, etc) to be included in our definition of “self-mutilation”? For the purposes of this paper, Walsh & Rosen’s (1988) definition of self-mutilation will be borrowed: “Self-mutilation is a direct, physically damaging form of self-harm, generally of low-lethality, often repetitive in nature, and commonly employing multiple methods.” Additionally, the term self-mutilation is used

expressly against the term self-harm, as self-harm is a more expansive term that may include behaviors such as cigarette smoking, drug abuse, eating disorders, and other behaviors generally considered to be harmful in an indirect way.

Self-mutilation may also be distinguished from other culturally sanctioned forms of self-harm. Many indigenous groups employ self-harming acts for spiritual or healing purposes, or to maintain established social order (Favazza; 1996). Armando Favazza describes the Hamadsha, Moroccan healers who “slash open their heads for the sake of ill persons who dip bits of bread or sugar cube into the blood and then eat them; it is thought that a therapeutic power rests in the healers’ blood” (Favazza; 1996). Whether it be to appease angry gods, initiate adolescent boys and girls into adulthood, or release a sickness-carrying spirit from an ailing tribal member, practices that act on the flesh have permeated indigenous cultures all over the world. It is important to highlight the distinction between culturally sanctioned forms of self-mutilation and what in the mental health community has been deemed “pathological self-mutilation” (Favazza; 1996). The interests of this paper lie in the complex interplay between the individual and culture, and the ways in which different truths and pathologies are constructed and maintained out of this interplay. Because of this focus, culturally sanctioned forms of self-mutilative behavior, though interesting, will not be considered.

This paper is divided into five sections. We begin with a discussion of self-mutilation—common perceptions of self-mutilation, various classifications of the self-mutilative act, and how the act is understood clinically. Chapter three details the historical emergence, theoretical foundations and methodology of narrative therapy, with a particular focus on the ways in which images and understanding of self-mutilation has

changed over time. Chapter four outlines one aspect of Nietzsche's thought—the death of God and the revaluation of values—that is relevant to our discussion of clinical practice. The discussion chapter looks at Nietzsche's influence on narrative therapy, and whether the claim can be made that narrative therapy is the practical application of Nietzsche's ideas. This discussion is articulated through the lens of self-mutilation.

A responsible author always names their bias; the perspective of the author will always come through in their writing, and the more transparent one can be about their perspective the more integrity their work will have. Having had studied postmodern philosophy quite extensively, I have formulated my own ideas regarding the utility of postmodern ideology, and have a particular investment in bridging the divide between the ivory tower and contemporary clinical practice. In addition to a professional bias towards philosophy, as a tattooed and pierced woman I have personal experience with a practice that has been considered to be self-mutilative. My subjective experience with body modification could lead me to have formed an agenda aimed at the creation of an alternate way to conceptualize the ways in which people act out on their bodies. With this in mind, we move forward.

CHAPTER II

SELF MULTILATION

*'This' pain I can see it but I can't feel it
It haunts me
When I cut myself I can see where the pain
Is coming from and watch it heal
And I can easily care for it
'This' pain doesn't have a specific place
It moves around and creeps into strange places
Melanie*

Christian Asceticism

The concept of religious (in this case, Christian) asceticism is a well-known one. Fairly commonplace in western culture are stories of monks in late antiquity fasting, abstaining from sexual intercourse, mortifying their flesh, and even martyring themselves in an attempt to obtain higher spiritual status, purify their essentially sin-ridden flesh, and place themselves before the throne of God. So commonplace is this imagery, in fact, that one could make the argument that these ancient practices have, in a way, conditioned some parts of western culture to view the body, and the body's connection to spiritual and emotional salvation, in particular ways.

Ancient authors of Christian tradition, as well as modern researchers and scholars, struggle to identify the place of "the body" in the early Christian ascetics' faith. On the one hand, the body and its accoutrements (i.e. the flesh) was viewed as a burden, "borne along by the spirit through its pilgrimage in this world, like bulky baggage that will be

cast off only after death” (Shaw; 1998, pg. 6)¹. In this sense, the body was something that was an impediment to be transcended. Simultaneously, however, this same body is the subject of intense scrutiny, interpretation, control and, in some cases, a certain type of reverence². This dichotomy is due to the fact that, though ascetics view themselves as aliens in a carnal world, impeded by the needs and desires of the flesh, the denial of those needs and desires paves the road to God’s grace and eternal salvation. The shedding of the shackles of their corporeal reality to adopt an almost stoic position in relation to the persistent needs of the flesh leads the ascetic to gain many spiritual advantages, including “protection from demons, improvements in mental facility and moral excellence, and preparation for paradise itself” (Shaw; 1998, pg.10). Indeed, through extolling the virtue of the virgin woman, the author of a Greek treatise on virginity describes this sexual fast as a way of making herself more appealing to Christ: “‘Adorn your body with this virtue, O virgin, and you will please the heavenly bridegroom’, for Christ does not require worldly cosmetics, but only ‘a pure heart and an undefiled body which has been mortified by fasting’” (Shaw; 1998, pg. 7).

The term *asceticism* comes from the Greek *askesis*, and is indicative of athletic training, exercise, practice or discipline. It was more broadly used in antiquity to indicate any athletic activity where training and discipline were required to achieve the goal of improvement of any kind (life, health, effectiveness of body and mind). This terminology, though typically reserved for athletics, “became a metaphor implying rigorous dedication, hard work, and discipline, to the point of self-denial, in a particular

¹ The characterization of the flesh as a “burden” is from an early Christian writer, Jerome, and is translated by Shaw. The original texts are in Latin.

² Reverence in the sense that the emaciated, flogged, virgin body could stand as a symbol of one’s faith and total dedication to God, and a recognition and emulation of Christ’s sacrifice to humanity.

philosophical or religious mode of life” (Shaw; 1998, pg.13). To this end, the practices of the newly-defined ascetic expanded to include sexual chastity, fasting, or poverty. In her book on fasting and sexuality in early Christianity, Theresa Shaw makes a distinction between those religious scholars that interpret asceticism in a more narrow sense, “as religiously motivated acts of physical discipline with the purpose of ‘subordinating the lower appetites to the dictates of right reason and the law of God’” (Shaw; 1998, pg. 11) and her own (arguably more useful) definition of asceticism as a “way of life that requires daily discipline and intentionality in bodily behaviors” (Shaw; 1998, pg.11). The difference is between one view that holds asceticism as a journey of self-conquest where the mind rules the impulses of the flesh through self-denial and the idea that the mind/spirit is more powerful than the body, and another view that sees asceticism more broadly, rooted in cultural context, as “any act of self-denial undertaken as a strategy of empowerment or gratification” (Shaw; 1998, pg. 12).

As Shaw points out, it is broadly written in ecclesiastical text that all Christians fast on certain days and adopt a certain level of sexual chastity in their marriages, however, she distinguishes the “Christian Ascetic” as a member of a particular group of individuals who perform these religious activities to a heightened degree: “Ascetic behaviors are thus not exclusive to any one group, but *rigorous observance of such behaviors* can define a particular type of Christian” (Shaw; 1998, pg. 6, my italics). Through this definition, Shaw seems to be making a distinction between those persons who hold Christianity as their religion, and those whose identity is soluble within their religion—where Christianity becomes part of them to the extent that they *narrate their*

religion onto their bodies—creating a tropological turn of the subject that denies their flesh while, at the same time, reinscribing it.

It is with this discussion of Christian asceticism and ancient images of and relationships to the body, that we move to a discussion concerning those who have their own somewhat different, though remarkably complex and fascinating, relationships with their bodies. Like the ascetics, these relationships are often hostile and fraught with conflict, but also carry with them the possibility for redemption and salvation.

Common Perceptions of Those Who Self-Mutilate

Hopefully it is clear at this point that self-injurious behavior is by no means a contemporary phenomenon. Prior to the nineteenth century, cases of self-mutilation (in Western society) were understood solely in terms of the above-described practice of Christian asceticism, or “mortification of the flesh,” where physical pain was used to atone for perceived sins. It becomes clear when taking into account the history of medicine that the identification and diagnosis of social and biological phenomena informs itself – that is, once something has a name and diagnostic criteria become clear, the phenomenon’s diagnosis occurs at increasingly higher levels. That being said, subsequent to the rise of medical concepts of madness and pathological behavior, an increasing number of case studies of patients who intentionally mutilated themselves began to arise in the psychological literature of the mid-nineteenth century. These cases usually involved extreme acts, such as self-castration or eye enucleation, and were usually performed in psychotic states; explanations of these acts remained steeped in religious concepts of atonement through suffering. Many of those who self-injured believed that they were commanded by God to remove an offending body part to atone

for what they judged to be sinful thoughts or actions. Later reported cases of self-mutilators, largely women, were diagnosed as “hysterics,” repeatedly puncturing their skin with needles. It has only been in the past fifty years that mental health professionals and the medical community have begun to understand self-mutilative behavior in more comprehensive and dynamic ways, removing the act from the realm of possession and masochism and understanding it as a complex coping mechanism.

Mental health professionals and laypeople alike have intense reactions to those people who intentionally mutilate themselves. These reactions range from horrified and disgusted, to angry, sad, and helpless. When self-mutilation began to be recognized as its own problem/phenomenon (distinct from suicidality) in the late 1980’s–early 1990’s, it was looked at in a similar way that severe anorexia was looked at in the 1970’s: that patients were attention-seeking, manipulative, and just needed to “snap out of it.” Nursing staff at inpatient units treated patients who self-injured with anger and irritation, seeing them as self-sabotaging and uncooperative (Levenkron; 1998, pg. 23). To a large extent this resentment continues to exist today, although self-mutilation has been increasingly studied and worked with, both in psychological circles and popular culture. Despite the relatively recent inclusion of research, theory and treatment of self-harm in western psychological and cultural discourse, many mental health and medical practitioners approach those who practice self-injurious behavior with particular antipathy, judging the self-harmer through the lens of their own overwhelming emotions that exist in response to self-injurious behavior. In *Bodies Under Siege*, one of the subject’s most decisive and comprehensive texts on the phenomenon of self-mutilation, Dr. Armando Favazza explains the difficulty of researching and, eventually, publishing a

book on the subject, citing an initial curiosity in the subject, growing excitement as he researched, and eventual confusion and frustration as he was met, through his research, with one of two responses—complete disinterest, or resounding horror and frustration. In talking with the hospital staff on psychiatric and surgical wards, Favazza was amazed by the intensity of the responses that the subject of self-harm elicited in caretakers:

When I asked what could possibly motivate persons to mutilate themselves, I usually received unedifying, terse responses such as, “It must be a chemical imbalance” or “It’s part of the borderline syndrome” or “It’s a way to get attention.” *It is as if the presence of a self-mutilator threatens the sense of mental and physical integrity of those around him or her.* What is it about a self-mutilator that is so unsettling for others? (Favazza; 1996, pg. xiv, my italics)

Favazza’s idea of the existence of a self-mutilator as threatening the sense of mental and physical integrity of those around them is an important concept when discussing the intense reaction to self-injuring patients that practitioners treat. Indeed, many of the articles written on the treatment of self-mutilators largely focus on the therapist’s own struggles to maintain emotional stability during the treatment of their patients. Favazza describes the “uncharacteristically poor judgment” of medical personnel in treating self-injuring patients; many cutters have disclosed that, “because of the brutish treatment they have sometimes received in emergency rooms, they will falsely admit to a suicide attempt in order to facilitate a warmer reception” (Favazza; 1996, pg. 232).

Perhaps as a response to overwhelming emotional reactions, those who work with or are exposed to self-mutilators can be quite rigid and narrow in their explanations and treatment recommendations. It is the belief of this author that social, cultural, psychological, and biological factors all contribute to the formation of identity, and that

self-injurious behavior is far too complicated a phenomenon to be understood by only one approach.

Portrait of a Self-Mutilator

In order to properly address the phenomenon of self-mutilation, there must be a picture painted of the person that is being discussed. Through data collected from 240 female, habitual self-harmers, Favazza was able to create a “prototype” subject: she is a 28 year-old Caucasian who first deliberately harmed herself at age 14. Skin-cutting is the most common practice, however, she has employed other methods (burning, self-hitting), and has injured herself on at least 50 occasions. Her decision to self-mutilate is impulsive, usually resulting from a desire for relief from a number of symptoms including racing thoughts, depersonalization and anxiety. She has either currently or in the past had an eating disorder, is concerned with her drinking, and has been a frequent user of medical and mental health services (though treatment has generally been unsatisfactory). Finally, this prototypical self-mutilator has most likely attempted suicide at least once, due to feelings of hopelessness and desperation over her inability to stop cutting (Favazza; 1996, pg. 251). Many other authors have described the “typical” self-mutilator as “female, adolescent or young adult, single, usually from a middle to upper-class background, and intelligent” (Suyemoto and MacDonald; 1995).

In addition to the litany of characteristics listed above, self-mutilative behavior has also been linked to different diagnoses, most notably borderline personality disorder (Walsh and Rosen; 1988), although dissociative identity disorder, major depression, minor depression, obsessive-compulsive disorder, sexual masochism, alcoholism, eating disorders, schizophrenia, anxiety disorders, trichillomania, and factitious disorder with

physical symptoms have also been linked to self-injurious behaviors (Suyemoto and MacDonald; 1995).

The prevalence of cutting and burning is thought to be about 1,400 cases per 100,000 population (although cutting and burning comprise only one part of the total definition of what a self-harmer is). To put this statistic in perspective, the suicide rate remains fairly constant at 10 to 12 per 100,000, and the rate for suicide attempts can range anywhere between 50 and 250 per 100,000 (depending on how the term “suicide attempt” is being defined) (Favazza; 1989). These statistics serve as concrete evidence against the (now antiquated) idea that self-harm is a sort of half-hearted suicide attempt or gesture. The reasons for this will be explained later on in the chapter.

Despite, or perhaps because of, the global/cultural pervasiveness of behavior that could be considered “self mutilative”, the definition continues to remain problematic. It is common practice amongst contemporary researchers of self-harming behavior to acknowledge some kind of difference between culturally sanctioned self-harming behavior and pathological/deviant self harm, though where the line is drawn between the two varies widely from author to author. For example, if self-mutilative behavior is defined as the deliberate altering of one’s flesh that results in the alteration of body tissue to any degree, then ear-piercing, hair trimming and nail clipping would be considered self-mutilative. Indeed, early attempts to understand and catalog the phenomenon of self-harm have included these superficial forms of self-care (Menninger; 1938). Recently, however, definitions of self-mutilative behavior have become increasingly dynamic and nuanced—including (and questioning the inclusion of) culturally sanctioned behaviors that, when taken out of the cultural context from which they were engendered, would be

considered incredibly deviant, harmful, even psychotic. In order to properly organize and classify the myriad of types of self-mutilative behavior, a distinction will be made between those self-harming behaviors that are culturally sanctioned (rituals, spirituality, healing practices), and the self-harming behavior that is considered deviant or pathological.

It is important for the clinical understanding and treatment of any disorder for there to be a logical ordering of experience to assist in the contextualization of puzzling and overwhelming behavior. Recent advances in the understanding and acceptance of self-mutilative behavior have resulted in a classification system of deviant/pathological self-mutilation that have both diagnostic and therapeutic value. Favazza (1996) has organized the plethora of acts of deviant self-mutilative behavior into three categories generally accepted in the mental health field: major, stereotypic, and moderate/superficial³.

- Major self-mutilation refers to infrequent (often isolated) acts that results in the significant damage to body tissue, such as castration, eye enucleation, or amputation of a limb. These acts tend to happen suddenly and with copious amounts of bleeding. Often times, after acts of major self-mutilation, patients seem oblivious or indifferent to their actions—a teenage girl told the nurse who found her holding her right eye in her hand that it had spontaneously and painlessly fallen out of her head while she was sleeping (Favazza; 1996, pg. 234).

³ It is necessary at this point to draw attention, as does Favazza, to the necessarily simplistic and reductive, yet clinically useful, nature of categorizing a phenomenon as complex as self mutilation. Categorization doesn't take into account the etiology of the behavior, and typically changes with increased knowledge and research of the subject. Yet despite these difficulties, the organization of this challenging behavior into a more coherent structure helps situate and direct practitioners' thinking on the subject so as to provide the most effective treatment possible.

This form of self-harm is usually associated with acute psychotic episodes, schizophrenia, mania, and depression, and manifests itself through various themes—religious, desire to be female, control of hypersexuality, repudiation of one’s genitals, preventing or correcting urges/body parts that are seen as offensive to others (usually loved ones).

- Acts of *stereotypic* self-mutilation manifest as monotonous, repetitive/rhythmic behavior, usually without identifiable meaning. These acts are the most likely to occur in the presence of onlookers, with no apparent embarrassment or cognizance that their behavior is unusual. Further, stereotypic self-mutilation appears to be driven by a primarily biological imperative to harm themselves, and the disorder is usually associated with mental retardation or other syndromes (i.e. autism, Retts disorder, Lesch-Nyhan syndrome, Tourette syndrome). The most common behavior is head banging/shaking, although other self-harming behavior occurs, such as tongue and mouth chewing, orifice digging, self-hitting, and eyeball pressing.
- *Moderate/superficial* self-mutilative behavior is usually characterized by skin cutting, burning, self-hitting and bone breaking, and is the most commonly encountered form of self-harm. These behaviors appear as symptoms of various disorders (as described above), and are broken down by Favazza into three types:
Compulsive – The behaviors involved in compulsive self-mutilation are repetitive/ritualistic, and usually occur several times daily. Symptoms usually include hair-pulling (trichotillomania) and psychodermatological behaviors, such as skin-digging in attempts to remove imagined parasites from the skin, and

neurotic excoriations—skin lesions caused by perfectionistic, obsessive-compulsive persons who are compulsively driven to remove real or imaginary skin blemishes. Symptoms of compulsive self-harm, if severe enough to require treatment, are usually treated by dermatologists or family physicians.

Episodic—Refers to behaviors that happen every once in a while. Practitioners of this type of self-mutilation “deliberately harm themselves to feel better, to get rapid respite from distressing thoughts and emotions, and to regain a sense of self-control” (Favazza; 1996, 243). There are usually no distraught feelings associated with the behavior, and the identity of the cutter is not intertwined in the self-mutilative act. In cases of episodic self-mutilation, the self-harming behavior is a symptom of a more fundamental diagnosis, and is not considered the primary diagnosis.

Repetitive – “Episodic self-mutilation becomes repetitive when the behavior becomes an overwhelming preoccupation in those persons who may adopt an *identity* as a ‘cutter’ or ‘burner’ and who describe themselves as addicted to their self-harm” (Favazza; 1996, pg. 250, my italics). With episodic self-mutilation, the behavior evolves from being a tool one uses for self-regulation of emotions to assuming its own autonomous course. Whereas episodic self-mutilation is considered a *symptom* of a larger disorder (i.e. borderline personality disorder, generalized anxiety disorder, etc.), in the case of repetitive self-harm the behavior *is* the disorder, and is usually placed in the separate category of impulse control disorders known as the repetitive self-mutilation syndrome. This syndrome usually begins in adolescence and is a lifelong struggle where episodes

systematically heat up and cool down, sometimes co-occurring with other impulse-control disorders (eating disorders, substance abuse, and kleptomania). Persons who engage in repetitive self-mutilation become preoccupied with the behavior, which (as was previously stated) assumes its own independent course and effects the patient's identity development in significant ways.

Because of the focus on identity, it is the experience of the repetitive self-mutilator that will be considered for the duration of this paper.

How Self-Mutilation is Understood Clinically

Self-Mutilation as Distinguished from Suicide

Not only the foundation of Hedonistic ideology, the assertion that “Human beings seek to maximize pleasure and avoid pain” lies at the heart of most (Western) descriptions of what could be called human nature. Indeed, Americans are bombarded daily with imagery of perseverance, strength, success over opponents, and are guided by a “bootstrap” ideology which dictates that one only needs to rally their internal strength, work hard, and they will be rewarded with the happiness that they have sacrificed for. Perhaps this is why the idea that someone would intentionally kill themselves is so abhorrent in our culture—it stands in direct contrast to everything we think we know about ourselves and the way humans operate. A closer look into the specificities of human psychology, however, shows that there are (and always have been) numerous ways in which people work against their success, happiness, and even their own physical well-being. This idea is echoed in the words of Karl Menninger when he observes that “It becomes increasingly evident that some of the destruction which curses the earth is *self*-destruction; the extraordinary propensity of the human being to join hands with external

forces in an attack upon his own existence is one of the most remarkable of biological phenomena” (Menninger; 1938, pg. 4).

Historically, a common misconception has been that those who employ self-mutilative practices are suicidal, though this belief has been rapidly changing with the increasing number of articles written and research conducted. In 1938 Karl Menninger, a Psychiatrist who founded the Menninger Clinic with his father and brother in Topeka, Kansas, wrote the book *Man against Himself*. In it he argued against the then-mainstream idea that those who cut, burned, or otherwise mortified their flesh, were displaying half-hearted or insincere suicide attempts. Menninger’s text was the first in psychiatric history to present a comprehensive analysis of self-destructive tendencies, contextualizing the myriad of actions whereby one injures themselves (either directly or indirectly) within life’s delicate dance between the will to create and the will to destroy.

In *Man against Himself*, Menninger affirms and re-positions Freud’s ideas of the life and death instincts⁴, and (albeit crudely) splits the act of self-harm into two categories: neurotic and psychotic, with “normal” people occupying their own third category. Neurotic self-mutilations, according to Menninger, are just that—acts of self-mutilation that occur during the course of a neurosis (Menninger; 1938). Menninger decides to begin his discussion of what he calls *focal suicide* with a discussion of neurotic self-harm, as “the behavior of neurotics is always much more closely akin to that of so-called normal people and therefore more easily understandable by them” (Menninger; 1938, 234). The crux of Menninger’s analysis rests on the idea of bargaining—making the best

⁴ Freud postulates the existence of the life and death instincts in all humans, which are strong propensities towards both self-destruction and self-affirmation. According to Freud, the life instinct mediates the death instinct – the drive towards self-destruction resulting in direct or indirect suicide only in exceptional cases when various factors come together to make it possible.

possible compromises for the success of the whole. In Freudian ideology, neurosis is seen as a compromise device between the drives and the ego (or the id and the superego), intended to save the self from the more serious consequences that would result if the drives were allowed to operate unchecked—“The ego, i.e. the discriminating intelligence, has the task of adjusting these demands [of the instincts] and if it finds itself failing it makes the best bargain possible, [conceding] as little as possible to the insistence of the conscience upon self-punishment” (Menninger; 1938, pg. 233). Menninger goes on to conceptualize the idea of bargaining:

The normal person is normal because he can make so much better a bargain than the neurotic; he can do so because he is not so much at the mercy of his stern or cruel conscience and this in turn is partly due to the fact that he is not so strongly moved by destructive urges. Compared to him the neurotic makes a bad bargain but compared to the total surrender of the psychotic person the neurotic’s bargain is not so bad (Menninger; 1938 pg. 235)

In other words, the ego of those organized at the neurotic level has a greater capacity to negotiate the self’s destructive drives, while the psychotic ego has no bargaining power at all, subsequently producing the spectacular and bizarre acts of major self-mutilation (including suicide) that we see from many psychotic patients.

So, too, is it with Menninger’s idea of self-mutilation–hate that is originally directed towards an external object is turned in towards the self and reinforced through the act of self-punishment⁵. This act differs from suicide, according to Menninger, in that it is a self-attack focused on one part of the body, rather than the total personality.

Hence, the death instinct is thwarted using the currency of physical pain—rather than

⁵ Remember the point made in the beginning of the chapter regarding the ways in which Christian ascetics simultaneously deny and reinscribe the existence of their flesh through its mortification (pg. 3). The hate for another (as the hate for the flesh) is being denied and then reaffirmed through the narration of their hate onto their flesh.

offering up their life they offer up their flesh, or a limb. If one conjectures the personification or autonomy of a body part or location, it is logical to Menninger, then, that the offending body part be the receptacle of the intolerable feelings that are denied.

Though Menninger's text was seminal in the field, it has since been largely discarded, mostly because of its connection to the idea of suicidality. Menninger's description of self-mutilation as being derived from a mediated drive towards suicide is what researchers like Barent Walsh and Paul Rosen argue against. In *Self-Mutilation: Theory Research and Treatment*, Walsh and Rosen articulate the immediate importance of terminology when discussing self-harming behaviors. They claim that the debate over self-harm terminology is "no mere quibbling over words;" that the importance of nomenclature in this area is evident when one considers the way treatment will be prescribed as a result of self-mutilative behavior's conceptualization (Walsh & Rosen; 1988). For example, the diagnosis and treatment of a person appearing in an emergency room with superficial (non life-threatening) wrist cuts will be radically different depending if their wounds are seen as an attempted suicide attempt versus an attempt at alleviation of painful or uncomfortable affect. Because of the vital importance of the distinction between self-harm and suicidality, Walsh and Rosen assert, "Our position is that the use of terminology that includes the word 'suicide' should be avoided in discussing self-mutilation ... to continue to describe self-mutilation in terms of suicide serves only to perpetuate an unnecessary conceptual confusion" (Walsh & Rosen; 1998pg. 17).

Subsequent to this pointed and diligent clarification of terms, the first major section of Walsh and Rosen's book continued with attempts to further clarify the

distinction between self-harm and suicide. The sustained efforts of researchers and mental health practitioners to adequately identify and categorize deliberate self-harming behavior has yielded four related factors as being centrally important in making the distinction between self-mutilation and suicidal intent: (1) the intent of the perpetrator of the self-harming acts; (2) the physical damage resulting from the self-harm; (3) the frequency or chronicity of the acts; and (4) the methods employed in inflicting harm upon oneself (Walsh & Rosen; 1988). Three of the four factors have been shown to be quite helpful in distinguishing self-harm from suicide—those who employ self-mutilative practices generally inflict minor injuries onto themselves which require minimal to no medical attention, employ these practices much more frequently than do suicidal patients, and have used multiple methods to harm themselves, whereas suicidal patients do not. Ironically, the most important and helpful factor in distinguishing between an act being determined as self-mutilative versus suicidal has traditionally been the most difficult factor to determine—assessing the perpetrator’s *intentions* in harming themselves. If it could be demonstrated that the motivation for an act of self-harm is markedly different than a suicidal gesture, the attempts to find support for hypotheses that self-mutilation and suicide are different acts would be greatly accelerated. The matter of intent regarding deliberate self-harming behaviors, however, has remained frustratingly elusive. This is not to say that huge strides haven’t been made in the field. On the contrary, there are many hypotheses that have been offered and given research-oriented support. The idea, though, that something as nebulous and amorphous as intent—especially the intent of such a complex and, at times, highly emotionally charged act such as self-mutilation—can be quantified is unrealistic and misguided for several reasons. Fundamentally, the acts of

self-mutilation are largely private to its perpetrators, “Self mutilators can never share with us in a direct, immediate way the complex determinants of their acts of self-harm. At best, they can describe after the fact what they remember their intent to have been” (Walsh & Rosen; 1988, pg.25). This memory, of course, is subject to all the distortions typical of a human subject. In addition, any attempt to quantify the intentions of acts of self-mutilation seems to make the assumption that the perpetrator’s intentions are immediately available to them, and are ready and waiting to be recalled when necessary (i.e. in a hospital or therapeutic interview). It is for these reasons that some researchers have abandoned altogether attempts to concretely identify patterns of similarity of intent amongst perpetrators of self-mutilation in favor of a more “reliable and objective” classification scheme, mostly centering around behavioral-descriptive rather than explanatory-based methodologies.

Trauma and Disconnection

Perhaps ironically, the most nebulous and problematic area that has the potential to be useful in distinguishing self-mutilation from suicide is the one that is the most interesting for this author, and the most fruitful for the discussion at hand. It seems to be the case that intent is so difficult to identify precisely because it is virtually impossible to quantify. This impossibility has many explanations, not least of all the extraordinary ability of the human mind to dissociate as a response to trauma.⁶ “The pathological condition, mentioned previously, in which a person experiences an alteration in the perception or experience of the self and of reality is known in psychiatry as a depersonalization disorder” (Favazza; 1996, pg. 247). Mild depersonalization is

⁶ For the purposes of this paper, trauma is being defined as an overwhelming of the ego’s capacity to respond to/process an event, thus contributing to the fixed (or pathological) disorganization of the ego.

common, though not associated with significant impairment (i.e. knowing the route home so well that one drives it automatically). Experiences of pathological depersonalization, however, can be quite disturbing. Individuals who experience this type of depersonalization may feel that their bodies are unreal, that time and the environment have suddenly and inexplicably changed, and that they are going insane. The idea that individuals self-mutilate in order to end the disturbing and destabilizing experience of depersonalization is quickly becoming accepted amongst mental health practitioners. It is an interesting paradox that, despite the contention that they are emotionally dead and estranged, individuals suffering from disconnection are capable of intense feelings of upset about that very sense of loss.

Indeed, all the manifestations of depersonalization are acutely unpleasant and not only motivate the patient to seek medical help but often drive him to vigorous activity or to inducing intense sensations in him/herself in order to break through the prison walls of his sense of unreality” (Favazza; 1996, pg. 148).

Bessel Van der Kolk, a psychiatrist and expert in the field of trauma and trauma-related psychopathology, asserts that complex and consistent patterns of psychological disturbance occur in individuals exposed to either chronic or severe interpersonal trauma during any or all of the developmental stages—but particularly with childhood abuse and neglect (Van der Kolk; 2005). Research outcome regarding attachment shows the startling significance of abusive or non-responsive caregivers to ego development. Under ideal conditions, caretakers are able to help children to restore a sense of safety and control when children are hurt or in danger. However, when caretakers are unable (for whatever reason) to help the child regulate themselves, or are emotionally absent, violent, intrusive, demeaning, neglectful, or are otherwise engaged with their own traumatic

histories, they do not serve as a source of safety and security for the child. In these situations, the child may become intolerably distressed and develop a sense of the world as intrinsically unsafe.

If children are exposed to unmanageable stress, and if caregivers are unable to help them modulate their arousal ...they are unable to organize themselves physiologically and fail to categorize experiences in a coherent fashion. This failure results in a breakdown in the capacity to process, integrate, and categorize what is happening: At the core of traumatic stress is a breakdown in the capacity to regulate internal states (Van der Kolk; 2005).

Indeed, research has shown that children who have been exposed to chronic abuse and neglect within the context of their primary relationships differ in their neurological and neurobiological development from children who have not been exposed to the same treatment. As a result, many traumatized children have problems regulating their emotions, knowing what they feel, verbalizing their experiences and feelings, and being comforted by an attachment figure (Van der Kolk; 2005).

The psychopathology of chronic developmental trauma, labeled in the DSM IV, TR as *disorders of extreme stress not otherwise specified* (DESNOS), outline seven categories of symptoms: (a) alterations in ability to modulate emotions, (b) alterations of identity and sense of self, (c) alterations in ongoing consciousness and memory, (d) alterations in relations with the perpetrator, (e) alterations in relations with others, (f) alterations in physical and medical status, and (g) alterations in systems of meaning (APA; 1994). When faced with any of these categories, depersonalization is typically experienced. It is the contention of many theorists, researchers and mental health practitioners that self-mutilative behavior serves as an effective response to the dissociation experienced when a patient is faced with any one of these symptoms, or a

combination of several. Looking back to the discussion of self-mutilation and suicide presented earlier in the chapter, hopefully it is now clear that the self-mutilative acts associated with complex developmental trauma and depersonalization are not suicide attempts, but rather are therapeutic attempts to end the unpleasant feelings of the disorder. A patient of Favazza's states:

I'd rather die than face being unreal. You go through life doing things automatically, like a machine. And then at the end of the day you try to match events with an emotion and try to experience them as a whole being. It's all right to hurt yourself because it proves that you are real" (Favazza; 1996, pg. 274-275).⁷

A large number of similar explanations exist regarding how the cycle of self-mutilation post-traumatic experience works. Generally, when intrusive thoughts overwhelm an individual who has suffered (or continues to suffer from) complex interpersonal trauma. These individuals need an outlet to be able to process their thoughts and overwhelming feelings. If they have no outlet, or if their current environment is unsafe, they dissociate to repress the trauma and the feelings associated with it. Self-mutilative behavior (cutting, burning, starving, purging) serve to either: a) facilitate the dissociation, or b) break through the dissociation to a sense of reality and control (Favazza; 1996, Strong; 1998). As Favazza gravely observes, "Suicide is an exit into death, but self-mutilation is a reentrance into a state of normality" (Favazza; 1996, pg. 271).

It is clear from the above discussion that acting out on one's flesh is far from the unrepresentative and aberrant behavior that laypeople (and some mental health

⁷ It is important to note here that, although the difference between self-mutilation and suicide has been established, individuals who self-mutilate often become demoralized or depressed over an inability to control their self-harming behavior. They may feel helpless in the face of what can be seen as an overwhelming "addiction". Additionally, in persons with specific characterological disorders where episodic self-mutilation occurs (i.e. borderline, histrionic, antisocial), suicide attempts are identified in the disorder itself as well as self-mutilative practices, and the two should not be conflated.

practitioners) tend to assume. From biblical times to the modern day, people have acted out on their flesh in numerous ways, and it seems clear that each act of self-mutilation tells a story. Shaw's distinction (outlined above) between those Christians who hold Christianity as their religion, and those whose identity is soluble within their religion—where Christianity becomes part of them to the extent that they narrate their religion onto their bodies—is foregrounded in an important way when looked at within the contemporary context of self-mutilation. Despite the two thousand year time gap, there is a striking similarity between the way in which self-inflicted pain—the acting out on the body—holds a meaning that transcends the blood (the corporeal injury), and serves to signify a mastery of one's own body for both Christian ascetics and modern day self-mutilators. If it is assumed that those who self-mutilate are doing so for a purpose, then that nebulous category of “intent” which was discussed earlier becomes supremely important when looking at the signification of the self-mutilative act. Given the arguments against using the category of “intent” in assessing and categorizing self-mutilative behavior—that it is nearly impossible to quantify and can remain largely hidden, even to its perpetrators—how can we use the idea of intent to understand the self-mutilative act in a more dynamic way? How does self-mutilation function in the lives of those who adopt its use?

CHAPTER III

NARRATIVE THERAPY

Today, psychologists have a favorite word, and that word is maladjusted. I tell you today that there are some things in our social system to which I am proud to be maladjusted. I shall never be adjusted to lynch mobs, segregation, economic inequalities, "the madness of militarism," and self-defeating physical violence. The salvation of the world lies in the maladjusted.

Martin Luther King, Jr.

Hopefully it has become clear from the previous chapter that there exists a litany of perspectives through which self-mutilation can be analyzed and understood. The mental health field (and Western popular culture generally) has come to understand the phenomenon of self-mutilation in vastly different and more complex ways than they did even fifty years ago. This acknowledgement may lead one to ask the question—what conditioned the possibility for this shift to occur? How is it that the dominant paradigm regarding self-mutilation has shifted from the belief that self-mutilation is a disgusting and manipulative attention-seeking attempt to contemporary explanations of self-mutilative behavior as attempts to manage overwhelming anxiety and end intolerable episodes of depersonalization? To be sure, there are those who exist that continue to adopt the former position, but they are rapidly becoming fewer and farther between. Certainly the advent of trauma-based research has aided this evolution, however, there seems to have been a more fundamental shift in the way mental health practitioners conceptualize both the therapeutic process and the people who come to utilize their services.

Narrative pervades human existence. It is difficult to think of a scenario that is devoid of, or not dependant on language and narrative not only for the successful transmission of ideas between people but, more fundamentally, for one to be able to cognize the world and maintain a coherent sense of self. In the book *Story Re-Visions*, Alan Parry and Robert Doan (1994) refer to Alasdair MacIntyre's suggestion that "conversation, understood widely enough, is the form of human transactions in general" (Parry & Doan; 1994, pg. 3). We fight, love, hope, fear, despair and anticipate all within the context of narrative (Parry & Doan; 1994). Despite (or perhaps *because*) of our dependence on narrative for communication and sense of self, its existence and importance are largely unseen and unacknowledged. It is like the air we breathe—because we live our lives in and through it, narrative remains an essential yet invisible element of human existence. It is through the act of making visible the process by which we story our selves and our lives that we may gain a greater understanding of the process of meaning-making from within various cultural contexts, and the ways in which change and progress occur within those contexts.

Subsequent to what has been called the "linguistic turn" in philosophy, there has been a gradual but steady increase amongst mental health practitioners towards an interest in more narrative-based treatment modalities. These modalities are language-based, client-directed, and focused on relational process, rather than on positivist assumptions of objectivity, where words are "clear signs or labels that point to objects or their attributes that were thought to exist independently from the word or label" (Rosen & Kuehlwein; 1996, pg. 310). Many researchers in the field of psychotherapy strongly resist any move away from the use of proper scientific inquiry from within a positivist

framework, citing a fear of loss of funding and, more apocalyptically, a fear that “psychology would become an arts-based discipline” (Roy-Chowdhury; 2003, pg. 65). Critics of the above model for conducting psychotherapy research assert that “the claimed objectivity of such methods is unachievable, that the methodologies applied oversimplify the complexity of social phenomena (as in psychotherapy), and that research within this paradigm makes erroneous presuppositions concerning the nature of psychotherapy conducted within clinical settings” (Roy-Chowdhury; 2003, pg. 65). Further, some practitioners in the field focus on the social construction of the individual and the function of narrative as a, if not *the*, fundamental means humans use to structure meaning and their everyday existence in the world (Rosen & Kuehlwein; 1996).

Due to the increasing focus on narrative treatment methods, interesting and passionate debates exist today surrounding the existence of an evidence-based justification for narrative therapy within the paradigm of evidence-based clinical practice. The push towards evidence-based treatment modalities appears to have its roots in certain scientific and epistemological assumptions: that there can be a defined “successful treatment outcome,” that the efficacy of clinical work can be measured against that defined outcome, and that if any particular treatment modality resists attempts to measure its outcomes against the backdrop of that defined “successful treatment outcome,” then it is not a valid or useful treatment method. On the other hand, practitioners of more narrative focused treatment assert that attempts to quantify the complexity of human experience into measurable outcomes leads to simplistic and reductive accounts of the work we do with our clients.

It seems clear at this point that the emergence of narrative therapy has been fraught with large amounts of both excitement and trepidation. As the opening paragraph to this chapter suggests, a particular socio-political shift occurred such that a focus on narrative and social construction within the therapeutic relationship was able to occur. It is towards this shift that our gaze will now move.

The Emergence of Narrative Therapy

In *A Different Story: The Rise of Narrative in Psychotherapy*, Christian Beels outlines the rise of narrative therapy out of the context of social work and family therapy in Australia and New Zealand. Beels names social workers as the original family therapists, citing the development of the social work perspective in the two countries as occurring within an “activist political movement” (Beels; 2001, pg. 155). Tracing the evolution of popular beliefs regarding “normal” family structure in Australia, Beels asserts that men were typically seen as naturally more “executive”, whereas women were seen as naturally more “expressive” (Beels, 2001). These ideas regarding men and women’s natural “roles” played themselves out within the family structure, creating a massive split between ideas about the way things “should be” in women’s personal and family lives, and their lived experiences.

During the 1970’s the “naturalness” of the Australian family structure and a women’s role within that structure was called into question, subsequently creating a huge shift in the social order: more women were working outside the home, families were stronger, and the divorce rate was rising (Beels; 2001). The rise in family therapy coincides with these structural changes, and “the women whose role had been to preserve

the family found the social work profession a natural place to labor for fairness and justice” (Beels; 2001, pg.160).

Beels asserts, despite the fact that the social work movement and, subsequently, the family therapy movement was essentially dominated by women, even supposedly “progressive” ideas regarding gender equality “led to a curious blindness to the power consequences of gender” (Beels; 2001, pg.158). This blindness was perhaps the most salient for those working with female victims of domestic violence. Assuming that an interaction which results in a man hitting a woman was a failure of mutual regulation, conventional therapists would hold both husband and wife as equally responsible for the violence that had taken place. This view did not hold the difference between total equality and equality in value. Real differences between men and women exist, asserted feminist critics of traditional couples therapy, and to ignore those differences is to perpetuate domestic violence.

Michael White and David Epton were watching these conversations take place and began to develop what would later serve as the foundation of narrative therapy. Using an anthropological lens, White and Epton noticed the way in which feminist critics placed themselves as observers of a particular phenomenon, rather than as experts. Further, White and Epton noticed that by using Foucault’s idea of giving power to the least heard, or subjugated, of society’s voices, the female victims of domestic violence which were the subjects of feminist analysis were able to re-story their experiences. It is the use of anthropological and Foucauldian approaches that narrative therapy as a clinical approach began to emerge.

Theoretical Foundations of Narrative Therapy

As was previously stated, narrative therapy is an approach to working with clients that carries with it basic assumptions about human interaction and the various ways that people make meaning through those interactions. These assumptions are based on advances made in postmodern philosophy—a philosophical position whose aim is the dissolution of the idea of “objective” truth, or “essentialism.” Postmodernism as a philosophical discipline concerns itself with the act of situating the human subject within their own particular socio-cultural context, and “localizing” the truths that are produced from those contexts. No longer does the human subject have the ability to remove themselves from their corporeal reality in order to adopt a “God’s eye view” of the way things “really are” (a feat that modernist philosophers, such as Descartes, boast). Postmodern ideology is the repudiation of the very idea that objective truth exists (that is, a truth that exists and is true for all people, across all cultures, is independent of the minds that think it, and is also accessible in its entirety to those human minds), and the application of the methods of obtaining that truth to activities and ideas that are essentially narrative-based. Narrative therapy takes as its foundation the postmodern idea that all truths and knowledges are situated within a particular socio-cultural context, do not enjoy a status that is higher than or independent of the human minds that think them, and that language and narrative (the stories that we tell about ourselves and our worlds) serve to shape and solidify our personal, cultural, and national identities.

The medium through which most therapy usually occurs is language. It follows, then, that most schools of thought regarding therapeutic treatment modalities necessarily contain ideas (implicit or expressed) about the nature and function of language as it

applies to human interaction. Postmodern philosophers have argued that language is used as an expressive tool, not something that merely corresponds to an external reality. This assertion can be seen as a significant break from the traditional enlightenment-based views of truth and reality, which assumes the rationality of human beings and the relation of words to things. In *Constructing Realities*, Kuehlwein and Rosen discuss the rise of narrative in psychotherapy against the backdrop of logical positivism, where in the empirical tradition “words were [meant] to be clear signs or labels that pointed to objects or their attributes that were thought to exist independently from the word or label” (Kuehlwein & Rosen, 1996, pg. 310). This text sets the stage for human subjects to be seen not as passive recipients of information sent from an objective and external world, but as active constructors of not only their lives, but of the truths that serve as the foundation of our lives.

The shift in thinking from the positivists’ paradigm that the world is immediately and accurately available to the perceiver on the one hand, to the view of the human subject as actively constructing their own truths and realities based on each person’s socio-cultural paradigm (or “situated knowledges”) on the other, is a critical one for advocates of a narrative-based therapeutic approach as the latter position serves as the foundation for the core beliefs of narrative therapy. In *Narrative Therapy: The Social Construction of Preferred Realities*, Freedman and Combs outline four postmodern ideas that support the structure of narrative therapy and the paradigm under which narrative therapists work: 1) realities are socially constructed, 2) realities are constituted through language, 3) realities are organized and maintained through narrative, and 4) there are no essential truths. These ideas are the result of an important and radical break from the

ways that language, cognition and, subsequently, pathology was conceptualized in the mental health community.

The idea that *realities are socially constructed* has had its roots in philosophy for quite some time, and began to take shape in a more concrete form through anthropology and the advent of the practice of ethnography. Ethnographers research and describe individual, specific human cultures—this can be anything from an indigenous tribe in South America to a youth subculture in a large urban American city. The ethnographer studies the group and sees how it functions; what their core beliefs are, rituals, customs, diet, and method of communication. Through this process anthropologists began to notice patterns by which ideas, practices, beliefs, et cetera—come to be granted “reality status” amongst groups. A postmodern, narrative-focused stance begins to emerge where “beliefs, laws, social customs, habits of dress and diet—all the things that make up the psychological fabric of ‘reality’—arise through social interaction over time” (Freedman & Combs; 1996, pg. 20).

To explain the process by which beliefs or customs become “real,” Freedman and Combs point to Berger and Luckmann’s concept of reification. The process by which something becomes reified contains three steps: typification, institutionalization, and legitimation. These steps “are important in the way that any social group constructs and maintains its knowledge concerning ‘reality’” (Freedman & Combs; 1996, pg. 23). We *typify* our perceptions into types and classes (e.g. the idea of romantic love), *institutionalize* those classes (e.g. the institution of marriage), and *legitimize* those institutions (e.g. the idea that marriage is between a man and a woman, is good, natural, and ought to be done). The process of reification is the process by which the products of

human activity and perceptions are granted a status independent of or higher than the human minds that think them. Subsequently, reification implies that humans are capable of “forgetting” (or not acknowledging) their own authorship of the human world (Freedman & Combs; 1996). The point here is that human perception and the beliefs that are engendered from that perception are not created in isolation—that “people interact with one another to construct, modify and maintain what their society holds to be true, real, and meaningful” (Freedman & Combs; 1996, pg. 22). It is interesting to think of the ways in which ideas and institutions regarding self-mutilation have been reified.

For narrative therapists, realities are not only socially constructed, but they are constituted through language. Language, and its relation to human perception and the outside world has been mentioned elsewhere in this chapter. It has been suggested that, contrary to the positivist belief that words are neutral containers that correspond accurately to a fixed external reality that is immediately accessible to the perceiver, language plays an active role in constructing the way we see and participate and act in the world. This is the second concept that serves as the foundation of narrative therapy—that as perceiving subjects we are simultaneously constituted by and constituting of language; that language is the lens through which we interact with each other and the world. Language does not have meaning independently of the speaker/s using it, and “meaning is not carried in a word by itself, but by the word in relation to its context, and no two contexts will be exactly the same” (Freedman & Combs; 1996, pg. 46). This concept has importance for narrative therapists in that it holds that any kind of change (belief,

relationship, feeling) necessarily requires a change in language. Thinking and behaving differently means speaking differently⁸.

The third grounding concept for narrative therapists is that those realities that are socially constructed and linguistically constituted are also organized and maintained through stories. Michael White and David Epsen describe the function of what they call *self-narrative*:

In striving to make sense of life, persons face the task of arranging their experiences of events in sequences across time in such a way as to arrive at a coherent account of themselves and the world around them. Specific experiences of events of the past and present, and those that are predicted to occur in the future, must be connected in a lineal sequence to develop this account. This account can be referred to as a story or self-narrative. The success of this storying of experience provides persons with a sense of continuity and meaning in their lives, and this is relied upon for the ordering of daily lives and for the interpretation of further experiences.

(1990, pg. 27)

It is important to point out that people are born into particular socio-cultural (or meta) narratives, and make sense of their lives through constructing narratives that exist in relation to those cultural narratives. In the narrative view, reality is determined through social interaction and language; identity is formed and maintained through stories.

It should come as no surprise at this point, that the fourth belief under which narrative therapists operate is that there are no essential truths. Because “objective reality” isn’t immediately knowable or accessible to us, we base our lives and beliefs on interpretations. This repudiation of the idea of objective truth necessarily extends to concepts of the “self”. There exists no concept of an “essential” self for narrative therapists – each self develops from within a particular social context and maintains itself through narratives that one develops over time. This current understanding of human

⁸ Of course, this is not to make a claim regarding which change happens first (i.e. thinking or speaking), or that the process is necessarily a linear one.

beings removes the psyche from inside the human container and posits human beings as beings-in-the-world with others. We can no longer see humans in the removed, Cartesian “I think, therefore I am” way, but rather as beings who are perpetually and simultaneously constituted by and constituting of each other and their surroundings, creating a tropological⁹ inauguration of subjectivity which necessarily remains always uncertain¹⁰.

This concept of the “situated self” doesn’t readily lend itself to an objective or stable foundation upon which pathology or deviance can readily be ascribed. If the human subject is dethroned from the status of “god’s eye viewer” and placed in the realm of the socially constituted, then pathology becomes arbitrary, and diagnoses become value judgments. In other words, the de-throning of the human subject renders the idea of “normal” powerless – there is no foundation upon which normalcy can rest. Because the idea of pathology or deviance is predicated on the existence of conceptions of what is normal, if normal is done away with, what happens to deviance? How would the act of, say, self-mutilation be reconceptualized in light of this shift in thinking about the human subject?

Treatment Techniques

Hopefully it is clear at this point that narrative therapy is the practical therapeutic application of postmodern philosophical ideas regarding truth, epistemology, objectivity, and the human subject. One result of seeing the world in this particular way, of eradicating the idea of objective truth and redefining “truths” as “perspectives,” is a de-legitimization of the grand narratives that have traditionally served to structure and

⁹ Turning in on oneself.

¹⁰ For a very interesting discussion of this idea, see Judith Butler’s *The Psychic Life of Power – theories in subjection* (Stanford University Press; 1997).

organize our experience in the world (i.e. narratives of scientific progress, Christianity, democracy, etc.). This de-legitimization subsequently disallows the possibility that these narratives may correspond to the complexity of the world that they were once able to explain. In other words, the grand narratives of modernity were unable to keep their promise of being the “one true answer” to life, “[leaving] us in a world in which no single story, however understood, is able to provide either legitimacy or sufficiency equal to the pace of change through what Fredric Jameson refers to as ‘hyperspace’” (Parry & Doan; 1994). Narrative therapy takes on the challenge of doing therapy in hyperspace¹¹.

As was previously stated, narrative therapy is a treatment modality; it is the practical therapeutic application of postmodern principles and therefore has techniques for treatment, which is important to outline. A chapter in the book *A Different Story: The Rise of Narrative in Psychotherapy* provides a comprehensive description of the practice of narrative therapy through the work of Michael White and David Epton. The beginning of the chapter is clear in pointing out the fact that this chapter “is a snapshot of a moving vehicle” (Beels, 2001, pg. 150), and not necessarily a contemporary look at the work of White and Epton, as they are always moving and re-defining their work. What can be gained from the reading is a narrative definition of what “therapy” is, and an idea of how narrative therapy works. According to Beels, narrative therapy responds to the least heard voices, or “subjugated knowledges” within the family and larger culture (Beels, 2001). Beels goes on to outline the basic strategy of narrative therapy as being:

1. Externalizing the problem and redefining it as an affliction;
2. Discovering alternatives; and,
3. Recruiting support.

¹¹ It is not the intention of this project to expound upon the techniques of narrative therapy; however, it seems fruitful at this point to highlight some main points of the therapy to further illustrate the ways in which narrative therapy can be seen as a performance of postmodern ideology.

Externalization seems to be the crux of treatment in narrative therapy; the foundation from which subsequent steps are derived. According to White and Epston, “‘Externalizing’ is an approach to therapy that encourages persons to objectify and, at times, to personify the problems that they experience as oppressive” (White & Epston; 1990, pg. 38). These ideas are based on the therapist always adopting a stance of not-knowing with regard to the client’s life, and the assumption that the client or family members are the experts on their own lived experiences. This idea is significant for several reasons. White and Epston are reacting against the “dominating discourse” of psychotherapy (and the mental health field in general) that defines deviance and pathologizes its clients based on those definitions without recognizing or acknowledging their own role as a situated observer. Michael White’s work is highly influenced by the writings of philosopher Michel Foucault, who writes “on the decentering of the [human] subject and the ubiquity of power pervading all human interaction, such that significant narratives are subjugated to serve the dominant discourse, which comes to define a culture and maintain the status quo” (Parry & Doan; 1994, pg. 9). Foucault’s definition of power is atypical; usually when we hear the word “power” we think of something restrictive, as in “power over” (i.e. the State has power over its people). Foucault, however, takes as his starting point the existence of power in every human interaction. In this sense, then, power is *positive*, or constitutive. In elucidating Foucault’s ideas about power, White and Epston explain that “[Foucault] is referring to [the positive effects of power] in the sense that power is constitutive or shaping of person’s lives” (White & Epston; 1990, pg. 23-24). Further, cultures are subjected to normalizing truths (e.g. constructed ideas that are granted truth status) that shape our lives and relationships.

So how did White and Epston move from Foucault's ideas about truth and power to the concept of externalization and the use of narrative in a therapeutic setting?

Foucault's redefinition of these concepts (concepts which are so fundamental to human interaction in general and the therapeutic relationship specifically) paved the way for the proposal that "persons give meaning to their lives and relationships by storying their experience and that, in interacting with others in the performance of these stories, they are active in the shaping of their lives and relationships" (White & Epston; 1990, pg. 20).

This observation was followed with questions concerning how, taking for granted the idea that people make sense of the world by storying their experiences, we may understand the ways in which people experience their problems and present them for therapy. It started to become clear that people absorbed the totalizing narrative of pathology and diagnoses in ways that led them to believe that they *were* their problems; that their identity was one and the same as their problem. To externalize their problem was to separate a client's identity from the identified problem, thereby redefining the relationship between the person and the problem and, the logic goes, allowing the client more freedom to dialogue with and ultimately negate the influence of their problem.

White and Epston (1990, pg. 39-40) identify the benefits/results of externalizing the problem as follows:

1. Decreases unproductive conflict between persons, including those disputes over who is responsible for the problem;
2. Undermines the sense of failure that has developed for many persons in response to the continuing existence of the problem despite their attempts to resolve it;
3. Paves the way for persons to cooperate with each other, to unite in a struggle against the problem, and to escape its influence in their lives and relationships;
4. Opens up new possibilities for persons to take action to retrieve their lives and relationships from the problem and its influence;

5. Frees persons to take a lighter, more effective, and less stressed approach to “deadly serious” problems; and
6. Presents options for dialogue, rather than monologue, about the problem.

After the problem is externalized, various other lines of questioning follow that assist the client and any family members or others who are close to the client in identifying and mapping the influence of the identified problem in their lives and, conversely, the influence of the client in the life of the problem. The questions presented subsequent to the externalization of the problem are intended to “bring forth the information that contradicts the problem-saturated description of family life and assist persons in identifying their competence and resourcefulness in the face of adversity” (White & Epston; 1990, pg.41).

In the beginning of this chapter a claim was made that a shift in thinking occurred in the mental health field that has conditioned the possibility for analyses of self-mutilation to emerge that characterize the behavior as a complex coping strategy, rather than “merely” disgusting and manipulative behavior. It has been the implicit argument of this chapter that the emergence of narrative therapy and narrative-based treatment approaches has facilitated this shift in attitude through a shift in focus away from pathologizing clients’ problems and towards their stories in an attempt to help them re-author their lives, and subsequently gain a sense of power and control. Staying on the theme of the grand history of paradigm shifts, we now must ask ourselves the question – where did the shift in thinking occur such that the concept of narrative and narrative therapy was able to emerge in the western world? To answer this we now turn to a discussion of Nietzsche and the emergence of postmodern ideology.

CHAPTER IV

NIETZSCHE

Here the ways of men [sic] part: if you wish to strive for peace of soul and pleasure, then believe; if you wish to be a devotee of truth, then inquire.

Letter to his sister, June 11, 1865

Friedrich Nietzsche is considered by many philosophers to be one of the most intense, prolific, and controversial thinkers of the nineteenth century. He is also one of the most misunderstood. Nietzsche has been held responsible for everything from postmodern ideology to the rise of Nazism in Germany, all based on readings from the same texts. Feminists both love and hate him, Christians just plain hate him, and he has been appropriated by both continental and analytic philosophical traditions. His analysis of the Western world, and predictions about the future can arguably be characterized as prophetic, if a not a bit harsh. Even in spite of all the controversy that surrounds Nietzsche, his life and his work, one would be hard-pressed to successfully argue against his importance as a thinker, or his cultural and academic influence.

Over the past 150 years Nietzsche's influence has extended far beyond the realm of philosophy and academia, and his ideas seem to become increasingly relevant as the years go by. This is not to suggest that a consensus has been reached regarding the content of his ideology; whether or not Nietzsche's work could even be characterized as an "ideology" has been debated as well. His aphoristic style of writing easily seduces his readers into the belief that his thought is non-linear and fragmented, and his sarcastic tone creates the illusion that he is more unforgiving than the undertones of his work suggest. Rigorous exegesis of the text coupled with an open mind, however, show Nietzsche to be

not only a cohesive thinker, but also fastidiously consistent throughout the breadth of his work, paradoxically optimistic, and kind.

Contributing to the influential and relevant nature of Nietzsche's work is the psychological and cultural analysis that is the fodder for larger observations about more "philosophically relevant" topics (the nature and function of truth, epistemology, metaphysics). It is the position of this paper that these observations were not only revolutionary in the field of philosophy, but redefined the concept of objective truth, human's relationship to truth and, subsequently, human psychology in such a way that has fundamentally impacted Western ideas about culture and psychological theories of human subjectivity. The breadth of Nietzsche's work is considerable, and while it would be interesting (and in many ways fruitful) to engage in an extensive textual analysis, for the purposes of this paper we will be looking at a snapshot of Nietzsche's work insofar as it applies to and has impacted contemporary clinical practice; narrative therapy specifically.

Nietzsche's Perspective

Nietzsche came of age during a great time for Germany and Western thought in general. Philosophically, he emerged under the shadow of Kantian metaphysics and Hegel's dialectic, grand meta-narratives that reflected the optimism of the time. Germany had enjoyed military victories, science and technology were making spectacular advances, and optimism was generally high. Strange, then, that Nietzsche characterized this time as nihilistic. For him, there was only one thing that mattered: God was dead.

The madman – Have you not heard of that madman who lit a lantern in the bright morning hours, ran to the market place, and cried incessantly: “I seek God! I seek God!” – As many of those who did not believe in God were standing around just then, he provoked much laughter. Has he got lost? asked one. Did he lose his way like a child? asked another. Or is he hiding? Is he afraid of us? Has he gone on a voyage? Emigrated? – Thus they yelled and laughed.

The madman jumped into their midst and pierced them with his eyes. “Whither is God?” he cried; “I will tell you. *We have killed him* – you and I. All of us are his murderers. But how did we do this? How could we drink up the sea? Who gave us the sponge to wipe away the entire horizon? What were we doing when we unchained this earth from its sun? Whither is it moving now? Whither are we moving? Away from all suns? Are we not plunging continually? Backward, sideward, forward, in all directions? Is there still any up or down? Are we not straying as through an infinite nothing? Do we not feel the breath of empty space? Has it not become colder? Is not night continually closing in on us? Do we not need to light lanterns in the morning? Do we hear nothing as yet of the noise of the gravediggers who are burying God? Do we smell nothing as yet of the divine decomposition? Gods, too, decompose. God is dead. God remains dead. And we have killed him.

“How shall we comfort ourselves, the murders of all murderers? What was holiest and mightiest of all that the world has yet owned has bled to death under our knives: who will wipe this blood off us? What water is there for us to clean ourselves? What festivals of atonement, what sacred games shall we have to invent? Is not the greatness of this deed too great for us? Must we ourselves not become gods simply to appear worthy of it? There has never been a greater deed; and whoever is born after us – for the sake of this deed he will belong to a higher history than all history hitherto.”

Here the madman fell silent and looked again at his listeners; and they, too, were silent and stared at him in astonishment. At last he threw his lantern on the ground, and it broke into pieces and went out. “I have come too early,” he said then; “my time is not yet. This tremendous event is still on its way, still wandering; it has not yet reached the ears of men. Lightning and thunder require time; the light of the stars requires time; deeds, though done, still require time to be seen and heard. This deed is still more distant from them than the most distant stars – *and yet they have done it themselves.*”

It has been related further than on the same day the madman forced his way into several churches and there struck up his *requiem aeternam deo*. Led out and called to account, he is said always to have replied nothing

but: “What after all are these churches now if they are not the tombs and sepulchers of God?”

(Nietzsche; 1974, pg. 181)

This breathtaking aphorism was Nietzsche’s announcement of God’s death to his readers. Purposefully intense and inflammatory, Nietzsche envisages himself a madman; for what else would it be to dismantle the very organizing principle upon which our society, our truths, ourselves, are built? To kill God? Does it follow, then, that Nietzsche is an atheist? It seems clear that the madman passage is a metaphor, but for what? There is no lack of literature explaining away this passage as Nietzsche’s reaction to narrow-minded Christians and his austere religious upbringing. As provincial as it is patronizing, this analysis not only misunderstands the point of the aphorism, but also makes it clear that the previous and subsequent aphorisms in the book were not considered. For a closer look at the text as a whole leads one to question whether Nietzsche is even referring to God in a *literal* sense. Note that nowhere in the aphorism does it say, “You have been told that there is a God, but I am telling you that you are wrong”; he claims that God is dead, implying that it was once alive. The contradictory nature of this assertion (isn’t the nature of God such that it transcends the biological process of life and death?) calls to our attention the *diagnostic* nature of the claim—that the death of God is not so much a metaphysical claim about objective reality as it is an attempt at a diagnosis of contemporary civilization (Kaufmann; 1974, pg. 100)¹².

Whether Nietzsche is using the term “God” to indicate a supernatural being or as a metaphor for an objective organizing principle for the Western world, it is clear that he is calling attention to a major cultural, academic, and psychological shift that is in process.

¹² Nietzsche’s concept of death of God has also been confused with his disdain for the Christian image of God. There is ample textual evidence for the latter idea, however, for the purposes of this paper, the death of God will be the focus.

Nietzsche was not unaware of the severity of his claim and of the impact that it would have, however unnoticed it may be at the time, on the larger culture. To proclaim the death of God and subsequently diagnose the age as “nihilistic” is to radically repudiate the meaning, value, and validity of the age and its products. Aside from the overwhelming despair that this position has the possibility to engender, another even more perplexing dichotomy emerges –if God exists, the value and significance of human life is diminished in deference to the divine; however, if God is dead it leaves behind a vacuous hole of existential meaning and significance: “Are we not straying as through an infinite nothing? ... Has it not become colder? Is not night continually closing in on us?” (Nietzsche; 1974, pg. 181). Nietzsche scholar Walter Kaufmann characterizes Nietzsche’s plight accordingly, “To escape nihilism—which seems involved both in asserting the existence of God and thus robbing *this* world of ultimate significance, and also in denying God and thus robbing *everything* of meaning and value—that is Nietzsche’s greatest and most persistent problem” (Kaufmann; 1974, pg. 101). Nietzsche doesn’t revel in his assessment that his times are nihilistic (as is so often assumed by his readers); he considers this newfound “breath of empty space” his most pressing problem to be *solved*, rather than a state that he is *advocating*. Indeed, Nietzsche wonders, “Who will attain anything great if he does not find in himself the strength and the will to inflict great suffering? ... not to perish of internal distress and uncertainty when one inflicts great suffering and hears the cry of this suffering—that is great, that belongs to greatness” (Nietzsche; 1974, pg. 255).

Again, readers must take care to not confuse the death of God with an atheistic attitude; there is a difference between religiousness and supernaturalism. That is—debate

regarding eschatological matters versus whether or not something exists beyond or above nature. Philosophical naturalism is a view that “simply limits itself to what is natural or normal in its explanations, as against appeal to what transcends nature as a whole, or is in any way supernatural or mystical” (Kaufmann; 1974, pg. 102). We may call Nietzsche a naturalist insofar as he wonders whether or not we may substitute naturalistic values in place of moral ones¹³. What begins to emerge in Nietzsche’s thought is his opposition to appeals to God (i.e. using God as a “trump card”) that shut down arguments and truncate productive discussions in the search for truth:

I do not by any means know atheism as a result; even less as an event: it is a matter of course with me, from instinct. I am too inquisitive, too *questionable*, too exuberant to stand for any gross answer. God is a gross answer, an indelicacy against us thinkers—at bottom merely a gross prohibition for us: you shall not think!

Kaufmann; 1992, pg. 692

Hopefully it is becoming clear at this point that Nietzsche’s analytic style is one that anticipates contemporary postmodern ideology. He performs a meta-analysis of the foundations and belief systems of his time, which few were capable of then, and which is much more commonplace now. His observation that “all great things bring about their own destruction through an act of self-overcoming” (Kaufmann; 1992, pg. 597) displayed not only a capacity for keen insight into the function and purpose of socio-political institutions, but an uncanny prediction for the future of those and institutions to come. Nietzsche’s line of questioning (looking at the ways in which the foundation of the time is no longer sufficient with regard to its explanations of the world) betrays a nihilistic perspective and diagnosis of society that inevitably brings with it concerns and an

¹³ Nietzsche uses the term “morality” to indicate the perspective of human judgment and intention: “Morality trains the individual to be a function of the herd and to ascribe value to himself only as a function” (Nietzsche; 1974, pg. 174).

anticipation of suggestions for a way to do and see things differently. We will now consider the problems that Nietzsche's death of God engenders, and his response to those problems.

Nietzsche's Problem

Two salient points have thus far emerged from this discussion: 1. Nietzsche's diagnosis of his times as nihilistic through his feelings of disdain for any process of interrogation which takes for granted the validity of a set of beliefs, values or assumptions that has as its foundation the sanction of religion, class, society or state. This position serves to dismantle the very foundations upon which social, cultural, political, and psychological ideas rest, and 2. Given this radical repudiation of meaning and value in Nietzsche's thought, what is the possibility of establishing universal truths and the procurement of a meaningful life in a Godless world?

Despair is not the only reaction that is possible to the abyss of nihilism – there are some who rejoice: “Indeed, we philosophers and ‘free spirits’ feel, when we hear the news that ‘the old god is dead,’ as if a new dawn shone on us ... At long last the horizon appears free to us again, even if it should not be bright ... the sea, *our* sea, lies open again; perhaps there has never yet been such an ‘open sea’” (Nietzsche; 1974, pg. 280). This passage seems to be clearly suggesting that a select few “philosophers and free spirits” approach the death of God with excitement and hope, rather than despair and dread. These people can see the endless possibilities, the “open sea” of the future, and delight in the fact that the death of God makes anything possible.

So who are these free spirits? Philosophers have been around for thousands of years before Nietzsche's assertion that God is dead; yet he simultaneously anticipates the

despair and chaos that are subsequent to the nihilistic times of the age. How is it that Nietzsche can say that philosophers and free spirits rejoice in the news that God is dead, while still making the claim that “this tremendous event is still on its way ... it has not yet reached the ears of men”? Nietzsche claims that a true philosopher *must not rationalize the valuations of their own society*, “Error is spread unnecessarily when moral doctrines, which are vitiated by personal bias or a compromise with State or Church, are allowed to become the basis for metaphysical or epistemological considerations. That this, however, has been the case in almost all philosophies up to now, Nietzsche never tires of insisting” (Kaufmann; 1974, pg. 107). Nietzsche believed that there was a way in which philosophers allowed opinions, institutions, and past thoughts to come “between [themselves] and things” (Kaufmann; 1974, pg. 108); that in the process of the search for truth one’s efforts may be corrupted by the demands of the State, institutions, or society.

Subsequent to this insight, Nietzsche makes a distinction between genuine philosophers and philosophical laborers. However self-righteous this may sound, Nietzsche is making an observation about something that is lacking in the work of those that are merely “philosophic laborers”—those that “have to determine and press into formulas ... creations of *value which have become dominant and are for a time called ‘truths’*” (Kaufmann; 1992, pg. 326, my italics), rather than reaching out for the future with a creative hand, “and all that is and has been becomes a means for them, an instrument, a hammer” (Kaufmann; 1992, pg. 326). The task of the philosophic laborer is clearly very important and necessary to the process of philosophic inquiry, however, the genuine philosopher is one who must go stand on each one of the steps upon which “his servants, the scientific laborers of philosophy, remain standing,” for the “*genuine*

philosophers, however are commanders and legislators: they say, 'thus it shall be!'" (Kaufmann; 1992, pg. 326). The model philosopher is pictured as a physician who applies the knife of his thought “vivisectionally to the very *virtues of the time*” (Kaufmann; 1992, pg. 327), sparing no thought, idea, or institution from the critical and (at times) devastating gaze of the thinker.

In light of Nietzsche’s views regarding those philosophers who are *genuine* it is interesting to take into consideration his views on the psychology of the human ego, and the ways in which he understands “truths” to be found: “As soon as we see a new image, we immediately construct it with the aid of all our previous experiences, *depending on the degree* of our honesty and justice. All experiences are moral experiences, even in the realm of sense perception” (Nietzsche; 1974, pg. 174). In this statement, Nietzsche is seeking to undermine the very idea that there are “things in themselves”, or objective truth; to not only say that experience is constructed, but that it is constructed *with the aid of previous human experience* is essentially to place human perception in a direct and causal relationship with the construction of our own truth. To turn even sense perception into a moral experience (where moral equals judgment) is to make unstable even the very possibility that there can be facts that exist independently of the human minds that think and perceive them. This is a devastating blow to the existence and attainability of objective truth, and serves to undercut the tradition of the meta-narrative that had been used to explain human existence and the dominance of detached reason as a way to attain independent knowledge of “things in themselves” and, subsequently, what kind of knowledge we can have about the world and ourselves:

Henceforth, my dear philosophers, let us be on guard against the dangerous old conceptual fiction that posited a ‘pure, will-less, painless,

timeless knowing subject'; let us guard against the snares of such contradictory concepts as 'pure reason,' 'absolute spirituality,' 'knowledge in itself': these always demand that we should think of an eye that is completely unthinkable, an eye turned in no particular direction, in which the active and interpreting forces, through which alone seeing becomes seeing *something*, are supposed to be lacking; these always demand of the eye an absurdity and a nonsense. There is *only* a perspective seeing, *only* a perspective 'knowing'; and the *more* affects we allow to speak about one thing, the *more* eyes, different eyes, we can use to observe one thing, the more complete will our 'concept' of this thing, our 'objectivity' be. But to eliminate the will altogether, to suspend each and every affect, supposing we were capable of this – what would that mean but to *castrate* the intellect? –

Kaufmann; 1992, pg. 555

Nietzsche doesn't link his perspectivism to his image of the genuine philosopher explicitly in his texts, however, they seem to be related in the sense that the genuine philosopher is the one who, by the application of their knife to the prevalent values of the time, would be able to see and understand the necessity of different perspectives and the ways in which they work together in order to achieve truth. One could make the argument that, by saying that "there is only a perspective seeing, only a perspective knowing" and that more and different eyes are required in order to achieve a more complete "concept" of a thing, Nietzsche has equalized perspectives in a way that seems contradictory to the hierarchy he creates between genuine philosophers and philosophical laborers (and, one could argue, a tacit hierarchy exists in Nietzsche's thought between philosophers and everybody else). Is he saying that every perspective is equal? To be sure, he would not make the claim that the philosophical laborer's perspective is equal to the genuine philosophers', which begs the question—whose eyes are needed in the search for truth? Does Nietzsche consider himself to be a genuine philosopher? He concludes the passage that defined genuine versus laborer philosophers by questioning "Are there such philosophers today? Have there been such philosophers yet? *Must* there not be

such philosophers?” (Kaufmann; 1974, pg. 326). Nietzsche has also made it clear elsewhere that he considers himself a precursor to the philosophers of the future; philosophizing with a hammer so as to condition the possibility for the emergence of the genuine philosopher.

Here the question emerges: Is Nietzsche, by dismantling the prevalent ideas of the time, actually facilitating the emergence of nihilism? It seems quite clear that Nietzsche has assessed his age as ill, “The health of our civilization appeared to him to be severely threatened: it looked impressively good, but seemed to Nietzsche thoroughly undermined – a diagnosis which, through trite today, was perhaps no small feat in the eighteenth-eighties” (Kaufmann; 1974, pg. 109). For Nietzsche, it would be cruel and gratuitous not to speak up and offer his assessment of the age, for to ignore the reality that our truths and values have become hollow, that traditional morality is inescapably dying, would be, paradoxically, to expedite and make ineluctable the dissolution of the age. “In other words, Nietzsche believed that, to overcome nihilism, we must first of all recognize it” (Kaufmann; 1974, pg. 110).

The Revaluation of Values

Much of this chapter has been spent discussing the ways in which Nietzsche has (to borrow a contemporary term) deconstructed the truths and values of his time. In light of the assertion of the death of God and the shattering of the truths and values upon which social institutions rests, it seems reasonable to expect that Nietzsche would offer his own set of values in its place. The question remains: was it Nietzsche’s intention for the revaluation of values to provide us with a new structure, with new ways to be and new values to uphold? To put it bluntly: No.

Much debate has existed on the issue of Nietzsche's intentions with regard to the creation of a value system or coherent set of prescriptive rules. Further complicating the issue is the confusing and often opaque manner in which Nietzsche expresses himself, which often leads one to assume that he is advocating something different or contrary to his original meaning. More specifically, Nietzsche has been accused of advocating a certain ruthlessness in one's treatment of others, and for a destruction of the weak. That he has used this language is not debatable, however, the meaning of his words may not be immediately accessible to the superficial browser of Nietzsche's writing. Indeed, Nietzsche's desire for his work to be obscure becomes clear when he asserts "Our highest insights must--and should--and like follies and sometimes like crimes when they are heard without permission by those who are not predisposed and predestined for them" (Kaufmann; 1974, pg. 232). Moreover, "Every profound spirit needs a mask: even more, around every profound spirit a mask is growing continually, owing to the constantly false, namely shallow, interpretation of every word, every step, every sign of life he gives" (Kaufmann; 1974, pg. 241). He is very clear that his writings must not be read capriciously, for to do so will likely result in misunderstanding and misguided ordinances.¹⁴

Irrespective of Nietzsche's personal values (of which he has many – honesty, courage, generosity, politeness, intellectual integrity), one must take many liberties with his writings in order to formulate what could be considered a coherent set of prescriptive values subsequent to the death of God and the advent of nihilism. Kaufmann invariably asserts that "it is one of Nietzsche's most serious faults that, in his great loneliness, he

¹⁴ It is interesting, though not at all surprising, to consider Nietzsche's assessment and predictions about being misunderstood in light of the posthumous use of his work by his sister and Hitler in the Third Reich.

injected into his writings elements that aroused such expectations” (Kaufmann; 1974, pg. 110-111). Fundamentally, the revaluation of values is not prescriptive; it is descriptive of an action or intellectual behavior that serves as a defense against nihilism by making present the “mendaciousness of millennia” (Kaufmann; 1974, pg. 783). At bottom, the revaluation is a war against accepted valuations; it is a “courageous becoming conscious” (Kaufmann; 1974, pg. 111). The diagnosis itself *is* the revaluation. Not an arbitrary action, where in individual philosopher enters into a battle to attack and dismantle prevalent valuations for sport (Kaufmann; 1974, pg. 112); it is an internal criticism directed at hypocritical and dishonest thinking, where “the philosopher only lays bare the cancerous growth” (Kaufmann; 1974, pg. 112) that is hypocrisy and dishonesty in the foundations of accepted morality. Nietzsche explains, “*Revaluation of all values*: that is my formula for an act of supreme self-examination on the part of humanity, become flesh and genius in me ... I was the first to *discover* the truth by being the first to experience lies as lies—smelling them out—My genius is in my nostrils” (Kaufmann; 1974, pg. 782). Hyperbole aside, in this passage Nietzsche makes clear his image of the revaluation of values as an *activity*, rather than a stagnant set of prescribed values. The significance of this activity lies in the optimism that it engenders, and the opportunity for liberation from dogma and hypocrisy.

Nietzsche’s contributions to the discipline of philosophy, psychology and cultural analysis cannot be ignored. As Kaufmann pointed out, though many of his ideas may be commonplace today, Nietzsche was working during a time that was, beyond being unsupportive of his thinking, did not possess a capacity to conceptualize or language to speak about the world in the ways that he was. In this sense Nietzsche was a true

revolutionary; he could indeed be considered prophetic, “He felt the agony, the suffering, and the misery of a godless world so intensely, at a time when others were yet blind to its tremendous consequence, that he was able to experience in advance, as it were, the fate of a coming generation” (Kaufmann; 1974, pg. 98). Despite—or perhaps because of—the revolutionary character of Nietzsche’s ideas, there is a way in which his ideology could be considered trite through the lens of contemporary social theory. This position, however, serves only to highlight the pervasiveness of Nietzsche’s thought—that, at this point, his cultural and psychological observations along with scathing social and academic analysis have become part of the fabric of social, cultural, and psychological discourses. It is, in fact, the position of this paper that without Nietzsche, contemporary social thought would look vastly different; that Nietzsche’s influence has even extended to the sphere of contemporary mental health treatment. We will now consider the impact of Nietzschean ideology on contemporary clinical practice.

CHAPTER V

DISCUSSION

In the previous chapter it was asserted that Nietzsche could be considered prophetic in that he assessed the times he was in and anticipated the fate of a coming generation. It was also said that it was perhaps one of Nietzsche's greatest faults that his work seduces his readers into expecting answers; i.e. the current way of going about seeing the world is wrong, and he is in possession of the "right" or "true" way to do things. After reading and absorbing Nietzsche's work, one is left with a feeling of unresolved anticipation—we want to know what to do! The problem of nihilism that plagued Nietzsche is one that we continue to face—by obliterating the idea of God (i.e. objective truth, structure, foundations of thought and morality) the result is that, simultaneously, a vacuum of meaning is created because there is no structure that is independent of human minds to which we may appeal to guide us. On the other hand, by dismantling the idea of objective truth we create a world in which people make their own meaning; a meaning that is not burdened by the requirement of adhering to an unalterable and objective truth.

Many ideas have been presented thus far, and it may leave the reader wondering as to how it all should be integrated. Creating a continuum from Nietzsche's philosophy to contemporary dialogue regarding self-mutilation may seem a bit contrived, though the subjects are not as disparate as a superficial glance may allow. It has been the position of this paper that postmodern philosophy, specifically Nietzsche's ideas on truth and values,

has impacted contemporary clinical practice, specifically narrative therapy, in explicit and important ways. Insofar as self-mutilation is a clinical issue that is both controversial and steeped in both cultural and psychological discourses, it is an ideal phenomenon through which to view the ways in which Nietzsche's ideas about truth are employed in contemporary clinical practice.

How Nietzsche Has Impacted Narrative Therapy

The power in Nietzsche's work lies not only in his analysis and critique of philosophical concepts (i.e. free will, truth, things in themselves, etc), but also in the ways in which he locates those concepts in the human perspective. That is—Nietzsche is the first theorist to cast doubt on the idea of objective truth by defining it as 1. dependent on human minds and 2. serving the psychological and material needs of people in communities. Further, subsequent to the dismantling of the idea of truth that exists independently of the minds that think it, Nietzsche assessed that, contrary to instinct, this was actually a liberating and exciting idea for those who could handle having the rug pulled out from under them, so to speak. The excitement comes from the realization that if God is dead, if no one truth is the right truth, then anyone may have a voice in the creation of their world. What Nietzsche does is, in effect, completely foreground and dismantle the foundation of the cultural, psychological and academic standards from which we come and to which we appeal to justify our actions and beliefs, thereby creating space for subjugated voices. This has the effect of equalizing voices and values so that one may not be used to dominate the others. If all truths are equally valid, the truth ceases to be something that is only accessible to the few and elite. This is the core of what narrative therapists are trying to do with their clients—provide them with a voice.

The dissolution of the idea of a reality that exists independently of the minds that think it creates an environment where everyone's voice is important and valid, thereby subverting the dominance of patriarchal, racist, and homophobic discourses that subjugate those who are not the elite.

The problem of the vacuum of meaning still remains. If there is no consensus, if "anything goes", how can we operate in society? This is where Nietzsche falls painfully short—he gives us no answer as to how to proceed. Perhaps this is why he claims that the search for truth—to be a genuine philosopher—is not for the faint of heart. Narrative therapists try to work with and in the void of meaning created by postmodernism through the vehicle of, not surprisingly, people's narratives. The question of where we may find meaning and value in a Godless world is answered through the way people story their lives and the world around them. Communities and egos alike are created and sustained through stories, and those stories serve as the structure and foundation for our thoughts, beliefs and interactions. Nietzsche recognizes *untruth* as being a condition for life—that is, the things we tell ourselves to preserve and cultivate our lives and species, "To recognize untruth as a condition of life—that certainly means resisting accustomed value feelings in a dangerous way; and a philosophy that risks this would by that token alone place itself *beyond good and evil*" (Kaufmann; 1992, pg. 202, my italics). Narratives can be considered an "untruths," insofar as narratives are not facts that are true for all people across all cultures. Take note that Nietzsche is not placing a value judgment with the term untruth, "The falseness of a judgment is for us not necessarily an objection to a judgment; in this respect our new language may sound strangest" (Kaufmann; 1992, pg. 201). Narrative therapy recognizes "untruth as a condition of life" (i.e. the importance of

narrative in structuring the client's world), and seeks to facilitate the client's creation of new truths that are not saturated with the untruths of others. Further, Nietzsche is tacitly imploring us to move "beyond good and evil"—beyond dichotomies that force things into being true/false, right/wrong, good/evil—to understand that things that are "untrue" are necessary for human interaction, and to see the world in more dynamic and productive ways.

Working in tandem with Nietzsche's ideas about truth is his perspectivism. He was perhaps the first philosopher to introduce the idea that the viewer's knowledge of a thing is dependent on their perspective, consequently challenging the idea that there is such a thing as the disembodied observer searching to find the thing in itself. Nietzsche provides an insight into the psychology of the thinker that belies the validity of the "objective observer"—a shocking and destabilizing move for hegemonic philosophical discourse up until that point:

Gradually it has become clear to me what every great philosophy has been: namely, the personal confession of its author and a kind of involuntary and unconscious memoir; also that the moral (or immoral) intentions in every philosophy constituted the real germ of life from which the whole plant had grown (Kaufmann; 1992, pg. 203)

This passage is a tacit criticism of theorists who do not account for their own perspective (and, we may now add, bias) when asserting a theory about the world. Similarly, narrative therapists criticize more traditional psychodynamic therapists for not accounting for their own perspective in the therapeutic dyad, thereby contributing to the formation and entrenchment of the problem-saturated narratives that define their clients as sick. What we may infer from the above quote with regard to narrative therapy's criticism of contemporary psychodynamic therapists is that every diagnosis and pathology is, to some degree, the personal confession or perspective of the therapist.

Narrative therapy seeks to undermine the hierarchy inherent in the therapeutic dyad that forces participants into the roles of weak/savior. Further, Nietzsche's perspectivism is glaringly present in narrative therapy's attempts to shed light on and deconstruct the workings of power and the ways in which power works to shape people's narratives about themselves. This action has the effect of dissolving any one grand narrative into a multiplicity of localized narratives, all of which are meaningful and "true" to the client. Although it took close to one hundred years for Nietzsche's ideas to be taken seriously, hopefully it has been shown that his investigations and discoveries have been woven into the psychological, social, cultural, and political fabric of contemporary discourses. Specifically, the "humanizing" of truth (i.e. redefining truth as located within the human perspective) and the dismantling of the idea of objectivity has had profound effects on contemporary clinical practice and the definition of pathology or "social problems". As the purpose of this paper is to illustrate the ways in which postmodernism (specifically Nietzsche) has impacted contemporary clinical practice through the lens of self-mutilation, we will now take a practical look into the ways that narrative therapy might work with a person who self-mutilates.

How Narrative Therapy Would Work With Self-Mutilation

An attempt was made earlier in this project to illustrate the ways in which images, stigmas and mental health assessment and treatment of self-mutilators have changed over time, and the role that narrative therapists and their way of working with people have played in facilitating that shift in thinking. To move from the thought that self-mutilation is a disgusting attempt to get attention to the more intricate and dynamic idea that self-mutilation is a complex coping mechanism to end episodes of depersonalization and

process trauma is no small feat. A suggestion was made earlier that we look at the ways in which ideas and institutions regarding self-mutilation have been reified and, further, how the work of narrative therapists may serve to both undermine the process of reification of self-mutilation, and foreground their client's authorship in their own world.

To recap: the process of reification is the process by which the products of human activity and perceptions are granted a status independent of or higher than the human minds that think them. The act of self-mutilation has existed since biblical times (and probably before), though it was cognized very differently. The advent of science and, subsequently, the medical model shifted the way self-mutilation was perceived from one of demon possession to pathology. That is, the "cause" of self-mutilative behavior shifted from a force that existed outside the subject (subject as victim) to being located inside, where the subject was seen as perpetrator, or "sick", and held totally responsible for their actions, without allowing for any interplay between the person and their environment. Over time, self-mutilation was typified into a deviant behavior, institutionalized as pathology, and the medical community legitimized that pathology. Eventually, self-mutilation came to exist as its own self-sustaining community of "deviants", with their own rituals, languages, and experiences.

Narrative therapy has done much to expose and challenge the process of reification generally, and specifically for those who self-mutilate. Clinical work with self-mutilators within a narrative framework looks very different than it would if it were practiced from within a more traditional psychodynamic or medical framework. The main theme that would dominate narrative treatment of a self-mutilator would be the client's story—the language that the client used would be the catalyst through which the

client's assumptions about themselves and the world would emerge. Keeping in mind the power structures that exist that not only define and maintain self-mutilators as "sick" or "disturbed", but also subjugate the knowledge that the client has about themselves, a narrative therapist would seek to facilitate the process by which the client's voice may be found and spoken.

Four assumptions that narrative therapists maintain have been outlined in previous chapters:

1. Realities are socially constructed
2. Social Construction happens through language
3. Realities become cohesive and are maintained through narrative
4. There are no essential truths (is no essential self)

Using these assumptions as the foundation for treatment, narrative therapy would seek to de-essentialize self-mutilation (or externalize the problem), defining it as a separate entity from the person who is, in effect, in a relationship with self-mutilation. Examining the way that the self-mutilating client speaks about themselves may betray not only the client's view of themselves, their place in the world, and the reasons they self-mutilate, but also the work of socio-cultural power structures that serve to pathologize and label them as deviant. Finally, by working with the client's experience as a narrative allows space for the client to understand the ways in which the reality of their relationship with self-mutilation has become cohesive and determinative of their identity and experience in the world.

Of course, as has been previously explained, the process by which narrative therapists work (externalizing the problem, discovering alternatives, recruiting support) involves a series of questioning that provides an opportunity for the client to see the ways in which self-mutilation impacts their relationships with others, their ability to (for

instance) go out in public in short sleeves, how other people's stories about them do not provide adequate space for the client to make up and live their own stories about themselves, and what role the client has in maintaining the relationship with self-mutilation. This process is facilitated by the therapist through their encouraging of the client to discover alternatives to their dominant story of self-mutilation. The effect of discovering alternatives is that the client is allowed to see themselves as separate from and as having power over self-mutilation. The process of questioning which narrative therapy employs is one that allows the space for the client to see themselves as separate from the problem of self-mutilation (e.g. "Can you tell me about a time when you were able to stand up to self-mutilation and not let it take over?"; "when does self-mutilation let itself in and impact your relationships in a negative way?"), thereby affording the client the ability to construct their own narrative, their own perspective, on their lives—a perspective that isn't problem-saturated or coerced by the dominant discourses which surrounds the client.

Up to this point, this discussion has mainly focused on narrative-based treatment methods for clients who self-harm. Hopefully it has been made clear, however, that narrative therapy is more than just a set of techniques—it is a way of seeing and operating in the world, as well as a position from which to engage clients. It is unclear exactly what narrative therapy would have to say about the causes of self-mutilation, or the self-mutilating client's intentions in harming themselves, as narrative therapists are opposed to totalizing and overarching discourses regarding clients' struggles or "pathologies." White and Epston (1990, pg. 24), however, in detailing Foucault's account of the ways in which people are recruited into taking on an active role in their own subjugation, state:

When conditions are established for persons to experience ongoing evaluation according to particular institutionalized “norms,” when these conditions cannot be escaped, and when persons can be isolated in their experience of such conditions, then they will become the guardians of themselves. In these circumstances, persons will perpetually evaluate their own behavior and engage in operations on themselves to forge themselves as “docile bodies.”

White and Epston go on to suggest that anorexia nervosa and bulimia may, in fact, reflect the “pinnacle of achievement” of this type of power. Insofar as anorexia and bulimia, though technically not included in this paper’s definition of self-mutilation, have been placed together under the rubric of “self-harming practices,” one may take liberties with White and Epston’s Foucauldian analysis of power and include self-mutilation alongside anorexia and bulimia as the result of the completion of the operations of forces of power that operates on the body to form and subjugate persons into docile bodies.

Earlier, Karl Menninger’s explanation of self-mutilation was described as a compromise made by the ego (or discriminating intelligence) between the destructive demands of the subject and the will to life. If the ego finds itself failing in this negotiation, it makes the best possible compromise—focal suicide, or self-mutilation. Admittedly, this analysis is rather outdated, though not to be totally disregarded. Menninger’s analysis of self-mutilation, though interesting and highly innovative at the time, did not offer an explanation as from *where* these destructive urges come. What it does offer, however, is a hypothesis as to the psychic life and intentions of the self-mutilator. Although narrative therapy offers no insight as to the personal and psychological intentions behind the self-mutilative act (a curtailment in thought that is painfully absent), an argument could be made in favor of a reframing of self-mutilation as an embodied narrative, or a storying of one’s experiences on the body. As the narrative

therapists make clear, “language” is seen as much more than spoken or written words. Language, or discourse, is a way of being in the world—actions, narratives (both thought and enacted), behaviors, dress, and social interaction. To the extent that an act of self-mutilation can be seen as a discourse—that the act is an insertion of the body into the world in a particular way—we may then go on to assert the narrative nature of self-mutilation.

Taking into account the multiple forms of self-mutilation (especially superficial repetitive), as well as explanations of the phenomenon and treatment methods outlined in chapter two, one aspect of the behavior seems to be consistent—that self-mutilation, to greater or lesser extents, becomes part of the identity of the person. Indeed, the enigmatic nature of the act, along with the fact that it is very difficult to study or to ascertain details of the event before or during (most likely due to the presence of trauma and dissociation associated with self-mutilation) suggests that the self-mutilative act has a source and a purpose. These may not be readily apparent to the protagonist, though self-mutilators almost universally speak of some degree of positive impact that self-mutilation has for them¹⁵. Narrative provides structure and a sense of consistency to one’s experience of themselves and the world. So, too, is it with self-mutilation. The ritual of the act along with the mental and emotional re-organization that occurs during and after the act serves to center and locate the protagonist back into their bodies and their life. Even the scars that are left after an episode of self-mutilation are symbolic, representing not only pain but also healing and perseverance:

[Scars] signify an ongoing battle and that all is not lost. As befits one of nature’s greatest triumphs, scar tissue is a magical substance, a physiological and psychological mortar that holds flesh and spirit together

¹⁵ And, also, the devastating impacts.

when a difficult world threatens to tear both apart (Favazza; 1996, pg. 322-323).

This point is further illustrated when examined in the context of the earlier discussion on Christian asceticism. The ascetic has a unique relationship to their body, and interjects it into the world in an extreme way. These methods are extreme because, through their emaciated and flogged bodies they are asserting, in no uncertain terms, their faith and dedication to God. Earlier, Shaw made the distinction between those who hold Christianity as their religion, and those whose identity is soluble within their religion. We may then go on to assert that, in an attempt to demonstrate and reinforce their faith, they narrate their religion onto their bodies. The ascetics' scars are part of their identity, and act as a symbol of their faith and guide the way they navigate the world.

The idea of self-mutilation as enacted narrative, as a storying on the body, could be seen as either liberatory or oppressive, depending on whose perspective is being used. Would narrative therapy see self-mutilation as an act of resistance to the existing cultural hegemony, or as a total surrender to the locationless gaze of the totalizing and institutionalized discourses that subjugates members into policing themselves into becoming docile bodies? Either way, it seems clear that self-mutilation can be seen as a narrating of one's experience on the body; a type of discourse, subversive or oppressive, that locates the protagonist in relationships and a culture.

Is Narrative Therapy the Practical Application of Nietzsche's Thought?

We have seen the ways in which Nietzsche's ideas have impacted contemporary clinical practice and conditioned the possibility for narrative therapy to emerge as a viable treatment method. It seems clear at this point that Nietzsche's thought has had a significant impact on not only philosophy and culture, but also on the way people and

their place in the world are viewed and worked with by clinical social workers. This discussion may, however, seduce readers into the belief that there is a direct correlation between Nietzsche's thought and the work of narrative therapy, rather than the suggestion that Nietzsche paved the way for something like narrative therapy to emerge. Insofar as this paper has claimed both that Nietzsche is the grandfather of postmodern thought, and that narrative therapy is the only current treatment method that claims postmodern ideology as its foundation—can we then take narrative therapy as the practical application of Nietzsche's thought?

The main link between Nietzsche and narrative therapy is the idea of truth. Nietzsche struggles with the idea of truth and untruth; engaging in a search for “the truth”, while stating clearly that we must recognize “untruth as a condition for life.” He also states that, through his ideas, “truth is entering into a battle with the lies of the millennia” (Kaufmann; 1992, pg. 783). Narrative also seeks to dismantle the idea of objective truth and the God's-eye observer, localizing truths in the experiences and narratives of people in communities. Do Nietzsche and narrative therapy share the same definition of what truth is? To the extent that Nietzsche redefines truth as an act--revaluation of values--rather than a state to which one aspires, they are similar. Narrative therapy deconstructs the idea of truth, then fills the subsequent void of meaning with people's stories, just as Nietzsche pronounces the death of God and the subsequent unraveling of the foundations upon which all knowledge had been based, and replaces traditional definitions of the term “truth” with the act of questioning (revaluation). In narrative therapy “truth” is dismantled and the “objective observer” (i.e. the therapist) is de-throned, leaving the client's narrative of self-mutilation as the vehicle that provides

meaning in their lives, not the therapist. Nietzsche speaks of the philosophers of the future, the “free spirits” who will come to understand and enact the ideas that he was playing with and discovering in isolation:

Are these coming philosophers new friends of “truth”? That is probable enough, for all philosophers so far have loved their truths. But they will certainly not be dogmatists. It must offend their pride, also their taste, if their truth is supposed to be a truth for everyman – which has so far been the secret wish and hidden meaning of all dogmatic aspirations. “My judgment is *my* judgment”; no one else is easily entitled to it – that is what such a philosopher of the future may perhaps say to himself.

(Kaufmann; 1992, pg. 243)

To be a dogmatist would be to espouse the virtues of the time (e.g. that self-mutilation is a disgusting attempt to get attention) in an uncritical and blind manner, to not rigorously examine each claim. To this end, narrative therapists are most certainly not dogmatists, as the majority of their process is one of questioning, though questioning in a slightly different sense than Nietzsche intends. For Nietzsche, the process of questioning, of the revaluation, has the goal of “lay[ing] bare the cancerous growth” (Kaufmann; 1974) that is hypocrisy and dishonesty in the foundations of accepted morality. The process of questioning is similar for narrative, however, the intention of narrative therapists is to uncover the power structures that coerce the self-mutilator into adopting particular images of themselves, and enacting and maintaining those images through mutilating their body.

Power and truth are connected in both narrative and Nietzsche in intimate ways, though they both speak about the two ideas differently. For Nietzsche, truths, or the virtues of the time, are designated by “the herd” based on what will benefit it at the time – they are not timeless and essential entities, “These valuations and orders of rank are always expressions of the needs of a community and herd ... Morality trains the

individual to be a function of the herd and to ascribe value to himself only as a function” (GS; III, 116). Similarly, narrative therapy adopts a Foucaultian analysis of power that is institutionalized, ever-present, and coercive in the sense that it calls upon the subject to participate in its own subjection. Here the question of identity arises – what is the human subject in both narrative and Nietzsche? More specifically, where does the human subject who self-mutilates fit in these two ideologies? A psychological theory of subjectivity seems to be missing from both narrative therapy and Nietzsche, for they are both more focused on the relationship between culture, power (or the herd), and truth; in both ideologies the individual seems to be subsumed into this larger discussion. The power structures that are in place that set up an individual to self-mutilate, and the ways in which those institutions employ the individual in the creation of their own docile (i.e. mutilated) body seems clear at this point, however, it is difficult to find a place to discuss the individual’s intentions, experience, and struggle with the phenomenon of self-mutilation in either Nietzsche or narrative.

Externalizing the problem appears to be a thought in narrative therapy that comes the closest to discussing individual process. When working with a client who self-mutilates, they would be encouraged to separate themselves from the act that has become so much a part of their identity, and to define themselves as an individual person that self-mutilation “comes and takes over” from time to time. The desired effect of externalizing the problem, it would seem, would be to de-essentialize and empower the client by creating a space for them to define themselves in a way that is more suitable to them – a space that is not tainted by hegemonic discourses. Questions regarding whether or not narrative therapy even allows for this space aside, Nietzsche would not necessarily

agree. The technique of externalizing the problem begs the question—is the client set up to be re-essentialized? In what ways is this re-inscribing the dichotomy of good and evil? In the attempt to liberate the individual from the totalizing discourses that serve to define people without their conscious participation, to ask the question, “Who is this person that self-mutilation comes and takes over?” seems to be re-inscribing the idea that there is something in the individual that is essential and separate from their “problem” (i.e. self-mutilation). This is not to say that people are their problems; narrative therapy argues expressly against this belief. However, if narrative therapy has the goal of allowing people the space to be something other than a self-mutilator, would the new definition be the “right” or “true” one? Presumably not; however, it is difficult to discuss the issue without superimposing a value—if self-mutilation is a discourse that one is, in a way, coerced into performing and is in need of liberating itself from, is it even possible to step outside the operations of subjugating power structures to find out who one “really is”? Is this possible? And if it is, is this newly re-defined person “better” than the old one, no longer bogged down with the weight of their pathology? Further, Nietzsche argues that the revaluation of values is a “courageous becoming conscious”; it is an act that requires strength and bravery. The way in which narrative therapy paints a picture of the individual as a pseudo-victim of inescapable power structures would be disagreeable to Nietzsche, as he advocates for the creation of the free spirit—the one who has the courage to philosophize with a hammer, rather than become a victim.

What does this all amount to? Perhaps the most salient assertion of this project is Nietzsche’s shifting concepts of truth in the human experience. Similar to narrative therapy, Nietzsche believes that this is not only a frightening stance, but also a liberatory

one – narrative therapists seek to liberate clients from the shackles of the dominant discourse that is prescriptive of one’s self-image and behavior. Taking this idea to its logical extreme—what if diagnoses and pathologies in general were substituted for Nietzsche and narrative’s idea of “objective truth”? Is it reasonable to then suggest that self-mutilation must be de-pathologized? One of the foundations of narrative therapy’s work, as has been outlined earlier, is the belief that there is no essential self. Since the concept of the essential self serves as the foundation of ideas of normalcy, if the essential self is de-throned what is considered “normal” must be redefined, or eradicated completely. Further, because deviance is defined against the standards of normalcy, if what is normal is redefined or disposed of, we must necessarily redefine or dispose of the idea of deviance, or pathology. The argument can be made that pathologies are, by definition, reifications—insofar as narrative therapy seeks to upset or derail the process of reification, it follows that narrative therapy then seeks to de-pathologize the act of self-mutilation.

Conclusion

The goal of this project was to demonstrate the necessary and essential connections between postmodern philosophy and contemporary clinical practice. Through textual exegesis of literature on narrative therapy and Nietzsche’s original text, presented through the lens of the phenomenon of self-mutilation, it is my hope that a connection has indeed been established. The issue concerning global implications of postmodern ideas and applications, however, is a discussion for another paper. For example, postmodern critiques of pathology and deviance, coupled with a discussion concerning what it would really look like practically and for mental health treatment

providers to subvert the dominance of pathology would be a fruitful and vital area for further study.

For clinical social workers to study philosophy and its effects on contemporary clinical practice has the result of expanding and augmenting the context of the work we do with clients. As clinicians, we work with individuals and communities. Philosophy seeks to work within the framework of human experience in order to understand what the human experience is (or whether or not the claim can be made that there is a “human experience”). The importance of these musings and conclusions cannot be disregarded.

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