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Erica Johnson Ronald
The Efficacy of Narrative
Therapy Approaches with
Self-Injurious Clients

ABSTRACT

This study was undertaken to determine the efficacy of narrative therapy approaches with self-injurious clients. Self-injury is an issue gaining momentum, particularly among adolescent clients. Narrative therapy is a therapeutic technique that has gained popularity globally in the last several decades, due to its movement away from the expert mentality in mental health care. Both self-injury and narrative therapy are issues with limited research available.

Fourteen clinicians trained in narrative therapy approaches were interviewed in a qualitative research design. The results of twelve of the interviews were utilized in the findings and two interviews were not included in the studies' findings due to the ineligibility to the participant sample. Questions were asked to clinicians about the methods of self-injury within their client population, the demographics of the self-injuring clients, benefits of the narrative therapy approach, and narrative therapy efficacy and general comments.

Major findings of this study indicate that narrative therapy is a beneficial and efficacious approach to treatment with self-injurious clients. Narrative therapy's client centered, empowering, non-pathologizing stance suits a self-injuring client, who has often been the recipient of treatment modalities that treat the client as the problem.

THE EFFICACY OF NARRATIVE THERAPY APPROACHES
WITH SELF-INJURIOUS CLIENTS

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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TABLE OF CONTENTS

ACKNOWLEDGEMENTS.....	ii
TABLE OF CONTENTS.....	iii
CHAPTER	
I. INTRODUCTION.....	1
II. LITERATURE REVIEW.....	3
III. METHODOLOGY.....	26
IV. FINDINGS.....	31
V. DISCUSSION AND CONCLUSIONS.....	43
REFERENCES.....	52
APPENDIXES	
Appendix A: Human Subjects Review Approval.....	54
Appendix B: Consent Form.....	55
Appendix C: Interview Guide.....	57

CHAPTER I

INTRODUCTION

Self-injury is a behavior that is documented in psychological literature throughout the twentieth and twenty-first centuries. It has been viewed as a symptom of other psychological disorders. Treatment options for self-injurious clients have varied over the years but the literature has yet to establish solid empirical evidence about client centered approaches that reduce, control or eliminate the devastation of this condition.

There are unique challenges when working with a self-injuring client. They are often young, disempowered and have a background of trauma. This population is frequently viewed negatively by the clinical community. The self-injuring client has been seen as problematic and untreatable, leaving the client at an impasse with the mental health profession.

Narrative therapy offers a client centered theoretical framework that views client problems as constructed and separate from the client or their systems. With narrative therapy, the client steps away from the stigmatizing cultural narratives that serve to subjugate them. The therapist is encouraged to view the client as a collaborator within treatment, instrumental in creating an alternative narrative that encompasses their wishes and desires. The societal context for the client, or client system is key to narrative therapy.

This study was undertaken to ascertain if narrative therapy would be a beneficial approach with clients who self-injure. This researcher believes there is a match between the self-injuring client population and narrative therapy approaches. The study seeks to fill the void that has been left with past therapeutic approaches used with self-injurious clients. This will benefit clinical social work practice by expanding the understanding of the usefulness of using narrative therapy approaches with self-injurious clients.

CHAPTER II

LITERATURE REVIEW

The purpose of this section is to review the scholarly literature about the theory, history and use of the narrative therapy approach and its emerging success with clients who self harm. To that end, this review will focus on several central aspects of this topic, including the etiology of self harm, treatment modalities and the greater understanding of narrative therapy approaches. The review is based on contributions made by investigators and specialists in each of these areas. In order to understand the complexities underlying self harm, a review of studies and articles that describe the etiology, or causes, of self harm will be included. This section will focus on the clinical challenges related to clients who self harm and an emerging approach that may improve clinical outcomes. Further, a review of research about treatment options for self harming clients will be provided. This will help define approaches used by mental health clinicians who treat self harming clients. Finally, a review of current literature about narrative therapy is provided in terms of how applications of this approach have been used in recent times to address self harm among client populations.

Self-injury: What is it?

Definitions of self injurious behaviors are varied in the mental health field. In their book, *Self Injurious Behaviors Assessment and Treatment*, Dr. Simeon and Dr.

Favazza (2001) define self-injurious behaviors (SIB's) as, "all behaviors involving the deliberate infliction of direct physical harm to one's own body without any intent to die as a consequence of the behavior" (p.1). Self-injury has had many names over the years including: partial suicide, parasuicide, anti-suicide, deliberate self harm, delicate self-cutting, wrist cutting syndrome, and self-mutilation (Simeon & Favazza, 2001, p.1). Similar to Simeon and Favazza's definition, White Kress (2003) defines self injurious behavior as, "A volitional act to harm one's body without any intention to die as a result of the behavior" (p.3). Another definition for self-injury is stated by Nock and Prinstein (2005) "Self-mutilative behavior refers to the deliberate destruction of one's own body tissue without suicidal intent" (p.140). A group at Cornell University has been studying self-injury and on their web site they broaden the definition of self-injury by stating:

Sometimes called deliberate self harm, self-injury, self-mutilation or cutting, self injurious behavior typically refers to a variety of behaviors in which an individual purposefully inflicts harm to his or her own body for purposes not socially recognized or sanctioned and without suicidal intent.

("What do we know about self-injury, 2007)

Self injurious behavior is considered a symptom, not a diagnostic category. Thus, it is not specifically described in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), a handbook for mental health professionals that lists different categories of mental disorders and the criteria for diagnosing them, and is published by the American Psychiatric Association (American Psychological Association, 2000). However, several of the diagnostic categories include self-injury as elements, including, Trichotillomania under Axis I, Impulse control disorder NOS, the Axis II diagnosis of

Borderline Personality Disorder and Stereotypic movement disorder with self injurious behavior, under other disorders of infancy, childhood or adolescence (Simeon & Favazza, 2001, p.3). White Kress (2003) points out that although these four DSM diagnoses are the only ones that contain criteria associated with self-injurious behavior, clients who self-injure have had various other diagnoses including: mood disorders such as major depression and dysthymia, dissociative identity disorder, anxiety disorders such as OCD, substance abuse disorders, adjustment disorders, schizophrenia personality disorders, and eating disorders (p.492). It is clear that self-injury is a varied disorder, with a wide range of etiology, as evidenced by the wide range in which these symptoms show up in both Axis I and Axis II diagnosis. Symptom reduction is a challenge to the treating clinician.

Historically, self injurers have been diagnosed as hysterics, psychotics or psychopaths. In the 1960's, Henry Grunebaum and Gerald Klerman hypothesized that the diagnosis a self-injuring client received had more to do with the doctor than the client's symptoms. They felt that a doctor's feelings and biases influenced the diagnosis and that misdiagnoses of schizophrenia or hysteria were due to the clinicians' detachment from their own adolescent "acting up." Sometimes clients were diagnosed as schizophrenics because of the catatonic state of some patients when self-injuring (Strong, 1988, p.59). Today, many self-injurers are diagnosed as borderline personality disorder and continue to be viewed in a negative light. Because of the alarming nature of self-injury to mental health clinicians the reasons behind the act of self-injury is often ignored or cast to secondary importance to the act itself (Strong, 1988, p.60). Throughout history, self-injuring clients have been misdiagnosed and seen as problematic, trouble and

“beyond help” by many of the clinicians who have worked with them, which has led to substandard treatment for these clients.

Favazza, one of the foremost researchers on self-injury, has created a classification system for self-injurious behavior. The first type is stereotypic, which is “repetitive” “driven” self-injury, which can range from mild to life threatening in its severity. Often people who engage in stereotypic self-injury have some form of mental retardation or developmental disability (Simeon & Hollander, 2001, p.6). The second type of self-injurious behavior in Favazza’s model is called Major Self-Injurious behavior. These are the most severe and often life-threatening self-injurious acts such as castration or amputation. The next type of self-injury is called compulsive self-injury which includes trichotillomania, compulsive skin picking and Tourette’s syndrome. Compulsive self-injury is often ritualistic and can occur multiple times within a day. And finally, there are impulsive self-injurious behaviors. Most common behaviors within this subtype are skin cutting, burning, self-hitting or sticking the self with pins. Impulsive self-injurious behaviors can be acted out multiple times daily or only once or twice in a lifetime (Simeon & Hollander, 2001, p.6).

Self-injury has moved from being seen as a symptom of psychosis or hysteria, to a trait of borderline personality disorder. Labeling self-injuring clients with these “difficult” diagnoses could be a reason for poor clinical outcomes and inadequate treatment approaches. More recently, some clinicians and researchers have begun to see self-injury as a maladaptive or even functional coping mechanism to deal with stress or trauma responses.

Who Does It?

There is some controversy in the clinical field about the prevalence of self-injury in the population. A widely disseminated current statistic about the occurrence of self-injury was recorded by Brier and Gill in 1998. They attested that 4% of the general population and 21% of the clinical population engage in self-injurious behavior (Yip, 2005, p.80). This is a significantly higher number than reported by Favazza and Conterio in 1988. Through their research at the time they found 75 of every 10,000 people in the general population engage in self-injurious behavior (Strong, 1998, p.25). Other research by Favazza indicated a prevalence of 1,400 out of 100,000 self injurers in the United States, which equals about 2 million people per year. In her book, *A Bright Red Scream*, Marilee Strong (1998) reports that this number is 30 times the rate of suicide attempts and 140 times the rate of “successful suicide” (p.25). A much larger number emerged when Favazza studied a group of 500 undergraduate psychology students and found that about 1 in 8 had either cut or burned themselves purposefully at least once in their lives (Strong, 1998, p.25). The rate of self-injury in the population is reported differently depending on the author but authors do agree that the issue of self-injury is a major area of clinical concern.

In 1988 Favazza and Conterio authored a study of 240 self-injuring clients and came up with the following common characteristics of self-injurers. Strong (1998) said:

They found that the ‘typical’ self injurer was a white woman in her late twenties who began hurting herself at age fourteen. She had injured herself at least fifty times, usually by cutting but also by other methods, including burning or self-

hitting....The people surveyed also acknowledged other behavioral problems, such as eating disorders and alcoholism. (p. 26).

This study stresses the repetitive nature of most self-injurers' behavior and the concurrence of other behavioral problems among the self-injuring population.

Nock and Prinstein (2005) assert that adolescence is a common time for self-injury. They state that studies have shown between 4 and 39% of adolescents engage in some form of self-injury and among adolescents in inpatient settings that numbers jumps to 40-61% of the population (p.140).

Women are often viewed as more likely to engage in self-injury than men, but Ross and Heath (2002) claim that the discrepancy is not huge. In their study they found that 64% of their participants were female and the rest were male. Other studies have shown close to equal rates of male versus female in the rate of self-injury. ("What do we know about self-injury, 2007)

Research related to diagnoses found the following prevalence of self-injury among client populations. Of people with Tourette's, 13 to 53% engage in self-injury. Of clients with mental retardation or developmental difficulty, 3 to 46% engage in self-injurious behavior. Of hospital patients diagnosed with borderline personality disorder, 75% engaged in self-injurious behavior (White Kress, 2003, p.1). Adolescence seems to be the most likely group to self-injure, regardless of gender, but according to literature females may be slightly more likely to self-injure. In terms of diagnostic categories, self-injury may be more prevalent in client populations diagnosed with borderline personality disorder. It is also important to note that research on self-injury is limited at this time. As

research expands and includes more information related to clients' race, ethnicity, sexual orientation and past trauma history, it may become more complete.

Why Do They Do It?

In his book released in 1930, *Man Against Himself*, Karl Menninger wrote that self injurers were searching for a means to heal and to stay alive. Menninger believed that self-injury represented a mediating force between life and death, where clients choose life. He said, "In this sense it represents a victory, even though a sometimes costly one, of the life instinct over the death instinct" (Strong, 1998, p.32). Menninger presents a more hopeful view of the self injurer who he sees as fighting for life.

Fifty years later, researchers Walsh and Rosen added that that self-injury may be a coping mechanism. Like Menninger, Walsh and Rosen believed that self-injury is a push towards life and towards healing. Walsh and Rosen further suggested that the cutters were more likely to have had a parent die, been taken out of the home, had a childhood illness, had surgery, been the victim of physical or sexual abuse or been a witness to abuse or destructive behavior such as alcoholism in the home (Strong, 1998,p.33). The authors explain that self-injurious clients are faced with intense psycho-social stressors that led them to their self- injurious coping mechanism.

In his book, *Bodies Under Siege*, Favazza, contributes to our theoretical understanding about self-injury with his explanation, "The short answer to the question Why do patients deliberately harm themselves? is that it provides temporary relief from a host of symptoms such as anxiety, depersonalization, and desperation. The long answer is that it also touches upon the very profound human experiences of salvation, healing and

orderliness” (Strong, 1998, p. 34). Favazza emphasizes the cultural meaning and significance of self-injury. Scars and blood are rich with meaning. They represent pain, injury and healing. Favazza wrote:

They signify a battle and that all is not lost. As befits one of nature’s great triumphs, scar tissue is a magical substance, a physiological and psychological mortar that holds flesh and spirit together when a difficult world threatens to tear both apart. (Strong, 1998, p.34)

Menninger, Walsh, Rosen, and Favazza all identify self-injury as a coping mechanism and a way to struggle towards health and healing.

Several authors focus on the childhood factors such as abuse, maltreatment or neglect play a role in the development of self-injurious behavior when they explain self-injury. For instance, Walsh and Rosen and Dusty Miller agree that self-injury can be a reenactment of roles from childhood such as the abused or abandoned child, witness violence or the attacker (Miller, 1994, p.10; Strong, 1998, p. 34)). Strong (1998) states, “There are many roots to cutting, but the single most causal factor is childhood sexual abuse” (p.64). Strong (1998) highlights researchers such as James Chu from Harvard University and Frank Putnam from National Institute of Mental Health as two individuals who believe sexual abuse is a determining factor in the diagnoses of borderline personality disorder, posttraumatic stress disorder and dissociative disorders. The aforementioned disorders are often concurrent with clients who self-injure.

A study by Favazza of 240 individuals found that half had been the victims of sexual abuse. In a study by the University of California at San Francisco during six months of 1988, 90% of all clients who reported being sexually abused were also cutting.

Sexual abuse is described as an assault on safety, an overwhelming source of over stimulation to the auto-regulatory system, and psychologically assaultive. Sexual abuse and incest can be extremely difficult for a client to metabolize and often a client will internalize their anger and shame as a way to manage their feelings. They are able to master themselves where they weren't able to master the perpetrator. The body can be seen as the enemy. Individuals can become dissociative and disconnected from their bodies and self-injury can be a way to punish oneself or feel emotion (Strong, 1998, p.64-67).

According to the Cornell Research Program on self-injurious behavior, self-injury may be a way to express emotion or it can be a way for the client to make visible their pain. Conversely, it can be a way to numb feeling or to have any feeling at all for a client who is dissociating. Very often self-injury is described as a way to relieve tension, anxiety or pressure. For some clients, self-injury serves as a way to be in control of the body ("What do we know about self-injury, 2007).

Brain chemistry may contribute to self-injury behavior. Favazza talked about low serotonin and dopamine levels in the brain can lead to self-injurious behavior. Several studies have shown that with the introduction of SSRI's and dopamine blockers, self injurious behavior was decreased (Favazza, 1988, p.262; Simeon & Hollander, 2001, p.33).

The production of chemicals in the brain is also thought to be a culprit in self-injurious behavior. The enkephalins, an opioid-like chemical, are produced when clients self injure and is thought to have addictive response for some individuals. Endorphins are released from injury and may also induce addiction from self-injury. Both chemicals

may also help to regulate emotion, due to their calming properties (Favazza, 1988, p.262; Simeon & Hollander, 2001, p.33).

There are many ways to conceptualize the reasons clients self injure. Authors have seen self-injury as a push towards life and health, as a coping mechanism, as a way to punish the self, as a result of physical, sexual and emotional abuse or trauma and as a response to brain chemical imbalance.

Treatment Approaches

In Simeon and Hollander's Book *Self-Injurious Behaviors: Assessment and Treatment* (2001), psychopharmacology is recommended for each of the four subtypes of self-injury including stereotypic self-injury, major self-injury, impulsive self-injury and compulsive self-injury (p.127-140). With regard to therapeutic treatment several modalities are recommended including psychodynamic psychotherapy, behavioral psychotherapy including cognitive behavioral therapy, dialectical behavioral therapy, and habit reversal. Hypnosis and relaxation techniques are also indicated as are EMDR, self-help and in extreme cases inpatient treatment (Simeon & Hollander, 2001, p.97-195).

For both compulsive and impulsive self-injury, Dr's Aronowitz, Guralnik and Simeon propose the use of psychodynamic psychotherapy. This treatment creates deepened awareness and insight into the self-injurious behavior. Through empathy and increased understanding of the function of self-injury in the life of the client, they are able to "work through" the issues behind the self-injury. Psychodynamic psychotherapy may be complimented with behavioral techniques such as breathing exercises, increased

body awareness and increased awareness of triggers (Simeon & Hollander, 2001, p.97, p.105, p. 195).

Psychodynamic theorists use the four psychologies to structure their understanding of self-injury. For instance specific to trichotillomania, some object relation theorists believe hair pulling is a way to work through issues with relationships, using the hair as the transitional object. With compulsive skin picking, a psychodynamic theorist hypothesized that skin picking revealed a problem relationships with both the body and with others. Drive theorists consider libidinal and aggressive drives as motivational forces behind self-injury. Self-psychology might view self-injury as a way to consolidate the self and perform self soothing functions. Ego-psychologists hypothesize that self-injury is a way of mastering strong feelings of guilt from a client with a harsh superego. Object relations theorists would consider the relationship to the body and others when understanding the self-injurious client. Within psychodynamic treatment self-injury can be seen as a communication to be understood and interpreted (Simeon & Hollander, 2001, p.97, p.176). Strong (1998) states:

The biggest hurdle and the biggest benefit to psychotherapy or psychoanalysis with cutters is the development of a safe and trusting relationship between doctor and patient. The ultimate goal is for patients to learn to soothe and care for themselves in a healthy manner by internalizing their therapist's care and concern. (p.165)

Behavioral treatments are also indicated for all types of self-injury. Cognitive behavior therapy views self-injury as a learned behavior that can be unlearned by altering thought patterns and learning new, healthier coping mechanisms (Strong, 1998, p.172).

CBT theorists believe that recalling the past may increase self-injurious behavior and that focusing on the here and now is a more effective intervention for these clients. A particular type of CBT that has gained widespread credit for its treatment of self-injury is Dialectical Behavior Therapy (DBT). DBT is thought to be especially effective for impulsive self-injury. DBT was initially conceptualized by Marsha Linehan as a treatment for clients with Borderline Personality Disorder. Its goal is to help clients manage emotional dysregulation, self-injurious behavior and suicide attempts among other behaviors. It is a structured, group and individual approach that works to build skills. Mindfulness, interpersonal effectiveness and the development of healthy coping mechanisms are all included in this modality (Simeon & Hollander, 2001, p. 149). For instance a typical DBT intervention for someone who self injures would be for clients to develop their impulse control by learning about mindfulness within their group training. Clients also often fill out diary cards outlining their treatment destructive behavior so that they can track their behavior within their groups and within individual therapy.

Habit Reversal has been studied as an effective method of treatment particularly for compulsive self-injury. Azrin was a researcher who emphasized this treatment modality. In it, the client learns “habit awareness” by observing and understanding their triggers and their response. Then they work to develop a different response called a “competing response,” other than the self-injury. An example of this would be to hold on to a piece of ice, or snap a rubber band on their wrist when a client has an urge to cut or pull their hair. The building of relaxation techniques and social supports are also key features of this technique (Simeon & Hollander, 1998, p.100).

Hypnosis is another treatment modality recommended for self-injurious clients. Hypnosis uses posthypnotic suggestion to help clients take control over their self-injurious behaviors. This is thought to deter clients from self-injuring after they hear the posthypnotic suggestion. Although there have been no controlled studies on this treatment, case reports from Barabasz, Gardner and Horne all report benefits of hypnosis with self-injurious clients (Simeon & Hollander, 1998, p.104).

Relaxation techniques address the underlying issue of anxiety and tension that many self-injurious clients communicate is the source of their behavior. Meditation, breathing exercises, physical exercise and yoga and self care are all recommended as relaxation techniques that may be helpful for self-injurious clients (Simeon & Hollander, 1998, p.104).

Because self-injury is often seen as a coping mechanism of a traumatized client, Eye Movement Desensitization and Reprocessing (EMDR) is also used by some clinicians to help clients process their trauma. Strong (1998) writes, “EMDR is a clinical technique that helps defuse the emotional impact of traumatic scenarios while in a relaxed state” (p.167). The relaxed state is created through the tracking of the therapist’s fingers moving back and forth in front of the eyes. Sometimes the therapist uses handheld vibrators or other instruments to initiate bilateral stimulation in the brain that is thought to help past trauma become “unstuck” from trauma centers in the brain. When the trauma becomes less forceful a client may be less likely to need a self-injurious coping mechanism to deal with their hyper-arousal.

Strong (1998) reports that group and family therapy are particularly helpful therapeutic modalities because they seek to reduce isolation and secrecy and may serve to

create a support network for a client (p.165). Self help is also noted as a resource for clients (Strong, 1998, p.182). Books such as, *The Habit Change Workbook* by Claiborn and Pedrick (2004), are used to help combat their behavior. Websites such as: www.palace.net/~llama/psych/injury.net and www.self-injury.net provide information, literature and ideas and sometimes support for self-injurious clients.

Finally, inpatient treatment may become necessary for self-injurious patients. Several treatment centers across the country treat self-injury in inpatient setting. A prominent inpatient setting designed to treat the symptoms of self injurious patients is the S.A.F.E. (self abuse finally ends) Alternatives program, located outside of Chicago, IL. This program requires that patients sign a no self-injury contract upon entering the facility. According to their website their treatment approach encompasses:

A treatment team of experts uses therapy, education, and support to empower the patient to identify healthier ways to cope with emotional distress. The S.A.F.E. Alternatives® philosophy and model of treatment focus on shifting control to the patient, empowering them to make healthy choices, including the choice to not self-injure. (“Philosophy and treatment description, 2007)

In the program, many clients have multiple forms of self harm such as eating disorders and cutting. This type of facility is considered the end of the line for chronic and severe self injurious clients (Strong, 1998, p.187).

Several treatment options such as psychodynamic psychotherapy, hypnosis and DBT have been studied and have been shown to be effective for clients who self-injure. However in almost all instances, studies are outdated or there are competing studies that negate the findings of effectiveness. Other treatment modalities such as EMDR and

relaxation techniques have yet to be studied extensively with regard to self-injury, but show some promise as treatment options. There is a real need for greater research related to self-injury and treatment modalities.

Limitation of Treatment Methods

Self injurious behavior is considered a symptom. The range of treatment options is vast and treatment for self-injurious clients is not a one size fits all process. There are different types of self-injury and therefore different treatments that are helpful. Clients are also unique in how they respond to different treatment modalities and in what their goals and preferences are. Very few studies have been conducted to study the above treatment options for self-injurious clients. Further, there continues to be debate about the actual location of self-injury within specific diagnostic categories. Without clarity on the specific diagnostic category, it is difficult to say which treatment option is the most effective. It has only been in the last 50 years that self-injury has gained notoriety and in that time it has been deemed as a highly pathological behavior.

Treatment is often based on general understanding of a problem and in regards to self-injury, these have been among a highly stigmatized client population. This negative view by clinicians results in poor clinical outcomes. It is only recently that many clients have emerged from their diagnoses of histrionic, psychotic or borderline personality disorder, as trauma survivors (Miller, 1994, p. 54). Clients who self injure have been subjugated under oppressive diagnoses and treatment providers who feel unable or unwilling to help because these clients have been viewed as beyond hope and alarming.

Clients and ethical mental health providers alike deserve treatment modalities to work with self-injurious clients that deliver compassion and respect for the client.

The Origins of Narrative Therapy

A possible approach that may improve the conditions of clients who self injure may be found in the narrative therapy approach. From an historical context, narrative therapy came out of the post-modernist, social constructionist movement of the 1980's. Theoretically, within modernist thinking in psychology, the world is there for observation. About modernism Freedman & Combs (1996) states:

In science it is the world view in which people believe it is possible to find essential 'objective' facts that be tied together into overarching, generally applicable theories that bring us closer and closer to an accurate understanding of the real universe. In the humanities, it is the kind of humanism that seeks to develop grand, sweeping meta-narratives about the human condition and how to perfect it. (p.20)

In contrast, post-modernist thought works with the idea that people's social reality is constructed. "Postmodernists believe that there are limits on the ability of human beings to measure and describe the universe in any precise, absolute and universally applicable way" (Freedman & Combs, 1996, p. 21). Language, or the narrative of people, is seen as central to social construction. Post-modernist thought labors to acknowledge and critique cultural "truths" and create a broader discourse (Gergen, 2001, p.806).

Narrative practice also has theoretical roots in the family therapy tradition. Family therapy's pioneers such as Salvador Minuchin investigated the meaning families make of

events in their lives. They also included the cultural context, such as how poverty can affect the family. Instead of imposing meaning onto the family unit, the field of family therapy pulled from the client's experience and their culture. Within family therapy, the "family system" was observed (Freedman & Combs, 1996, p. 4). Narrative therapists work with problems of the individual, group and family context, and their techniques were originally informed by family therapy.

Although most modalities of psychotherapy have some inclusion of the client's narrative, the practice currently known as narrative therapy was conceptualized by Michael White and David Epston based out of Australia and New Zealand, respectively. White and Epston relied heavily on the thinking of Michael Foucault. Foucault was a philosopher in the twentieth century who wrote about how the "self" is a changeable social construction. He also argued that power is not inherent, but that power is an action. He wrote that where there is power, there is also resistance. He thought people cultivate power in society by creating dominant discourses through language that become cultural 'truths.' These truths serve to gather power for some and subjugate others who do not fit the dominant 'truths'" (White & Epston, 1990, p.1-37).

White and Epston argue that the psychological practices of objectification and normalizing work to subjugate individuals. People make meaning of their lives through language and the dominant narrative that is constructed within their culture. People can unwittingly take an active role in their subjugation by deriving the meaning of their lives from the dominant narrative. In their book, *Narrative Means to Therapeutic Ends*, White and Epston write:

And, instead of believing that therapy doesn't have anything to do with social

control, we would assume that this is always a strong possibility. Thus, we would work to identify and critique those aspects of our work that might relate to the techniques of social control. (White & Epston, 1990, p.29)

White and Epston's theoretical orientation for narrative therapy is that the work in therapy is to challenge the techniques of power that serve to define meaning for the client.

As philosophical understanding of reality shifted in the twentieth century partially due to the writings of Michael Foucault and others, Michael White and David Epston began to rethink their theoretical approach to the practice of psychotherapy. In their model, the therapist and client can understand how their narrative is a part of the cultural context. The client may resist the dominant discourse and shift their narrative. The client takes agency in how their narrative is shaped and the therapist collaborates with the client, paying attention to how language and action within the therapeutic relationship can re-enact the power dynamics that exist in greater society.

How Narrative Therapy Works in Practice

Stories

According to the narrative therapy approach, we all have stories about ourselves that affect our lives. The stories can be about our strengths, weakness or failures. People may have a story that they are an excellent cook, or that they are a hateful or useless person. There is a cultural context that shapes the stories we have about our lives. For instance a client may believe she is fat, which is fed by a culture that puts an enormous emphasis on thinness.

The stories clients bring to therapy are often related to problems. White and Epston describe how, what they term “thin descriptions,” are often used early in therapy to define problems. For instance a client’s family might say, “Sally is a drug abuser.” Sally begins to be described as her problem. This description doesn’t take into account that Sally uses with her friends as a way to stay thin and focus on her academics. Within narrative therapy the goal is to move toward “rich” or “thick” descriptions so that the problem can be better understood. As time goes on the client might begin to talk about alternative stories of how they would like to their life to be. This may broaden a client’s understanding of who they can be and might break them out of the negative labels that define them (White, 2004, p.124) (Morgan, 2000, p.15).

Externalizing Conversations

Clients come to therapy with a presenting problem that they might see as a part of them. For instance, a client might say, “I’m a cutter.” With this client a narrative therapist might work to move the problem away from the client. The therapist might say, “When did the cutting start?” By inserting a “the” into the phrase the person is no longer the problem, the problem is the problem. The insinuation is that the problem is a foreign object that entered the client’s life at some point for complex reasons.

Within externalizing conversations a name may be given to the problem. “The problem” or a nickname such as “Rex” for anorexia or “the cutting” might be used to further conceptualize the problem and move the problem away from the person. Feelings can also be named such as “the shame,” or “the sadness.” Cultural or social influences can also be named as problems. Examples of these problems might be “mother-blaming, heterosexual dominance, racism and classism.” Within the narrative therapy technique, it

is important that the client is involved in the naming of the problem. Often there is more than one problem for the client to externalize. The therapist might collaborate with the client by listing the problems that the client has stated. Connections between problems, such as problem “allies” might be pointed out (Morgan, 2000, p.18).

Important in externalization is to consider the social context so that the problem is more fully understood. If the social context is ignored you risk minimizing the effect of the problem and naming the problem as something that doesn’t fit with the client’s experience (Morgan, 2000, p.22).

Within externalizing conversations the problem might be personified. For instance the problem might be described to have “tricks,” “plans” or “lies.” The client’s relationship to the problem can also be explored. A client may describe their relationship to the problem as conflictual, love/hate or friendly (Morgan, 2000, p.25).

Mapping the Influence of the Problem

In Narrative Therapy, tracing the history of the problem is part of the practice. Questions such as, “When did you first notice the problem?” “What was life like before the problem entered your life?” “When was the problem strongest, when was the problem weakest?” help to understand the history of the problem. Scaling might be done to further understand the nature of the problems at different periods of time within the client’s experience. By looking into the history of the problem a client might be able to see that the problem has changed over time and understand some of the elements that contributed to the different presentations of the problem (Morgan, 2000, p.34).

The next part of the therapy involves talking through how the problem has affected the client. For instance, the therapist might ask, “How has the cutting affected

your friendships?" Or, "How has the worry affected your school work?" (Morgan, 2000, p.40).

Deconstructing conversations might also be utilized in narrative therapy. Asking a client about their beliefs is central to deconstructing conversations. It is the stance of narrative therapy that problems are helped by the beliefs that people hold. By beginning to name their beliefs a client may begin to connect how their beliefs affect their problem (Morgan, 2000, p.46).

By discovering unique outcomes the client might discover their own agency in relation to the problem. The client and therapist might consider times when the problem had a smaller amount of influence on the client (Morgan, 2000, p.51). All of these techniques are attempts at gaining deeper understanding about the meaning the client has related to the problem. Furthermore, all these approaches may begin to cultivate an alternative story for the client.

Naming and Thickening an Alternative Story

As the history of problem is considered and unique outcomes related to the problem are uncovered the therapist may begin to see an alternative story emerging. Then the therapist and client can work together to "re-author" an alternative story. In the techniques described above, the client and therapist are developing "thick" descriptions of the client's experience. With re-authoring conversations, the alternative story is presented that incorporates the strengths, skills, hopes and dreams of the client (Morgan, 2000, p.74). White (2004) states:

This thick or rich description of lives and relationships is generative of a wide range of possibilities for action in the world that were not previously visible. It is

in these re-authoring conversations that people step into other experiences of their identity. These re-authoring conversations are actually shaping of, or constituting of, life and identity”(p.126).

Rituals, Ceremonies, and Letters

Ways of “thickening” the alternative story within the narrative therapy tradition include rituals, ceremonies and letters among other practices. Witnesses might be included in the ceremony to become an ally in developing the alternative story about one’s life. Ceremonies might be included in the therapy as a way to celebrate the client and their accomplishments. A certification of completion of therapy or of the defeat of a problem might be highlighted as something to celebrate. Finally, a therapist might use letters to summarize therapy, to build on the relationship, or letters might be written to other people in the client’s life as a way to build connection (Morgan, 2000, p.85-127).

In summary, narrative therapy seeks to check the balance of power in the therapeutic relationship and challenging the client and the therapist to have the client at the helm of their change process. The narrative is central to both the philosophical understanding of how reality is constructed and how this therapy is implemented with clients. Clients are actively engaged in deconstructing their narratives and re-authoring narratives that better fit their goals and desires. Thus, it can provide a powerful approach through which the self injuring client can gain insight as well as control over symptoms that have not responded to other clinical approaches.

Conclusion

Self-injury is a complex and narrowly researched topic. Due to the multi-faceted nature of what is being seen as an epidemic, alternative and promising treatment modalities should be researched and utilized in order to determine their efficacy. Narrative therapy is a treatment based on a world view that challenges the “expert” in the human condition. There is a stance in narrative therapy that human beings are capable of breaking from the subjugating “truths” of societies and that they can instead construct their own realities.

As a result, a study demonstrating strengths of an emerging clinical approach that reduces self-injury symptoms is indicated. This study is designed to describe how narrative therapy is a beneficial approach used by clinicians in the field who treat self-injuring patients. The results of the study will expand clinical social work practice success in achieving positive outcomes with clients who self injure.

CHAPTER III

METHODOLOGY

Project Purpose and Design

The purpose of this study was to examine the value of using narrative therapy as a means for helping self-injurious clients seen for treatment in outpatient clinics. Treating self-injurious clients is currently an increasing challenge to mental health clinicians. With this increase comes a heightened demand for clinical efficacy in achieving desired outcomes. Identifying clinical approaches with positive outcomes is a growing interest to the clinical community. Within my investigation of research related to treatment modalities used with self-injurious clients, there appears to be little focus on the use of narrative therapy with this population. Because of this lack of literature and research, a study is indicated to find the value of this clinical modality. By researching the value of narrative therapy with self-injurious clients, my goal is to increase clinical efficiency with this client population as well as expand clinical treatment options.

For this project, my research question asks if narrative therapy is an effective approach for helping clients who self-injure? I employed a qualitative design in order to access perceptions about the usefulness of narrative therapy with self-injurious patients from the perspectives of clinicians. Research was gathered through interviews over the phone and via email with clinicians trained or who have extensive experience in the narrative therapy approach.

The Characteristics of the Participants

The study sample is comprised of participants from around the United States. Fourteen individuals participated but the results of only twelve interviews will be utilized. The reason for this is that one individual had never worked with self-injuring clients using narrative therapy approaches and one participant did not send all of the necessary paperwork back to me. Participants are licensed professional social workers, licensed clinical psychologists and licensed marriage and family therapists with expertise with narrative therapy. One participant had received a PhD, but was not yet licensed. Two participants were both licensed clinical social workers and licensed marriage and family therapists. Exclusionary criteria included clinicians who have not completed formal mental health training, those who have no formal training or experience working with narrative therapy, and those who have never worked with clients who self injure. In the recruitment process I tried to compile a diverse sample in order to provide representative and diverse points of view related to the subject matter. To protect the anonymity of the clinicians I will not disclose information about the specific demographics of the participants.

The Recruitment Process

The Dulwich Centre was the organization where I sourced most of the participants. Although the Dulwich center is located in Australia, there is a connections page listed on the website which assisted in contacting clinicians around the country. I contacted potential participants over the phone and by e-mail correspondence. I also

looked online for organizations that specialize in narrative therapy approaches and recruited several clinicians from those sites.

Once potential participants were identified I communicated with them via email about a time I could interview them over the phone. Three participants were less available by phone and therefore elected to answer the questionnaire by email. I utilized a screening that includes questions regarding the inclusion and exclusion criteria with potential participants. Once participants were selected from this initial step, snowball sampling methods were utilized to access additional participants who fit the inclusion criteria. An interview guide was used to interview participants (See Appendix C). Every effort was made to generate a diverse sample of varied racial, ethnic, and gender groups. I continued to follow up with leads until I reached the desired sample size of 12 participants. I did interview fourteen participants but the results were valid for only twelve of the participants.

The Nature of Participation

Participants were involved in an interview that was no longer than one hour in length. Attention was paid to time involvement because of the burden it could place on a busy clinician's schedule. Interviews took place over the phone or by email, dependent on the convenience for the participant. Demographic data was gathered from the first several interviewees, but as time went on I came to find that some participants found these questions to compromise their anonymity, due to the small narrative therapy community. Interview questions were asked that related to my research question. I did my own transcription.

Risks of Participation

Although risks for participation were minimal, the potential risks involved for the participant involved the vulnerability that could develop with divulging professional opinions about a potentially debatable approach. I made it clear to the participants that all information will be held in confidence.

Benefits of Participation

A major benefit for participants was the opportunity to reflect on their practice with this particular population. Another benefit was the contribution made to further the research about this topic and its goal of expanding the understanding of treatment modalities for clients who self-injure. There were no monetary or material benefits related to participation in this study.

Informed Consent Procedures

A letter of informed consent was given to each participant (See Appendix B). For participants interviewed over the phone or by email, two copies of the informed consent were mailed or emailed to them. The interview process will not convene until a signed copy of the informed consent form has been returned to the researcher. The participant maintained a copy of the consent. Participants were notified that this study is voluntary and they had the right to withdraw from the study by April 1, 2007.

Precautions Taken to Safeguard Confidentiality and Identifiable Information

Methods were employed to protect confidentiality of participant information. In order to safeguard identifiable information, several steps were taken. Informed consent forms were stored separately from the transcripts of the interviews. A code was created for each participant by the order they were interviewed. Transcripts were coded #1-#12 in the order of the interviews. There were no outside sources transcribing or analyzing data.

Confidentiality was assured because the data is locked and no one will have access to the materials. Confidentiality was also addressed by coding the transcripts and using codes to reference the participants within the interview. I asked participants not to give any identifying information about any of the clients they discussed. Furthermore, when participants were referenced in the thesis materials their identities are concealed. My thesis advisor had access to data after identifying information was removed, but she did not have access to the raw data compiled. All presentations and publications have and will protect the identities of the participants and data will be in aggregate form. Illustrative vignettes and direct quotes are disguised by means of the coding system, and will not link to an individual.

Data compiled is stored in a secure place. All data will be kept secure for three years as required by Federal regulations. After that time it will be destroyed.

CHAPTER IV

FINDINGS

The findings in this chapter are derived from an analysis of research questions, and are based on the following: description of the types and range of self injury of clients; client demographics; different interventions from narrative therapy used with clients who self injure; narrative therapy benefits; and general comments about narrative therapy from participant practice experience.

The first part of the findings describes the demographics of the study sample based on the demographics questions. The next part of this chapter presents the narrative therapy findings based on the analysis of the research questions about the benefits of narrative therapy with a self-injurious client population. Quotes taken directly from interviews are included to illustrate the meaning of the specific findings.

Description of study participants

There were twelve participants in this study. Four participants were licensed marriage and family therapists, one had received her PhD and was working towards her licensure, two were licensed psychologists and seven were licensed clinical social workers. Two participants were both licensed marriage and family therapists and licensed clinical social workers. Although most participants were asked identifying information

about their race, gender, sexual orientation and location, I will not divulge specific information due to concerns of participants about their anonymity. Participants came from a range of locations around the country, and were varied in how they identified their genders, races, ethnicities and sexual orientations.

Participants' background of training with narrative therapy also differed. Eleven of the twelve participants had received multiple trainings and workshops related to narrative therapy approaches. Five of the twelve participants were trainers or professors of the narrative therapy approach themselves. Supervision was another way that participants in this sample learned the narrative therapy approach. Of the group, three individuals received narrative therapy supervision individually or as a group. Three participants also participated in narrative therapy consultation groups or consulted with other narrative therapy participants. On the job formal narrative therapy training was provided to two participants. Six of the participants noted that meeting one or more of the founders of narrative therapy, specifically Michael White and David Epston, was a key influence of their narrative therapy background. One participant conducted research related to narrative therapy. Another participant received a one year diploma for her narrative therapy education and another clinician published multiple articles about narrative therapy.

Who Self Injures and How

Participants in this study have worked with a wide range of types of self injury. All of the participants had worked with clients who engaged in cutting. Anorexia or self inflicted starvation was listed as a type of self-injury of their clients by participants. About this a participant said, “A lot of what I do is work with people who have severe self-inflicted starvation. There may be cutting and burning behaviors that go along with that.” Participants listed suicide attempts as types of self-injury of their clientele. A participant stated, “The most prevalent type of self-injury is cutting. From mild superficial wounds to deep, potentially life threatening cuts. The injuries are usually on parts of the body covered by clothing.” Scratching, burning, over-exercising (including exercising when injured), and drug and alcohol abuse were included as types of self-injury of clients. Unique types of self-injury mentioned by participants included carving, self-hate, over-eating, isolation, poking, stabbing, running into or falling off of things, head banging and purging including vomiting and using laxatives. About the wide range of self-injury in her caseload one participant stated that her clients, “(were) Cutting on their arms with razors, over-exercising, under-eating, using multiple drugs, drinking and drugging.”

The majority of participants highlighted that many of their self-injuring clients were women, some of whom noted that teenage women were more likely to self-injure among their client populations. One participant said, “This is primarily an issue with women. Usually teenage, young women.” Several participants talked about the fact that they had treated men who self-injured, and several stated that they’d never treated a man who self-injured. A participant said, “Only women. I haven’t met any men who are

cutting.” Another participant said, “It seems like it’s all women.” Related to the topic a participant said, “It’s mostly women, but that could be skewed. More women come to therapy.” Half of the participants noted that, in their experience, teenagers were most likely to self-injure among their clients. One participant noted, “Some of my teenage clients have engaged in cutting on themselves.”

For some participants, it appears that self-injuring clients had a trauma history including sexual abuse history. Explaining the demographics of her self-injuring clients one participant said, “The most common predictor is a past history of trauma.” While another participant said, “It’s young women with a history of trauma or abuse.” Three participants also reported that most of their self-injuring clients are Caucasian. Two participants said that they had Latina and African American clients who self-injure. One participant noted, “I’ve seen self harmers who are Hispanic, African American and Caucasian.” While another participant said, “I’ve had one Latina, one White and two African American clients who were cutting.” In some instances, self-injuring clients had the concurrence of depression with their self-injury. This participant noted about her self-injuring clients, “(They’re) Teenagers, male and female with depression, some with sex abuse history.” There appears to be little socio-economic link to self injury. Some participants noted that self-injuring clients are upper to middle class, while another said her self-injuring clients are from a lower socio-economic class. About the diversity in her clinical caseload one participant said:

I have worked with and continue to work with a fairly wide demographic, from rural, low-SES clients, to urban, high-SES clients. They represent a range in terms

of intellectual functioning, liberal and conservative views, ethnic and cultural backgrounds, and acceptance of therapy as well.

In addition, it appears that there is a great range of diagnostic and age related characteristics for self injurious clients. One clinician said that many of the clients who self-injure are diagnosed as borderline personality disorder and one clinician each reported that their self injuring clients were undergraduate college students, and children. A participant said, “I’ve worked with children who had extreme trauma who were cutting, scraping, scratching and some head banging.”

Benefits of Narrative Therapy

Participants in the study identified many clinical approaches used specifically with their self injuring clients. The great majority of participants indicated that the narrative therapy approach of externalizing language is a practice they’ve engaged with self-injuring clients. Explaining his practice of externalizing one participant said, “Externalizing the criticism and voices which say that the person and the rest of the world would be better off if the person were dead. Having this externalization fleshed out as fully and as contextually as possible.” Another participant noted about externalizing:

People have internalized their sense of worthlessness. They would be the first to agree that they are completely worthless. Compliments patronize them.

Externalizing language doesn’t do this. You have to repeat it, emphasizing voices of self hate. When you were cutting, who was telling you to cut? Who stands with this voice? Where does this voice come from? How does this voice convince you that you’re worthless?

Nearly half of the participants said they've used naming and/or personifying the problem with clients who self-injure. One participant said, "Talk about self harming as something trying to trick them. Personify the problem, discovering its sneaky ways." Mapping the influence of the problem was also a practice they've used with this client population. A participant stated, "To explore the effects the problem has had on their lives, what it has stolen from them in terms of freedom or happiness. What it has blinded them to as far as their strengths and intentions." About mapping the influence of the problem, a participant described the questions she might ask a client and then how she proceeds:

Can I be an ally to you in banishing the cutting? What happened to you? How has what's happened to you affect you now? What do you need in order to heal? They are creating their own plan of how to deal with the problem. I always try to hold that position and let them go where they need to go. I find they can go to beautiful places.

Developing discrepancies in individuals' narratives and discovering an alternative story were named by several participants each as practices they've used with self-injurious clients. One participant described developing discrepancies by explaining that she might ask, "How in spite of what's happened to you, have you been able to triumph?" Another participant said that he might ask, "In the midst of criticism, to what degree have you been able to hold your own voice? This separates their own voice from the critical voice." About alternative stories a participant said, "To discover alternative stories of positive intentions, precious values, acts of love, trusted people in their history, etc. and to build on these."

Exploring a client's context was identified as an element of narrative therapy they emphasize with self-injurious clients. A participant said, "I'll be curious about the context that could be contributing to feelings of sadness." The use of metaphor through art or poetry was also described as a part of their narrative therapy practice with self-injuring clients. About discovering metaphor through art a participant stated, "They were involved in my poetry circle. It became a way to talk about their problems without getting specific. There were a lot of metaphors going on." Participants also named the influence of outsider witnesses, giving the client agency and the practice of deconstructing as elements in their narrative therapy practice that were beneficial. About giving the client agency one participant said he often asks at the beginning of a session, "If I could ask, why did you want counseling for yourself? This empowers the client and puts the power in their hands." Although several participants reported they use narrative approaches exclusively, one clinician stressed that she uses a variety of techniques with clients and several other participants expressed flexibility in their model of practice in their work with clients.

Participants described the specific benefits of narrative therapy that make it an approach of choice in many instances. As my interviews progressed, I realized that a valuable question to ask would relate to participants-perception about the overall benefit of narrative therapy approaches. Shifting the focus of the problem away from the person is a beneficial approach. One participant said, "It reflects the approach of 'the problem is the problem, the person is not the problem.'" Another participant said, "It goes back to externalizing. They so think that they're worthless. They agree with traditional approaches."

Participants also stated that the optimistic or positive nature of the practice is what makes this approach beneficial. A participant said, “I believe it is an optimistic, strengths-based approach that can elicit clients’ ideas, knowledge, successful practices, and preferences so that the preferred way of being actually ‘fits’ for the client.” Another participant said, “Narrative is positive and goal directed. Clients get to tell their stories and do so from a place of strength.” The same participants also said that this narrative therapy practice gives the client agency. One participant said, “They have been given a tool with which to challenge the totalizing discourses to which they have been subjected.” Another participant echoed that narrative therapy is empowering, “Still, I believe that the narrative stance can help people feel they have more agency in their lives, or at the very least, they don’t have to ‘buy into’ (internalize) oppressive/marginalizing discourse, which can have profound effects in itself.” And still another participant said, “Narrative approaches have a benefit of emphasizing self-determination and a sense of agency and personal accountability. They have a right to decide what’s important to them and they have encouragement to act with personal agency.”

Participants also said that narrative therapy’s recognition of oppression made it a beneficial approach. A participant said, “This point of view doesn’t deny the very real oppression and/or marginalization that occurs in people’s lives that certainly limits their options.” Another participant said, “The model allows for recognition of issues of oppression.” The fact that it is considered respectful, creative, effective, strengths based, non-pathologizing, oriented towards social justice, post-structural and goal directed were other attributes mentioned. A participant said:

I also appreciate the approach’s non-pathologizing stance. Narrative therapy’s

post-structural, and I would say, social constructionist orientation, plus its emphasis on social justice, fit with my feminist perspective, and I think, help clients feel less like flawed human beings with limited options, and more like people with self-efficacy and agency to exercise a wider array of choices that they thought were available previously.

The benefits of narrative therapy with self-injuring clients were reinforced by all of the participant pool. Narrative therapy's non-pathologizing stance was identified by participants as a beneficial element for clients who self-injure. A participant said, "It de-pathologizes and emphasizes personal accountability in a very real way. I think it's a heck of a lot more fun to think about things in a de-pathologized way."

Uncovering and building or rewriting alternative stories was seen as beneficial by many participants. One participant described this by saying:

Allowing people to recognize the meaning systems that are constraining them, to see where theses come from and to question their 'truth status' and to being to access alternative ways of being in the world that allow for the reclaiming of preferred lives.

Another participant said, "It has also been helpful in guiding me to support clients to uncover and build on the myriad of profound alternative stories that have generally been neglected or discounted." About how developing alternative stories are beneficial to a client a participant stated:

Usually there's a lot going on for the client. Usually clients aren't coming in to deal with cutting. It's a way to deal with overarching issues. Often these women have a history of abuse. Narrative therapy is helpful in rewriting their history.

There's a failure identity there, due to the history of abuse in their story. It's a little bit indirect how narrative therapy helps clients who self-injure. It helps that underlying identity story to shift.

Empowerment, or gaining of control, was highlighted as a critical element of narrative therapy practice for self-injuring clients. A participant noted, "Clients have a sense of control over their relationship with cutting. We can discover the ways in which cutting tricks clients into joining it and how to take a stand against cutting." While another participant said, "The thing that comes to mind is that it externalizes, it empowers them and gives them a new perspective. It separates the person from the problem. It's an empowering theory." A third participant said, "With narrative people have other ways to stand. It takes away pathologizing."

It also appears that narrative therapy approaches help therapists pay closer attention to the client context through narrative therapy. One participant described this.

With narrative you don't automatically take a position. I take a curious position with clients. 'Treatment' for people who are cutting or injuring themselves is highly behavioral. There's a stand that cutting's abnormal. This renders the context invisible. In that way, narrative's helpful.

Another participant said, "This work requires that you don't ignore societal context."

Narrative therapy's challenging of dominant discourse, also known as "oppressive cultural dynamics" was named as a key practice within narrative therapy practice among the sample participants. One participant stated, "It is particularly helpful in supporting people to recognize that the self hate or urges to self-harm have their origins in

oppressive cultural dynamics or historic dynamics that are not somehow intrinsic to their nature.” Another participant said:

The therapist should always be looking for ways that the dominant stories of a client’s or the culture can contaminate their work, and they may have to acknowledge the ways in which they can be seduced by these voices of triumph or whatever describes their particular life circumstances.

Finally, it appears that narrative therapy cultivates hope, gives clients a new perspective, and allows the clinician to view their presence with a client as a privilege, because the problem not the person is viewed as the problem. One participant said, “Narrative therapy allows the therapist the privilege to be in the room with a person who is struggling valiantly. You will be in the presence of a client who is certain to be strong.”

Narrative Therapy Efficacy and General Comments

Narrative therapy was viewed as a beneficial and effective approach by all the sample participants. One participant described narrative practice as “very effective.”

Another participant said:

I don’t have outcome data to share, but it seems that the self-injury comes to ‘make sense’ to clients in the context of (1) self injury is a sign that something is wrong and they need to respond to whatever it is, (2) self injury signals a desire to alleviate emotional pain, which is perfectly understandable, (3) that anger directed inward may be more about anger towards someone else that can’t be expressed, and (4) that self injury doesn’t really fit with the client’s preferred identity, and that there may be other options for addressing the client’s pain that align more closely with who the client is becoming, or wants to become. These insights (or

sub-plots), seem to normalize what many clients view as abnormal, stigmatizing problem, so that anxiety is lowered (reducing the desire for self-injury), and so that the client can begin to consider options that are preferable. At least, that is what I think I've observed, and what clients have reported to me.”

Many participants talked about personal benefit and enjoyment from using the narrative therapy approaches. One participant said:

Again I think I will say that self-injury is some sort of expression. The thing about narrative that helped with that is that I could be very afraid of the behavior but there's something about narrative that lets you externalize the problem. There were a couple of times where I just got scared. I had one client who was self-injuring and her boyfriend was injuring her too in the name of sexual play. You just wanted to lock them up someplace. With Narrative therapy you don't answer to the crisis, but see it as something they can take of themselves.

The findings provided sufficient information to answer the research questions and lead to a solid resolution of the study hypothesis. A full discussion of these findings is offered in the discussion chapter that follows.

Chapter V

DISCUSSION AND CONCLUSION

This discussion will look at salient findings in relation to the literature review. Specifically, the topic areas will be the study participants, a discussion of who self-injures and the methods used, the benefits of narrative therapy, the efficacy of narrative therapy and general comments, the implications for social work practice and the implications for future research. New topics that have emerged in the findings section will also be discussed and the emerging theoretical orientation of narrative therapy will also be laid out. Finally, this section will discuss implications for future research as well as clinical social work practice.

Who Self Injures and How

Major findings of this study indicate that adolescents and women, and often the combination of the two, are the most common groups who self-injure. This is consistent with the literature reviewed. Nock and Prinstein (2005) noted that between 4% and 39% (or: 4-39%) of adolescents engage in some form of self injury and among adolescents in inpatient settings that numbers jumps to 40-61% of the population (p.1).

It is interesting to note that one participant in this study indicated that the fact that more women than men in her caseload are self-injuring could be skewed because more women than men attend therapy or seek counseling. Because of bias within the mental health field related to the causes and demographics of self-injurers, men may be often overlooked as potentially self-injuring clients. Within more recent literature, including

research by Ross and Heath (2002), it is stated that the discrepancy between men and women self-injuring clients is smaller than previously thought.

It is reasonable to assume that due to the history of pathologizing clients who self-injure, clients who self-injure have attended treatment due to the stigmatization of their struggle. Due to the stereotype the older stereotype that individuals who self-injure are psychotic or hysterical and the more recent stereotype that all self-injuring clients are diagnosed with borderline personality disorder, young and female, it possible that mental health clinicians missed the possibility that clients meeting differing demographic categories might also be self-injuring.

The connection between self-injury and sexual abuse history or a history of past trauma was also an important finding of this study. Strong (1998) said, “There are many roots to cutting, but the single most causal factor is childhood sexual abuse (p.64).” Study participants echoed this sentiment. Findings also aligned with the literature of Walsh and Rosen about the reenactment of roles from childhood such as the abused or abandoned child, witness violence or the attacker. One study participant said, “The “voice of the problem” and the way a problem dominates a client seem very similar to an external, abusive relationship. It makes sense, that in some cases, the relationships with a problem may be patterned after an abusive relationship between the client and another person (such as a parent).....” This finding once again speaks to the bias that has existed within the mental health field. Whereas self-injuring clients have often been deemed untreatable or intractable within the mental health community, the findings show that often self-injury is a coping mechanism utilized after living through sexual trauma or abuse.

The range and diversity of types of self-injury named by study participants was extensive. Some clinicians named the common forms of self-injury such as cutting, burning and scratching as the major types of self-injury within their caseload, while others took a broader view of self-injury, including anorexia and drug use. I believe this speaks to differences of opinion of the definition of self-injury or self-harm. Because self-injury is not listed within the DSM-IV with a standardized definition, interpretation is left to the clinician as to when or how their clients are self-injuring. Because of this finding in the literature, confirmed in this study's findings, it appears that the narrative therapy-model of deconstruction and the general mistrust of labeling within its practice, may lend itself to a more expansive view of what constitutes self-injury within this study.

Prominent researchers in the field of self-injury also utilize ambiguous definitions. Dr. Simeon and Dr. Favazza define self-injurious behaviors (SIB's) as, "all behaviors involving the deliberate infliction of direct physical harm to one's own body without any intent to die as a consequence of the behavior." This is a broad definition that could encompass many actions. Researchers at Cornell University define self injury by stating, "Sometimes called deliberate self harm, self-injury, self-mutilation or cutting, self injurious behavior typically refers to a variety of behaviors in which an individual purposefully inflicts harm to his or her own body for purposes not socially recognized or sanctioned and without suicidal intent ("What do we know about self-injury, 2007). This definition includes the caveat of social acceptance of behavior, which again can be dependent on the environment of the client.

Not having a standardized definition of self-injury could be problematic in providing appropriate treatment to clients. Inclusion of self-injury in the DSM-IV as a

diagnostic category rather than a symptom might help to clarify its definition and give the behavior the credence it deserves, given the large quantity of clients who are engaged in self-injury. Also, with the inclusion of self-injury as a diagnostic criteria, more research may be funded to understand who is self-injuring, why they do so and how best to treat the issue with clients.

Cutting was unanimously named by study participants as being a type of self-injury they see within their client population. The prevalence of cutting compared to other forms of self-injury is not established within this study, since it was referred to with equal emphasis as other forms of self injury. However, it is the most frequently cited source of self injury noted across all of the literature reviewed.

Bias and the stigmatization of self-injuring clients have led to misdiagnosis and less than adequate treatment of these clients. Self injuring clients have been misdiagnosed and are often treated as “problem children” within the mental health field. As views have changed about the nature of self-injury, consensus about the definition of and treatment for self-injury has not been arrived. Not having a standardized definition of self-injury may lead to confusion within social work practice. Although there are a few efficacy studies about treatment modalities for self-injury, they remain limited. There is ~~not a~~ a lack of standard definition of self-injury and an understanding of who is engaging in self-injury and how social workers can work with self-injuring clients effectively, remains ambiguous. The current study findings confirm the treatment voids and need for effective approaches resulting from the continuing clinical debate and confusion related to clients who self injure.

Benefits of Narrative Therapy

Within this study, narrative therapy was found to be beneficial with self-injuring clients because of its empowerment of the client and critique of the bias and stigmatization that is present within the mental health field. As is quoted by the founders of narrative therapy:

And, instead of believing that therapy doesn't have anything to do with social control, we would assume that this is always a strong possibility. Thus, we would work to identify and critique those aspects of our work that might relate to the techniques of social control. (White & Epston, 1990, p.29)

Narrative therapy views the client as the expert and the client as the expert of their story, and also holds the client accountable for their outcomes. Whereas self-injuring is often a way of exacting control over the body, therapy with a narrative therapist presents an opportunity where the client can learn to be in control of becoming who they want to be. The client has the opportunity to gain control and be empowered.

Within this study, participants talked about how the social constructionist underpinnings and social justice inherent in the model make it a beneficial practice. In this instance, the mental health community has constructed a reality that self-injuring clients are “troublesome,” “unable to be treated,” “dangerous,” and “borderline personality disordered.” How can a client be helped within a model that holds the view that they are beyond help? Narrative therapy then becomes beneficial because instead of being adversaries with their self-injuring clients who are seen as “problematic,” narrative therapists are advocates for their clients' own wishes. This presents the opportunity for the client to open to the realities that lie behind utilizing self-injury as a coping

mechanism, such as sexual abuse. Narrative therapy's theoretical orientation leads the client to take control of his/her self-injuring behavior. Through carefully constructed personal narratives, clients learn how to reconstruct their self-defeating behaviors.

Another major finding was that within narrative therapy, externalizing language is particularly helpful with self-injuring clients. This is a key tenet within narrative therapy. The client and the clinician are invited to see the problem as separate from the client. For many years the client who self-injures has been seen as the problem. This separation of the person and the problem offers a new perspective and gives the client hope and empowerment to create their own narrative.

The development of alternative stories with self-injuring clients was found to be beneficial by study participants, thus corroborating literature reviewed. Often clients who self-injure have experienced trauma, abuse or struggles in their lives that affected their coping capacity. As a result, they experience a sense of hopelessness when confronted with challenges. The cultivation of hope and empowerment through narrative therapy practice appears to reconstitute coping skills through a safe, therapeutic experience. As one participant said, narrative therapy is a goal directed therapy. The client is involved in directing the therapy as s/he develops their alternative story.

Narrative therapy was found to be a beneficial practice with self-injuring clients because it is an empowering model with clients. The fundamental social constructionist underpinnings were also found to be beneficial with this client population. Another beneficial practice is the development of alternative stories that encompass the clients' own goals. A client collaborate with the therapist to uncover and develop the narrative

that fits them. Findings of the study confirm that the theoretical underpinnings of narrative therapy make it a powerful approach when used with self-injuring clients.

Narrative Therapy Efficacy and General Comments

Narrative therapy was found to be an efficacious practice with clients who self-injure. As one clinician so aptly described, within the context of narrative therapy the client steps away from the stigmatizing rhetoric that can make the problem seem “stuck.” In doing so, they are able to begin to envision, develop and implement their alternative narrative.

Within the findings it also emerged that study participants enjoyed working with clients with a narrative therapy approach. The clinicians view their role as a collaborator instead of an expert. This changes the power dynamic within the therapeutic relationship and can create a new kind of relationship for the client where the client can step away from dominating cultural dynamics that may serve to subjugate them.

Implications for Social Work Practice

The field of social work is unique in its focus on the use of self, taking client centered approaches and advocating for clients and for social justice. Narrative therapy is aligned with these values. Specifically for clients who self-injure, there is a history of bias and stigmatization that characterizes their treatment. It is important that social workers continue to assess their role and the mental health community’s role in subjugating populations who have not been served well in the mental health community. To continue to treat these clients as “untreatable” or problematic, denies the context that

surrounds a clients' history and leads to less effective treatment. Narrative therapy provides an opportunity for effective and ethical treatment of clients who have not been treated well in the past.

Implications for Future Research

A weakness of this study was its sample size. A larger sample would have provided a more accurate understanding of the benefits of narrative therapy. Future research may benefit from quantitative survey design-to gain a more representative and larger sample to have a diverse range of viewpoints about the topic.

Another difficulty with this study was the lack of research related to narrative therapy. Future studies are indicated to research the efficacy of narrative therapy practice. Although the study participants spoke to the efficacious nature of narrative therapy, the empirical studies were scarce. Because of the need for introducing empowerment into the client life through therapy, future studies that compare clinical outcomes between narrative therapy and Dialectical Behavioral Therapy (another empowerment related therapy) would be revealing. Much more comparative study is indicated.

Further research is also indicated to study the demographics of the self-injuring population. Several researchers contradict each other in their findings related to the gender breakdown of self-injuring clients and as one study participant stated, the stereotype that females are more likely to self-injure may be skewed because more females attend therapy than males. Furthermore, within this study several clinicians spoke to a racially and ethnically diverse pool of clients who are self-injuring. This is an

important area of study as self-injury has largely been viewed as a White female phenomenon. Issues of class, sexual trauma and sexual identity and self-injury would be other important areas of future research to better understand the dynamics of the behavior. -

Strengths included the diversity within the sample of participants. Various regions of the country, sexual identities, racial and ethnic backgrounds, genders, educational background and number of years in the field were all represented.

The results of this study indicate that narrative therapy is a beneficial and effective practice with clients who self-injure. The importance of context within the model, the empowerment of the client and the separation of the person from the problem allow the client and the therapist the opportunity to step away from the pathologizing and stigmatizing dynamics that surround the treatment of self-injuring clients. Although more research is indicated to discover more about the nature of self-injury and the efficacy of narrative therapy, this study provides promising for social work practice with self-injuring clients.

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Appendix A

Human Subjects Review Approval

January 15, 2007

Erica Johnson Ronald
3430 Cripple Creek Square
Boulder, CO 80305

Dear Erica,

Your final revisions have been reviewed. I am glad you have widened your net in your recruitment process and settled on *training or experience*. We are now glad to give final approval to your study. The International Journal of Narrative and Community (whatever the right name is) published by the Dulwich Centre came out just this week. It is on responses to violence and I would think would be very useful to you. You can find out more about it, I am sure, on the Dulwich Centre website.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain signed consent documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck with your project.

Sincerely,

Ann Hartman, D.S.W.
Chair, Human Subjects Review Committee

Appendix B

Consent Form

Dear Participant:

I am a graduate student in social work conducting a study of clinicians' experience using narrative therapy with self-injurious clients. This study is for my Masters thesis and for possible presentation and publication. You are being asked to participate in this study because of your status as a licensed clinician who uses narrative therapy to treat clients who self- injure.

If you agree to participate, you will be asked to partake in a face to face or phone interview that will take no more than one hour. You have been asked to participate in this study because of your training or experience with the narrative therapy approach, your experiences using narrative therapy with clients who self injure, and the possession of a license to practice clinical therapy. The questions asked will relate to issues of the use of narrative therapy in your clinical practice. The interview will last about an hour, and will be audio taped. I will be doing all of the transcription.

The risks involved during your participation involve the vulnerability that could develop with divulging professional opinions. During the process you may become distressed due to the personal nature of the material you are sharing.

A benefit is the opportunity to reflect on your practice with this particular population. Another benefit in participation is that this research will work to expand the understanding of treatment modalities for clients who self-injure. There will be no concrete benefit for participation in this study, such as money or material goods.

You will likely have understandable concerns about confidentiality for yourself and for your clients and with whom the personal information will be shared. All material related to this study will be maintained in a locked, secure environment that only I have access to. My thesis advisor will have access to information only after identifying information has been changed. Your name will not be used within the thesis and transcripts will be held in a locked file for three years, as is federally mandated. After three years the materials will be destroyed. The transcripts will not be shared or distributed to any third parties. The parts of the information that will be included in my master's thesis and in subsequent presentations will be presented as a whole and disguised to protect your identity along with the identities of any client information. In addition, please avoid giving me any identifying information about your clients.

Your participation in this study is voluntary. You may refuse to answer any question, should you wish to do so. Furthermore, you have the right to withdraw from this study at any point. The final date for withdrawal is April 1, 2007. If you have further questions or wish to withdraw, please contact me at (303)746-5510 or ejohnso3@mail.smith.edu.

YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THIS STUDY.

Signature of Participant:

Signature of Researcher:

Date:

Date:

PLEASE KEEP A COPY OF THIS DOCUMENT FOR YOUR RECORDS

Appendix C

Interview Guide

1. Are you a licensed mental health clinician? Please name your license.
2. Please describe your training and background as a clinician using Narrative Therapy.
3. In your opinion, why is narrative therapy a beneficial approach with clients?
4. Please describe the types of self injury of your clients. Is there a type of self injury that is more prevalent than others? Could you describe the demographic data of your clients who self injure?
5. What different approaches from Narrative Therapy have you used with clients who self injure?
6. How has Narrative Therapy been beneficial with clients who self injure?
7. General comments?