

5-2015

# The Personal Is Political: Integrating Clinical Social Work Practice through Narrative Therapy

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## Recommended Citation

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The Personal Is Political: Integrating Clinical Social Work Practice through  
Narrative Therapy

by

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MSW Clinical Research Paper

Presented to the Faculty of the  
School of Social Work  
St. Catherine University and the University of St. Thomas  
St. Paul, MN  
In Partial fulfillment of the Requirement for the Degree of

Master of Social Work

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The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, MN and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.

## Abstract

Social justice has been identified as the core organizing principle of the social work profession. As social workers increasingly move into clinical practice, there is a more pronounced need to develop concrete practice methods consistent with this professed value. Literature suggests that narrative therapy theoretically contributes to social justice by deconstructing dominant discourses and by empowering people to author their own life stories and connect with one another to address social problems. This study seeks to understand the extent to which narrative therapy is aligned with a feminist social justice framework as it is currently practiced. The study offers qualitative data organized into themes and subthemes from six Licensed Clinical Social Workers who participated in semi-structured interviews on their practice of narrative therapy in clinical social work. The research indicated both strengths and challenges of using narrative practices to integrate social justice into clinical work. Findings suggest clinical social workers must value and engage in systems change efforts in order to incorporate social justice into practice. Social workers can utilize narrative therapy to further integrate the social work profession, but further developments in the field of narrative practice are needed to affect social transformation in the course of clinical work.

*Keywords:* clinical social work, social justice, narrative therapy

### Acknowledgements

I want to thank the participants in this study who were willing to contribute their experience and knowledge in addition to their time to make this project possible. Thank you to my supportive and insightful committee members, Michele Braley and John Stillman, who generously volunteered their time and expertise. Thank you to my committee chair, Lance Peterson, who motivated me with his faith that it would all come together. I could not have completed this project without the encouragement from my husband, Jamison, and the rest of our extended family and friends whose support has been a constant contributor to our success. I am forever grateful to those in my life who have given me the opportunity to explore my passion and to share it with others.

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Social workers are increasingly moving into clinical practice. According to a study conducted by the Center for Health Workforce Studies (2006), mental health is the largest specialty area of social work practice representing 37% of active licensed social workers surveyed. This is compared to the next three largest: 13% in child welfare, 13% in health and 9% in aging. As more social workers move into clinical settings, some argue that the integrity of the profession is at risk of being subsumed by the goals of larger institutions (Collins, 1986; Dietz, 2000; Marsh, 2005; McLaughlin, 2011; Swenson, 1998). Today many clinical social workers practice within the confines of the highly criticized “medical model,” traditional scientific medical practice which determines patients’ pathology and thereby assigns them a diagnostic label (Dietz, 2000; Evans, Kincade, Marbley & Seem, 2005; Chang & Nylund, 2013; McLaughlin, 2002). This shift to clinical practice has also been criticized for individualizing issues which are inextricably linked to their social, political and economic contexts, a practice which further obscures the political nature of problems and reinforces power and oppression (Almeida, Hernandez-Wolfe, & Tubbs, 2011; Evans et al., 2005; Reynolds & Hammoud-Beckett, 2012; Rose, 1990; Pelton, 2001; Vodde & Gallant, 2002).

Some argue that a natural tension exists between micro and macro practice (McLaughlin, 2002, 2009; Specth & Courtney, 1994). Many social workers see macro practice as primarily advocacy (McLaughlin, 2009). This dichotomy of constructing micro and macro practice as opposites has been contested by post-structural theorists (Vodde & Gallant, 2002), and efforts to more fully integrate micro and macro practice



continue (Swenson, 1998; Vodde & Gallant, 2002). Still, as social work micro practice proliferates in the profession, and macro practice remains undervalued and underdeveloped (McLaughlin, 2009), social workers risk losing sight of the profession's expressed goals for more comprehensive social change beyond policy advocacy towards shifting cultural views and beliefs.

At the core of the social work profession is the explicit value of social justice (Finn & Jacobson, 2013; Marsh, 2005; Pelton, 2001; Plitt Donaldson & Milgram Myer, 2014; Swenson, 1998). This value challenges social workers to create a just society while practicing in ways that align with that vision. Should social workers depart from their underlying value of social justice either in means or in ends, they will fail to change the contexts with which the pain, harm or suffering of individual clients and families is intricately connected. Therefore, social workers are called to consider how clinical social work methods can reshape society as a whole in socially just ways.

One such method to consider is narrative therapy which arose out of the post-structuralist paradigm. Narrative therapy offers an alternative to the medical model by valuing people's ability to author their own lives, by addressing problems as external from people, by deconstructing dominant discourses which contribute to oppression, and by connecting people with one another to engage in social and political action to address problems (Combs & Freedman, 2012). Social work professes that problems arise not out of individual deficits but out of social, political and economic structures, and as such the profession should seek clinical methods which offer social and political solutions. This study explores the use of narrative therapy, both the strengths and the challenges, for achieving social justice through clinical social work practice.

## Literature Review

### Social Justice as *the* Core Value of Social Work

There is consensus within the social work literature that social justice is the core value of the social work profession (Finn & Jacobson, 2013; Marsh, 2005; Pelton, 2001; Plitt Donaldson & Milgram Myer, 2014; Swenson, 1998). Social justice is one of six values cited in the National Association of Social Work (NASW) Code of Ethics (2008), and as such social workers are mandated to uphold the value in practice. Social work's commitment to this value has been described as the defining element that makes the profession unique from all other professional roles (Lundy & van Wormer, 2007; Marsh, 2005; Swenson, 1998). Marsh (2005), former Editor-in-Chief of the journal *Social Work*, wrote her final editorial on the importance of social justice as *the* organizing principle of the social work profession and emphasized the need to maintain this part of the social work identity. The goal of social justice is both an obligation and a distinct advantage for the social work profession in the current global era where disparity is great and continues to increase (Lundy & van Wormer, 2007).

Today social workers are faced with globalization which has led to even greater wealth disparity and inequality worldwide. Several scholars cited global capitalism and neoliberal politics as current issues social workers must not only understand but also address if they are to uphold their commitment to social justice (Lundy & van Wormer, 2007; Reynolds & Hammoud-Beckett, 2012). Lundy and van Wormer (2007) further pointed to increased militarization and conflict as well as the floundering social welfare state in the United States and Canada as pressing issues of our times. These issues, they argued, require an understanding of politics and the global economy through a radical

social justice and human rights perspective. Furthermore, they pushed for social workers to carry out social justice through their practice by engaging politically in policy advocacy and social change as well as by working with individuals, families and groups.

The NASW Code of Ethics (2008) explained the ethical principle of challenging injustice as the way in which the social justice value is embodied in the profession:

“Social workers pursue social change, particularly with and on behalf of vulnerable and oppressed individuals and groups of people. Social workers’ social change efforts are focused primarily on issues of poverty, unemployment, discrimination, and other forms of social injustice. Their activities seek to promote sensitivity to and knowledge about oppression and cultural and ethnic diversity. Social workers strive to ensure access to needed information, services, and resources; equality of opportunity; and meaningful participation in decision making for all people” (p. 5).

However, the international social work profession has struggled to define social justice in ways that social workers can articulate and enact. In her study of clinical social workers in mental health settings in Canada, McLaughlin (2011) found that many of the participants felt uncertain about how the value of social justice affected their work. Many expressed that they did not feel they had enough knowledge to speak about social justice in their role adequately, if at all. This highlights the lack of clarity around social justice in social work education and practice. Citing social workers’ difficulty in managing their obligation to social justice in coercive and controlling workplaces, Pelton (2001) implored social work educators to better prepare students for the challenge of implementing the value of social justice in practice.

### **Defining Social Justice**

Social justice has a multiplicity of meanings which have changed throughout time. According to *The Social Work Dictionary*, social justice is defined as: “An ideal condition in which all members of a society have the same basic rights, protection, opportunities, obligations, and social benefits. A key social work value, social justice entails advocacy to confront discrimination, oppression and institutional inequities” (Barker, 2003, p. 404-5). Similarly, Finn and Jacobson (2013) defined social justice as equality in opportunity and in obligation as well as in benefits and rights. The core of the debate around social justice hinges on the tension between individual freedom and the social good (Finn & Jacobson, 2013).

Most scholars tend to focus on social justice in terms of society’s distribution of resources, and they identify three theoretical orientations to distributive justice: libertarianism, utilitarianism, and egalitarianism (Finn & Jacobson, 2013; Pelton, 2001; Plitt Donaldson & Milgram Mayers, 2014). Libertarian theories defend individual freedom and choice as well as individual ownership over the resources one legally obtains. Utilitarian theories, on the other hand, understand justice through the framework of the greatest good for the greatest number. Lastly, egalitarian theories argue that benefits and burdens should be distributed fairly to all individuals, and that societies should be based on cooperation in order to meet people’s basic needs in terms of resources as well as access to opportunity and power in order to maximize human capacity (Finn & Jacobson, 2013). Of the three, most scholars cited egalitarianism, particularly as conceived of by the political philosopher John Rawls, as the framework most consistent with social work values (Finn & Jacobson, 2013; Pelton, 2001).

Of course, social work's orientation toward and conceptions of social justice have shifted throughout time (Abramovitz, 1998; Finn & Jacobson, 2013). In the early days of the Settlement houses, social workers focused not only on meeting needs but also on social reform, particularly for immigrant communities. The methods they employed were founded in group work, an inclusive and empowering practice which facilitated participatory decision-making. However, McCarthyism took a toll on group work's democratic function, and in time it shifted into being used primarily for treatment rather than community organizing. By the 1960s, influenced by many major social movements, social work regained its focus on social justice (Finn & Jacobson, 2013). Thompson (2000) noted that social work, though not a social movement in and of itself, has been connected to and influenced by many movements including: the women's movement, black power, grey power, the disabled people's movement, gay liberation, mental health survivors, and people first movements.

Finn and Jacobson (2013) noted several additional social justice perspectives which are currently contributing to the social work perspective, namely racial contract theory, the human rights approach, processual justice, and the capabilities perspective. Racial contract theory critiques social contract theory as being based on white privilege and argues that it must be deconstructed in the quest for racial and social justice. The human rights approach argues that social justice should be based upon the United Nations' Declaration of Human Rights in order to further clarify social work goals in more tangible terms. Processual justice, as conceived by Iris Marion Young, calls into question the power dynamics around decision-making processes related to the distribution of resources, particularly the dynamics between dominant and subordinate

groups. According to Young (1990), social justice must focus not only on the ends, but also on the means of distribution. Lastly, the capabilities perspective, developed by Martha Nussbaum, advocates for the distribution of resources and power in ways which promote each individual to achieve their goals and live up to their full capability. Rather than focusing on equality, this perspective emphasizes self-determination, wellbeing and quality of life.

Christian Social Work scholars have suggested that social justice is not only a practice value but should also be emphasized in social work as a personal virtue (Adams, 2013; Plitt Donaldson & Milgram Mayer, 2014). Plitt Donaldson and Milgram Mayer (2014) pointed out that social work literature primarily identifies social justice as a macro-level practice. However, they also noted that more social workers are beginning to see social justice as a micro-level practice as well. They argued that cultivating social justice as a personal virtue through social work education can help to integrate the value of social justice into social work practice at all levels.

### **Social Justice and Clinical Social Work**

The elements of social justice and its role in social work continue to be debated—particularly as they relate to clinical practice. The NASW Standards for Clinical Social Work in Social Work practice (2005) defined clinical social work using Barker’s definition from the *Social Work Dictionary*: “*Clinical social work* is the professional application of social work theory and methods to the diagnosis, treatment, and prevention of psychological dysfunction, disability, or impairment, including emotional, mental, and behavioral disorders” (p. 9). The NASW Standards (2005) mandated social workers to abide by the six core values of the profession, including social justice, in clinical practice.

However, beyond the mandate, the standards fail to lay out a definition of social justice or to link the value to clinical practice in concrete ways. McLaughlin (2009) found in her interviews with clinical social workers that most identify advocacy as the primary link they use to work for social justice in their practices, yet advocacy is not a large part of their social work roles in practice, and it is not well developed in the profession.

Despite social workers use of a person-in-environment perspective, they often fail to identify social justice as a key concept. In their study of Australian social workers, Hawkins, Fook and Ryan (2001) found that social workers talked very little about social justice, even when the case examples created an opening for that discussion. The social workers did rely on person-in-environment in their language; however, it was not used in a way that was consistent with social justice. Instead, their analysis of people's relationships with systems individualized social issues. For example, when presented with vignettes which centered on racism and sexism, participants more often used an individualistic perspective as evidenced by their use of terms such as "counseling," "attitude change," "mediate," "assessment," "problem," and "monitoring" rather than social justice oriented terms like "discrimination" and "policy." Furthermore, their work failed to include efforts toward social action. Swenson (1998) pointed out that other professions in medicine and education also rely on the systems-based person-in-environment perspective and that social work should be unique in its incorporation of the goal of social justice.

McLaughlin (2011) found that not only did social workers feel inept at talking about social justice, they were also unable or unwilling to connect the value to their clinical work in concrete ways. To the Canadian clinical social workers she interviewed,

social justice related to (1) social systems, in particular how people related to institutions and to political and economic systems; (2) resources, especially the distribution of resources, both goods and opportunities, and the ability of people to meet their needs; and (3) “transformative respect,” meaning the attempts by the social workers to value and dignify their clients. Many, however, raised questions about whether social justice is consistent with clinical social work. Some worried that social justice goals would put extra burden on their clients and could harm them more than it would help them. These social workers felt that clinical social work should be focused more on alleviating individual suffering than on the political goals of social justice.

However, many social work scholars argued that therapists are inherently political as are therapeutic processes, and that the notion of neutrality is a denial of inherent power dynamics (Abramovitz, 1998; Handsaker, 2012; Parker, 2003; Reynolds & Hammoud-Beckett; Vodde & Gallant, 2002). In fact, social workers have been some of the harshest critics of the direction that the profession is heading—towards an individual focus and away from a more radical social justice perspective. In 1973, NASW published an anthology titled *Social Work Practice and Social Justice* which identified and grappled with the ways in which social workers are complicit in racism and social inequality. The authors also faulted the social work profession for its inability to live up to its values and ethics in challenging unjust systems; they critiqued methods that pathologize individuals and questioned the idea of neutrality on issues that are inherently political (Finn & Jacobson, 2013).

The primary critiques social workers have launched at clinical practice are aimed at the reliance on the medical model (McLaughlin, 2002). This method of diagnosing



and pathologizing individuals fails to confront social injustices that may be contributing to their conditions. Pelton (2001) asked whether social workers are perpetuating injustice by individualizing social problems and claimed: “We disrespect clients when we regard their ‘presenting’ problems as mere symptoms of underlying personality problems, and we teach social systems approaches nonreflectively when we insist that clients must be changed even while their situations remain unaddressed” (p. 439). Vikki Reynolds, in her interview with Sekneh Hammoud-Beckett (2012), further identified individual therapy as “accommodating people to oppression” (p. 59) rather than challenging it. The social work field has also debated over whether diagnosis is inherently at odds with a strengths perspective (McMillen, Morris & Sherraden, 2004). Furthermore, social work’s rich connection to social movements has called into question the medical model’s notion that “experts” have more understanding of people’s lives, experiences, and thought patterns, than people do for themselves (Thompson, 2002). Not only does this undermine client empowerment, but Vodde and Gallant (2002) suggested it also upholds harmful subject/object relationships. In other words, experts are designated “subjects,” who *act*, and clients are the “objects,” who *are acted upon*. This subject/object dichotomy reinforces hierarchical power structures and perpetuates social injustice.

Feminist theorists offered some of the earliest critiques calling attention to privilege and power dynamics in social work in general and clinical practice in particular (Dietz, 2000; Collins, 1986; Evans et al., 2005; Finn & Jacobson, 2013; Thomson, 2002). Evans, Kincade, Marbley, and Seem (2005) explained that feminist therapy arose out of the 1960s women’s liberation movement and consciousness-raising groups, as well as the battered women’s and anti-rape movements. Feminist therapists critiqued traditional

therapy for individualizing social problems and for its assumptions that only experts can “fix” women’s mental health problems. Furthermore, they challenged diagnosis for pathologizing women’s normal reactions to oppression and reinforcing a hierarchy which places more value on experts than on clients themselves. Social worker, Barbara Collins (1986) warned against the medical model in her piece on integrating feminism into social work:

Although social work must certainly deal with its own resistance to research, theory, and integration of research and practice, it is also essential that social work not succumb to the pressure to become instrumental, emphasizing a ‘scientific practitioner’ model for practice (p. 218).

Collins suggested that this approach would lead the profession away from its unique values and cause it to fail in its attempts to transform society. Dietz (2000) claimed social work is at exactly that juncture as the profession focuses to a greater extent on micro practice without giving enough attention to macro-level social justice issues like oppression, thereby contradicting a feminist empowerment philosophy.

Still, the tendency of social workers to individualize clients’ problems arises perhaps as much out of their practice settings as it does out of their theoretical perspectives. McLaughlin (2009) identified three barriers to incorporating social justice into clinical social work practice. First, many clinical social workers stated that social justice work, defined as macro practice, is outside of their organizational job descriptions. Second, when social workers desired to incorporate social justice, they were fearful that their views would be marginalized rather than accepted in their workplaces. Third, the social workers defined advocacy for individuals in terms of opening up options or

navigating systems which never reached the macro level. Perhaps practice settings as much as philosophical perspectives influence social workers' approaches.

Pelton (2001) argued that social workers are not prepared to practice social justice in settings which undermine it. They often face repercussions for challenging the status quo by advocating for social justice in their workplaces (Moreau, 1990). Reynolds & Hammoud-Beckett (2012) suggested that social work burnout is related to working in ways that are not in line with one's values and ethics. This has led many social workers to separate micro and macro practice and fulfill their personal and professional obligations to social justice by engaging in activity outside of paid work (Moreau, 1990; Pelton, 2001; Reynolds & Hammoud-Beckett, 2012).

Additionally, some social workers argue for the separation of micro and macro practice to maintain boundaries and integrity in clinical practice. McLaughlin (2009) found that some of the social workers expressed concern that having a social justice orientation would create professional-driven rather than client-driven services. Some also believed that by focusing on social justice, they would not be able to appreciate differences within groups as well as between groups. They expressed concern that individual differences may be obscured for more stereotypical understandings of group issues. Their concerns are not new to the field of social work as it grapples with the connections between micro and macro practice.

### **Micro and Macro Practice**

The social work profession, similar to other disciplines including sociology, has historically debated about whether greater attention should be given to micro or macro work (Abramovitz, 1998; McLaughlin, 2002; Morell, 1987; Vodde & Gallant, 2002).

The social work profession has moved from arguments over individual “case” orientations versus “social reform” movements to more recent arguments for a clinical focus versus a social justice perspective. The underlying debate, which centers on the tension between liberation and social control, persists (McLaughlin, 2002). Within the debate are three camps. Specht and Courtney (1994) argued that clinical social work cannot be reconciled with social work values. Others claim this can be resolved through a merger of micro and macro practice with separate focuses but attention paid to both (McLaughlin, 2002). This perspective emphasizes that social justice activism and therapy are distinctly different but are connected, and that the limitations of therapy in achieving social justice can be met with policy advocacy (Reynolds & Hammoud-Beckett, 2012). Still others claimed the best approach is to integrate the two into one unified practice (McLaughlin, 2002).

Feminist and post-structuralist theorists align with the last camp in their deconstruction of the very foundations of the dichotomy. Post-structuralists, based on the work of Michel Foucault, claim that separating micro and macro practice falsely constructs the two as opposites. Foucault challenged the construction of dichotomies as artificial distinctions and noted that they have the effect of reinforcing oppressive systems (Vodde & Gallant, 2002). Similarly, the dictum of much of the feminist movement has been “the personal is political” emphasizing the inherently political nature of all things including one’s individual experience and suggesting that micro and macro cannot be separated from one another (Dietz, 2000; Evans et. al, 2005; Sands & Nuccio, 1992; Collins, 1986). Almeida and colleagues (2011) suggested that the distinction between

micro and macro practice has been created and reinforced by the valuing of clinical practice over advocacy practice in the field of social work.

While some identify clinical social work and social justice as at odds (Specht & Courtney, 1994), others claim that this is not necessarily so. Swenson (1998) argued that clinical social work is wrongly associated with the medical model which pathologizes clients and blames the victims of structural injustice. She claimed that clinical social work does not need to take this approach. The social work profession can instead choose to be informed by the ongoing debate surrounding social justice in clinical social work to move forward with integrating the value into practice (McLaughlin, 2002). McLaughlin (2002) concluded that exploring this tension is healthy and implored social workers to progress together in their challenges and reflections to further integrate the value of social justice into clinical practice.

### **Integrating Social Work Practice**

As the social work profession moves further into clinical practice, social workers are identifying new frameworks and methods which more fully integrate micro and macro work. Several common themes of these practices emerge in the literature as depicted in *Figure 1*. Most scholars cited the necessity of not only understanding difference and cultural diversity but also addressing power, privilege and oppression within the therapeutic context (Almeida et al., 2011; Combs & Freedman, 2012; Dietz, 2000; Finn & Jacobson, 2013; Parker, 2003; Rose, 1990; Williams and Barber, 2004). Rose (1990) and Almeida et al. (2011) are united in their critique of “cultural competency” for being too narrow and reinforcing injustice through reliance on static cultural stereotypes. Instead, they offered therapeutic frameworks which are founded on

both the practitioner and client examining power dynamics at play within and outside of the therapy room throughout the therapeutic process.

### Social Justice Practice Methods

#### Address power, privilege and oppression

- Almeida et al., 2011; Combs & Freedman, 2012; Dietz, 2000; Finn & Jacobson, 2013; Parker, 2003; Rose, 1990; Williams and Barber, 2004

#### Understand individual diversity within groups

- Sands & Nuccio, 1992; Almeida et al., 2011

#### Break down dichotomies (i.e. expert/client, subject/object)

- Dietz, 2000; Combs & Freedman, 2012; Rose, 1990; Sands & Nuccio, 1992; Thompson, 2002

#### Foster collaboration

- Combs and Freedman, 2012; Dietz, 2000; Parker, 2003; Rose, 1990; Thompson, 2002

#### Include social and political action

- Almeida et al., 2011; Combs & Freedman, 2012; Dietz, 2000; Parker, 2003; Rose, 1990; Sands & Nuccio, 1992; Williams and Barber, 2004

*Figure 1.* Social justice practice methods. This figure depicts the main themes that arose out of the literature review of social justice in social work practice.

Two other themes for integrating social justice into clinical social work come from postmodern theorists. Postmodern theorists argued that social justice oriented clinical social workers must see categories of people as diverse in themselves (Sands & Nuccio, 1992; Almeida et al., 2011). They suggested methods which appreciate the many voices, perspectives, and experiences of individuals from any given group. They also advocated for breaking down dichotomies such as “expert” and “client” as well as “subject” and “object” inherent in the medical model (Dietz, 2000; Combs & Freedman, 2012; Rose, 1990; Sands & Nuccio, 1992; Thompson, 2002). Dietz (2000) offered a model called “safe connection” which allows for the social work profession to examine the role of professional boundaries in reinforcing hierarchical, dichotomized therapeutic

relationships and to find an ethical way forward which respects both the practitioner's and client's need for safety in the healing relationship.

Another theme to emerge from the literature on integrating social justice into practice is that of collaboration between practitioner and those who consult with them (Combs & Freedman, 2012; Dietz, 2000; Rose, 1990; Thompson, 2002). Dietz (2000) claimed that working collaboratively opens solutions more readily than does pathologizing a client's behavior. Almeida and colleagues (2011) moved collaboration one step further by calling for group work practice that includes not only one practitioner but a team of therapists, advocates, mentors and clients. Parker (2003) cited the importance of raising consciousness around power and oppression and pursuing accountability in therapy through public rather than private formats and in the context of connection to other members of the therapeutic team and community. In this way, those with more power are held accountable for affecting social change. Furthermore, the change is more likely to take effect because it is not an individual working in isolation but a group effort supported by a community.

Lastly, the literature suggests that integrating micro and macro practice into clinical social work must include some form of social or political action (Almeida et al., 2011; Combs & Freedman, 2012; Dietz, 2000; Parker, 2003; Rose, 1990; Sands & Nuccio, 1992; Williams and Barber, 2004). For many, this meant connecting people who are in therapy to others with either similar or different issues which will potentially result in social change, on a group, community or societal level (Almeida et al., 2011; Dietz, 2000; Handsaker, 2012; Parker 2003). For others, assisting people in seeing how their lives are tied to cultural norms and beliefs is a political act in itself (Sands & Nuccio,

1992). Rose (1990) seemed to combine the two emphasizing that therapeutic processes need to address both people's "objective conditions," the context in which they live, as well as "subjective entrapment," their internalization of harmful cultural beliefs (p. 51).

Swenson (1998) named ten approaches which offer opportunities for integrating social justice into clinical social work practice. Topping the list was the strengths perspective which encourages practitioners to identify individuals' strengths and work from a foundation of their resilience. This has been suggested by some as an alternative and by others as a complementary practice to the medical model which tends to pathologize individuals (McMillen, Morris & Sherraden, 2004). However, Finn and Jacobson (2003) questioned whether traditional social work theories like structural, systems, strengths and empowerment go far enough to address pressing issues like global capitalism and increasing inequality. Beyond the strengths perspective, Swenson (1998) suggested ethnic-sensitive practice, feminist practice, justice-oriented practice, and self-awareness for incorporating social justice into clinical work. She claimed that narrative approaches may also offer a clinical approach consistent with the profession's value of social justice. Vodde and Gallant (2002) also declared that narrative therapy has the potential to fully integrate clinical social work practice and keep social justice at the core of social work's professional identity.

### **Narrative Therapy as a Practice Method**

Narrative therapy, as conceptualized by White and Epston (1990), is founded on the poststructuralist theorizing of Foucault. Narrative therapy starts with the premise that meaning comes from the ways that people story their lives (Combs & Freedman, 2012). According to Foucault's orientation to post-structuralism, modern power oppresses



people through internalizing, or what Foucault calls “interiorizing,” of “dominant discourses,” the prevailing cultural narratives which story people’s lives (Vodde & Gallant, 2002). In this approach people are seen as complex with many versions of stories at work in their lives, and these stories change over time. Furthermore, people’s stories are socially constructed. Therefore, it is more important to understand the meaning that people give to their lives than to seek out universal truths (Combs & Freedman, 2012).

White and Epston proposed theories and methods which assist people in deconstructing dominant narratives so that they can see the influence of those narratives in order to undo their power and come instead to be self-defined and empowered on their own terms (Vodde & Gallant, 2002). Narrative therapists help people to change their relationships to their problems and to open to new possible stories (Combs & Freedman, 2012). White used the phrase “the Ruse” to describe ways in which people buy into dominant discourses, which leads them to believe in their own pathology. Narrative therapy encourages people to examine the impact of these dominant discourses through inherently political methods, to externalize problems, and to take not only individual action but also collective action to solve their collective self-defined problems (Vodde & Gallant, 2002).

Narrative therapy has several distinct characteristics. First, narrative therapists attempt to eliminate dichotomy between the therapist and those who in a traditional sense would be “clients.” In narrative practice, therapists are not seen as “experts” and as such there are no “clients.” Instead they see clients as people who are seeking consultation about a problem, and people are seen as experts in their own lives (Combs & Freedman,

2012). Wade (1997), who has written extensively on client resistance to oppression as a strength, found narrative therapy to be one practice which assumes a “pre-existing ability” (p. 24) in people, meaning that people have within themselves the ability to respond to their situations. In this way, therapists take a back seat, in order not to be seen as an expert, and allow marginalized voices to arise. White and Epston (1990) call this practice “supporting persons from behind” (p. 148-149). The therapeutic relationship is a collaborative one (Vodde & Gallant, 2002). The relationship that is built has an impact on both the practitioner and the person seeking consultation (Combs & Freedman, 2012).

Second, narrative therapists believe that the therapeutic relationship is inherently political. Therapists cannot be neutral (Combs & Freedman, 2012; Vodde & Gallant, 2002). Combs and Freedman (2012) explained:

As members of a culture we recognize that power influences the political context of people’s lives both in and out of the therapy room. This leads narrative therapists to work to expose discourses and power differentials that support problems and to work from a position of collaboration, recognizing clients as the privileged authors of their own stories (p. 1036).

Through their philosophy and methods, narrative therapists take a stand for social justice by exposing power, including modern power, and countering it in practice (Combs & Freedman, 2012). White and Epston (1990) argued that therapists must be cognizant of local, relational politics and must confront attitudes and beliefs which contribute to issues such as violence and abuse, or they risk contributing to their clients’ oppression (p. 49).

Third, narrative therapists externalize problems rather than labeling or pathologizing those who seek consultation. Narrative therapists often cite the words of

White in their philosophy that “the person is not the problem, the problem is the problem” (Combs & Freedman, 2012, p. 1039). According to White and Epston (1990), “‘Externalizing’ is an approach to therapy that encourages persons to objectify and, at times, personify the problems that they experience as oppressive” (p. 38). Externalizing happens in two stages. First-order externalizing helps people to name the problem rather than thinking it is inherent within themselves or someone else (Vodde & Gallant, 2002). Narrative therapists prefer questions to statements. Methods for externalizing include listening for openings to other potential preferred stories, developing preferred stories, and extending the story into the future (Combs & Freedman, 2012). In second-order externalizing, the therapist acts as more of a facilitator in connecting people to other resistors so they are less marginalized. Involving others is one way in which narrative therapists counter their own power (Vodde & Gallant, 2002). Some methods which have been used for including others are: documenting, outsider witnessing, incorporating other people, and co-research (Combs & Freedman, 2012; Handsaker, 2012; Acharya, 2010; Vodde & Gallant, 2002).

Fourth, preferred stories are solidified through “performance,” or social action, by living them out in front of others to facilitate the creation of meaning within the context of relationships (Vodde & Gallant, 2002). White and Epston (1990) identify performance as a means to help people “identify their resistance to the effects of the problem or its requirements,” and therefore, “refusing to submit to the effects of the problem renders the problem less effective” (p. 63). Because a narrative approach assumes that problems are not only personal but also social and political, the solutions that are offered are also social and political in nature (Combs & Freedman, 2012). Vodde and Gallant (2002) cautioned

that collective action cannot be prescribed by the practitioner because it would fail to be liberatory. Instead social action often arises naturally from simply connecting people who have been affected by similar or related problems. This can create camaraderie and lead to action for social change.

Chang and Nylund (2013) pointed out that empirical research on the use of narrative therapy is limited. Narrative therapists question the discourse around what constitutes “evidence” as it conflicts with the underlying assumptions that there are no experts. The idea that people can be grouped and reduced down to a set of characteristics is also viewed as at odds with narrative practitioners’ philosophy that people are complex. It is for these reasons that narrative practitioners have been hesitant to pursue scientific research. However, many scholars have emphasized qualitative approaches as well as participatory action research or co-research as potential options consistent with narrative philosophy (Combs & Freedman, 2012; Etchison & Kleist, 2000; Vodde & Gallant, 2002).

Still, available studies demonstrate that narrative therapy can be used successfully with many client populations. Etchison & Kleist (2000) in their systematic review of the literature identified four empirical studies, all of which showed promising effects of narrative therapy. Narrative therapy was shown to improve parent-child relationships, empower personal agency in families, increase children’s understanding of conflict at home, and contribute to problem transformation in families. Combs and Freedman (2012) found an additional three empirical studies which also all showed a great degree of success. These studies demonstrated a reduction in childhood stealing, positive results using externalizing with children’s soiling behavior, and decreasing depression and risk

for eating disorder. Additional qualitative studies have indicated that narrative practice may be useful in supporting those working for social change (Acharya, 2010), as well as in working with African Americans, particularly when combined with critical race theory (Devance Taliaferro, Casstevens & Decuir Gunby, 2013), and in working with childhood sexual abuse survivors when integrated with other therapies (Miller, Cardona & Hardin, 2006). Furthermore, Mutigl (2004) found in his linguistic-semiotic case study of a couple's therapy sessions that narrative practice successfully helped them produce new narratives of self-agency to transform their problems.

Practitioners and scholars have highlighted narrative therapy's congruence with social work and its connection to social justice and social change (Combs & Freedman, 2012; Vodde & Gallant 2002). Vodde and Gallant (2002) argued that narrative therapy can be used to unify micro and macro practice in clinical social work in order to address power and oppression and remain true to social work's organizing value of social justice. The present study explores narrative therapy as a potential method for integrating socially just means for social justice ends into clinical social work practice. It seeks to understand both the strengths and the challenges of using narrative practice to achieve social justice.

### Conceptual Framework

This study will employ a feminist conceptual framework for integrating social justice into clinical social work practice. Defining feminism can be challenging because there are many streams of feminist thought, each with their own analyses, goals, strategies and actions. Despite the contradictions between some feminist theories, Hyde (2013) offered similarities that occur across perspectives. Most feminist perspectives emphasize that feminism is not only about women helping women, but also about challenging sexism and patriarchy, which also impacts men. Furthermore, feminism is not solely focused on what are traditionally viewed as “women’s issues” but on all issues as they relate to oppression. Most feminist theories critique and challenge patriarchy as well as other oppressive hierarchies (Hyde, 2013). In her article *Cause is Function: Toward a Feminist Model of Integration for Social Work*, Morell (1987) offered a useful definition capturing the common themes of feminist thought which is the one that shall be used for the purposes of this study:

Simply put, feminism is a transformational politics. It seeks individual liberation through collective activity, embracing both personal and social change. The broad goal of feminism is not limited to the elimination of dominant-subordinate relationships between sex groups but aims at the dismantling of all permanent power hierarchies in which one category of humans dominates or controls another category of humans. Therefore, feminism aims at the complete method of releasing human power and social power for the welfare of all” (1987, p. 147-148).

Hyde (2013) identified five core principles of feminist social work practice. First, feminist practice incorporates a gendered lens in understanding power dynamics at play in society. Second, feminists stress that “the personal is political,” meaning that people’s lived experiences are inextricably linked to political structures. Feminists encourage the analysis and deconstruction of the politics influencing one’s life in order to create self-defined meaning as the expert in one’s own life. Third, feminist practice offers democratic, participatory structures underscoring the importance of the *means* as well as the *ends* of social justice practice. Fourth, feminist practice is inclusive and diverse. While historically feminism has been critiqued for being centered on white women, more recent developments have moved feminist theories to focus on ending *all* oppression and recognizing how privilege and oppression of different forms intersect in people’s lives. Fifth, feminist practice is transformational in that it requires social and political action to change both individuals and society (Hyde, 2013).

Young’s work *Justice and the Politics of Difference* (1990) is an essential resource for understanding the third core principle of feminist theory which emphasizes the importance of democratic structures. While the social work literature tends to focus on distributive justice, Young questioned the merits of distributive justice frameworks and outlined ideas for focusing as much attention on the means of decision making as on the material ends. Finn and Jacobson (2008) termed Young’s conception of justice “processual justice.” According to Young, justice is defined as

The institutionalized conditions that make it possible for all to learn and use satisfying skills in socially recognized settings, to participate in decisionmaking, and to express their feelings, experience, and perspective on social life in contexts

where others can listen. This understanding of justice ... requires a societal commitment to meeting the basic needs of all persons whether or not they contribute to the social product... Justice equally requires, however, participation in public discussion and processes of democratic decisionmaking. All persons should have the right and opportunity to participate in the deliberation and decisionmaking of the institutions to which their actions contribute or which directly affect their actions... Democracy is both an element and a condition of social justice (1990, p. 91).

The five methods of clinical social justice practice identified in the literature fit easily within a feminist conceptual framework (see *Figure 1*). First practitioners must address power, privilege and oppression within clinical settings. Rather than making assumptions, they must understand that all social groups consist of diverse individuals. They must seek to break down dichotomies, particularly that of subject/object which often exists in therapeutic settings as expert/client. Social justice clinical practitioners must foster collaboration with clients and others in the community including social justice activists. Lastly, they must facilitate collective social and political action by fostering connections between people with similar interests and challenging people to think critically about social and cultural influences on their individual experiences.

These methods are further supported by the National Association of Social Work's *Code of Ethics* which, in addition to social justice, emphasizes the social work values of service, dignity and worth of the person, importance of human relationships, integrity, and competence (2008, p.5-6). Service entails not only helping those in need but also addressing social problems implying some form of social action. Valuing the



dignity and worth of the person means respecting each person's self-determination and being "mindful of individual differences and cultural and ethnic diversity" (National Association of Social Workers, 2008, p. 5), which is consistent with understanding individual diversity within groups. Furthermore, in valuing human relationships, social workers are encouraged to "engage people as partners in the helping process" (NASW, 2008, p.6), a practice akin to breaking down dichotomies.

The conceptual framework of this study is depicted in *Figure 2*. Grounded in feminist theory and employing the five social justice methods as identified in the literature review, practitioners can expect individually and socially transformative outcomes. Processual justice moves beyond distributive frameworks alone, which are primarily concerned with the end results, and calls for social justice practice methods, emphasizing the means as an important part of therapeutic practice. An integrated clinical social work practice helps people to examine and understand the inherently political nature of their lives and empowers them to take both individual and collective action which has the potential to transform not only themselves but also the social context in which they live.

Theoretically narrative therapy embodies this integrative framework through its philosophy and practice methods. Narrative practice is rooted in postmodern theories which deconstruct dichotomies and dominant discourses (Combs & Freeman, 2012; Vodde & Gallant, 2002). This leads to practice methods which foster collaboration and understanding of individuals' uniqueness while taking into account the influence of culture and social location as well as how power dynamics affect people's lives. Narrative therapy helps people to examine power dynamics and to facilitate social and

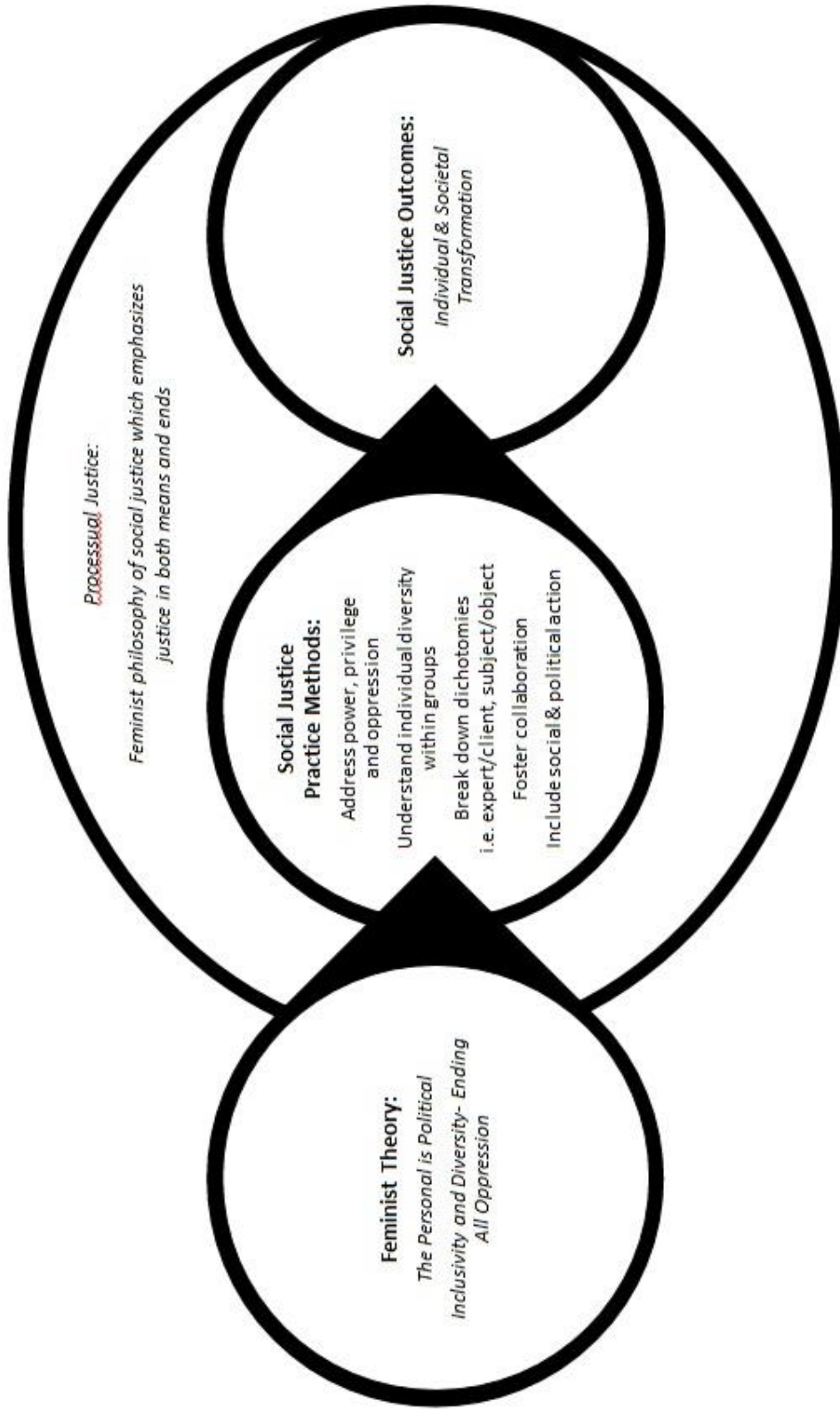


Figure 2. Feminist framework for integrating social justice into clinical social work. This figure depicts an integrative model of clinical social work practice which is grounded in feminist theory and social justice practice methods to affect individual and social transformation. Feminist theory is indicated in italics.

political action, challenging dominant discourses and creating new meanings not only individually but also collectively (Vodde & Gallant, 2002). In this way, narrative therapy corresponds philosophically with feminist theory and all five of the social justice practice methods.

The present study seeks to understand the degree to which narrative therapy is aligned with a feminist social justice framework as it is currently practiced. How do narrative therapists conceive of social justice? How is their work informed by the value of social justice? Do they see their role as well as the means and ends of their work as political in nature? Do they carry out the five identified social justice practice methods or identify others? Have they seen outcomes which suggest not only individual but also societal transformation?

## Methods

### Research Design

The present study explores whether narrative therapy is aiding clinical social workers in integrating micro and macro practice by infusing social justice into their clinical work. It seeks to understand whether and how clinical social workers employing narrative methods see social justice as part of their practice. The study relies on qualitative data from semi-structured interviews with licensed clinical social workers who utilize narrative therapy in a clinical setting. As Vodde and Gallant (2002) suggested, qualitative methods are more consistent with narrative philosophy than are quantitative methods given their focus on individual voices and the meaning people make of their own experiences (see also Chang & Nylund, 2013). Narrative practitioners emphasize the importance of co-research, research not just *about* but *with* participants, for understanding the impacts of the practice (Vodde and Gallant, 2002). Qualitative interviews, consistent with this philosophy, allow more freedom and flexibility for participants to offer their own analysis. This is also fitting given the exploratory nature of the study.

### Sample

The population for this study is Licensed Clinical Social Workers in the Minneapolis/St. Paul, Minnesota area who are known to be using narrative practice in a clinical setting. Because there is no complete listing of this population, this study relied on availability or “convenience” sampling, meaning that participants were chosen through a non-random sample of those identified by the researcher who were willing to participate (Monette, Sullivan, & DeJong, 2011, p. 150). Snowball sampling, asking

participants to refer other clinical social workers using narrative therapy, was implemented to recruit additional participants.

### **Protection of Human Subjects**

Several measures were taken prior to conducting research to ensure the protection of participants. The study proposal was approved by a research committee made up of a University of St. Thomas research chair from the School of Social Work and two licensed clinical social workers from the community. Additionally the study was approved by the St. Thomas University Institutional Review Board (IRB) prior to the recruitment of any participants.

**Recruitment Process.** The researcher obtained potential participants' contact information through the online counseling directory Psychology Today (<http://therapists.psychologytoday.com/>). The researcher then contacted potential participants by email and follow-up phone calls explaining the goals of the study and soliciting their participation. Additional participants were recruited through snowball sampling. The researcher attempted to schedule interviews with the social workers who replied to the request within the timeframe offered.

**Protocol for Ensuring Informed Consent.** Before interviews, the researcher presented and explained a consent form (see Appendix A) to the participant. The consent form was approved by the St. Thomas IRB prior to data collection. The consent form included background information on the study, information about the nature and procedures involved in their participation, a thorough explanation of confidentiality measures as well as a description of the voluntary nature of the study and the process for opting out. The consent form also clearly stated that there were neither risks nor benefits

for participating in the study. Participants agreed to be interviewed by the researcher and agreed to have the interview audio-recorded. Participants had an opportunity to ask the researcher any questions prior to signing the form to ensure they fully understood what their participation entailed.

**Measures to Ensure Confidentiality.** While interviews could not be anonymous, participants' identities have been kept confidential. All documents, including audio-recordings, containing participants' names were stored on the researcher's password protected computer until the completion of the study. Some demographic information is used in the study. However, there is a large enough community of narrative practitioners in the area to ensure that their demographic information can be included in the report without concerns of violating confidentiality.

### **Data Collection**

Data for this study was collected through semi-structured interviews lasting approximately 30-45 minutes. Interview questions were developed by the researcher prior to the study and were approved by the research committee and IRB prior to data collection (see Appendix B). The interview schedule contained eight open-ended questions about the social workers' backgrounds in narrative therapy, their orientations to social justice and the extent to which it is present in their practices as well as their experiences of the strengths and challenges of using narrative therapy to bring about individual and social change. The researcher inquired about professional experiences and impressions; no questions were personal in nature. Interviews were audio-recorded and transcribed. Handwritten field notes regarding the researcher's impressions and insights

during the interviews and throughout the course of data collection were utilized in addition to data transcribed from the audio-recordings.

### **Data Analysis Plan**

Interview transcripts were reviewed closely several times to identify codes and themes, common patterns that appeared in the raw data (Padgett, 2008, p. 151). The researcher utilized a grounded theory approach called “sensitizing concepts” (Glaser, 1978 as cited in Padgett, 2008, p. 152), which allowed the researcher to use some flexible concepts from the literature review as a guide from which to start coding the raw data. As much as possible, codes and themes emerged from the raw data itself. From there, common codes were organized into themes which are presented in the this report utilizing direct quotes from participants as much as possible to allow participants’ unique and individual voices to be heard. Consistent with narrative practice, participants had the opportunity to collaborate in making meaning from the interviews. The researcher solicited participant feedback on the draft of the results section, particularly the use of participants’ direct quotations, to ensure greater accuracy in data analysis.

## Findings

### Participants

**Demographics.** The present study consisted of interviews with six licensed clinical social workers (n=6). All participants were white/Caucasian. One was male and five were female. All currently practiced clinical social work in the Minneapolis/St. Paul metropolitan area. Their clinical practice experience varied from three to twenty-five years.

**Practice Settings.** The participants' practice experience and settings varied widely. One was currently practicing in an outpatient mental health clinic. One had previous experience in this setting but was currently practicing in a pre-school setting. One worked both as the Clinical Director at a community agency and was also in part-time private practice. One was part-time in private practice and also contracted to lead trainings and provide community education. The remaining two were currently in private practice full-time, one with prior work experience in Children's Therapeutic Services and Supports (CTSS) and the other with experience in nonprofit work with adolescents.

**Client Populations.** Due to the variety of practice settings, participants' client populations also varied. Each had some combination of experience with individual, family and group work. Population ages ranged from 5-year-olds to 70-year-olds. Two of the participants in private practice mostly worked with women with a history of trauma. This was also true for the participant in an outpatient mental health setting. Another participant in private practice specialized in working with clients with severe and persistent mental health diagnoses as well as diverse populations including the lesbian, gay, bisexual, and transgender community.



**Training in Narrative Therapy.** The amount of training participants had specific to narrative therapy varied widely. For the purposes of understanding the results, participants are categorized into two groups. Those with less extensive training included one participant who was self-taught through her own reading; one who learned about narrative during her graduate-level social work coursework, a 1-day workshop, and some personal reading; and another who attended a 3- to 4-day training given by Michael White. Those with more extensive training had all completed a 1-year certificate program in narrative therapy. Two had participated in ongoing narrative-specific training and consultation groups, one of whom attended it for nearly seven years. The other participant had also completed a 1-year international training program in narrative therapy.

**Reliance on Narrative Practices.** Participants all described their clinical practices as integrative with varying degrees of reliance on narrative therapy. The three with more training in narrative therapy described their clinical work as relying heavily on narrative practice. One participant shared that she is always using narrative values even when integrating other methods. Another stated that narrative therapy underlies everything she does in clinical practice. The third shared that he relies on narrative as a foundation and has found it compatible with many other models and approaches. He stated:

*I consider myself kind of an integrative therapist. ... I think all of those things, components, get integrated in or are tossed out there for clients to grab on to... I think that narrative is really great at being able to allow for space for those things.*

In contrast, the three participants with less extensive training in narrative practice stated that they rely only on certain components of narrative therapy.

Table 1  
*Components of Narrative Practice Used by Participants*

Deconstructing problems/systems
Externalizing
Developing preferred stories/narratives
Formulating questions
Non-pathologizing
Not being in charge
Helping clients share their stories
Connecting clients with others
Statement of positioning
Creating therapeutic documents
Using a whiteboard to track client's story

The components of narrative practice that all of the participants suggest they rely on most commonly are listed in *Table 1*. Participants often determined their approach based on how well one method or another fit for each individual client. They suggested that people's lives do not fit neatly within one model. All participants indicated the need to use multiple models and methods in order to be effective in clinical practice.

*Table 2* contains a list of the other practice methods that participants identified which also influence their clinical work. These are practices which they currently use, have had training in, have

Table 2  
*Other Practice Methods of Influence*

Ann Gearity's Developmental Repair Model
Art, Collages, and Creativity
Attachment Theory
Body Movement and Yoga
Brent Atkinson's Pragmatic/Experiential Therapy
Cognitive Behavior Therapy (CBT)
Dialectical Behavior Therapy (DBT)
Eye Movement Desensitization and Reprocessing (EMDR)
Functional Family Therapy
Literature and Writing
Mindfulness and Meditation
Motivational Interviewing
Multisystemic Therapy (MST)
Nature Walks
Neurology
Pia Mellody's Post-Induction Therapy (PIT)
Play Techniques
Role Identification
Sensory Grounding
Somatic Techniques
Systems Advocacy
Terry Real's Relational Life Therapy (RLT)
Timelines and Social Histories
Trauma Repair
Trauma-Focused Cognitive Behavior Therapy
Virginia Satir's Change Process Model

used in the past, or feel impact their work. The four most frequently cited by participants were Cognitive Behavior Therapy (CBT), Dialectical Behavior Therapy (DBT), Eye Movement Desensitization and Reprocessing (EMDR) and mindfulness.

### Conceptions of Social Justice

**Defining Social Justice.** Participants were asked to define social justice. Several significant concepts were prominent in their definitions. First, many participants discussed the central role of equity to social justice. Second, several participants cited access as a key component. Third, many of the participants pointed out that social justice includes actions taken to move society towards their conceptions of justice. Participants also mentioned the inherent worth of each individual and the importance of being aware

Table 3

#### *Definitions of Social Justice*

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*I think of social justice is kind of having that equitable distribution of power- some equality.*

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*I guess really what it comes down to for me is equity. Equity in privilege. Equity in burdens and obstacles. Equity across the board. We share the load; if something is hard. If there's an opportunity, we all have an opportunity at it, and to work towards that.*

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*I think just recognizing that as a whole, as a community, we aren't any better off than the person who is struggling the most, or the community or the group that is struggling the most and that we do have to help each other in order to raise all of us up. I guess I just think of what's fair, equal and fair aren't the same things, and making sure that things are fair for our most neglected populations.*

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*Social justice is based on the concept of inherent worth, that we all have inherent worth that we all have the right to access to the same things. That's in theory, but social justice as a verb is doing anything towards that, towards that for people who are traditionally underprivileged in some way or being shut out of different things.*

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*I think ideas of fairness, equity, accessibility, respect of the individual/family/community/whatever group. Change in all of those, all of those things I just listed towards more of each of- towards more fairness, towards more equity and accessibility.*

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*I think it's when you go above and beyond what you're expected to as a person or a human being or a social worker and recognize and realize that the aspects of society are not acceptable, that it's not ok to discriminate and to treat poorly. As a social worker I would define it as the role we have... to work towards change on a more global level, a social level.*

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of social issues. Their definitions are shown in *Table 3*.

**Conceptualizing Micro and Macro Practice.** Throughout the interviews, all of the participants connected social justice with both micro and macro social work practice in some way. Those with more training in narrative therapy cited a strong belief in individual-level and societal-level work being part and parcel of one another, as evidenced in this participant's view:

*Narrative believes that problems are formed from the social constructs and the social context, so for those problems to change, the social contexts have to change. It's hard for me to imagine individual change happening that's not broader than that; I mean, I just don't think that's how life works... to work at change on any level feels like it is about all the levels to me.*

These participants' beliefs in micro and macro practice being integrally connected rested in their views of their work with individuals as being counter-cultural and subversive which is evidenced in the following quotes from two of the participants:

*Narrative says, "The person is not the problem, the problem is the problem," so I think that a statement like that is radical, counter-cultural and is about social justice because it's looking at the broader context and acknowledging that change needs to happen on that level.*

*I think that's pretty subversive, too. Just inviting people to talk about themselves and their identity and also how they were sort of trained about what they can and can't do and who they are.*

The three participants with less training in narrative therapy also conceptualized micro and macro practice as being connected to social justice, but they seemed to distinguish micro and macro practice from each other in a way that the participants with more extensive training in narrative therapy did not. These three participants conceptualized macro practice as policy advocacy or advocacy within systems. For example, one of the participants cited her work in nonprofits which focused on providing direct services as well as raising awareness and advocating for clients in the community

and at the legislature. She viewed these areas as being connected in some ways but also described them as separate tasks.

*I think that really was two branches of the agency, so sort of the internal focus of the day-to-day therapeutic endeavors and then the external focus of advocacy in the community. ... I think they were often times able to utilize success stories from clients in promoting the advocacy.*

The participant with no formal training in narrative therapy saw the telling of stories as connected to macro practice, but she viewed this work as distinct from therapeutic work.

The following quote shows how she sees the two as connected but distinct.

*I think there is different roles not in a therapy setting, and I think that's perhaps why I'm feeling like I'm not coming up with the kinds of examples that maybe speak to what you're researching but in other roles that haven't been doing therapy per se have been more helpful in... re-storying, telling somebody's story, encouraging them to tell their own story. I sit on the Minnesota Advisory Council for Mental Health for the Governor's board and have worked closely with NAMI and doing county-level marketing campaigns about mental illness.*

### **Social Justice in Clinical Work**

**Social Justice Practices.** In describing how social justice is present in their clinical practices, the participants cited several social justice oriented practices not specific to narrative therapy. Advocacy was one common theme which included advocating for clients within systems, helping clients to access resources, as well as legislative policy advocacy with or on behalf of clients' interests. The following quotes are two examples:

*Sometimes it's accessing resources. It may be finding employment. It may be accessing social security disability. It may be accessing insurance benefits and maintaining insurance benefits. It may be advocating for housing and housing assistance. All across the board.*

*When I was [working] at ... a group home for teenage boys with mental health stuff and legal issues and lots of attachment disruptions, ... every year we'd go to the capitol, and we'd bring some of those kids that wanted to speak up about their needs. And we would go and talk to our local senators and representatives. And that was really cool. That was neat to see how their faces lit up, and they actually*

*had some power. They were empowered, which, you know, 15-year-old boys in the legal system with sex offenses on their record, they don't really have much power so that was cool.*

The participant in the latter quote did not see this practice as connected to her narrative therapeutic practice with these clients.

The majority of other social justice practices described were related directly to narrative therapy. Many participants described social justice in their clinical practice as empowering clients to tell their stories, validating their stories, and encouraging them to go after their preferred stories. Furthermore, the three participants with the most training in narrative therapy described in detail how their decentered, non-expert stance—a central tenant of narrative practice—contributes to social justice in clinical practice. The following quote from one of the participants articulates some of their shared views.

*I think that [social justice is] present because to a larger part narrative allows me to do that. Narrative allows me to not be centered, not be in charge, not always be the expert. To some degree, you are a clinician, and you are seen as an expert and people are coming to you for help, but being able to take a position of curiosity and asking them to come up with the plot of their story, the names for things, how they actually affect them, and interact with their lives in positive and negative ways allows for there to be equity or closer to equity. It becomes more of a shared burden. I think it really allows me to practice social justice as often as I possibly can in this kind of a system.*

He went on to give an example of what this decentered stance looks like in practice.

*A concrete example is allowing a young man that I'm working with for him to be able to come up with the label of what he's working on, for him to be able to define what is his problem as opposed to it just being placed upon him. Him having a file. Him having an expert with a title and degrees asking a bunch of questions and then telling him, you know, you have bi-polar and here's what it does to you and here's why it's bad and here's what you need to do to fix it. ... I ask him what he thinks the problem is, what does it do to him? What is the good in it? What is the bad in it? And allowing him to come to his own determination about what he wants to do about it and approach it and work on it or not.*

Addressing social issues with clients during session was also raised as a way in which social justice was present in clinical practice; however, the approach of two participants with extensive training in narrative therapy was quite different from the approach of another with no formal training in narrative therapy. The participant without formal training in narrative described her approach as an effort to challenge her clients' prejudices:

*I think social justice comes out clinically for me in a way that I not only challenge, when appropriate or needed, an individual's perceptions and beliefs about themselves and their relationships, but I also challenge that when it comes to lack of awareness or intentional types of stigma or belief systems that people have whether it's hatred towards a group or an entity.*

In contrast, the participants with more training in narrative practice described addressing social issues with clients as opening up a discussion during a clinical session of the ways in which social and cultural messages contribute to one's experiences and one's story. One participant described how narrative practice has been helpful in inviting social justice conversations into a clinical session:

*When we ask those sort of questions about what are the societal messages or what are the bigger culture contexts, it brings [social justice] into therapy in a way that if I didn't ask those questions, they would never come up. ... Before I was trained in narrative practices it just wasn't things that people were talking about. You have to invite it into the room. ... Social work has that whole person-in-environment thing but even then social work didn't directly give me questions to ask about that the way narrative has. To really bring in and have people thinking.*

Another participant described this further as allowing space for preferred stories.

*If clients want to take on a particular issue, like often things that strengthen negative stories about people are things like racism and oppression and poverty and these huge systems that are really negative for people that bring about things in my opinion that we historically call mental illness or whatever, so supporting clients in advocating for themselves in that way— validating their stories, pushing to allow spaces for their stories, for them to tell their stories, for them to demand change or go after their preferred stories.*

Lastly, when asked about how social justice is present in their clinical work, two of the participants with more extensive training in narrative therapy explained their views that narrative practice is often interchangeable or synonymous with social justice.

*I would say whenever I use narrative well, I feel like I'm doing [social justice]. Definitely. ... I'm sitting here trying to imagine would it be possible to be a narrative therapist and not care about social justice because I know for me they are so closely related that they're synonymous for me.*

*... to practice from a social justice perspective, narratively. Often I would say they're interchangeable for me.*

**Effect of Setting.** Several participants pointed to one's work setting as a contributing factor to being able to integrate social justice into clinical practice. Two participants stated that nonprofit work was more conducive to working on social justice than private practice due to services being provided to more vulnerable populations with lower socioeconomic status as well as the support and necessity of nonprofit organizations to advocate on client issues. Three of the four in private practice expressed feeling "social worker guilt" for being in private practice and felt more disconnected from social justice work than they had in other work settings. They described what they have seen in the progression of their own and others' careers from nonprofit work to private practice:

*I think me coming from that social justice background, and that's actually what my degree was in, makes me even more like I call it "social worker guilt" for even being in private practice. You know? It's like this, "That's not what social workers do."*

*It just feels a little bit like that's the way it goes, is when you first start in the field you tend to do more of that working in nonprofits and all of that, and ... you work with that population and then as time goes on it's like as you get more experience you tend to work with like the "worried well." It's kind of weird; it's kind of backwards, but ... I've seen that happen. I don't know maybe it's partly the progression. People just get more into their niche.*

Another expressed initial guilt, but also emphasized the rewards.



*I am doing therapy which I swore I would never do because I felt like it was selling out and found it, after many of my other experiences with different types of positions, to be really rewarding.*

**Professional Choices.** The participants, both in private and in nonprofit practice, also referred to their personal and professional choices as having an impact on their ability to incorporate social justice into their clinical work. Factors affecting their professional decisions, such as where and how to practice, included their desires to prioritize their own financial stability, their family, their personal freedom and developing a way of practicing that fit with their values and interests. One participant found that the transition to private practice allowed her to integrate social justice more fully into clinical practice by offering several sliding fee spots, where clients pay what they can. She also had more freedom to develop her own client-centered assessments. In addition, this freed some of her time to pursue other social justice-oriented volunteer work. Other participants mentioned volunteer work as well. One suggested that she may be more heavily involved in social justice work in her retirement, which will allow her more time for volunteering.

**Client-Centered Practice.** In discussions about social justice in clinical practice, participants voiced both the importance and the challenges of client-centered practice. All participants emphasized the need to put the client's needs at the forefront of therapeutic endeavors. However, some suggested that this may inhibit discussions of social change. Many explained that the focus of therapy must be on the individual but that social change can be a byproduct of that work.

*I'm more interested in working with where they are, and some people really are—thinking of Prochaska's stages of change— they're really in the pre-contemplation mode. They're not even sure they want to think about [social justice] topics, and I think that's ok. So I'm less interested in making my clients socially or racially aware. I mean as much as I am open to talking about it.*

This requires attention to where clients are at, particularly when they may become emotionally flooded. One participant, who suggested that social issues can be brought into therapy throughout the process explained a tool she frequently uses in therapy sessions to check-in with clients. While she uses this technique for many situations, not only in relation to social issues, she shared it as one method for remaining client-centered while engaging clients in discussions about social issues that may feel overwhelming to them. In the following quote she described her process for helping clients to both test their limits and stay within them.

*I think you want to keep someone on the edge of that... that's where that learning happens is right on the edge. So a lot of communication and reading people and asking them, "Where are you at?" I have a window of tolerance thing that I talk about all the time. I'm like, "Where are you at in this window?" I introduce it right away with people. "Here's the window: where are you at? If you're right in the middle and comfortable, fine. If we push you a little bit here, that's good, but we don't need you emotionally flooded, 'cause what's the point then?"*

**Barriers to Social Justice in Clinical Work.** Participants noted many barriers to incorporating social justice into clinical practice. These included both individual and structural barriers. As explained in the quote above, clients may not be ready to look at the social issues impacting their lives. One participant pointed out that therapists themselves must overcome their own discomfort, fear and guilt, and in order to explore issues of social justice in session, and even when they do, they may experience fatigue from the constant presence of injustice.

*Therapists in Minnesota are mostly white women, and mostly white women who haven't looked at issues of race in particular. It's just uncomfortable. I think until you really have a lot of experience and a lot of training in it, you just feel found out, on the spot, uncomfortable. There's all that. Just those experiences of if you do buy into that's something to look at then there's guilt and all that kind of stuff and there's a lot of barriers. ... People are afraid of talking about things directly and then you add an issue like race in a group of white people. Whew, it's hard for people. It's hard. I'd say that's not mainstream yet.*

Furthermore, participants pointed to many more structural barriers. First, many cited funding, particularly the insurance system, and the inability of vulnerable populations to access mental health services. Second, a couple of participants cited the need to be “the expert” within the medical model and how this compromised their sense of social justice in practice. One participant described his view of working within such a system:

*I think the biggest barrier is the funding, the structure, and the power. The hoops that you have to jump through to be able to financially do the work you want to do. I think there's the expectation of having clinical diagnosis and doing long assessments ... sitting somebody down and you're the expert and you ask a thousand questions and then you tell them what's wrong and what they need to do. ... I do some work that I don't think is very social justice-focused in order to be able to do the real work, the work that I think is really helpful for people, really validating and empowering for them.*

Another participant, who serves many self-pay clients, shared her experience of greater freedom outside of the insurance mandates. She stated that she has clients assess their own sessions rather than completing a clinical assessment on her own. She described feeling as if she has much more freedom to do this within her practice than most therapists who are working more extensively within the insurance system.

One participant cited three barriers to social justice in clinical practice including the medical model, a culture of individualism and the impact of individualism on professional training institutions.

*I think barriers, oh yeah. I think the medical model. I think insurance companies. I think some current training practices.... I think there are many, many barriers. I think the individualism in our society is a barrier to it.*

Another barrier that several participants described was their uncertainty about how and to what extent they have incorporated social justice into their clinical practices.

*I think [social justice is] what drew me in. And now, I don't know. I don't know if I do much of it.*

*I don't know how far along I will ever get. I don't know if I will be out there in the trenches, out in the community... I don't know. I think, maybe I do that now. I don't know. Something to think about.*

### **Social Work Perspective**

Four of the six participants commented on the differences between their perspectives as social workers and the perspectives of clinicians with other licensures.

Three of these participants are the only social workers in their settings. They spoke about being the lone voice for social justice in their practice settings. One described this experience in the following quote:

*I'm the only social worker in my office. It's all psychologists, marriage and family therapists, and I'm the one who's always raising issues of social justice or race in our consult group. ... I probably push it more there than with clients because these are professionals, so I want them to get to their edge.*

They also discussed the important role that their training as social workers has in informing their perspective on social justice.

*I don't know if any of my psychology colleagues would sit down with the person at the computer and help them do the data entry to accomplish [a social security] application. They would not regard that as a therapeutic goal. And there have been occasions when I've used sessions with clients with more of that case management capacity because this is fundamental to their ability to survive, for basic necessities of food, clothing and shelter. They have to have income, and I don't think... it's ethically correct to work with them on resolving trauma when they haven't got their basic needs met today.*

*Our training is a little bit different. Our orientation is a little bit different, not in the clinical sense but in the more of what are our core values. ... That's always a tough thing for me as a narrative therapist to be in clinical consultation with a myriad of other backgrounds and... not know if there is that same shared value. Some clinicians are just there to do the diagnosis and fix this person, replace that part in the engine so it starts working again... for me that's like social control versus equity, freedom, social justice. ... I think that's really important. I think that to a large extent I don't think I'd be a clinician if there wasn't a social work profession. I wouldn't do this work. So I'd do some other kind of work. I don't know, but I don't think I'd be a psychologist or a marriage and family therapist or a psychiatrist.*

## Narrative Practice and Individual Transformation

**Narrative Practices.** Those with formal training in narrative therapy pointed to externalizing the problem as the most significant contributor to individual change for those who have consulted with them. The following quotes are from two of the four participants who shared examples of the impact this can have, particularly with clients who harbor shame.

*Definitely externalizing. I mean that's the number one thing I would say. ... huge, huge, huge. So that would be the biggest piece.... I have a client who was in prison for a number of years for an accessory, or whatever they call it, to murder. Shame is huge for her. Externalizing shame and then being able to explore what shame looks like and the impact of shame has gone some way to being able to step back a bit from it and have a little bit of something left in her identity that's not just shameful.*

*It helps them to get out of the shame. That it's not who they are. This is something that's come into their lives. And it gives them a little bit more power and so they're not at the whim of this addiction. That they can engage it.*

In addition to externalizing the problem, participants noted several other narrative practices as contributors to individual transformation including: a non-blaming, decentered, non-expert stance; curiosity; a strengths-based approach; asking good questions; and having clients tell their story. One participant shared how these approaches look in practice:

*I don't have to wrestle with people about their problems. Just the assumption that they have values and interests and abilities that they can put to work against it and that they already are. ... Questions about the times when the problem isn't present and then hearing what people say and then watching them be surprised by themselves, "Oh, it's not present when I'm driving" or "It's not present when I'm at work," that is fun to see. I guess it's just so alive it's like it takes all the pressure off. Like it's not my job to solve their problems. I'm meeting with them and if I ask really good questions, we're going to figure out some cool stuff.*

**Individual Outcomes.** Most participants suggested that narrative practices contributed to their clients' sense of empowerment. One participant pointed out that

clients no longer felt defective or alone. Another participant discussed a client's feelings of being deeply respected in a narrative research process known as consulting those who consult with you.

*There's a person I've worked with for many years, and at one point five or so years ago, I had asked her if she wanted to write a paper together about our work, and it very much came out of a narrative process and kind of consulting, a consulting the person who's consulting you about your work together. ... It's almost like she and I were sitting on the same side of the table externalizing the last ten years of our work together and talking from our different places of what this meant, and then we wrote a paper together that was published. ... I think [it] really contributed to an experience of being deeply respected which it was true; she's been one of my great teachers in the last fifteen years.*

Four participants also indicated that narrative practices opened up possibilities for clients that would not otherwise have been present. Their examples illustrate how these openings create more opportunities for clients to experience personal agency and move beyond accepting social norms and expectations into a place of making decisions for themselves.

*Especially when I worked with teenagers, I think that it was really helpful for them just to figure out that they aren't the problem. They aren't defective. If your narrative is, "I'm defective and there's something wrong with me, and I'm bad," you can't do a lot with that. Where do you go from there? But if you help them to see, you've got a learning disorder that makes it hard for you to learn the same as everyone else in your classroom, now there's somewhere to go. Now we can move. We can have choices and get help.*

*I would also say the personal agency piece which for me is connected. Like if this therapy session is not about me knowing and telling you what to do, then how do you... get more in the driver's seat, and do you want to, or who do you want in the driver's seat, or what does that even mean to you? I mean it just opens up lots of possibilities.*

*So I think that a specific example would be this young man that came with a label or a story of having bipolar and him being able to decide that he wanted to break pieces of that apart and try and work on keeping some very important pieces... like his artwork and his creativity, while saying no and taking a stand against some of the more negative aspects of that label. I think that was very powerful for him. It allowed him to pursue a dream that he felt had been shut off to him.*

*When in doubt I just pull out a narrative question, and it just opens things up.*

### **Narrative Practice and Societal Transformation**

Most participants expressed some difficulty in identifying examples of the effects of narrative practice on social change beyond the people who have consulted with them. The narrative practices that were identified as creating larger social change included having clients share their stories and connect with others, enabling contribution, outsider witnessing, and narrative community work. While participants named narrative practices which could contribute to social change, only one gave a concrete example of using one in her practice. The participant who shared about her consulting of a person who consulted her returned to the example again as an illustration of affecting social change beyond the individual.

*When I approached her about the idea... she said, "I am not interested in reviewing the work of the last ten years. I know what we've done. I don't need to do that for therapy's sake; however, if there is a way that the work of the last ten years can be beneficial to other people healing from trauma, I would love to participate." So that was really the motivation for that, and it led to this series of conversations where she did not pay me. We sat in different places in the room. It was not a therapy process, but it ended up having therapeutic benefits... So within ... narrative community work a huge part of that is how to enable contribution, how to help people contribute to a bigger sense of self, so that was very much what that whole project was about. And she named it. And then we went there.*

Other participants could name some narrative techniques that may contribute to social change, but they had not used them to a large extent in their own practices. The following is a quote from a participant who identified one of these narrative practices but had not used it yet:

*I think it brings a lot of meaning and strength to alternative stories to preferred stories to share them and have them connect to other people. So I think that has a huge amount of potential. Just even my experience of being trained and hearing other people use that practice. I think it can make huge social change on a larger*

*community scale. I don't know that my direct practice has yet- I could put my finger on here is how something has changed.*

Likewise, the following participant seemed to know of a narrative practice that could contribute to social change, but was unfamiliar with its use:

*Especially at the end... that last part of the process with narrative therapy... that witnessing part, maybe?*

Participants identified several examples of clients affecting a larger social change which were not a direct result of narrative therapy. Two participants emphasized that simply building trust with clients and helping them to find a secure base could shift their perspectives in a way that could enable social change. Other participants identified examples of clients' stories being shared for the purpose of advocacy but stated this practice did not arise directly out of a narrative work. One participant shared the story of a client who had advocated for policy changes related to her situation before seeking therapy. Another described the story of a client who took mindfulness practices from therapy and incorporated them into her work life.

*This individual has gone and integrated [mindfulness] into their classrooms and teaching kids about mindfulness... So it individually helps them manage their workday but it helps the kids learn new ways of changing... it's passing it down in that way.*

Four participants professed a belief in a "ripple effect," that individual change impacts other people in their lives, the systems they are connected to, and future generations. One participant described this ripple effect in the following quote:

*When I was doing my internship they were incorporating components of narrative therapy in with the batterer intervention, and [in that program] externalizing the problem helped a lot again with the shame and helped the men be able to own their behaviors without having to own a label with it. And I think, I don't know specifically, but when men responded to treatment and when men learned another dimension of communicating in interpersonal relationship that was beyond "I win, you lose" and more "here's what I think; what do you think," in that equitable exchange it makes a difference for them with their partners. It makes a*



*difference for them as parents to their children, and it makes a difference to the next generations down the line.*

Others brought up the same concept but in a way that showed they also had some doubt about its truth.

*If people are feeling better individually they can be more effective in their communities and in their environment. I guess there's a trickle-down effect of that. I guess that would be [laugh] that'd be a really positive way— [laugh] positive spin [laugh].*

*Gosh I don't know. I'd like to think that when we ask these questions they can have a kind of ripple effect or a larger context, but... there's also a lot of forces that are really reifying other models... It's not having sort of a momentum that I wish it was.*

Though few of the participants could share concrete examples of times when narrative practice contributed to societal transformation in their practice, one participant shared her belief that this was possible through narrative therapy if a therapist should want to pursue it.

*I can see where it could. Like if narrative therapy really fit your style as a therapist, I think you really could take it there.*

While two of the participants with the most training in narrative therapy expressed a strong desire to incorporate social action into their clinical practices, their uncertainty about how to incorporate it seemed to be a barrier to following through on these aspirations.

*That one's more difficult. I'd like to say that yes. I'd like to say down the road as I continue to practice more and more, I'd like to develop things like having people share their stories with other people that go beyond just their immediate system, their immediate community. ... It is something that I would be very interested in doing.*

*I have so much respect for that and also not really knowing how to bring that more into my work is what I would say. Definitely an aspiration to do so. I would love to do so, especially in this role that I have as clinical director which is like, wow, what a role to do that, and yet I kind of draw a blank at that actually. I'm not sure how to do that. And I don't know if that's lack of creativity, it's certainly*

*not a lack of values around it or wanting to do it. I'm not sure, but I'm often thinking about that, like how- what would this look like?*

### **Strengths of Narrative Practice in Bringing about Social Justice**

Participants were able to identify many strengths of narrative practice to bringing about social justice. Three participants cited empowerment as a strength, both that it is anti-oppressive in nature and that the practices have an empowering effect on clients, as evidenced in the following quotes.

*Allowing people to have the space to tell their own story and not place a lot of judgment or my expert knowledge or oppress people.*

*There's such power I think in just helping people to realize that they can write the story of their life in their own pen rather than having other people write that story for them. It's very empowering. And it's a real huge realization for a lot of people that it's even possible.*

For one participant empowerment was tied in with another theme of connecting with others.

*I think that it does empower people. If the problem is outside of you, then it probably would feel really empowering just to step up and make some change in the world. You know, ok I'm better, but maybe I'm gonna step up and help others make that change. Even just in the local level like in the community and making places safer or whatever it is, whatever the issue is.*

The three participants with the most training in narrative therapy cited the decentered, non-expert stance of the practitioner as a major strength of the practice. The following are quotes from two of them:

*As a narrative therapist, it's my job to constantly be asking myself and observing myself about how centered I am, how much am I taking the position of being in charge or in control or the expert, exerting social control. And I think that is huge. I think that's one of the biggest strengths in it.*

*The positioning for sure. And that's a big one in that to me. It's almost an ethical consideration. Narrative approach is part of my ethical approach in terms of how I position myself.*

For the third, the non-expert stance was tied in with another theme of connecting with others to enable contribution.

*I think the narrative principles that again point to that would be things like enabling contribution, would be externalizing, would be non-pathologizing, would be a non-expert stance of the therapist, would be really being curious and care, valuing the other person's experience over mine.*

While several participants mentioned how powerful creating and telling one's story can be for the individual, one participant described the telling of stories as a strength in terms of the impact an individual story can have on others.

*To create that social justice piece of it globally, hopefully, is that narrative in and of itself, whether it's therapy or techniques or how you tell your own story as a person. People attend to the individual story. ... People grab on to those individual stories and that spurs them towards a greater cause.*

While she had the least training in narrative therapy, she was the only participant to point to social justice on a global scale.

The participant in the following quote emphasizes externalizing as well as the formulation of questions, particularly transport and deconstruction questions, in narrative therapy as strengths of the practice to bring about social justice.

*I like to ask a transport question at the end of any gathering. So kind of sharing: what sticks out? What's one thing you're taking away? What would this look like? ... What from this conversation might you either see in your life or bring forth in your life? Those kinds of questions. ... I think the simple concept of externalizing the problem again. But also those deconstruction questions of understanding.*

She goes on to describe the philosophical basis of personal failure questions and why they are also a strength of narrative therapy.

*It's based on Foucault's work about this idea that... we're being watched and measured and that we don't actually know what we're being measured against as opposed to traditional power structures where, if you spoke out against the king, you got thrown in the dungeon. That was it. Now it's like there's no soldiers in the corner, but there's this feeling of not measuring up, of not being enough. That concept of personal failure. ... In modern power it's like we're all being measured against something so ... there's this layer of defensiveness kind of all*

*the time that we have to prove that we're not failing, right? And in the personal failure questions, one of the questions is questions about how you're feeling and blah blah blah, and then the question is failing in relation to what? ... I love watching that. Like, "I don't know, I'm just- but I am!" And it's like, "No, no, no, in relation to what?" And when they start to realize it's a paper tiger, like there's not actually someone judging them. That's not actually happening. That's a powerful sort of thing.*

This participant felt that the value in narrative questions is that they are both subversive and responsive.

*So it's like you have to sort of wait for the openings, and I guess that's one of the pieces of narrative is it's responsive.*

The three people with the most training in narrative practice suggested that one of its strengths is in using it as an ethical approach. It is something they try to follow both in a clinical setting and with how they interact with people in their personal lives. They thought of it not only as a practice but also as a paradigm through which to view the world and a socially just way of being in the world. One participant shared this view:

*I think of narrative as both a paradigm and a set of values and then a toolbox and set of practices. So in terms of the paradigm and the set of values and the underlying principles, assumptions of narrative, I would say ... I always use narrative. I use it in my parenting. ... I use it in my entire life.*

### **Challenges of Narrative Practice in Bringing about Social Justice**

**Accessibility.** The most common theme that participants cited as a challenge to narrative therapy in bringing about social justice is that it is not mainstream in a way that makes it accessible to practitioners. Within this theme participants' comments fell into two categories: structural barriers to mainstreaming narrative practice and individual barriers to practicing narrative therapy. First, in terms of structural barriers, two participants emphasized that narrative practice is outside of the mainstream because it goes against the grain of what is expected in clinical practice, as described in this quote:

*I think our systems are set up to make experts... it sort of works against the system a little bit, so... it's like an outsider. That's how I see it.*

Furthermore, one suggested that narrative practice lacks power and funding because it is less concerned with obtaining empirical validation through methods which generalize people's experiences.

*I think it's just the larger structural system of what gets funding, what gets power, what gets validation. Individualized stories ... that are only put in an "n" of one have a lot less power in our society than an "n" of 10,000. You know in research. And research gets money. Evidence-based practice gets money. Evidence-based practice gets endorsed by individuals that historically have power. And I think that's a big struggle. ... My experience with evidence-based practices are the manualization of things. And I don't think that's necessarily the worst thing in the world that "Oh, this practice works really well for 70%! We worked with 5,000 people and 70% of them did a whole lot better after we did this!" But my question is always, "What about that 30%?"*

The loss of Michael White, one of the founders and an influential leader in narrative therapy, was also cited as a barrier to mainstreaming narrative ideas. In the following quote, a participant discussed the loss of Michael White as an ambassador in attracting new clinicians to the approach.

*I like who people are when they do narrative stuff, and Michael was such a great ambassador of that that when you saw him speak or teach a common thing expressed, that I certainly feel, is "I want to be like that. I want to have that effect. I want to not be squishing people. I don't want to accidentally shut people down or make them feel judged or whatever," and he just did that. ... I think the lack of his presence is problematic for narrative. Absolutely. He should have lived twenty more years, thirty more years and been just modeling it. ... I would have liked him not to have died. I'll say that. I think that was a big blow.*

She also described the general lack of interest and therapist buy-in to practicing narrative therapy.

*When you give a class on narrative therapy, only people who are already interested will go. No one else wants to go. So yikes. So it has to be not the headline. It has to be worked in there.*

Secondly, participants cited individual barriers to practicing narrative therapy, which may prevent the field from growing. Two of the participants with extensive training described how difficult narrative therapy is to learn and to practice.

*It's so hard to learn. It takes so long. ... It took me five or six years to really feel like I got it.*

*That the therapist is influential but decentered, and that is hard to do, and that is so hard to do. ... Oh my gosh, that is so hard to do.*

One participant also explained how difficult it is to succinctly articulate what narrative practice is.

*When I was really studying narrative, and it was a bit newer to me ... I'd be at a dinner party and people would say, "So what's narrative therapy?" And I'd go like, "Uhhhhh." ... because it's this thing of how do you articulate something that feels so important to you and so right and almost kind of just, well of course it's this way, right?*

Another participant discussed how narrative therapists can come off as too critical of other approaches.

*That's a thing I keep hearing that narrative therapists don't support other therapy. I've heard that repeatedly. ... I think there's some truth to that. But that's true of any new therapy: people get all evangelical at first... but there is this sort of narrative, like we're deconstructing traditional therapy. ... lots of new narrative therapists are sort of, "This is the right way." And that's just human nature, so it's not built into narrative per se, but I do see that. And then they go out and yell at people for doing non-narrative ideas.*

**Barriers with Clients.** The strengths of narrative practice also present some barriers with clients. For example, one participant explained how narrative therapy is challenged by clients' traditional expectations of therapy and their cultural tendencies toward blame and praise.

*Once people come in the door, their ideas about the scope of what we're gonna treat. Sometimes even inviting those [social justice] questions, they don't want to go there. They've never thought about it before. ... I think people's expectations about what's the point of therapy. What even is it? I think that can be a limiting*

*factor. ... I think some people have ideas about what therapy's going to be based on TV shows.*

*The idea that you're not going to be the expert. I mean even my clients fight me on that. They call me doc. ... "Well you're the expert. Tell us! Fix us!" You know? [laugh] Or stuff like, "Oh you helped us," or "You saved our life," or "You did this." And I'm like, "No, we had these great conversations, and then you did that." But there's just this wanting to. This is how we praise people, right? We tell them they're responsible or ... we blame them when it's bad, and we try to give them credit, so it's a... larger cultural thing.*

Another participant shared that narrative concepts like externalizing are sometimes difficult for her clients to grasp.

*Sometimes people have a real difficulty separating problems from individuals or from classes of individuals. You know our brains are kind of biologically wired to categorize. And just that moving differently, seeing the problem different from the person can be a real challenge sometimes.*

Lastly, a participant commented on the challenges of using narrative approaches when clients are in immediate crisis or are emotionally flooded.

*For the most part I think if you're talking about somebody really impoverished it is really hard to get out of the moment of the crisis. Just trying to keep someone regulated and calm is sometimes just it. That's all they can do.*

**Invisibility.** In addition, clients are often unaware of narrative approaches that are being used and how they may be helping. One participant explained how this invisibility contributes to a lack of acknowledgement of the therapist's efforts and described it as a challenge for growing the field of narrative practice.

*I think Michael [White] said this— the joke is if you're doing narrative therapy well your clients don't think you did anything. And that's real. That is real. The most effective conversations I've had, they are like, "You didn't even do anything." I'm like, "Yay!" But there's a little part of me that's like, "Ugh." So they're not even going to go and spread this. And clients don't care what kind of therapy you're doing. ... I mean when it's technique-based, like EMDR, they know what that is, but otherwise, it's invisible to them. So they're not even talking about it. They're not even talking about it! ... I've written narrative letters, and they're like, "Oh yeah, my therapist wrote me a letter. It was all my words." Like that somehow erases. ... It takes a certain level of humility to not be in the*

*center, which I think is great. I like being humbled in that way, but not everyone wants that.*

**Stand-Alone Effectiveness.** Two of the participants who primarily serve clients with a history of trauma, one with more extensive training in narrative and one with less, both described the need for integrating other approaches to address trauma. One stated:

*It can be used with trauma, but ... it's not quite enough, I think.*

**User limitations.** One participant with extensive training in narrative practice felt that the limitations on bringing about social justice were not so much with narrative therapy but with the extent to which clinicians are able to put the ideas into practice.

*I don't feel like it's a limitation on the idea and the values and the practices, it's more on our experience with it or ... what we're bringing to it that might limit that.*

**General Challenges.** Some of ideas that participants offered as challenges to bringing about social justice with narrative practice were consistent with those already discussed as challenges to incorporating social justice into clinical work regardless of the model that is used. Two participants wondered if the barriers were more inherent in clinical practice than they were specific to narrative therapy. One shared this thought:

*I don't know if it's any different than others. I think [narrative therapy is] more conducive [to social justice] probably than any other approach.*

### **Understanding Themes and Subthemes**

Interviews primarily focused on how participants integrate social justice into clinical social work and the extent to which narrative therapy aided in their efforts.

*Figure 3* depicts the themes and subthemes, described above, which arose out of interviews with participants. It shows the factors that participants identified as influences on social justice practices, what they viewed as the outcomes of those practices and



themes related to the strengths and challenges of using narrative therapy to bring about social justice.

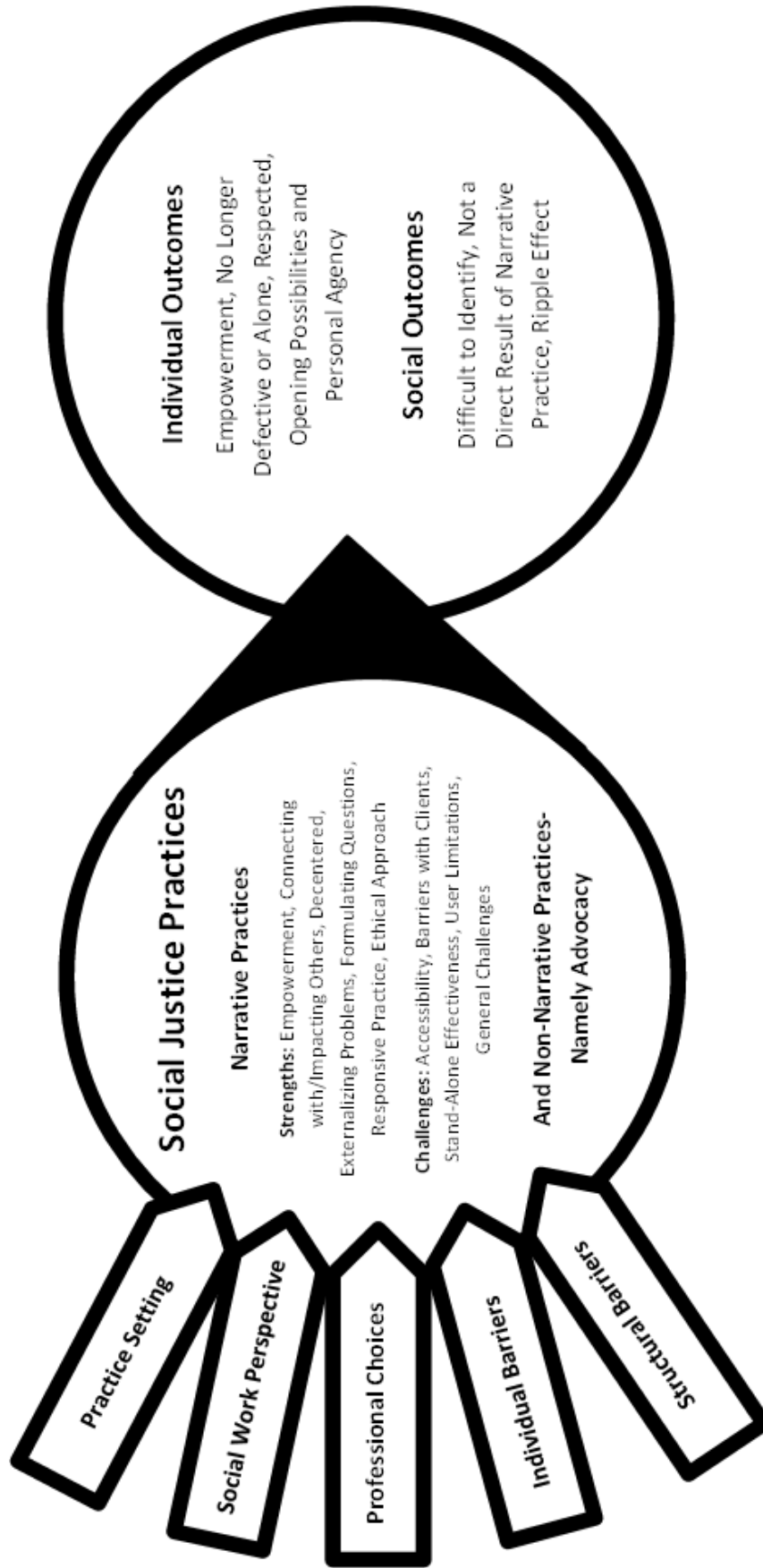


Figure 3. Influences on and outcomes of social justice practice. This figure depicts the themes and subthemes of the study, particularly the influences on and the outcomes of social justice practices identified by clinical social workers who utilize narrative therapy.

## **Discussion**

The present study focused on understanding the use of narrative therapy as it is currently practiced by licensed clinical social workers. Participants shared their operational definitions of social justice and gave examples of how they believe social justice is present in their work. Additionally, they provided information about the extent to which they employ narrative therapy, shared examples of the impacts this practice has had both on clients and larger systems, and described the strengths and challenges they see in the practice of narrative therapy to bring about social justice. The following discussion examines the relationship of the findings to the literature and discusses the implications for social work research, policy and practice.

### **Definitions**

In past research, social work participants expressed hesitancy to speak about social justice at all because they believed they did not have enough knowledge on the topic (McLaughlin, 2011). However, that did not hold true for this group of narrative practitioners. When asked to give their definitions of social justice, several participants expressed difficulty in immediately articulating a definition. Though, after some thought, each came up with a definition, and all participants seemed comfortable discussing the topic.

The definitions of social justice used by participants in this study focused heavily on equity, which closely aligned with the definition developed by Finn and Jacobson (2013) of equality in both opportunities and in obligations. Several participants also cited the value of social justice as being infused throughout their personal and professional lives. This operational definition seems consistent with the conception of social justice as

a personal virtue (Adams, 2013; Plitt Donaldson & Milgram Mayer, 2014). Furthermore, several participants identified social justice as the key element that makes social workers' perspectives distinct from other professionals' perspectives in the field of clinical mental health services. This is consistent with the literature on social justice as the core value of the social work profession (Finn & Jacobson, 2013; Marsh, 2005; Pelton, 2001; Plitt Donaldson & Milgram Myer, 2014; Swenson, 1998).

### **Narrative as a Paradigm, Narrative as a Practice**

The most noticeable differences among participants were the amount of training they had in narrative therapy and how integrated narrative practices were in their clinical work. One participant aptly described narrative as “both a paradigm and a set of values and then a toolbox and set of practices.” The three participants with the least training relied only on components of narrative in their clinical work and tended to view narrative therapy as a set of practices. In contrast, the three with the most training in narrative therapy relied on narrative as a conceptual or ethical framework or set of values underlying all of their clinical work, extending even into their personal lives. These participants with more experience and a broader conception of narrative therapy were also more likely to describe narrative as being a central component of social justice in their clinical work.

None of the participants interviewed incorporated all of the ideas of narrative philosophy into practice regardless of the extent of their training. For example, one of the primary tenants of narrative practice as cited in the literature was not seeing clients as “clients” but as people who are seeking consultation about a problem (Combs & Freedman, 2012). While the three participants with the most training professed an effort

to decenter their practice in this way, all of the participants used the term “clients” throughout the interviews for ease of reference.

These findings suggest that further training provides a deeper awareness of the paradigmatic shift called for in narrative practice. However, a commitment to one element or component of the practice does not necessarily indicate a commitment to all others. The findings raise questions about the effectiveness of narrative therapy when used as components of a whole without more extensive training in or awareness of the conceptual foundations of narrative philosophy. Must practitioners have an in-depth understanding of the model’s philosophy in order to use it in a way that integrates social justice into clinical practice, or can the practices stand on their own in contributing to the larger goal of social justice? To what extent must practitioners understand narrative therapy as a paradigm and use the tools in order for them to be fruitful in bringing about social justice?

### **Focus on the Individual**

Theoretically narrative therapy is aligned with the feminist social justice conceptual framework laid out in this study. The intent of the study was to determine whether this alignment extended into practice. Overall, participants described their practices as focusing largely on empowering individual clients. They tended to either view social justice as a “ripple effect” or “byproduct” of that individual work. One participant suggested that social justice is part and parcel of her work with individuals. The findings suggest that the narrative components most commonly used by participants effectively incorporated three of the five identified social justice practices (See *Figure 1*) including recognizing individual diversity within groups, breaking down dichotomies,

and fostering collaboration. However, narrative therapy in the participants' clinical practices did not necessarily entail addressing privilege, power and oppression, nor did it seem to rise to the level of stimulating social and political action or affecting societal transformation in concrete ways.

**Addressing Power, Privilege and Oppression.** Addressing power, privilege and oppression in the clinical setting, a key component of social justice practice, was raised in several of the six participants' interviews. Two of the participants with more extensive training in narrative practice discussed narrative therapy as creating openings for talking with clients about the impact of these factors on their clients' experiences, particularly in relation to race, gender, and sexual orientation, in a way that other therapeutic models do not offer. In fact, one stated that without using narrative questions to invite these conversations into therapy, they would simply go unaddressed. Others were not as explicit in making space for these conversations despite using narrative practices.

The findings raise questions about the extent to which narrative practitioners incorporate this element of social justice into practice. One of the participants suggested that clinicians need to become comfortable with these conversations themselves and do their own self-reflection in regards to privilege and oppression. This practice on the part of clinicians would allow them to acknowledge such conversations as critical to clinical work and to feel comfortable and competent addressing such issues with clients. The findings indicate that this is not common even for those with some training in narrative practice.

**Including Social and Political Action.** While the literature on narrative therapy and the philosophy underpinning it emphasize collective social and political action as a

necessary component for deconstructing dominant discourses and validating preferred stories, only one of the participants in the study could provide a concrete example of using these methods in her practice. The example she shared was a process of co-research or consulting the person who had been consulting her which resulted in sharing their story through publication. Other participants identified social or political actions that were not the result of narrative work. While participants identified narrative practices that could potentially contribute to social change, they stated that they did not employ them in their clinical work. These findings suggest that social and political action is not seen to be a critical component of narrative therapy for those who practice it. Furthermore, social and political action may arise from other factors, perhaps more so than narrative practice itself.

**Desire and Uncertainty.** Two of the participants with more extensive training in narrative therapy expressed their aspirations to incorporate broader community work and social action into their clinical practices. These same two participants saw social justice as part of their work with individual clients but also sought to bring their work with individuals more into the community and stretch the boundaries of the therapy room. However, despite their training and desire, both expressed uncertainty in how to proceed. This finding suggests that incorporating social and political action into clinical social work requires more than training in narrative therapy and a commitment to its practices; it may require breaking down additional barriers to these practices.

**Barriers.** Participants raised concerns about several barriers to incorporating social justice into clinical work that were also identified in the literature. The largest contributing factor seemed to be one's work setting which had implications for the degree

of reliance on the medical model, the impact of insurance mandates, the inaccessibility of mental health services for some people, and the difficulty of practicing in a decentered, narrative way. As one participant suggested, power, structure and funding in the workplace all contributed to one's ability to incorporate social justice into clinical practice. Participants expressed concerns that narrative practice is inconsistent with such contexts which, for many reasons, make it difficult for the practice to flourish, especially if social workers are not well trained in navigating these oppressive work settings as Pelton (2001) suggested. Still, several participants indicated that they have found ways to work both within this system and around it in order to empower and serve clients in socially just ways.

Another barrier to social justice addressed by several participants was the impact of professional choices, namely decisions to leave nonprofit work for private practice. Several described guilt, particularly over decisions to leave their early work with more vulnerable populations to work with more affluent populations, partly motivated by their desire to balance their personal and professional lives. Many made decisions based on their own or their families' priorities and financial stability. Furthermore, some were more interested in individual work and followed their passion in a direction that led them to professional development on individual work and away from addressing issues of social justice. One participant felt that the transition to private practice actually gave her more time to pursue social justice work outside of clinical practice. She shared that having that freedom empowered her in the same way that she hoped to empower her clients. While the participants each had a clear sense of purpose, they also grappled with how to navigate tensions around their own interests and the interests of social justice.



**Social Justice Outcomes.** In summary, the findings suggest that narrative therapy as it is currently practiced by clinical social workers is in some ways consistent with practice methods identified to be socially just. While this contributed to individual outcomes of therapy consistent with social justice, it did not extend to societal outcomes. Participants could not identify concrete ways that their practice of narrative therapy impacted the social and political context to build a more just society. If using the definition laid out by Iris Marion Young (1990, p. 91), narrative therapy serves some democratic functions in creating one's preferred story as opposed to the dominant discourse on one's life. However, as it is currently practiced, it is hard to link narrative therapy to tangible effects on the distribution of resources. In other words, narrative therapy as practiced by participants in this study may be a socially just means to the end goal of social justice, but does not, in ways that are tangibly known, result in societal transformation.

Furthermore, as Lundy and van Wormer (2007) pointed out, social work is increasingly tasked with addressing global inequalities; yet only one participant, the one with the least amount of training in narrative practice, spoke about the importance of affecting larger global inequality. Findings suggest that much more must be done to deconstruct and merge the micro/macro practice dichotomy to develop narrative therapy into a practice which can affect social and political change on a global scale. Accomplishing such an ambitious vision for the field of narrative therapy perhaps requires a cultural shift within the profession of social work. Those with great influence on the direction of the profession, including social work leaders, scholars, and educators must join with social work clinicians to further these efforts.

### **Strengths and Limitations**

The research design used for this study has both strengths and limitations. Using a qualitative approach brought out the nuanced similarities and differences between practitioners. The exploratory nature of the study provided a starting point from which to understand the strengths and challenges of narrative therapy to bring social justice into clinical work as it is currently being practiced by the licensed clinical social workers who participated. The differences between practitioners in terms of the populations they served, their work settings, and their experience and education in narrative therapy provided a broad perspective on how narrative therapy is practiced. However, the results of such a small number of practitioners are not generalizable to any larger population, particularly given these differences. Furthermore, while the participants had a wide variety of experience in clinical social work, they were not demographically diverse in terms of race and gender, and likely not representative of the larger field of social workers using narrative practice.

Additionally, narrative practitioners have backgrounds in many professional disciplines including psychology, counseling, and marriage and family therapy. This study looked specifically at the use of narrative therapy by licensed clinical social workers. Many cited their education in social work as heavily influencing their perspective on social justice, a perspective they did not feel was shared to the same degree by professionals from other disciplines. It is difficult to determine the extent to which practitioners incorporated social justice into their clinical work due to their training in narrative therapy as compared to their more general social work education since both certainly play a role in influencing their perspectives. The interview results may also

have been affected by a social desirability bias particularly in regards to the pressure a social worker may feel in identifying social justice as present in one's work. Including narrative practitioners from other disciplines in the study may have further elucidated the influence of social work education on the practice of narrative therapy and could have helped to determine whether practitioners from other disciplines feel the same pressure to incorporate social justice into their work.

### **Implications for Future Research**

Despite their intentions, even well-trained narrative therapists expressed uncertainty about to integrate social action into their clinical work. In light of these findings, future research could focus on evaluating narrative training and the degree to which it provides practitioners with the tools to practice not only the initial work with individuals of decentering oneself, externalizing problems, asking deconstruction questions and building preferred stories, but also to incorporate the social action components of second order externalizing, outsider witnessing, sharing preferred stories and connecting with others to challenge socially constructed problems. Quantitative studies of narrative practitioners from all disciplines could investigate which narrative methods are relied on to the greatest extent and focus on the barriers to practicing narrative's social action oriented components.

Those engaged in future research must also seek to understand whether it is possible, even with the use of narrative therapy, for practitioners to share power with those who consult with them given cultural constructions around "professionalism" and "clinical practice." Several participants in the study spoke about the difficulties of pushing against a culture, supported both by professionals as well as clients, which

constructs practitioners as the experts. Given this cultural norm, to what degree is power sharing possible?

Furthermore, with this power differential presumably always at play, how can narrative practitioners encourage social action ethically and without coercion? The field of narrative practice must seek to develop tools for understanding the points in therapy when clients may be ready to bring in action beyond individual wellness in order to mitigate the risk of overwhelming those who are already vulnerable or struggling. In addition, as Almeida (2001) suggested, narrative practitioners must further develop tools for addressing privilege as well as oppression in clinical sessions in order to hold those in society with more power accountable for change. While one participant in this study stated that she addresses privilege with those who choose to discuss it in therapy, this is far from a common practice.

Challenging clients to reflect on issues of power and privilege, particularly in cases where clients may deny their own privilege, poses ethical dilemmas for therapists who wish to remain client-centered. In addition, a tension exists between the social justice practice methods of “addressing power, privilege and oppression” and “understanding individual diversity within groups” because clinicians cannot presume to know who has privilege and power based solely on group identification. Future researchers could explore whether goals around individual accountability for social power and privilege are even consistent with narrative philosophy and practice given its client-centered focus and preference to each client’s own interpretations of their experiences.

### **Implications for Social Work Practice**

Social workers, professionally bound to the interests of social justice, must challenge structural barriers to incorporating social justice into clinical work. This includes understanding the pathologizing effects of the medical model and creating space within such frameworks for both professionals and those who consult with them to see themselves as the experts in their own lives. It requires social workers to deconstruct the growing reliance on “evidence-based practice” and to consider the ways in which this type of research reifies systems of power in society. It also necessitates social action against insurance mandates for clinical practices which do not serve individuals or society and to persuade such systems to value individual and public health over private profits. Social work education must also respond by emphasizing clinicians’ critical self-reflection on privilege and power, both personally and professionally, and provide training for social workers on how to incorporate social justice into their work when practicing within coercive and controlling settings. What is typically seen as macro work must be valued by clinical social workers for creating a future of clinical social work practice consistent with social justice.

Social work as a profession will certainly continue to struggle with integrating social justice into practice, particularly in clinical settings. In this struggle, social workers can look to narrative therapy for opportunities to break down the socially constructed dichotomy of micro and macro practice. Certain barriers must be overcome to reveal the potential of narrative therapy to integrate clinical social work. First, clinical social workers must be trained in and committed to “going against the grain,” pushing to creating openings in limiting practice settings which are based on the medical model even when this means taking personal and professional risks. Secondly, clinical social workers

must develop tools and strategies for incorporating social action into clinical work in ways which remain client-centered. Lastly, social workers must commit themselves to the goal of incorporating social justice into their clinical work, not only in terms of their approach and positioning towards people who consult with them, but also with vigilant attention to the ways in which their work can foster social action to create both individual and societal transformation. Clinical social workers can utilize, but must also build upon, narrative practices to move the profession towards integration.

### **Conclusion**

Social work scholars have generally agreed that social justice is the key organizing value of the profession (Finn & Jacobson, 2013; Marsh, 2005; Pelton, 2001; Plitt Donaldson & Milgram Myer, 2014; Swenson, 1998). However, as more social workers move into clinical practice, researchers have raised questions about the ability of the profession to carry out its mission within the confines of the medical model (Almeida, Hernandez-Wolfe, & Tubbs, 2011; Evans et al., 2005; Reynolds & Hammoud-Beckett, 2012; Rose, 1990; Pelton, 2001; Vodde & Gallant, 2002). Furthermore, while micro practice has proliferated, macro practice has remained underdeveloped (McLaughlin, 2009). To some the dichotomy between micro and macro practice is necessary (McLaughlin, 2002, 2009; Speeth & Courtney, 1994), but to others it is falsely constructed and should be re-examined (Vodde & Gallant, 2002).

Arising out of this latter camp of post-structuralism is narrative therapy, a practice which seeks to empower individuals to author their own stories, to deconstruct dominant discourses, and to join with others to promote social change. As it is currently practiced, narrative therapy employs social justice means for individual transformation. However,

additional developments in the field of narrative therapy are needed to further break down barriers to incorporating social action into clinical work and affect societal transformation on a larger scale. Clinical social workers can engage in this effort in order to further the integration of micro and macro practice.

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**Appendix A**  
**CONSENT FORM**  
**UNIVERSITY OF ST. THOMAS**

**The Personal Is Political: Integrating Clinical Social Work Practice  
through Narrative Therapy**  
IRB Log Number 687474-1

I am conducting a study about the practice of narrative therapy in clinical social work. I invite you to participate in this research. You were selected as a possible participant because you are a Licensed Clinical Social Worker who has been identified as utilizing narrative practices. Please read this form and ask any questions you may have before agreeing to be in the study.

This study is being conducted by Taryn Tessneer, MSW Candidate at the University of St. Thomas/St. Catherine University. The project is chaired by Dr. Lance Peterson, School of Social Work at the University of St. Thomas/St. Catherine University.

**Background Information:**

Previous social science research has indicated that there continues to be a divide in the profession of social work between what is viewed as micro-level or individual practice and what is seen as macro-level or policy practice. Furthermore, some research has shown that clinical social workers have difficulty understanding and integrating the profession's value of social justice into their work. The purpose of this study is to identify the extent to which social justice is integrated into practice for clinical social workers utilizing narrative therapy. This exploratory study will also examine the strengths and challenges of integrating micro and macro social work practice through narrative therapy. Findings will help clinical social workers consider whether and how narrative approaches can be used to integrate social work practice and achieve the profession's goal of social justice.

**Procedures:**

If you agree to be in this study, you will be asked to participate in one in-person, audio-recorded interview with the researcher lasting approximately 45 minutes.

**Risks and Benefits of Being in the Study:**

This study has no risks or benefits for participants.

**Confidentiality:**

The records of this study will be kept confidential. In any sort of report I publish, I will not include information that will make it possible to identify you in any way. The types of records I will create include this consent form, an audio-recording and a transcript of the interview and a master list of participants linking you with your interview records. The signed consent form will be stored in a locked box in the researcher's home. All other records, including the audio-

recording, will be stored on the researcher's password-protected computer until May 31, 2016 at which point all identifying records, including the consent form, will be destroyed.

**Voluntary Nature of the Study:**

Your participation in this study is entirely voluntary. Your decision whether or not to participate will not affect your current or future relations with the University of St. Thomas or St. Catherine University. If you decide to participate, you are free to withdraw within one week of the date of the interview by contacting the researcher or the research chair at the contact information listed below. Should you decide to withdraw within that time frame, data collected about you will not be used. You are also free to skip any questions I may ask.

**Contacts and Questions**

My name is Taryn Tessneer. You may ask any questions you have now. If you have questions later, you may contact me at 612-554-5921 or runc2859@stthomas.edu, or you may contact my research chair, Dr. Lance Peterson, at (651) 962-5811 or pete2703@stthomas.edu. You may also contact the University of St. Thomas Institutional Review Board at 651-962-5341 with any questions or concerns.

**You will be given a copy of this form to keep for your records.**

**Statement of Consent:**

I have read the above information. My questions have been answered to my satisfaction. I consent to participate in the study and agree to be audio-recorded. I am at least 18 years of age.

\_\_\_\_\_  
Signature of Study Participant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Study Participant

\_\_\_\_\_  
Signature of Researcher

\_\_\_\_\_  
Date

## Appendix B

### Interview Questions

1. What is your training in narrative therapy?
2. To what extent does your practice rely on narrative therapy?
  - a. Probe for any additional theories/methods used.
3. NASW identifies social justice as a practice value for the social work profession.  
How do you define social justice?
4. How is social justice present in your clinical work?
  - a. Probe for specific, concrete examples.
  - b. Probe for barriers.
  - c. Probe for other social justice work outside of clinical practice.
5. How has narrative practice contributed to individual change for those who consult with you?
  - a. Probe for specific, concrete examples- practice methods/outcomes.
  - b. If it has not, probe for barriers.
6. In your practice, how has narrative therapy contributed to social change beyond the individuals who consult with you?
  - a. Probe for specific, concrete examples- practice methods/outcomes.
  - b. If it has not, probe for barriers.
7. What do you see as strengths of using narrative therapy to bring about social justice?
8. What do you see as challenges of using narrative therapy to bring about social justice?



- a. Probe for tensions of integrating social justice into practice.
- b. Probe for ideas of what else could be included to further integrate social justice into clinical work.