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COMPELLING PLIGHTS: AN EXPLORATION OF THE USE OF NARRATIVE THERAPY IN SUPPORTING INDIVIDUALS' DEVELOPMENT OF SELF-CONCEPT FOLLOWING ACQUIRED BRAIN INJURY

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Abstract

There is increasing recognition of the emotional and psychological needs of acquired brain injury survivors, and for psychotherapeutic interventions which support such needs, to be integrated in brain injury rehabilitation. This paper focuses on the issue of self-concept following brain injury specifically. Existing literature regarding the impact of acquired brain injury on self-concept is reviewed, with a particular focus on adult populations who have experienced both traumatic and non-traumatic acquired brain injury. Conditions specific to the experience of acquired brain injury which can give rise to changes in individuals' sense of self are identified, and the development of revised self-concepts stimulated by the injury experience is acknowledged also. The practical application of narrative therapy to support ABI survivors' development of self-concept post-injury is presented. Externalising and re-authoring practices, and the use of outsider witnesses are described, and the relevance of such methods of narrative therapy in work with ABI survivors specifically is proposed. This paper concludes that narrative therapy's focus on facilitating people to revise problem-saturated self-narratives and to develop preferred ones, has particular merit in supporting ABI survivors to establish improved understandings of themselves and more positive self-images following brain injury.

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Effective therapy is about engaging people in the re-authoring of the compelling plights of their lives in ways that arouse curiosity about human possibility and in ways that invoke the play of imagination.

– Michael White

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Chapter 1:INTRODUCTION

The World Health Organisation defines acquired brain injury (ABI) as "damage to the brain that occurs after birth and is not hereditary, congenital or degenerative" (ABI Ireland, 2018). ABI can be subcategorised into traumatic ABI and non-traumatic ABI. Traumatic ABI is "an alteration in brain function, or other evidence of brain pathology caused by an external force" (Brain Injury Association of America, 2018), e.g. trauma to the head caused by a road traffic accident. Non-traumatic ABI is caused by an internal force, such as a cerebral vascular accident (stroke) (Brain Injury Association of America, 2018). Acquired Brain Injury can cause impairments in an individual's sensory and motor functioning, their cognition and/or communication. It can also cause behavioural changes, psychological and emotional difficulties (Headway UK, 2018). It is estimated that 13,000 people per year in Ireland experience an acquired brain injury (Acquired Brain Injury Ireland, 2018).

There is an increasing recognition of the emotional and psychological needs of ABI survivors, and correspondingly the need for counselling and psychotherapeutic interventions to be incorporated into brain injury rehabilitation programs (Nochi, 1998). Particularly, the impact of ABI on an individual's sense of self is an emerging issue in academic literature and interventions which target this specifically are becoming a vital element in holistic rehabilitation for ABI survivors (Segal, 2010).

This paper will seek to explore how one particular psychotherapeutic approach, narrative therapy, may be used to support ABI survivors' development of self-concept following injury. Firstly, existing literature examining the impact of acquired brain injury on self-concept will be reviewed, with a specific focus on adult populations who have experienced both traumatic and non-traumatic acquired brain injury. Secondly, the foundations of narrative therapy will be discussed,and its application with adult ABI survivors will also be presented. Finally, limitations of narrative therapy in this context will be acknowledged, as will opportunities for further research.

Chapter 2: THE IMPACT OF ACQUIRED BRAIN INJURY ON INDIVIDUALS' SENSE OF SELF

Changes to the self

There is empirical evidence to support the position that acquired brain injury can significantly affect an individual's sense of self (e.g. Nochi, 1998; Cloutes et al., 2008; Gelech and Dejardins, 2011; Gracey et al., 2008). Historically, there was an emphasis on "personality change" as a result of neurological damage in specific parts of the brain which were linked to personality traits. This painted a bleak picture in terms of the opportunities for therapeutic interventions in this regard (Yeates et al., 2008). However, over time a wider range of hypotheses emerged in relation to psychological and psychosocial processes which could contribute to changes in ABI survivors' self-concepts (Yeates et al., 2008). It seems that the diverse nature of the self means that loss or changes to aspects of the self-concept can be experienced in various forms by ABI survivors (Nochi, 1998). Below, I will discuss some of the key findings among existing literature in relation to the impact of ABI on sense of self. I will summarise these findings into three specific conditions through which changes to the self can be experienced in this context–1) biological factors, 2) comparison drawn with the pre-injury self, 3) attitudes of others.

Biological factors

Whilst there seems to be a greater appreciation now for the psychosocial factors which impact ABI survivors' self-concepts, biological changes in the brain or neurological damage, remains an important contributing factor to changes in survivors' subjective experiences on themselves following brain injury. Yeates et al. (2008) notes that there is research to suggest that damage to neurological structures in the brainstem, basal forebrain, paralimbic and parietal cortices can produce changes in cognition, psychology and perception of emotion which in turn affect individuals' subjective experiences of themselves following injury. Neurological damage also often results in physical deficits which can change how individuals view themselves post-injury (Yeates et al., 2008).

Nochi (1998) conducted a qualitative study,which examined the self-narratives of 10 individuals who had experienced a traumatic brain injury. The author identified loss of self-knowledge as a result of cognitive impairments, including memory difficulties, following

brain injury, a key condition under which participants experienced changes to their individual self-concepts post-injury. Loss of short-term memory, related to the events immediately before and after the injury, affected participants understanding of their selves in the post-injury present, leading to distress and confusion in some cases. Loss of long-term memory resulted in loss of important material in the individuals' stories of their life and how they have come to be the person they are now in the present. A qualitative study by Cloute et al. (2008) also identified ABI related memory deficits a significant factor in changes to post-injury self-concept.

Medved and Brockmeier (2008) and Polkinghorne (1991) emphasise the importance narrative discourse and thought in subjective structuring of the self. Narrative structuring of the self involves the organisation of an individual's previous experiences and proposed events and actions together into a comprehensive unified whole or plot, so that they take on significance and meaning (Polkinghorne, 1991). When this narrative is interrupted or restricted as a result of memory deficits, this can pose a significant challenge to one's sense of self (Medved and Brockmeier, 2008).

Nochi (1998) also highlights difficulties experienced by some participants in his study, related to comprehension of the consequences of cognitive impairments on their day to day functioning, as ABI-related cognitive issues are less visible than physical impairments. This resulted in confusion and lack of confidence for some participants about their various capacities (Nochi, 1998). Medved and Brockmeier (2008) note that changes in cognitive functioning can interfere also in the process of narrative structuring of the self and sense-making in this regard.

Comparison drawn with the pre-injury self

The comparison that ABI survivors draw between the concept they have of themselves in the present post-injury, and that which they had of themselves pre-injury is frequently mentioned in qualitative accounts of survivors among the literature. Yeates et al. (2008) describes this experience for survivors "a subjective discontinuity in their felt embodied or social experience of who they are now, in comparison with who they were" (pg. 567). Morris (2004) suggest that the pre-injury self can become "distorted, alien and unacceptable" (pg. 16) following ABI.

In a quantitative study, conducted by Tyerman and Humphrey (1984) with survivors of severe traumatic brain injuries, results showed that the majority of participants viewed themselves as having changed significantly following injury and by comparison, their pre-injury selves were mostly seen as more favourable. Ellis-Hill and Horn (2000) conducted a similar quantitative study with stroke survivors, and results also showed that the majority of participants held a more negative view of their current post-injury self, than that of their pre-injury self.

Myles (2004) suggests that often ABI survivors report negative self-evaluations, in regards to changes in their physical, cognitive, emotional or social functioning post-injury. Miller (1993) posits that this is most common among survivors who held very positive perceptions of their functioning before their brain injury. These authors' positions appear to be supported by existing qualitative research.

Nochi (1998) found that 80 % of ABI survivor participants in his study drew comparisons between their pre and post-injury levels of function, and they highlighted changes particularly within their social relationships after the injury. In a 2011 qualitative study by Gelech and Desjardins, with 4 individuals with moderate to severe brain injuries, participants drew a similar comparison between pre and post-injury selves. This comparison was attributed to changes experienced in participants' functioning and the corresponding impact this had on practical competencies and dependency levels, patterns of social participation, and social relationships also (Gelech and Desjardins, 2011). Gracey et al., (2008) conducted a qualitative study with 32 individuals with ABI. Results of this study found that perceived or experiences changes in cognitive, physical, sensory and social capacities were significant in how participants viewed themselves post-injury. This led the authors to conclude that subjective experiences and differences in practical and social activity between pre- and post-injury are important in terms of individuals' concept of themselves following ABI.

Nochi (1998) notes that the comparison drawn between the pre- and post-injury self was closely associated with change in how participants in his study viewed their futures also. This author highlights that a loss was experienced by participants, of the future that they thought they had for themselves.

Attitudes of others

Qualitative accounts among the literature allude to self-concepts which have been mediated by other people's attitudes and actions towards ABI survivors after their injury. Among the literature, there is an increasing focus on the impact of social meanings and discourses on post-brain injury self-concepts (Segal, 2010).

Yeates et al. (2008) highlight that neuro-affective and neuropsychological deficits related to ABI can sometimes mean that an individual's presentation following their injury does not align with others' perceptions of who the person was before their injury. Changes to social behaviours, difficulties with social judgements or decision-making that can sometimes occur following brain injury, can alter the views, attitudes and responses of people within the ABI survivor's social world, towards him/her.

Nochi (1998)'s study found that participants experienced changes to self-concept post-ABI, as a result of messages or labels given to them by others in society which suggested that they were not the same person as they were before the injury. This author posits that individuals who accept such labels are susceptible to loss of the validity of their own self-concepts, and their sense of having their own unique individuality.

Gelech and Desjardins (2011) similarly found that negative evaluations by others significantly impacted study participants' self-concepts, and the sense that they possessed and valued their own unique self. Participants in this study also talked about the "social identity of a generic marginalized and dependent person" (pg. 5) being thrust upon them by others in society, which was in conflict with how some individuals saw themselves following their injuries. They felt others defined them according to their injury status, dependency levels, differences and incapacities. These authors point to "diagnostic and authoritative discourses" from medical, rehabilitation and legal professionals (Pg. 6) that were experienced by participants, which sent the message that somehow survivors were "drastically altered" (pg. 6) by their brain injury. These discourses were perceived by participants to be threatening to their own inner self-concepts. Participants also reported their family and friends adopting similar discourses, breaking off contact, adjusting behaviours and adopting positions of grief and pity for the survivor. In these ways, those within participants' immediate social networks became part of the "delegitimation process" (Gelech and Dejardins, 2011, pg. 7).

Cloute et al. (2008)'s qualitative study examined the impact of language and interactions with medical services specifically, on self-concept post-injury. Results of the study showed that ABI survivors often find themselves in the "passive role of patient" (pg. 665), dependent on "expert" medical advice and intervention. Discourses within this dominant medical model such as "patient-expert, abnormal-normal, sick-healthy" (Segal, 2010, pg. 306) were found to have a significant impact on how participants viewed themselves following their brain injury. Medical model-referencing limited survivors' own subjective perceptions of their own unique selves (Cloute et al., 2008).

Development of the self

Understanding the circumstances under which people can experience threats or changes to their self-concept following brain injury is important. However, there is also recognition among the literature that for some people pre-existing aspects of the self can be retained after injury. For example, participants in Gelech and Desjardins (2011)'s qualitative study felt that that rather than losing their entire sense of themselves post-injury, aspects of their self-concept or who the individuals are at their core were retained, albeit often under threat by key others who undermined this continuous self-image by diagnostic discourses, as discussed above.

Medved and Brockmeier (2008) found that the narratives of ABI survivors in their study, who experienced severe memory impairments as a result of their brain injuries, revealed that all participants' sense of themselves remained largely intact post-injury. Continued self-concepts were represented by participants' "persisting intentions and readiness to participate in everyday activities" despite adversity (Medved and Brockmeier, 2008).

A study conducted by Nochi (2000) examined qualitative data gathered from 10 individuals who appeared to be coping well with changes in their lives following their brain injuries. Nochi (2000)'s study revealed five particular themes within self-narratives described by participants following their injuries. The theme of "The self better than others" (pg. 1797) involved participants comparing their current selves to images which they felt could be more negative, such as the image of a more severe brain injury. "The grown self" (pg. 1798) was a narrative of the person having developed in a positive sense as a result of their injury experience. "The recovering self" (pg. 1799) involved a belief that the person was on their

way back to the self that pre-existed the brain injury. “The self living in the here and now” (pg. 1799) was a narrative of being confident in the present and finding self-worth without comparisons to others or the pre-injury self. “The protesting self” (pg. 1799) narrative included a perspective that difficulties arise as a result of oppression within the social world around the person and that actions could be taken by the person themselves to change their environment (Nochi, 2000). According to the author, these narrative themes represent successful negotiation of positive self-images post-injury in spite of ABI (eg. the self better than others or the recovering self) or because of ABI (eg. the grown self and the protesting self). The author posits that this negotiation appears to be a revision of the individuals’ self-narratives following their injuries (Nochi, 2000).

Ownsworth and Haslam (2016) describe a process of development of the self post-ABI which includes a balance between maintenance or continuity of aspects of the pre-injury self, and adaptation to change or discontinuity of other aspects. Individuals can achieve self-continuity by reconnecting with their core values, by re-engaging in meaningful activities where possible (e.g. hobbies or employment) or roles (e.g. as a wife or parent). Adaptation to self-discontinuity refers to emotional and psychological adjustment to potentially life-long impairments which may result in some necessary permanent alterations in the individual’s lifestyle. The authors note that this adjustment can sometimes be achieved by the individual developing new life interests, priorities, or goals for their future (Ownsworth and Haslam, 2016).

Qualitative accounts of ABI survivors reveal that the self-concepts of people who experience acquired brain injury are susceptible to significant change as a result of physiological processes related to brain injury, sudden changes to functional capacities and lifestyle, and inter-subjective relations. However, additional empirical evidence discussed identifies that it is also possible for rich conceptualisations of the self to unfold across the injury experience, which enable people to find meaning among chaos, and cope with what has happened to them on a psychological and emotional level. Gelech and Dejardins (2011) consider that the self is an entity which has the capacity to develop and grow in a positive sense. Psychotherapeutic intervention which is concentrated on facilitating positive development of the self following brain injury could be particularly beneficial in helping people with the “coping process” (Nochi, 2000, pg. 1802).

Chapter 3: USING NARRATIVE THERAPY TO SUPPORT INDIVIDUALS DEVELOPMENT OF SELF-CONCEPT POST-ACQUIRED BRAIN INJURY

Understanding formation of self-concept from a social constructionist perspective

The notion of the self has evolved into a complex and fascinating problem for researchers (Baumeister, 1999). It is a multi-faceted topic with varied understandings and perspectives, which have emerged from different academic disciplines (Gelech and Desjardins, 2010). Social constructionism offers one particular perspective on the self and its structure, which may serve to shed some light on how individuals negotiate meaning from a multiplicity of factors, and reorganise their internal self-concepts across the experience of an acquired brain injury, in order to achieve ultimate psychological and emotional resilience and growth.

Social constructionism is a theoretical movement hinged on the fundamental belief that meanings of human experience are derived largely from social and interpersonal influences (Gergen, 1985). It posits that there are multiple ideas of reality and therefore our own individual knowledge and assumptions about the world are always open to challenge and critique (Burr, 2003). Social constructionism emphasises historical and cultural factors in the creation of meaning, and negotiated understandings between human beings through all types of social interaction, but particularly language (Burr, 2003). Meaning-making and its close relationship to linguistic expression is essential within social constructionist theory (Morris, 2004). If knowledge has its origins within the social realm, then language within social relationships is the device that is used to derive meaning (Gergen, 2011).

From a social constructionist perspective, the self is a product of interpersonal relationships and social processes (Gelech and Desjardins, 2011). It is conceptualised within a specific historical and cultural context and structured by language (Gergen, 2011). Crucially, social constructionism emphasises the plural nature of the self. It is not a fixed or static entity, but something which is continually evolving according to an individual's ongoing interactions with the world throughout their life (Gergen, 2011). Morris (2004) describes the self within this paradigm, as a "dynamic, changing aspect of human experience that is not only amenable to change, but depends upon change to exist" (pg. 16).

According to Morris (2004), adopting a social constructionist understanding of the self and its structure within communication and social processes, has significant

implications for the understanding of self-concept following acquired brain injury and how it may be influenced. It creates important hope and opportunity for ABI survivors, who have been "thrust into an accelerated rate of change" (pg. 16), that they can develop or re-establish their own unique sense of themselves according to unlimited possibilities following their injuries. The clinical application of narrative therapy, as one particular psychotherapeutic intervention to support ABI survivors in this process of developing a coherent sense of self following brain injury, has been suggested by a number of theorists (e.g. Nochi, 1998 & 2000; Cloute et. al, 2008; Gelech and Desjardins, 2011).

Introduction to Narrative Therapy

Narrative therapy was developed by Michael White and David Epson in the late 1980s (Combs and Freedman, 2012). It is an approach which is rooted in social constructionism (Morris, 2004) and is heavily influenced by the work of French philosopher, Michel Foucault, regarding power relations within social discourses and their influences on people's identities (Segal, 2010). Narrative therapy takes the position that individuals use stories (which are constructions) to make sense of their experiences, their relationships and their identities.Individuals participate in each other's stories, and shared stories contribute to building communities, culture and subgroups within society. Power and authority dictate which stories will be told and which will not (Combs and Freedman, 2012). Central to narrative therapy is the position that human problems arise and are maintained by oppressive stories that individuals tell themselves, which are out of sync with their actual lived experiences, yet dominate their lives (Carr, 1998).

Narrative therapy seeks to challenge individuals' perceptions that their problems are a reflection of their own identities. It seeks to externalise or objectify problems faced by individuals so that they are no longer seen as representations of the individuals' self-concepts, which in turn increases the visibility and accessibility of successful problem resolution (White, 2007). It assumes that all people, regardless of their circumstances, have resources including skills, abilities, beliefs, values and motivations that they can use to help them to reduce the influence of problems in their lives (Morgan, 2000).

Narrative therapy seeks to assist people in the authoring of preferred self-narratives, which have previously been limited by dominant discourses which maintain problems rather than

help people to deal with their difficulties (Segal, 2010). This process of re-authoring self-narratives changes how people conceptualise themselves, their experiences, their capacities and in turn, supports people to better deal with whatever challenges they face in life (Carr, 2010).

Narrative therapy provides opportunities for such individuals to "redefine their existence based on their preferred view of their individual selves" (Morris, 2004, pg. 17). In the context of working with people who have experienced ABI, the goal of narrative therapy is to help survivors to re-author more empowering self-narratives (Cloute et. al, 2008), to develop or indeed reconnect with more positive self-images post-injury (Nochi, 2000), and to overcome invalidating discourses of others (Gelech and Desjardins, 2011).

Application of narrative therapy with ABI survivors to support development of self-concept

The following are the central tenets in narrative therapy which have particular relevance in work with ABI survivors, to support their development of a preferred or positive self-concept.

Externalising the Problem

As mentioned above, narrative therapy works from the basic assumption that "The person is not the problem. The problem is the problem" (Combs and Freedman, 2012, pg. 1039).When an individual feels that his or her "self" is the problem and therefore cannot be changed, this can lead to a feeling of helplessness (Nochi, 1998). Externalising the identity of the problem from the identity of the individual frees people from "negative certainties" (White, 2007, pg. 26), and a dysfunctional belief that the source of their difficulties are located within themselves (Nochi, 1998). In turn, this separation can mobilise people to take responsibility for actions to address or resolve problems situated outside of themselves (White, 2007). Applying a narrative therapeutic approach in interventions with ABI survivors can facilitate an important separation between the brain injury and its related changes in functioning or capacities or interpersonal relationships, and the core of the individual's self (Morris, 2004).

White (2007) summarises externalizing practices within narrative therapy into four categories of inquiry collectively known as a Statement of Position Map. Inquiry Category 1 is the first

stage of the externalising process within which the therapist supports the person to define their problem(s) based on their own unique understandings and experiences (White, 2007). Working with ABI survivors in this context, the presenting problem may be the brain injury itself or a change in an aspect of functioning as a result of the brain injury.

Inquiry Category 2 focuses on supporting the person to identify the principal consequences of the defined problem (White, 2007). Effects of brain injury on engagement in activities of daily living, work or education life, interpersonal relationships, and one's own values, hopes and aspirations are prevalent in narratives of ABI survivors among the literature (eg. Nochi, 1998; Cloute et al., 2008; Gracey et al., 2008). These are examples of what may be highlighted by the client during this stage of the externalising process.

Inquiry Category 3 involves the therapist supporting the person to evaluate the activities of the problem including its effects on the individual's life, as identified during the previous stage (White, 2007). This process facilitates that person to stop and reflect on the changes that have occurred within their life post-brain injury (White, 2007), including potential changes in how the person views their future (Nochi, 1998). The therapist's questioning facilitates the person to explore how they feel about such changes (White, 2007).

Within Inquiry Category 4, the person is invited by the therapist to explore the reasons why they feel certain ways that they do, about developments in their life as a result of the problem. This can reveal important information about the individual's values, aspirations, their knowledge about life and their life skills (White, 2007).

Combs and Freedman (2012) note that externalising questions can be used to explore how the context of an individual's life, including their environment and their social world, influences the problem. Examples of such questions include: "What feeds the problem?" (pg. 1044) and "What groups would proudly advocate for the problem?" (pg. 1045). This line of questioning could be particularly relevant in work with ABI survivors who experience marginalisation through the discourse of others (Gelech and Desjardins, 2011).

Re-authoring Life Stories

On first presentation, people may present with "thin" stories about their lives, with limited information about their lived experiences (Morgan, 2000). Meanings derived from such stories may not be what people want for themselves in their lives (Combs and Freedman, 2012). Re-authoring is a collaborative process, within which therapist and client become co-

authors of the client's stories about their life, experiences and relationships, their effects and meaning, and the context within which such stories have developed (Morgan, 2000). Through the process of developing, telling and re-telling stories, problem enhancing discourses and power differentials are exposed (Combs and Freedman, 2012). Positive events, experiences, possibilities and directions which were previously neglected in dominant oppressive storylines also begin to emerge. Within narrative therapy, these are referred to as unique outcomes (White, 2007). Examples of unique outcomes include events or experiences that do not fit with the problematic story of the brain injury (Combs and Freedman, 2012). They could be literal exceptions and counter examples to the problem, and messages of what is valued by the individual (Combs and Freedman, 2012). Such messages may be in the form of plans, actions, feelings, desires, dreams, thoughts, beliefs, or commitments featured in the person's narratives throughout the course of the therapy (Morgan, 2000). Combs and Freedman (2012) provide examples of questions which may be useful in identifying unique outcomes: "Is the problem always with you?" (pg. 1045) and "Has there ever been a time…when you were able to resist its [the problem] influence?" (pg. 1045).

When these unique outcomes are uncovered, narrative therapists use questioning which invites people to speak more about these outcomes and their meaning, "by stretching their minds, by exercising their imagination and by recruiting their lived experience" (White, 2007, Pg. 80). This process provides an aperture for spontaneous development of memorable and vivid stories (Combs and Freedman, 2012). Throughout the course of narrative therapy as life stories are re-authored, the original problem stories can be viewed with a new perspective and may become less significant (Combs and Freedman, 2012).

In the context of supporting ABI survivors in the development of their self-concept post-injury, life narratives which have been revised throughout the course of therapy, become the cognitive structures that form the person's coherent sense of self (Polkinhorne,1991). In this way, moving away from problem-saturated narratives (White, 2007) towards preferred self-narratives can facilitate the development of a more positive self-image post-ABI.

The therapeutic relationship

The collaborative nature of the relationship between the therapist and the person within the re-authoring process seeks to counteract the power relations that can often be at play in the therapy room (Combs and Freedman, 2012). In the context of working with ABI survivors, the person who has experienced the ABI, oppression as a result of their brain injury and

pathologising discourses associated with it, is placed in the empowering position of a "privileged author of their own lives" (Combs and Freedman, 2012, pg 1034). The therapist adopts the position of their consultant, ready to assist the person to fight back the challenges that have dominated their lives since the injury (Carr, 1998).Within narrative therapy, the person's language is privileged, rather than the therapist's (Carr, 1998). This could be a refreshing and important experience for ABI survivors, who may have become accustomed to medical-model definitions (Cloute et al., 2008) by others, in relation to their injury and its consequences.

Outsider witnesses and definitional ceremonies

Narrative therapy considers that a person's re-authored preferred self-narratives have more of a chance of becoming integrated within their life into the future if they are witnessed by others (Carr, 1998). Narrative therapy may include definitional ceremonies which offer the person opportunities to tell their new life stories to carefully chosen people called outsider witnesses (White, 2007). The role of outsider witnesses is not to give advice or opinions, but rather to acknowledge the story told by the person. Through specific questioning by the therapist, outsider witnesses are invited to speak about the narrative they have heard from the person, to highlight certain expressions within the story that they were drawn to, images that were evoked and personal experiences resonated from such expressions. After hearing the outsider witnesses' stories about their story, the person is then invited by the therapist to speak about the witnesses' reactions to their story, and the images and personal experiences evoked within them as a result (White, 2007).

Outsider witnesses are chosen collaboratively by the person and the therapist. They may include members of the person's social network (such as family members, friends, carers, work-colleagues) or others who understand the problem faced by the client (Carr, 1998). For ABI survivors, outsider witnesses who have also experienced brain injury may be particularly useful, as they could possess "insider knowledge" (Combs and Freedman, 2012, pg. 1049) and skills that may be shared with the person, to assist the person in facing their own unique challenges into the future (Carr, 1998).

Limitations

It is important to state that narrative therapy may not be a suitable therapeutic approach for all people who have experienced a brain injury. It is one particular intervention that could be effective in helping people to reconnect with their own unique personhood (Gelech and Dejardins,2011), to develop more positive self-images (Nochi, 2000) and ultimately adjust to changes in life following ABI (Block and West, 2013). However, this is not to say that there are not other psychotherapies which may also be useful interventions in this regard. A review of the application of other approaches is beyond the scope of this paper.

It is very important to identify individuals' cognitive and communication limitations (if any) as a result of their brain injury (Block and West, 2013). ABI can result in difficulties with learning, memory, attention, concentration, information processing, executive functioning, as well as expressive and receptive language issues (Block and West, 2013). Cognitive and communication impairments need not preclude people from accessing psychotherapies, including narrative therapy. However, therapists may need to adapt their approaches, in order to meet survivors' individual needs. For example, the therapist may need to encourage a person with memory difficulties to write down what has emerged in a therapy session, so that they can come back to it later to jog their memory of previous work done (Block and West, 2013). In the context of narrative therapy, this would include writing down new self-narratives as they emerge.

Chapter 4: CONCLUSION

The importance of the inclusion of interventions such as psychotherapy in brain injury rehabilitation programmes, to meet the psychological and emotional needs of survivors has been acknowledged among the literature (Segal, 2010). This paper has focused specifically on the issue of self-concept for adult acquired brain injury survivors. A review of the literature, predominantly qualitative studies with ABI survivors, examining the impact of ABI on self-concept has been presented. Particular conditions through which people can experience changes to their self-concepts following ABI have been highlighted. Processes, stimulated by such changes, related to the development of revised self-concepts and growth post-ABI, were also identified.

A social constructionist perspective was employed in order to understand the dynamic nature of the self and its structure within communication and social processes. This went some way towards rationalising the use of psychotherapeutic interventions generally to support individuals in the development of a coherent sense of self and a positive self-image following brain injury.

Narrative therapy was suggested as one particular psychotherapeutic approach that could be used to support adult ABI survivors' development of their self-concept following injury. Particular practices which are unique to narrative therapy, such as externalising the problem, re-authoring narratives and the use of outsider witnesses were outlined, and their relevance in work with ABI survivors specifically was set out. Upon examination of the practical application of such methods with ABI survivors, the use of narrative therapy appears to be particularly advantageous in work with ABI survivors, in terms of its ability to empower survivors to develop improved understandings of themselves, which are not defined solely by their brain injury or based on the oppressive discourses of others. Narrative therapy can assist individuals to connect with who they feel they truly are and to find meaning following the chaos and trauma of acquired brain injury (Morris, 2004).

Areas for Further Research

This research has concluded that narrative therapy may have particular merit in supporting ABI survivors' development of their sense of self following injury, whilst also acknowledging that it is one approach among a range of other psychotherapies that may be

useful in work with ABI survivors. Upon review of the literature, there does not appear to be any existing studies which examine the efficacy of narrative therapy exclusively in this context. As such, a controlled clinical trial of the use of narrative therapy with ABI survivors in supporting self-concept development and growth following brain injury, may be a worthwhile focus of a future research project.

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