2012

Exploring Email Letter Writing To Augment Therapy Relationships with Clients Who Self-Injure

Babette A. Rosabal
Nova Southeastern University, babetteroseabal@gmail.com

Exploring Email Letter Writing To Augment Therapy Relationships With Clients Who Self-Injure

by

Babette M. Rosabal

A Dissertation Proposal Presented to the

Graduate School of Humanities and Social Sciences of Nova Southeastern University

In Partial Fulfillment of the Requirements for the Degree of

Doctor of Philosophy

Nova Southeastern University

2012

Nova Southeastern University

Graduate School of Humanities and Social Sciences

This dissertation was submitted by Babette Marrisa Rosabal, under the direction of the chair of the dissertation committee listed below. It was submitted to the Graduate School of Humanities and Social Sciences and approved in partial fulfillment of the requirements for the degree of Doctor of Philosophy in the Program of Marriage and Family Therapy at Nova Southeastern University.

Approved:

July 12, 2012
Date of Defense

Patricia A. Cole, Ph.D.
Patricia A. Cole, Ph.D.
Chair

Christopher F. Burnett, Psy.D.

John K. Miller, Ph.D.

Aug. 23, 2012
Date of Final Approval

Patricia A. Cole, Ph.D.
Patricia A. Cole, Ph.D.
Chair

Acknowledgments

I would like to express my warmest sincere appreciation for my committee chair, Dr. Patricia Cole, for the guidance, support, and continued encouragement that she offered throughout my dissertation process. As an older student returning to school, this dissertation process often seemed overwhelming and isolating. I feel very fortunate to have had the wonderful opportunity to have such a wonderful committee chair.

I would also like to thank my committee members for their contribution and continuous dedication to my dissertation study. My deepest gratitude is extended to Dr. Chris Burnett for always picking me up when I felt I would fall. Your kind words have helped me to know that I always could reach out to you throughout my education at Nova Southeastern University. Thank you, Dr. John Miller for stepping in to be my third committee member. Your expertise, knowledge, and insight have been enormously valuable.

And finally, there are certain people that I want to convey my deepest love and appreciation to. Thank you to my husband, Russ Rosabal, for always encouraging me to move forward and for your enduring support and inspiration. And, thank you to my two dear children, Shelby Rosabal and Kylie Rosabal for your continued willingness to support your mother and understand and endure when I had so many challenges during this process. Thank you to my mother, Harriet Abrams, for being the guiding light of my life. I am eternally grateful for all of your support and love.

Table of Contents

List of Tables

Abstract

This study seeks to explore, based on a small sample of case studies, the usefulness of collaborative email letter writing (CELW) communication with a self-injuring population when used in conjunction with live therapy sessions. Currently, most email counseling consists of exchanging communications without live clinical intervention (Heinlein, Welfel, Richmond, & Rack, 2003). While self-injury behavior (SIB) is on the rise (Conterio & Lader, 1998; Zila & Kiselica, 2001), there is little evidence that shows that either traditional or systemic postmodern therapies are useful in treating SIB in adolescents or young adults. Alternative forms of communication, such as letter writing (White & Epston, 1990; White, 1995; Freedman & Combs, 1996), may benefit clients who have a difficult time expressing emotions in live therapy sessions, although relatively few clinicians use this intervention with clients (McDanial, 2003; Pyle, 2006; Tubman, Montgomery & Wagner, 2001: White & Murray, 2002). The empirical research exploring the use of CELW as an additional therapeutic technique in already established relationships with clients who self-injure has not been studied. However, several clinicians have found that email communication may provide a safe venue for exploration with clients who are less comfortable with live verbal communication (Adler & Adler, 2008; L'Abate, 2001; McDaniel, 200; White & Murray, 2002). In this qualitative case study, I employ a layered account to explore how CELW can be used with clients who self-injure.

CHAPTER I: INTRODUCTION

In this chapter, I describe the difficult and intractable problem of self-injuring behavior, explores the problem of treating such behavior, details the purpose and significance of the study, and finally, presents the research question.

Statement of the Problem

My interest in collaborative email letter writing (CELW) stems from my desire to find an alternative pathway for therapists and clients to communicate within the context of therapy relationships. Regardless of professional orientation, most clinicians adhere to traditional face-to-face therapy sessions with most of their client population. This study seeks to explore, based on a small sample of case studies, the usefulness of email communication when used in conjunction with live therapy sessions. My interest is in understanding how therapists might add CELW to ongoing therapy relationships to enhance therapeutic communication and trust. The use of CELW will serve to highlight client stories that may have gone unnoticed, promote additional client control, assist clients in thinking about problems in different ways, and provide a concrete, lasting form of exploration in clinical relationships, while offering a new creative way to express difficult emotions.

Several years ago, I began to explore the use of CELW in my clinical practice. Upon reflection, the impetus for asking clients to consider this alternative to their live therapy sessions stemmed from my suspicion that writing might provide a safe alternative avenue for certain populations to express difficult emotions, as well as to tell and revise their stories.

> Through writing we revisit our past and review and revise it. What we thought happened and what we believed happened to us, shifts and changes as we discover deeper and more complex truths. It isn't that we use our writing to deny what we've experienced. Rather, we use it to shift our perspective. (DeSalvo, 1999, p. 11)

With this new understanding, I became curious as to how this technique might be used by therapists to augment live therapy sessions with certain client populations. This knowledge compelled me to explore this technique for my own purposes, and to collaborate with others in my profession who had little knowledge or opportunity to explore its use. During this time, I became aware that little empirical research existed to explore the use of CELW as an auxiliary technique in clinical relationships with clients who self-injure.

Early in my doctoral studies at Nova Southeastern University, I became licensed as a marriage and family therapist and became acquainted with social constructionist, narrative theory, and collaborative strength-based methods of treatment. Practicing as a licensed mental health counselor for 15 years facilitated a solid foundation for understanding traditional methodology. However, today my therapeutic stance has continued to evolve, and I consider myself to be a collaborative, strength-based therapist, informed by social construction and narrative theories. I believe that my client is "the expert" and that the therapist must assume a "not-knowing" stance (Anderson & Goolishian, 1988). I find this stance essential for establishing collaborative strength-based relationships with my clients, where genuine curiosity and respect can be initiated and maintained. These elements include the exploration of multiple truths, respectful

relationships, and the need for collaborative communication where solution-oriented change and liberating narratives can become possible (Anderson & Goolishian, 1988; Freedman & Combs, 1996; Penn & Frankfurt, 1994; Selekman, 2002, 2010; White, 2007; White & Epston, 1990).

Social constructionist, narrative, and collaborative strength-based therapists use the power of language to help clients develop new or alternative stories that can lead to a more preferred narrative or way of being. Emphasis is placed on exploration of social discourses that can restrain, limit, and keep "individuals trapped within a limited vocabulary, behavior codes and constitutive conversations for which the contours of their lives are molded" (Gergen, 2006, p. 18).

In addition, these therapy models place emphasis on the therapist's ability to use the client's verbal expression during therapy sessions. Therapists find it equally important to acknowledge that a change in language can lead to a change in client experiences (Anderson & Goolishian, 1988). Penn and Frankfurt (1994) say that client problems are constructed in relationships, and that therapists use the client's language for therapeutic context.

My quest for knowledge regarding how to use the client's language to practice CELW has resulted in many new opportunities for discovery and exploration. After conducting a comprehensive literature review, I find that very few therapists use CELW to augment live therapy relationships. My review consisted of an exploration of the history of letter writing, therapists writing letters to their clients as a therapeutic technique, and the use of collaborative letter writing between therapist and client. Of the clinicians who do use CELW, few have conducted empirical research to support its use.

Notably, however, L'Abate (2001) is one clinician who finds that collaborative letter writing "widens professional mental health repertoires by offering professionals as well as respondents options and possibilities not otherwise available through traditional professional relationships" (p. 3), and other therapists find that the process of collaborative letter writing enhances the therapeutic alliance, creates autonomy, encourages safe client reflection, and creates extra time to take action to solve problems (France, Cadieux, & Allen, 1995; Walsh, 2006).

Purpose of the Study

The purpose of this study is to explore the use of collaborative email letter writing (CELW) as an additional form of communication in ongoing therapy relationships with certain client populations. In 2007, I began to explore the use of CELW with certain clients in my private practice to augment already established therapy relationships. During this time, a confluence of events prompted this need for experimentation with an auxiliary therapeutic communication technique: First, my practice began to see an increase in the young adults referred to my office presenting with self-injury behavior (SIB); second, as a result of my returning to school to work toward my doctoral degree in marriage and family therapy, I became familiar with a social constructionist, narrative theory and collaborative strength-based methodology. My return to school facilitated the multiplicity of technique perception and the modernization and standard use of computer technology as a vehicle for communication in my clinical practice.

My first collaborative email communication relationship began with an 18-year-old female client, who experienced repetitive, nonsuicidal SIB. During my second session with this client, I introduced the possibility of using CELW as an auxiliary form of

communication to augment our therapy relationship. My suspicion was that she might be more comfortable expressing some of her emotions using this alternative form of communication. It was also my belief that by implementing email letter writing as an additional pathway for communication, I might be able to provide a new creative avenue for her to describe uncomfortable, spontaneous, and unexplored thoughts between and after therapy sessions. In addition, it appeared that my client often had difficulty expressing many of these emotions during our actual therapy sessions. My first email communication consisted of a summary of our session, initiation of a response to questions regarding some of the narratives that we had discussed in her therapy session, and a brief discussion of how we could co-create a type of ongoing email communication that she would find useful. My client responded in a lengthy email the following day that she was delighted and eager to participate in this therapeutic modality. The collaborative exchange that developed over the next few years proved to be an excellent therapeutic technique that enhanced therapeutic understanding and meaning.

Upon entering counseling in my office, this client explained that she had previously been treated for several years by a number of clinicians who lacked understanding, compassion, and respect pertaining to her presenting problem of SIB. These clinicians, as she described the situation, lacked useful strategies for reducing the occurrence of SIB, while at the same time, explaining to her that they understood how to treat the problem of SIB. As a result, my client felt judged, ashamed, and skeptical to return for a follow-up appointment. After several years of exploring this phenomenon, I learned that most professionals still remain uniformed, disenchanted, and profoundly inadequately trained to treat clients who present with SIB (Conterio & Lader, 1998).

With this understanding, it became critical for me to understand how to provide efficacious treatment to this this vulnerable population.

Significance of the Study

This study is significant because it brings understanding from the perspective of both the client and the therapist of how collaborative email letter writing (CELW) can be used with individuals in therapeutic relationships who experience repetitive nonsuicidal SIB. Currently, most email counseling consists of communication exchange without live therapy relationships (Heinlein, Welfel, Richmond, & Rak, 2003). Counseling without live therapeutic interaction has been termed e-therapy, web counseling, cybertherapy, and computer-mediated psychotherapy, and is referred to as ongoing, interactive, text-based, electronic communication that occurs between client and a counselor for mental health improvement (Alleman, 2002). Debate continues as to the effectiveness of this form of counseling. Clinicians have critical questions about quality control, professional compliance, competence, and treatment outcome of email counseling without live therapeutic interaction (Heinlein et al., 2003). Concurrently, some research suggests that communication online is effective when used appropriately (Alleman).

By adding email letter writing to my ongoing therapy relationships with certain clients, I can provide a new venue for therapeutic communication and trust, highlight narratives that may have gone unnoticed during client sessions, and provide an alternative way to think about problems. Furthermore, identifying important information from client letters has become a way for me to promote additional exploration during in-session therapeutic conversations, while offering my client a creative way to express difficult emotions. Letter writing can offer one possibility for the replacement of SIB, and may

encourage more effective personal communication during and outside the therapy session. Finally, although my letter writing exchange places emphasis on key strengths, values, and client resources, it is my contention that therapists must also spend time with discussion, understanding, and reflection of the client problems for the problem to change.

In the formative years of exploring alternative forms of communication, it was not clear to me which clients would develop, appreciate, and actively participate in the art of collaborative expression through CELW. After several years of experimentation, I began to notice that certain clients expressed a strong desire to participate with this alternative venue. In addition, there was a compelling correlation between the clients who had difficulty expressing emotion in live therapy session and the clients who experienced the phenomenon of SIB. Although my interest in this technique began as a standard practice with many of my clients, it soon became obvious that the majority of individuals who would actively participate in CELW were young adults who struggled with SIB. It appeared that this form of communication provided a safe, more comfortable way for these clients to express difficult emotions.

As I began to participate in email letter writing with a series of clients who presented with SIB, I watched myriad changes and I became curious as to how my clients' experiences with CELW may have promoted change. I learned that rigid patterns of client behavior might need alternative therapeutic techniques and that writing email letters for certain clients reduced inhibitions and appeared to lead to effective resolution of problems.

> Writing can be used to discover and fulfill your deepest despair, to accept pain, fear, uncertainty, strife. And too find a place of safety, security, serenity, and joyfulness, as well as to share your gift of your work with others and. so, to enrich and deepen our understanding of the human condition. (DeSalvo, 1999, p.9)

Watzlawick, Weakland, and Fisch (1974) noted that through writing a client becomes active and uses other thinking skills, which can create a new context for the opportunity for change in perception, expectancies, and behavior. Levenkron (1998), Walsh (2006), D'Onofrio (2007), and Selekman (2002, 2010) explain that letter writing may have multiple benefits with individuals who exhibit SIB because these clients tend to be less verbal, have a sense of false self, and use SIB to express emotions.

In my collaborative email letters, I asked questions that are informed by a social constructionist, narrative theory, and collaborative strength-based methodology in an effort to elicit feelings for therapeutic support and caring. At the same time, I invited responses that create room for new discussion during and outside therapy sessions. I followed the suggestion of Freedman and Combs (1996) that therapeutic letters need to be substantive, concise, and concrete, and that each letter writing exchange becomes a nonintrusive pathway to check in on clients during the week, while at the same time, facilitating new ways to encourage client control and the pacing of their own response (Walsh, 2006, D'Onofrio, 2007).

Research Question

My aim was to explore, "How email letter writing may have an effect on the therapeutic experience?" The therapist's perspective was provided from observation and email letter writing; the client's perspective was provided from a selection of examples of

the clients' personal email letter writing exchanges, which occurred during the therapeutic process. A cross-case analysis offered patterns across a small series of cases, and promoted a thick description of the phenomenon being studied (Stake, 1995; Yin, 2003).

Overview of the Chapters

In chapter II, I provide a comprehensive overview of the phenomenon of SIB, frequently used therapy models, as well as a summary of social constructionist, narrative therapy, and collaborative strength-based models that can be utilized to help facilitate therapeutic change. I then reviewed the literature on the use of letter writing in therapy relationships, providing examples of how letter writing has been used in therapy with such clients. I concluded with a brief summary of the use of computer technology and email correspondence in therapy relationships.

In chapter III, I describe the methodology of the study and outline the rationale for the research design that I have selected. An extensive review of the data collection and analysis procedure is presented, with a cross case analysis to find variances, themes and patterns across the cases.

In chapter IV, I first present each individual case study of observational data as a vignette; second, I presented pertinent examples from each case study's collaborative letter writing exchange; third, I assessed the data by using a cross case analysis design to establish patterns and themes of variances and consistency across the sample of cases.

In chapter V, I discuss the results as they relate to the existing literature. In addition, I presented new meanings and discoveries, along with limitations, implications, and suggestions for future research.

CHAPTER II: LITERATURE REVIEW

In this chapter, I review of the theoretical underpinnings of the understanding and treatment of SIB, including a discussion of the methods used for treatment efficacy from both the therapist's and the client's perspective, as shown in the literature. Then, I review the literature on the use of letter writing in therapy relationships and provide a summary of ideas of how therapists might use collaborative email letter writing (CELW) as an auxiliary form of communication with certain client populations in an out-patient setting.

The Theoretical Underpinnings of Self-Injury Behavior (SIB)

The population discussed here are young adults who exhibit repetitive, non-suicidal self-injurious behavior (SIB). SIB is defined in this study as self-cutting, which is the most common, least severe form of SIB (Favazza, 1992). SIB is defined as a complex behavior in which an individual deliberately alters or destroys his or her tissue without the intent of death (Simeon & Favazza, 2001). Examples of SIB can include cutting, burning, and deliberate self-hitting. Cutting and burning are the most common forms of SIB (Selekman, 2002). These behaviors are usually repetitive, intermittent, and discrete acts of self-directed, self-injury (Simeon & Favazza, 2001). It is estimated that 15% to 20% of the adolescent population report engaging in SIB at least once (Muehlenkamp & Guitierrez, 2007; Ross & Heath, 2002). Some studies find the rate of SIB occurrences as an ongoing behavior between young adults as high as 14% to 28% (Craigen & Foster, 2007; Moya, 2008).

Although, most research studies indicate that SIB is on the rise (Austin & Kortum, 2004; Conterio & Lader, 1998; Miller & Glinski, 2000; Zila & Kiselica, 2001), most research is inconclusive pertaining to which treatment is most effective with clients

who experience SIB. Furthermore, the studies that suggest treatment efficacy are typically conducted in hospital or clinic settings. Few research studies exist that have been conducted to represent treatment outcomes in private clinical practice (Trepal & Webster, 2007).

Individuals who self-injure are typically reported as females between the ages of 13 and 25 who have experienced some form of ongoing physical or emotional trauma, and who are attempting to gain some relief from the emotional stressors of their lives (Favazza & Conterio, 1988; Whitlock, Powers, & Eckenrode, 2006). SIB most often begins in late childhood or early adolescence and may continue for 15 to 20 years if not treated (Ross & Heath, 2002).

Predisposing factors for SIB may include physical or sexual abuse in childhood, caregiver neglect or violence, parental alcoholism, perfectionist tendencies, inability to tolerate and express feelings, and dissatisfaction with body image (Conterio & Lader, 1998; Favazza, 1992; Himber, 1994; Whitlock et al., 2006; Yip, Ngan, & Lam, 2002). Some behaviors associated with SIB have been found to co-occur with such mental health concerns as general anxiety disorder, depression, eating disorders, posttraumatic stress disorder (PTSD), bipolar disorder (BPD), antisocial personality disorder, and drug addiction (Favazza & Conterio, 1988; Gibson & Reynolds, 2004; Kress & Walsh, 2006; Linehan, 1993; Muehlenkamp, 2006;), although the majority of SIB is evident without the intention of suicide or life-threatening injuries (Kress, 2003).

Most incidents of SIB go unreported (Yip et al., 2002), and many of the families of individuals who self-injure are often unaware that it is occurring (Williams & Bydalek, 2007). Recently, SIB is receiving attention in the research literature, although efficacy

regarding treatment and intervention is unclear (Kress, 2003), and most professionals have little, if any, formal training in managing clients with SIB. As a result, many of these clients receive inadequate services and care (White, McCormick, & Kelly, 2003).

Individuals who struggle with SIB are often reluctant to attend medical or therapeutic evaluations (Conterio & Lader, 1998; Favazza & Conterio, 1988) Many of these young adults show excessive secrecy concerning their condition, have a fear of harsh clinical treatment, and go to great lengths to avoid attention from professionals because of the potential for hospitalization (Kress et al., 2004; Miller, 1994). Consequently, many of these same individuals report feeling socially isolated, have trouble communicating their problems to others, and experience low self-esteem (Austin & Kortum, 2004; Conterio & Lader, 1998; Selekman, 2002; Selekman & King, 2001). The difficulty in engaging these individuals in therapy treatment resides in the fear of judgment and harsh treatment that they have received previously from most professionals. Therefore, clinicians who work with this population are eager to find methods of treatment that promote trust, alliance, client control, responsibility, and autonomy.

Despite the recent increase in SIB among adolescents, most of the literature does not address the specific ethical considerations for working with this phenomenon, and there is insufficient research or understanding regarding effective treatment guidelines for clinicians who work with this population (Deiteer & Pearlman, 1998; Yip et al., 2002). Most mental health professionals are reluctant and unprepared to treat these individuals, at least in part because of the emotional investment and potential for health and safety complications (Hoffman & Kress, 2008).

As suggested earlier, very few studies provide evidence-based research for SIB treatment, and most of the research on SIB is conducted in clinical settings or hospitals. Trepal and Wester (2007) describe what little is known about how therapists are treating clients in private clinical practices. The American Mental Health Association (AMHA) (2000) conducted a random survey of 1,000 clinicians and found that 78% of counselors reported the treatment modalities that they used. The results were as follows: approximately 40.5% used Cognitive-Behavioral Therapy, followed by Dialectic Behavior (17.6%), Behavioral (10%), Cognitive (6.8%), Psychoanalytic/Object Relations (6.8%), Gestalt (5.4%), Narrative (4.1%), Humanistic (2.7%), Solution Focused (2.7%), Rational Emotive Behavior Therapy (2.7%), Eclectic (2.7%), and Psychodrama (1.4%). Counselors reported that they found additional treatments beneficial, such as, pharmacology, safety contacts, creative writing or art, relaxation training with the use of imagery, self-care/health, psychoeducation, mindfulness, substance abuse counseling, and movement exercise.

A review of the literature shows that the majority of therapists use Cognitive Behavioral Therapy (CBT) or Dialectic Behavioral Therapy (DBT); therefore, I briefly describe both therapies in the following section. In subsequent sections, I discuss social constructionist and narrative theories, and then describe several therapies that incorporate a strength-based collaborative approach.

Traditional Treatment Methodologies

Cognitive-Behavioral Therapy (CBT) and Dialectical Behavior Therapy (DBT) (Linehan, 1993) are the most prevalent methods used with adolescent clients who demonstrate SIB (Klonsky & Muehlenkamp, 2007; Trepal & Wester, 2007). CBT and

DBT interventions are based on the teaching, facilitation, and successful implementation of client change from an expert therapeutic stance, with the therapist directing the cessation of SIB (Hoffman, Fruzetti, & Swenson, 1999; Muehlenkamp, 2006).

The CBT approach is based on empirical research, knowledge, and finite outcomes (Klonsky & Muehlenkamp, 2007; Selekman & King, 2001), while the DBT approach is rooted in the CBT approach, and incorporates some aspects of a postmodern, social constructionist philosophy. The DBT approach is distinct from CBT in that an individual is viewed as having multiple realities and or truths, and therefore, therapy seeks to change single unitary truths (Hoffman et al., 1999; Linehan, 1993).

Clients are encouraged to open themselves up to new experiences and knowledge, learn greater acceptance of other people's feelings, and have harmonious relationships with others (Linehan, 1993). This approach requires the young adult to participate in individual, group, and family therapy sessions, with the expectation that this multi-systemic process will promote mindfulness, enhancement of shared social skills, and create the potential for present and future problem-solving skills (Trepal, 2010).

A CBT approach with clients is essentially based in problem-solving and skill training; whereas, the DBT approach combines elements of Zen Buddhism, cognitive-behavioral interventions, problem-solving, and skill training (Muehlenkamp, 2006). According to Linehan (1993):

> DBT strategies include the following elements: (a) validation of the client's experiences; (b) problem-solving techniques, including behavioral analysis of the self- injurious behavior along with teaching of adaptive coping behaviors;

> (c) behavioral skills training in mindfulness, emotional regulation, interpersonal effectiveness, and distress tolerance; and (d) contingency management strategies. (p. 113)

Muehlenkamp (2006) suggests that there have been a handful of rigorous treatment studies to determine the efficacy of DBT. Each of the randomized clinical trials demonstrated significant reductions in SIB for individuals participating in the DBT compared to other treatment methods. Similarly, Bauserman (1998) found significant reductions in SIB among participants in DBT-oriented therapies.

Although DBT was adapted for the use of adult clients in hospital settings, recently some therapists are using this model in their private practices (Muehlenkamp (2006). In addition to Linchan's approach with adults, A. Miller (1999) utilized DBT with adolescents with SIB and found it to be effective in reducing the behavior, as well as in improving psychosocial adjustment. These findings were significant because Derouin and Bravender (2004) contend that little research has been conducted on the treatment efficacy of DBT with adolescent and young adult populations.

Some research suggests that traditional treatment methods, such as CBT and DBT may be counterproductive for clients with SIB because in these models successful therapy is defined as complete behavior cessation by therapist intervention (Selekman, 2010; Zila & Kiselica, 2001). Craigen and Foster (2009) find that these therapies may perpetuate the disempowerment of individual strengths and resources and diminish client independence. There is also evidence to suggest that these therapy methods can increase anxieties, inhibit client's decision making, and compromise long-term behavioral change **(**Hoffman & Kress, 2008: Stone & Sias, 2003).

Social Constructionist, Narrative, and Collaborative Therapies

Social constructionist theory maintains that reality and knowledge are socially constructed phenomena. The social construction of reality is a process that replicates and presents a communal view of agreed upon truths, and the social construction of reality is the perception of an individual process that replicates and disseminates socially agreed upon truths, which occurs most often without an individual's understanding of these truths (Gergen, 2006). The understanding of these truths is based on the interpretation of collective knowledge (Gergen, 2001). From a social constructionist perspective, no one arrangement of words is more objective or accurate in its depiction of reality than another (Gergen, 2006). Social constructionist therapists believe that reality is not objective, and that language challenges these truths and invites the appreciation of relationship. "Through relationship we find the appreciation of common knowledge is not in the individual mind in which knowledge, reason, emotion and morality reside, but in relationships" (Gergen, 2006, p. 19). Social constructionist, narrative, and collaborative therapists believe that a person's identity conclusions are the result of a socially constructed reality, one that is often based in concepts related to cultural or historical dominant discourse and power influences (White, 2007).

The foundational assumptions of these therapy approaches is based in the need for respectful, collaborative communication between therapist and the client, where solution-oriented change and liberating narratives can become possible (Anderson & Goolishian, 1988; Freedman & Combs, 1996; Gergen,2006; Selekman, 2002, 2010; White, 1995, 2007). Therapists enter respectful relationships with their client in an attempt to challenge the social discourses that may be supporting problem-saturated stories (Freedman &

Combs, 1996; White, 1995, 2007; White & Epston, 1990). A safe therapeutic environment is considered essential for clients to be able to explore alternative stories without therapist control and judgment (Hoffman & Kress, 2008; Stone & Sias, 2003; White, 1995, 2007; White & Epston, 1990; White et al., 2003).

Unique to narrative theory is that therapeutic inquiry should be performed from a decentered but influential position (White, 1995, 2007). From this position, the client has primary authorship or priority in regard to the knowledge of their lives. The therapist is considered influential because therapy is directed with therapeutic intention, and thoughtful inquiry is used as an attempt to illicit client reflection from their own knowledge, language and life experience (White, 2007). Narrative therapy is often a process of collaborative inquiry designed to help in the deconstruction of problem-saturated stories (White, 1995), and problems are separated from the person through externalization conversations (Freedman & Combs, 1996; White & Epston, 1990; White, 1995, 2007). As therapists collaborate with clients to externalize the problem from the person, conversations bring forward narratives about past, present and future client experiences. Unique outcomes are identified within these narratives, with the anticipation of challenging the dominant problem-saturated story (Freedman & Combs, 1996; White, 1995; White & Epston, 1990), and to focus on dreams, hopes, purpose, and the values which provide meaning and future narratives for client lives (White, 2005, 2007).

Overall, these models view counseling as a way to help the individual begin to understand that the problem of SIB is not an inherent part of their identity, and that "They can define their own position in relation to their problems and then to give voice to what underpins this position" (White, 2007, p. 39). The adoption of curious inquiry, as well as

a not-knowing therapeutic stance relinquishes expertise to client realities (Anderson & Goolishian, 1988; White, 2007), thereby helping clients to regain or attain feelings of self-control, self-esteem, and autonomy (Hoffman & Kress, 2008; Brown, Weber, & Ali, 2008). Social constructionist, narrative theory, and collaborative therapists assume that the SIB has a grasp on the whole family system. Therapy encounters may include family consultations; however, when a family member is not present, therapists attempt to bring into the therapy session other family members' voices. Therapists use respectful inquiry, and clients are encouraged to tell richer stories in addition to the SIB stories that may still have influence and power over them. Emphasis is now placed on stories of lost dreams, intentions, and experiences (Hoffman & Kress, 2008; Stone & Sias, 2003).

Social constructionist, narrative, and collaborative therapists would each view their role as only one part of the construction, definition, and movement towards behavioral change (Anderson & Goolishian, 1988; White & Epston, 1990), and predetermined agendas or goals for the cessation of SIB is not considered paramount. Furthermore, these models emphasize that the person's SIB is only a small part of the person's identity, therefore therapists seeks to explore and develop resources separate from the SIB. Therapists help clients to understand and connect stories and themes that have shaped and empowered their lives. Past attitudes and techniques of power and social discourses that had previously been justified may now enter into new exploration for alternative meaning of preferred ways of being (White, 1995), and therapy becomes a conversation in which the therapist facilitates client collaboration to understand and develop new narratives away from the SIB.

> Persons who have virtually lost their lives to problems find it difficult to escape despair, even with evidence that they had some success in reclaiming themselves. It is imperative that those persons have devices that enable them to map this influence. (White & Epston, 1990, p. 116)

The process of inquiry and letter writing can facilitate the development of externalizing conversations to make client internal dialogue external, and brief reflective summary is communicated back through dialogue or writing to the client to ensure accurate understanding and client meaning. Therapists ask questions, "to invite people to pause and reflect on specific developments of their lives" (White, 2007, p. 44), while attention is given to a multitude of variables for exploration of life narratives without clients feeling judgment and shame" (Freedman & Combs, 1996; Hoffman & Kress, 2008; Stone & Sias, 2003; White & Epston, 1990; White, 1995, 2007; White et al., 2003).

Few therapists specialize in working with a self-injuring population. One therapist who combines a social constructivist, narrative theory, and strength-based collaborative therapy approach is Matthew Selekman. Selekman (2002, 2010) introduces several new elements in his collaborative strength-based therapy approach that focuses on the need for therapeutic freedom, improvisation, flexibility, and the need to be integrative in the effort not to limit therapy expression to one particular model. Central and similar to a narrative therapy approach, "Is on the wellness of the self-injuring person, not on what is supposed to be wrong with them" (Selekman, 2010, p. 18), and clients are invited to share their unique stories. By listening to client storylines and themes, Selekman (2010) is able to identify how self-injury and other destructive behaviors have benefited the client as a strategy for coping with internal stressors (e.g., unpleasant emotions and oppressive

thoughts and external stressors such as family, peer, school, community). It is important to be respectful and generous listeners and avoid being narrative editors of the adolescents' self-injuring stories by making interpretations and prematurely offering replacement behaviors. Instead, we should be curious to learn more about their stories by asking open-ended questions (p. 18).

Selekman's (2002, 2010) therapeutic expertise invites individuals and family members to define goals for their own treatment, session agendas, session attendance, and the frequency of therapy sessions. Clients become involved within the therapeutic process and are asked questions to target specific concerns that are unique to each individual and family member. Although family therapy is encouraged, Selekman (2002) explains that therapists can have alternative methods when they have difficulty engaging other family members in the therapeutic process. In these situations, he suggests that clinicians use "One-person family therapy" (p. 152). This method of therapy works well for families who may be disconnected and are not willing to attend therapy sessions. This technique invites the wisdom, strength, and connection-building strategies of clients to improve family communication, and to encourage, "The focus of treatment to involve learning coping strategies, life skills, and creating a life outside of the family for each individual" (p. 154).

In the following section, I include nine areas of therapeutic focus that I consider to be a standard practice in my collaborative email letter writing exchange. This focus was developed from the foundational tenets of a social constructivist, narrative theory, and collaborative strength-based methodology. These variables will used in later chapters for exploring observations, propositions, and assertions to be obtained from the

therapists' observations and collaborative email letter writing exchange, and by the client's perception derived from their individual email letter communication. I narrow my focus to these variables for the results and discussion section of this case study research design.

Curious, Respectful Questioning, and Use of the Client's Language

Therapists have dialogue and may write therapeutic letters as a way to honor client language and stories (O'Hanlon, 1994; O'Hanlon & Weiner-Davis, 1989; Pyle, 2006). In narrative therapy (White & Epston, 1990), letters may be used as an extension of counseling sessions that document and privilege a person's lived experience. Collaborative therapists invite the individual to define goals for their own treatment, session agendas, session attendance; clients become involved within the therapeutic process and are asked questions to target specific concerns that are unique to each individual (Selekman, 2002).

The Client is the Expert of Her or His Own Narratives

The idea that the client has expert knowledge on the stories of their lives does not deny that the therapist has expertise in their theoretical, experimental, professional, and personal experiences (Anderson & Goolishian, 1988). The client is believed to be the expert of his or her own life, and therapist has expertise in the area of process instead of the area of the content of the conversation. It is equally important for therapists to validate and honor client narratives as important and that the process of writing about elements related to past, present or future are encouraged. A social constructivist perspective will facilitate the use of language that constructs the means by which thoughts, feeling, and behaviors are produced, and that language is historically and

culturally located, and cannot be taken as absolute truth (Gergen, 1999). Social constructivist therapists focus on the facilitation of the transformation of client social discourse into new narrative that generate strength based-knowledge and resources to assist clients to achieve and experience a heightened sense of personal agency (White, 1990).

Deconstructive Questioning of Dominant Discourses

The deconstruction of narratives involves the acknowledging and challenging of assumptions about a client's life events. Therapists seek to accomplish the reviewing, revisiting, and the revising of narratives that have been constructed to form the problem-based dominant story. Most problem saturated stories become internalized through the individual's socialization process, resulting in the unconscious holding of social preferences or "truths" (White & Epston, 1990). The technique of therapeutic deconstruction questioning facilitates the need for the client to call into question these stories and find new angles for opportunity so that "other possible narratives" and emerge (Freedman & Combs, 1996, p. 57).

Externalization of Problems

Externalization is a technique described by White (2007) in which a therapist encourages persons to experience an identity that is separate from the problem. In this way, the problem becomes the problem, not the person. Thus, externalization creates a separation between persons and their problems. This, in turn, may open up space for new preferred ways of relating to the problem (Tomm, 1988; White, 2007; White & Epston, 1990).

Highlighting and Promoting Absent But Implicit Unique Outcomes

Finding "unique outcomes" often enables persons to locate and embrace their own unique story of struggle, and to identify alternatives to problem stories (White & Epston, 1990). Clients identify alternative themes that challenge the already formed discourses and find subordinate storyline to give expression to her experience of trauma (Denborough, 2006; White, 2006).

Relationship to the Problem Begins to Change

New narratives and relationship dynamics may be noticeably different from the dominant story (White, 2007). Clients become involved within the therapeutic process and are asked questions to target specific concerns that are unique to each individual in the attempt to change the relationship with the problem (Anderson & Goolishian, 1988). The focus is on the need for therapeutic freedom, improvisation, flexibility, and the need to be integrative in the effort not to limit therapy expression to one particular model (Selekman, 2002, 2010).

One-Person Family Therapy

It is possible to effectively treat an individual who are struggling with SIB without having family members present in family therapy session (Selekman, 2002). In these situations, clients become the active agent of change for their entire family system. The goal of this type of therapy is to focus on learning coping strategies, bring in the voices of family members, rely on outside support systems, and create autonomy outside of the family system

Developing Autonomy and Creating Possibilities for the Future

When individuals begin to understand that the problem is not an inherent part of their identities, "They can define their own position in relation to their problems and then to give voice to what underpins this position" (White, 2007, p. 39). The adoption of curious inquiry, as well as a "not-knowing" therapeutic stance relinquishes expertise to client realities (Gergen, 1999), thereby helping clients to regain or attain feelings of self-control, self-esteem, and autonomy (Hoffman & Kress, 2008; Brown, Weber, & Ali, 2008). In addition, clients are encouraged to identify their own preventive measures that will provide information, benefit, and control of problem stories (White & Epston, 1990), therapists encourage clients to answer future-oriented questions thereby co-creating positive self-fulfilling prophecies. In so doing, they find meaning around those aspects of themselves and of their relationships that they can appreciate, but that do not fit with the norms and expectations already established. In this process, persons actively engage in the redescription of their lives, and in the establishment of alternative narratives of personhood and of relationship (Freedman & Combs, 1996; Selekman, 2010; White, 2007).

Retelling Client's Preferred Story in Writing

By highlighting the relationship with the problem, the therapist attempts to help the client transform old narratives into a new alternative story away from the discourses that have had power over her (White, 2007). Michael White (1995) suggests:

> Within the process of this therapy, I provide a safe place for remembering and build a context within which our client's story could be written and

> rewritten, thereby allowing them to make a distinction between the past, present and future. (p. 146)

Writing is a way to use the client's language to revisit important information from clients session, highlight new narratives never addressed, ask questions in a more concrete and understandable way, help facilitate new learning through a safer communication format, encourage autonomy, check in with clients during session, assist less-verbal clients to express and test the expression of important emotions that may help with verbal communication in the future.

Clinician Perspectives on Effective Treatment

SIB is considered a complex and multidimensional phenomenon (D'Onofrio, 2007). Clients who engage in these behaviors are often resistant to treatment (Conterio & Lader, 1998; Trepal & Wester, 2007). Many of these individuals report having experienced significant interpersonal loss and rejection, and trauma during their lives. Muenhlenkamp (2006) explains that this may be why individuals with SIB have difficulty forming trusting intimate relationships with others; therefore, clinicians may need to work hard to engage clients in treatment.

Most clinicians agree that establishing a trusting relationship with the individual who struggles with SIB is necessary for a good therapeutic relationship to be established (Craigen & Foster, 2009; D'Onofrio, 2007; Levenkron, 1998; Muehlenkamp, 2006; Selekman, 2002, 2010; Trepal & Wester, 2007; Walsh, 2006). However, the literature explains that most professionals who work with clients who struggle with SIB report feeling helpless, ambivalent, and frustrated when faced with working with this population (Favazza, 1992). Compassion fatigue is a term that refers to the overwhelming

helplessness that clinicians may feel when they engage in an effort to help individuals with SIB (Connors, 2000), and many counselors have a tendency to lose their sense of professional boundaries and become over involved. When this occurs, counselors report that they become aware that what they have offer is not enough to change or alter the SIB, and thus, their stance may shift to anger and rejection (Conterio & Lader, 1998; Connors, 2000).

In many of the traditional therapies, CBT and DBT, the emphasis is placed on the identification of client emotional deficits, and the teaching of new skills to assist in the enhancement of social skills, ability to tolerate stress, and to regulate emotional imbalances (Robins & Chapman, 2004). Muehlenkamp (2006) explains that these models emphasize the "development of collaborative and empathetic alliances between therapist and client with the primary importance being placed on the structure of therapy and the adherence to outcome goals" (p. 173). Furthermore, therapists who practice CBT and DBT focus on the elimination of SIB and place expectations on clients to replace the behavior with more adaptive behaviors. In addition, therapists working within these models feel that treatment outcome efficacy is done by teaching individuals to problem solve and replace maladaptive behaviors (Linehan, 1993; Zila & Kiselica, 2001).

Most of the literature on working with clients with SIB, encourages the involvement of other support systems in therapy such as parents, friends, or significant others. Therapists recommend that these support systems or professionals learn to react to SIB in a neutral, yet supportive fashion (Muehlenkamp, 2006; Zila & Kiselica, 2001). Linehan (1993), Muehlenkamp (2006), and Zila and Kiselica (2001) also recommend that

the therapists communicate caring and compassion to clients with these concerns in order to ensure positive treatment outcomes.

There is some evidence that suggests that monitoring clients during, after, and between therapy sessions is useful (Levenkon, 1998), and some therapists do this by having clients sign a contract specifying therapist and client expectations during treatment. The usefulness of the development of a "non-harm" contract is often a topic of dispute with counselors working with this population. Conterio and Lader (1998) suggest that these contracts can specify limitations to confidentiality concerning SIB, define expectations related to these behaviors, and can be individualized to each client's needs, while Selekman (2010) and Walsh (2006) find that these contacts are generally not looked upon favorably and are usually ineffective.

D'Onofrio (2007), Levenkron (1998), Selekman (2002, 2010), and Walsh (2006) approach working with clients who exhibit symptoms of SIB in a similar fashion: The therapist should be the collaborator in understanding client concerns and the builder of the therapeutic experience. They further suggest that individuals who exhibit SIB are typically less verbal, have a sense of false self, and use SIB to express difficult emotions. Therefore, the therapeutic experience would need to facilitate the discovery of learning healthier ways to communicate discomfort and emotional pain. Talk therapy is one form of useful communication, while letter writing may be an alternative form of communication in the treatment with clients with SIB (D'Onofrio, 2007; L'Abate, 2001; Muehlenkamp 2006; Selekman, 2002, 2010; Trepal & Wester, 2007). These clinicians believe that letter writing can open up new avenue for client expression (Bacigalupe, 1996; L'Abate, 2001; Madigan, 2007; Pennebaker, 2004; White & Epston, 1990), while

providing an even more powerful therapeutic intervention for less verbal client populations (D'Onofrio, 2007, Moules, 2003).

Many of these clinicians debate how to use letter writing in therapy relationships. Using letter writing as a collaborative therapeutic exchange to augment live therapy encounters is a relatively unexplored phenomenon. To date, no empirical research exists pertaining to the use of CELW as an additional technique in therapeutic relationships with clients who experience SIB.

Finally, the American Counseling Association (1995) Code of Ethics and Standards of Practice provides an overview of some general recommendations for counselors working with a self-injuring population. These suggestions are important and include: to increase their general knowledge base of self-injurious behavior; understand and monitor the likelihood of the difficulty and emotional investment when working with this population, conduct a thorough suicide assessment; assess for the need for medical treatment, complications, and need for alternative consultation.

Client Perspectives on Effective Treatment

While some studies report treatment efficacy from the therapist's perspective, it is equally important to explore the client's therapeutic experience as it relates to effective therapy for self-injuring individuals. Crouch and Wright (2004), Dunne, Thompson, and Leitch (2000), and Pierce (1986) suggest that most psychological interventions have been based on the clinician's experience rather than on the client's experience. Craigen and Foster (2009) explain that only a few studies have been conducted from the client's perspective on professional treatment for SIB in outpatient settings. Additionally, the research that has been conducted suggests that individuals who self-injure indicate a high

rate of dissatisfaction with the treatment they receive from professionals (Favazza & Conterio, 1989; Ryan, Heath, Fischer, & Young, 2008; Shaw, 2002).

Clients who experience SIB explain that this behavior is a means of self-punishment, expression of emotional pain and trauma, escape from dissociative states, a coping mechanism for dealing with stress, and a way to assert control and autonomy (Kiselica & Zila, 2001; Muehlenkamp, 2006; Stone & Sias, 2003). Conterio and Lader (1998) report that clients commonly refer to SIB as a specific language of pain, which facilitates the person expressing difficult emotions through self-injury behavior. Most professionals have limited understanding regarding this phenomenon; therefore, it would be valuable to understand the voices of the clients who struggle with SIB.

Ryan et al. (2008) conducted an internet exploratory study to survey 96 young women with a history of SIB. This study sought to understand which clinical interventions were deemed most beneficial. Individuals struggling with SIB reported that they would prefer professionals to always remain calm, acknowledge the severity of their distress, assist and be available if needed, permit emotional expression, and show concern without judgment. In this same survey, participants reported being opposed to caregivers that were controlling or forced them to reveal cuts and wounds. These studies findings were consistent with Craigen and Foster's (2009) study in which they addressed the experiences of 10 clients who had been treated by therapists for SIB. Prominent themes that emerged included the need for therapists to listen to client stories, take an understanding stance, become actively engaged in the treatment process, and display nonjudgmental therapeutic behavior. Additionally, clients explained that no-harm contracts were ineffective, and all participants preferred counselors to put less emphasis

on the occurrence of SIB and more on other aspects of their lives. The therapists who did not take an expert stance were revered. Finally, Walsh (2006) conducted a study with a group of young women who experienced SIB and found that most clients report the importance of the quality of a trusting, nonjudgmental counseling experience. Participants explained that in order for change to occur, treatment needed to not overlook the client's internal struggles, and emphasis should not be placed on symptom cessation.

History of Therapeutic Letter Writing

The historical foundations of therapeutic letter writing can be traced back over many years**.** It appears that Sigmund Freud was one of the first therapists to use of the written word for therapeutic purposes (Bacigalupe**,** 2003, Farber, 2005). Freud utilized therapeutic writing in several ways without collaborative therapist client exchange, and for his own self-analysis, personal memoirs, and self-imposed treatment, to write extensively to other professionals, and to express his own theories in regards to therapeutic orientation. Freud also encouraged clients to use writing as a form of free association to help them uncover unconscious and conscious motivations. Additionally, the use of written text used by Freud's is for his own personal change, while also serving as a therapeutic agent of change in his professional work with clients (Bacigalupe, 2003).

Since Freud, many practitioners have explored the use of therapeutic letter writing within clinical settings (Farber, 2005; McDaniel, 2003; Moules, 2003; Pyle, 2006; Walsh, 2006; White, 1995; White & Epston, 1990). Although therapeutic letter writing is not a new development, one recent practice of therapeutic letter writing can be attributed to the narrative work of Michael White and David Epston (White, 1995; White & Epston, 1990). White and Epston describe a variety of different types of therapeutic letters that

might be useful for therapist and client communication. These letters are usually generated by therapists as a form of communication that does not require a written response from the client. During therapy relationships, clients may be invited to use letter writing or other forms of self-expression to augment in-session conversations.

Freedman and Combs (1996) use letter writing to promote the relationship of the therapist with the client. The letters enable them to thicken client narratives by summarizing, recapping therapy sessions, and extending ideas and stories that were initiated in therapy. Tubman, Montgomery, and Wagner (2001) use letter writing as a motivational tool for brief counseling interventions to increase positive strength-based behaviors, and Wojcik and Iverson (1989) report that letter writing promotes additional client empowerment, and the identification of individual resources. Madigan and Grieves (1997) find that narrative letter writing can be an excellent form of communication between therapy sessions when a client is struggling with an assortment of difficulties, such as feelings of isolation and acts of self-harm.

Letter writing has been used by therapists as a way to help clients find subordinate narratives around past trauma (Rasmussen & Tomm, 1992; White, 2007; Zimmerman & Shepherd, 1993), as well as to foster personal agency and authorship of their life stories for the exploration of possible future selves (Goldberg, 2000; Madigan & Grieves, 1997; White & Epston, 1990). Research indicates that the use of letter writing in therapy relationships may reduce the number of therapy sessions. White and Epston (1990) received feedback from their clients that suggests that one therapist-written letter was worth, 4.5 therapy sessions. Nylund and Thomas (1994) report that their clients rated therapist letters used in conjunction with therapy to be worth 3.2 face-to-face sessions,

and credited therapist letters to be 52.8% of the change that was experienced from therapy. Farber (2005) suggests that "letter writing served as a transitional way station between mind and body" (p. 263). Therapeutic letter writing offers extensive evidence for a range of positive psychical benefits including improved immune system functioning, as well as the overall improvement of health, psychological well-being, physiological functioning, and general functioning (Pennebaker, 1990; Pennebaker & Seagal, 1999; Smyth, 1998;).

Collaborative Letter Writing in Therapy

Some literature explores the use of collaborative letter writing with clients as part of a therapeutic practice (Pyle, 2006; Tubman et al., 2001; White & Murray, 2002). Zimmerman and Shepherd (1993) posit that when clients respond to therapist's letters, this communication can produce an additional way to physically externalize, name, and then confront the problem. Rasmussen and Tomm (1992) identify that letter writing is a way for clients to have control of the pacing of their letter writing, while Goldberg (2000) and White and Murray (2002) find that adding the written word or other forms of expression to verbal dialogue provide a permanent, concrete means for future reflection for new identity conclusions. Woljcik and Iverson (1989) use letter writing as a way to check in with clients in between therapy sessions. Goldberg (2000), Madigan and Grieves (1997), White and Epston (1990), and White (1995), believe that certain client populations might feel more comfortable with written communication when compared to face-to-face dialogue.

Steinberg (2000) finds that the use of letters from the therapist can aid in the therapeutic process. He suggests that, "a letter can take the form of an agreed treatment

plan, and aide-memoire, an informal contract between the therapist, patient, and family and the beginning of an agenda for the next meeting" (p. 2). Additionally, therapeutic letters can summarize the client recent session, while defining a new direction for future sessions. Madigan (2007) implements the use of letters to externalize problems, and highlight client's strengths, while using letter writing as a tool to stay closely in tune with clients who struggled with eating disorders. Pyle (2006) finds that clients were more invested in the therapeutic relationship when they wrote letters to their therapist.

Few clinicians have implemented the use of collaborative letter writing as an ongoing tool for communication in therapy relationships. Although this phenomenon is extremely rare, there are several professionals who report and document the effectiveness of this technique. "Most mental health professionals are not aware of its effectiveness as a systemic alternative or planned adjunct to traditional, face-to-face therapeutic practices based in talk" (L'Abate, 2001, p. 1). Even so, L'Abate (2001) and Bacigalupe (2003) use collaborative letter writing in therapy relationships to help orient clients towards the context of change, help them to define the problem, and help them to clarify their expectations by developing and understanding future therapy goals. Penn and Frankfurt (1994) use writing as a part of ongoing therapeutic conversation within the context of therapy relationships by stating that, "Writing as part of the therapeutic conversation elicits a reflexive process and fosters the exploration of multiple meanings," further suggesting that, "these meanings made visible during therapeutic conversation can be expanded and given voice through writing" (p. 364).

Bacigalupe (1996) suggests that, "The voices of clients in the writing of therapists are frequently absent or filtered by the language of academic and professional discourses"

(p. 362), therefore, suggesting that when clients write they are actively collaborating, which gives the clients a visible way to voice their values. Fox (1983) advocates that clients and therapists use collaborative letter writing as a way to "Become pattern-makers rather than pattern-finders" and to" re-create the pattern in written words" (p. 199). Finally, Riordan (1996) summarizes the use of letter writing by stating that this practice in counseling relationships is useful in the labeling and describing trauma, helps individuals gain control, reduces feelings of inhibition, and assuage obsessive internal rumination and negative emotions that can exacerbate health and psychological problems.

Interestingly, collaborative letter writing is used in the Japanese therapeutic approach adapted from the Morita Therapy, which specifically recommends letter writing in therapy relationships (France et al., 1995). These researchers describe the foundation of Morita Therapy by Shoma Morita in 1917 as a way to encourage clients to be more accepting of life and the cycle of nature to resolve conflicting thoughts. Today, Morita therapy practices use letter writing as an interactive tool that provides an opportunity for the therapist to offer advice and follow the progress of the client's life outside of therapy. According to France et al. and Reynolds (1976), Morita letter writing is a convenient way for therapists to communicate with clients between therapy sessions, promote continued contact, provide a permanent way to document client-therapist written exchanges, and reinforce the expression of inner conflicts and feelings.

France et al. (1995) present a study that illustrates the use of letter writing as a powerful counseling tool that can be used with a number of clients in such a way that letter writing often takes the place of live sessions when counselors are unavailable for live therapy sessions. As specific steps are used in model development, so too is letter

writing offered as a way to help clients reassess strengths, focus on positive behaviors, and take responsibility for their actions. In addition, some therapists are finding letter writing to be a useful intervention when counseling families with an individual who self-injures (Hoffman, Hinkle, & Kress, 2010).

To summarize, although the empirical evidence for the efficacy of collaborative letter writing is sparse (Riordan, 1996), the literature indicates that implementing letter writing in ongoing therapy relationships can facilitate the externalization of problems (Keeling & Bermudez, 2006; White & Epston, 1990), create new narratives that can lead to unique outcomes and client autonomy (White, 1995; White & Epston, 1990**),** promote the telling and retelling of a client's stories (Freedman & Combs, 1996; White & Epston, 1990), highlight client strengths and resources (Moules, 2003; Rombach, 2003; White & Epston, 1990), provide a private, less intrusive form of communication (L'Abate, 2001), and provide a vehicle for conveying and processing difficult psychological material, as well as providing a way to produce concrete evidence of thoughts and participation in therapy (Bacigalupe, 1996; Riordan, 1996). At the same time, letter writing encourages clients to take responsibility for their own treatment and outcomes (White, 2007). The process of collaborative letter writing encourages client reflection and experimentation, and affords the client time to take action to solve problems by opening doors for new possibilities (France et al., 1995; L'Abate, 2001; Selekman, 2010).

The Use of Social Technology for Treating SIB

Social technologies continue to evolve at a rate that affects the daily lives of millions of individuals and families (Bacigalupe, 2011). The introduction of these new technologies may have the ability to promote, transform, and augment therapeutic

communication with certain client populations. Miller & Gergen (1998) explain that, "a substantial degree of "therapeutic work" can and does spontaneously take place on the internet" (p. 200). However, according to Coiera (2006) there are still significant gaps in the attention, challenges of reaching certain groups, and the understanding of the role of communication services in the support of health care delivery service systems. In this study, my focus is on the exploration of how clinicians might use collaborative email letter writing exchange as an auxiliary health care support system for certain client populations, which at this time is one possible form electronic communication in therapy relationships.

Debate continues over the effectiveness of internet counseling without live therapeutic interaction, and the literature reveals that most therapists using the internet for therapeutic purposes are doing so in place of traditional face-to-face counseling services. In addition, the cyber world offers many individuals a place to find information, experiment, connect with others, and try out new identities (Adler & Adler, 2008).

Whitlock et al. (2006) examined how self-injury internet boards (a type of chat room) have both positives and negative effects. The positives largely outweigh the negatives, in that adolescents believe their collaborative communication reduced feelings of isolation, and produce a reduction in feelings of judgment, shame, and isolation. For some individuals, internet communication can lead to the formation of unhealthy relationships that, as a result, can cause an increase in SIB. The authors conclude that people receive the most benefit from internet communication when these communications are monitored by professionals to promote positive peer relationships that decrease SIB.

Adler and Adler (2008) conducted a study to explore the cyber-world of a self-injuring population. The researchers in this study used participant-observation, face-to-face and telephone interviews, and 10,000 email postings to understand and analyze this phenomenon. Similar to Whitlock et al. (2006), the researchers found that the people who use these sites may have mixed emotions about the usefulness of participation. Some individuals state that the use of these sites may reinforce self-injurious behavior, while others report receiving significant benefit from participating in this virtual form of communication. Reported benefits included being able to speak truthfully without judgment, maintaining anonymity, receiving anonymous advice, and provision of a place for people to try out different identities (Adler & Adler, 2008). One article on computer-mediated bulletin board use found that individuals who engage in the topic of suicide might achieve one type of therapeutic benefit. In this study, Miller and Gergen (1998) conclude that in order for on-line communication to be transformative, clinical intervention would need to occur.

One study, conducted by Shaw and Shaw in 2006, found that fewer than half of the internet counselors were following the accepted practices outlined by the American Counseling Association (ACA) for ethical standards for online clinical services (ACA, 1999). Online counselors need to be knowledgeable pertaining to ethical codes for online counseling services with specific recommendations, such as the ACA; the International Society for Mental Health Online (ISMHO), and the National Board for Certified Counselors (NBCC) (ISMHO, 2000; NBCC, 2001). Shaw and Shaw's study objective was to identify the ethical practices that were or were not being provided by online counselors. Along with ethical considerations, there are clear disadvantages to the use of

online counseling. These disadvantages include: (a) difficulty maintaining confidentiality over the internet; (b) difficulty handling emergency situations; (c) inability to access nonverbal information; and (d) difficulty developing a therapeutic relationship with a client who is never seen face-to-face (Bloom, 1998; Morrissey, 1997).

Presently, there are few guidelines for therapists who provide online counseling services. Shaw and Shaw (2006) found that many online counseling websites were not in compliance with ethical standards outlined by the ACA. Furthermore, some of these counselors were not licensed and were practicing online counseling in another state. When therapists are interested in using email communication to augment therapeutic relationships, they must be fully conversant with the ethical concerns and standards set forth by their professional oversight committees and organizations. Each type of clinical practice must be knowledgeable of the information pertaining to guidelines for the use of electronic communication over the internet. These guidelines include counselors providing credentials from an accredited institution, providing a state license or certificate number from the state issued, and counselors should be giving alternative means for clients to contact therapists in case of emergencies (Koocher & Keith-Spiegel, 1998). In addition, counselors are cautioned that they must exercise extreme care when working with clients who are likely to physically harm themselves or others.

Internet Email Letter Writing Therapy and SIB

The internet affects the way people understand the world, communicate with others, and receive information (Northey, Jr., 2005). Most professionals use the internet for a vast assortment of services and products (Heinlen et al., 2003), and researchers predict that the use of the internet will continue to grow in epic proportions as a source of

communication and information in the years to come (Heinlen, et al., 2003). Subsequently, clinicians have increased the use of the internet and email in their offices to communicate with their clients, colleagues, and third-party payers (McDaniel, 2003).

The empirical research exploring the use of CELW as an additional technique in already established therapy relationships with clients who self-injure has not been studied. However, several clinicians explain that they find the internet to be a powerful medium for therapeutic letter writing with clients outside of and between sessions (Adler & Adler, 2008; L'Abate 2001; McDaniel, 2003; Sundqvist & Ronnberg, 2010; White et al., 2003; White & Murray, 2002). Whitlock et al. (2006) suggest that the internet can be used as a tool to extend one's reach and expand one's senses while studying clients at a distance. Similarly, Messina and Iwasaki (2011) find that discussion boards and social networking sites provide a type of therapeutic outlet for groups of individuals with SIB. However without clinical internet intervention, the authors contend that the therapeutic value is limited and compromised. Mann and Stewart (2000) note that we have only begun to imagine ways to use the internet to augment therapeutic research.

Sundqvist and Ronnberg (2010) conducted a 12-week exploratory study with Swedish children who attended a regular school and who experienced communication disabilities. In their research, the children were instructed to use the internet to communicate with other children to develop better social skills and enhance live social relationships. By utilizing the internet as an additional form of communication, they found that these children learned new social skills, found common ground with other children, and were able to create a larger social network. Similarly, Bacigalupe and Lambe (2011) introduce the need for information communication technologies (ICT) to

enhance communication. In this study, they discuss how the internet in general and email in particular holds significant potential as alternative forms of communication for clinicians in family therapy. In this particular article, they discuss the benefits of this form of communication in the lives of transnational families.

L'Abate (2001) terms email letter writing distance writing (DW), or computer-assisted intervention (CAI), an effective alternative intervention to augment therapy services for outpatient clients. In his study, he explains that this medium of communication may be more appropriate for clients who find verbal communication difficult and uncomfortable. According to L'Abate, only one third of the clients seeking treatment improve using traditional face-to-face psychological intervention techniques. This suggests that the remaining two thirds—those clients who do not improve using traditional intervention techniques—may be helped by the use of computer-assisted communication as an alternative to face-to-face traditional psychological intervention. The internet, he contends, should only be used as an alternative or as an adjunct to face-to-face, verbal therapy or, when that is not feasible, for logistic (distance) or for diagnostic reasons.

Moules (2003) discusses the possible benefits and risks of using email communication for the therapeutic purposes of healing and relieving suffering. The advantages of email communication, she explains, may be that it allows for immediate, uncensored communication responses, it can be used by multiple recipients, and it is portable. The disadvantages may include degradation in the quality of communication; a lack of human relationship; diminished attention to form and correctness; and a loss of tone and affect. Overall, Moules is concerned that these risks and benefits might shift

over time, and may depend on how therapists use email communication as it relates to clients' preferences, the nature of the therapist-client relationship, and the circumstances in which email letter writing is used.

Breaches in client confidentiality and privacy may occur when communicating with clients by internet exchange. McDaniel (2003) and Leslie (2002) recommend having a separate descriptive consent form signed by the client that explains the stipulations of the security issues pertaining to protecting client confidentiality, as well as access to the Health Information Portability and Privacy Act (HIPPA). In addition, public or private organizations need to promote the highest level of security of client records when patient email communication is used as part of the therapy process (McDaniel, 2003). Finally, Leslie (2002) suggests that marriage and family therapists practicing therapy via the internet should determine respective state laws and licensing board recommendations, and understand the complexity of the potential risks and benefits of this experimental treatment.

To summarize, researchers have found that email communication may be suitable for clients who are less comfortable with verbal expression of emotion (L'Abate, 2001) or who need time to contemplate a response (Baligalupe, 2003., Email communication may provide an additional safe avenue for a client to express difficult emotions in therapeutic relationships.

Conclusions

In my review, I explore the phenomenon of self-injury behavior (SIB) and prevalent methods used for therapeutic treatment. Also, in my review, I address the enormous challenge that clinicians face when working with a client who struggles with

SIB. Although this problem continues to be on the rise, information, knowledge, and resources are still extremely limited for most therapists in private practice.

I explore traditional therapy methods used to treat SIB, and provide a description a social constructionist, narrative theory, and collaborative strength-based epistemology. In addition, six elements are outlined from these approaches that will define the focus for the research and design of this case study.

The history of letter writing in therapy relationships is explored in the next section, with a discussion of a variety of computer technology practices used by individuals who experience symptoms of SIB. The benefits and deficits of collaborative email communication are explored as, increasingly, clinicians use this technique as an adjunct to live therapy sessions.

CHAPTER III: METHODOLOGY

In this chapter, I explain my research interest and detail the methodology and design I plan to use for this study.

In the formative years of exploring the use of collaborative email letter writing (CELW) as a standard practice in my office, I began to notice that only certain clients would actively participate in this alternative form of ongoing communication. I became interested in understanding *how* CELW might be used with specific individuals in ongoing therapeutic relationships. In this study, I chose to utilize a qualitative, naturalistic case study research methodology to understand the phenomenon. As I experimented with CELW, I found that the clients who exhibited self-injury behavior (SIB) seemed to show a significant interest in this alternative form of communication. It appeared that many of these individuals were eager to participate in this additional form of communication. Using CELW appeared to provide a safe way for those clients who exhibited SIB to express difficult emotions. In addition, using CELW provided a way to extend the therapy relationship after live sessions had ended, thereby enhancing therapist-client alliance and trust, while also providing new opportunities for client and therapist understanding during, in-between, and outside of live therapy sessions.

In the following sections, I review a qualitative research method. I then discuss the ideology of a case study design and provide an integrated form of case study research to include the technique of layered account for the exploration and understanding of the use of CELW in ongoing clinical relationships.

Qualitative Research

Qualitative research is defined by Creswell (1998), "As a process of understanding based on distinct methodological traditions of inquiry that explore a social or human problem," and in doing so, "the researcher builds a complex, holistic picture, analyzes words, reports detailed views of information, and conducts the study in a natural setting" (p. 15). In contrast, quantitative research tends to use large random samples of data to quantify phenomena and to generate findings. Validity is usually regarded as a strength in most qualitative research because participants are not subject to rigorous controls, large samples, and are studied in their natural environment (Carr, 1994), and emphasis is not placed on the measurement, analysis of large sets of data, and cause and affect relationships (Denzin & Lincoln 1995). In comparison, Stake (1995) explains that qualitative research moves away from cause and effect relationships, places importance on personal interpretation, and encourages holistic treatment of phenomena. Qualitative research is interested in small nonrandomized samples that provide the researcher with a greater understanding of the phenomena or subject being studied, and the researcher is expected to have a more intimate relationship and understanding with the study participants, and for the data collected (Stake, 1995).

Some qualitative research begins by gathering detailed information from participants and then forms this information into themes or categories (Creswell, 2009). Creswell refers to "The development of themes and categories into patterns, theories, or generalizations as varied end points for qualitative studies" (p. 64). Propositions, thick description, and interpretation is sought to understand and aid in the subjective experience in qualitative researcher, and thus, "Subjectivity is not seen as a failing

needing to be eliminated but as an essential element of understanding" (Stake, 1995). Stake explains that, "that the function of qualitative research is not necessarily to map and conquer the world but to sophisticate the beholding of it, thicken description, use experimental understanding, and multiple realities" in the researchers attempt to be an interpretive (Stake, 1995, p.43).

Case Study Design

One way of conducting qualitative research is by using a case study design (Yin, 2003). In this study, I used a naturalistic, exploratory, qualitative approach to interpret several exemplary case studies. In addition, I utilized several de-identified case studies from my private clinical practice with individuals who presented with non-suicidal SIB, and who participated in live therapy sessions in conjunction with collaborative email letter writing (CELW). I selected a naturalistic, exploratory, case study design for this research to "investigate a contemporary phenomenon within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident" (Yin, 2003, p. 13). In order to ensure that the boundaries of this study remain reasonable, the researcher will limit her objectives, and consideration to time and activity (Stake, 1995), and to definition and context (Miles & Huberman, 1984) will prevail.

As the researcher, my responsibility is to help the reader attain a thorough understanding of the phenomenon being studied (Stake, 1995), as well as to "establish patterns of unanticipated as well as expected relationships" (p. 41). This research "seeks to portray the case comprehensively, using ample but nontechnical description and narrative" (p. 134). Moreover, this case study will not represent a large sample or generate numerical frequencies as in a quantitative research study (Yin, 2003).

A case study design is a way of investigating an empirical topic by following a set of procedures. These procedures will begin with a strategy, whereby the researcher will explain three stages of logic, which is unique to this case study's design and is expected to help the reader arrive at a natural generalization with understanding of the phenomenon being studied. (For detailed information on natural generalization, see Case Study Data Analysis.) The researcher's observations are interpretive and subjective, while at the same time offering the reader an opportunity to understand the case in its natural setting. Stake (1995) suggests that "the way the researcher interacts with the case is presumed unique and not necessarily reproducible for other cases and research" (p. 135), "and is an exercise in such depth, the study is an opportunity to see what others have not yet seen" (p. 136). Qualitative case study research is recognized as being subjective, where new questions for inquiry are frequently produced rather than solutions. According to Stake (1995), "Subjectivity is not seen as a failing needing to be eliminated but as an essential element of understanding" (p. 45).

Collecting data from different sources is one way to strengthen and increase the validity of the case study design (Stake, 1995). In this case, the researcher will provide multiple perspectives to consider and reconsider as the study progresses (Stake, 1995). In this exploratory case study, the researcher defines multiple sources of perception as the therapist's observations from live therapy sessions, and examples of the propositions are derived from collaborative email exchange with the sample of clients during therapeutic treatment.

Examples from the collaborative email exchange are considered archival documentation that was collected and stored during treatment. Stake (1995) explains that

"the most important use of documents is to corroborate and augment evidence from other sources." He further suggests, "That the researcher can make inferences from these documents, while explaining that this information is only an inference, but not a true or definitive finding." When using archival documentation it is equally important for the researcher to be cautious regarding the accuracy and interpretation, and "should be used in conjunction with other sources of information in a case study" (Stake, 1995, p. 89).

In addition, Yin (2003) suggests that a case study should have a specific strategy and its "design should have five components: 1) a study question; 2) its propositions; 3) its units of analysis; 4) the logic linking the data to the propositions; and 5) the criteria for interpreting the findings" (p. 21). Utilizing Yin's five components for my case study design, I explore the contextual conditions in a real-life setting, and provide the reader with the most pertinent variables from the multiple sources of evidence collected. I use three stages for my theory-building logic to distinguish my research strategy (Yin, 2003), while using triangulation to develop propositions to guide data collection and analysis (Yin, 2003).

According to Yin (2003):

> The overriding principles that are important to any data collection include the use of a) multiple sources of evidence (evidence from two or more sources, but converging on the same set of facts), b) a case study database (a formal assembly of evidence distinct from the final case study report), c) a chain of evidence (explicit links between the questions asked, data collected, and the conclusions drawn. (p. 83)

The researcher combined the data from direct observation and from stored archival email letters to create possible observations, and propositions and to "make meaning" of the phenomenon being studied (Yin, 2003). The therapist's direct observation and archival data was used both for the purpose of obtaining multiple perspectives, and to describe the phenomenon from the therapist's perspective. The researcher's interpretation was considered to be subjective (Yin, 2003), and was delivered in the form of vignettes of each case study. By weaving the therapist's experience of email exchanges into each case study vignette, I develop the first stage of logic, thereby contributing to a rich description of the phenomena being studied and "develop[ing] vicarious experiences for the reader, to give them a sense of being there" (Yin, 2003, p. 63).

Case study vignettes are made up of data collected from the email exchanges in three client case studies. Each client's written collaborative exchanges provides a new and important source of information based on the client's perspective, and produces the second stage of this study's theory-building design. Once the case study vignettes are fully developed, the researcher provides pertinent examples of ongoing collaborative email exchanges during therapeutic treatment. In each case study, emphasis will is placed on nine elements in the form of propositions of client-therapist exchange that provide examples pertinent to curious, respectful questioning, the client's use of language, the client as the expert, externalization of problems, highlighting and promoting absent but implicit unique outcomes, deconstructing of problem saturated stories, one-person family therapy, changes in the relationship to the problem, the development of autonomy and creating possibilities for the future, and the retelling of client's preferred story in writing.

After the researcher has completed the first two stages of this study's design, the co-investigator is introduced to collaborate with the researcher to compare and contrast patterns across each case (Yin, 2003). A cross-case analysis matrix (Stake, 1995; Yin, 2003) provides information by the researcher and co-investigator for the third stage of this study's design to compare and contrast the patterns of propositions from the therapist's and the client's perception of the phenomena being explored.

Layered Account

In this study, I have elected to use a layered account to present my findings to the reader and to provide additional possibilities to fill in the gaps related to the interpretation of the writer's narrative. Layered account is a "postmodern ethnographic" reporting format that enables the researcher to draw on as many resources as possible in the writing process, including theory and lived experience (Ronai, 1997, p. 420). The use of an ethnographic technique would be defined as "the act of writing about people," by which the researcher focuses on cultural description, critique or beliefs (Chenail, 2011). According to Ronai (1995), a layered account approach provides complexity and encourages the reader to construct his or her own interpretation of the CELW. By using the technique of layered account, I have four sections that provide the reader with examples from the client and therapist CELW propositions, relevant information collected from the literature, and the researcher's observations. The use of a layered account is suggested to reduce the researcher's bias and to assist the reader in finding new meaning for interpretations through multiple sources of data (Fry, 2010).

Data Generation, Collection, and Preparation

Data collection generally begins before the researcher decides to conduct a case study (Yin, 2003). Data is considered to be informal impressions, and therefore, is subject to being replaced or refined during the life time of a case study (Stake, 1995). To increase the quality of any case study, the researcher will need to use multiple sources for data collection (Yin, 2003), which seeks to converge on the same set of findings. Different sources of data collection are applied to search for meaning, understanding, and to find patterns of consistency. The researcher analyzed behavior, issues, and context with regard to each particular case and across cases. By using multiple sources of data, the researcher expected to enhance the rigor of a study, and provide a more precise understanding of the phenomenon being studied (Stake, 1995; Yin, 2003).

In this case study, I explore several cases that are similar and that meet the criteria for the phenomenon being studied. I use more than one case study because the evidence from several case studies is considered to be more compelling and is regarded to be more robust with enhanced external validity (Stake, 1995). Gerring (2007) suggests that it is common to combine several cases in a single study when a case in considered "most similar" or "most different" and that "a sample consists of whatever cases are subjected to formal analysis" (p. 21), while Yin (2003) explains that a single case design and the use of multiple cases "are variants within the same methodology framework, and the choice is considered one of research design, with both being included under the case study method" (p. 46).

To minimize the researcher's bias or misperception, triangulation was used during data collection, data interpretation, and data analysis (Stake, 1995). A co-investigator was

introduced in the final phase of analysis to assist in the process of investigator triangulation by participating in the cross-case analysis of each case study. According to Stake (1995), using a co-researcher reduces bias, increases validity, and enhances the understanding of the phenomenon being studied from the perspective of the researcher. Bias that arises from the researcher's own beliefs, values, and prior assumptions needs to be considered as an influence when analyzing the case study evidence (Darke, Shanks, & Broadbent, 1998).

This researcher anticipated, but did not assume, that collecting data from the therapist and clients would yield information that corroborates the researcher's propositions. Stake (1995) suggests that propositions are helpful in any case study and provide a conceptual framework for the focus and scope of the study, while Baxter and Jack (2008) find that, "propositions may come from literature, personal/professional experience, theories and/or generalizations based on empirical data" (p. 551). In this case study design, the researcher will use propositions in such a way to be "progressively focused," whereby, as the study ensues, organizing concepts can change (Stake, 1995, p. 133).

Case Study Participants

Following IRB approval, the researcher selected a sample of clients who met the criteria for this study's research design. The clients who were selected to participate in this study were de-identified for the purpose of privacy and client anonymity. Each individual client case met the criteria of non-suicidal, repetitive SIB upon entering clinical treatment, and was 18 to 25 years old at the time of the research for this study. In addition, each participant received therapy treatment in the office of the therapist

researcher between the years 2006 and 2011. The duration of therapy ranged from one to two years, and each case study participant or guardian signed a consent form agreeing to participate in ongoing collaborative email communication in conjunction with therapy treatment in my office. (See the Appendix for a copy of the consent form.)

A co-investigator was enlisted by the researcher to obtain important information pertaining to interest, confidentiality, and competency to participate in this study. In an effort to reduce therapist bias, the co-investigator chosen was a licensed therapist, CITI certified, who has no fewer than five years of experience treating clients, but who does not specialize in the treatment of SIB. The co-investigator signed agreement forms pertaining to client confidentiality, and met with the researcher for a 60-minute meeting prior to conducting an analysis of the three client cases to discuss the importance of, client respect, and general SIB information. (See the Appendix for a copy of the co-investigator's agreement.)

All participant case information including collaborative email letter writing exchanges were stored as de-identified information to protect the anonymity of each individual. In addition, collaborative email letter writing exchanges were collected and stored in such a way as to prevent identification of clients by age, demographics, and dates. Client letters were electronically stored from each case and will remain in the researcher's secure Adobe Acrobat file as de-identified data.

In conclusion, this case study research combined the therapist information gleaned from live therapy sessions with the focus on nine elements and propositions of therapist-client email communication. These aspects of the researcher's observation and

archival data (email letters) yielded a rich source of understanding of the phenomenon, which was used to prepare the first part of the logic of this study's design.

The second part of the logic of this case study design utilized CELW exchange to provide ample case study understanding from the clients lived experience relating to how change might have occurred during the therapeutic process. Specific examples of ongoing CELW are provided throughout therapy treatment and will, presumably, add a new understanding of the client's firsthand experience. Developments from these different sources converge in the third and final stage of logic, where cross-case analysis matrices and a summary identify patterns of similarities and differences of the propositions being identified and studied across all three cases.

A case study design "can be considered to be an all-encompassing research strategy that covers the logic of design, data collection, techniques, and specific approaches to data analysis" (Yin, 2003, p.14). Case study design is not used for sampling research but is deliberately implemented to cover the contextual conditions in an attempt to understand the phenomenon of the study (Stake, 1995). I used this research strategy to explore the phenomena of "how" email letter writing is used as an additional therapeutic technique in ongoing therapy relationships. According to Yin (2003), the strength of any case study research is its ability to deal with a variety of sources of evidence that are not necessarily available in more conventional studies, and to increase the rigor of the study.

Case Study Data Analysis

Case study data analysis is not defined by a particular point in time (Stake, 1995), but consists of examining and categorizing the qualitative evidence to address the initial

propositions or assertions of the study (Yin, 2003). These initial propositions help to organize the entire study, while pointing the researcher towards the most important aspects of the data to be analyzed (Yin, 2003). In essence, case study research attempts to search for additional meaning, rather than to find confirmation of a single meaning or truth. Stake (1995) explains:

> Researchers act in much the same way when they encounter strange phenomena. And they have certain protocols that help them draw systematically from previous knowledge and cut-down on misperception. Still, there is much art and much intuitive processing to the search for meaning. (p. 72)

In this study, the researcher hoped to reach new understandings about the cases being studied through both direct interpretation and through the aggregation of variables and propositions. The researcher used a case study design to search for meaning by trying to understand the changes in behavior, issues, and contexts from the therapist's observations and CELW collected during therapy with regard to each particular case study (Stake, 1995). Six propositions or elements were used to find patterns that were coded and categorized from both the therapist's perspective data, and from the client's email communication. Once the data had been collected, the researcher attempted, "to pull apart and put back together a more meaningful analysis" (Stake, 1995, p. 75). Three stages of data analysis activity were used in this research. Miles and Huberman (1984) suggest:

> Data display refers to the organized assembly of information to enable the drawing of conclusions. Data display includes narratives, matrices, graphs and charts. Conclusion drawing/verification involves drawing meaning from the data

> and building a logic chain of events. Data reduction refers to the process of selecting, simplifying, and abstracting. (p. 21-23)

The cross-case tables and summary were designed to illustrate the three stages of the data analysis. The first stage of analysis focussed on the selecting, simplifying abstracting, and transforming of the eight elements and propositions collected from each unique case study. The second stage of analysis displayed the patterns of similarities and differences found in the therapists' observations and CELW across each case study. The final stage consisted of linking together conclusions to build meaning of how change may have occurred during the therapeutic process. Cross-case analysis tables and summaries were developed by the researcher to display relevant patterns of information. By implementing these three stages of analysis, I increased the rigor and reliability of my research. Furthermore, I expected to promote ongoing reflecting of the data, triangulating, as well as being skeptical about first impressions and simple meanings (Stake, 1995). The researcher offered in a summary a "thick description" and "the interpretation of the data by the people who are most knowledgeable about the case" (Stake, 1995, p. 102).

Case studies are not designed to generalize to other cases. Rather, most case studies are designed to provide an in depth understanding into a unique phenomenon. Therefore, Stake (1995) introduces the idea of natural generalization, whereby people learn about a phenomenon by receiving generalizations from their experience with others or with the material that they read. "Natural generalizations are conclusions arrived at through personal engagement in life's affairs or by vicarious experiences so well constructed that the person feels as if it happened to themselves" (Stake, 1995, p. 85).

Natural generalizations are important in case study research because the experience of the reader is crucial to the understanding of the case. Furthermore, the researcher, according to Stake, is responsible to provide propositions that will allow for the researcher to assist the reader in making a high quality of natural generalizations. Stake suggests that the researcher increase the likelihood of natural generalization to increases the validity and reliability of the case study research.

Roles of the Researcher

In this case study, my goal was to use several roles as I decided, studied, and wrote my research. It was presumed that the variety of these roles would produce a plethora of variables, which would allow the reader to become intimately involved with this case study research. By integrating Stake's (1995) suggestion that the researcher assume the roles of a teacher, participant-observer, evaluator, biographer, and interpreter, I provided opportunities and experiences for understanding to develop in a natural setting, as a teacher would. My role as a participant-observer helped to produce possible descriptions of observational interpretations for the reader during both live therapy sessions and in my examples of CELW. As the researcher, I am aware that my observations and propositions are not value free, but are shaped by my own personal experience. In my results and discussion, I explained the subjectivity of my research. According to Stake (1995), all case studies are evaluation studies. With this understanding, I searched for observations that are worthy of evaluation. In my vignettes of each case study, my intention was to have the reader into explore the life occurrences and the uniqueness of each individual case, while finding new ways to interpret and comprehend the phenomenon being studied.

Case study research uses "the domain of an artist" (Stake, 1995, p. 99). In this way, I wanted to encourage the reader to find new knowledge and understanding that exceeds my own comprehension and portrays the complexity of each case study. I did this from the position of a social constructionist model of the world. Investigator triangulation was introduced in the analysis of this case study research, and to provide multiple research perspectives. I introduced a co-investigator during the analysis stage of logic to uncover new meaning from the therapist-client collaborative email letter writing (CELW) propositions from the three case studies. My aim was to allow the reader to discover his or her own perspective of the phenomenon being studied by providing multiple perspectives of information from each case study in a naturalistic setting (Stake, 1995). I expected my epistemology to help the reader to realize and to verify that there is no one truth to understanding. I also hoped the reader would consider all participant views as equally important and thereby to seek multiple sources of understanding throughout the analysis of the data.

Strategies for Achieving Trustworthiness, Credibility, and Validity

Several basic elements are described in the design and implementation of case study research to enhance trustworthiness and credibility (Baxter & Jack, 2008). The authors suggest that "researchers using this method will want to ensure that enough detail is provided so that readers can assess the validity or credibility of the work" (p. 556). My research began with a basic foundation to ensure the reader that my research question is clearly addressed, and pertinent propositions are provided. The aim was to explore how CELW could be used as additional communication tool with individuals who struggle with SIB. The use of the therapist's observations and ongoing CELW was considered to

be an appropriate sampling tool for this case study. Data collected used eight guiding propositions for the management of strategies and the binding of boundaries. Baxter and Jack (2008) propose:

> Case study researchers design principles that lend themselves to include numerous strategies that promote data credibility or "truth value". Triangulation of data sources, data types or researchers is a primary strategy that can be used to support the principle in case study research that the phenomena be viewed and explored from multiple perspectives. (p. 556)

The triangulation of three sources was used for analysis, and included data triangulation, investigator triangulation, and theory triangulation. To understand the phenomena, I use direct therapist interpretation and collaborative email letter writing exchange for theory triangulation. A co-researcher assisted in the protocol of the investigator and theory triangulation by providing a less biased and unique interpretation of the phenomenon being studied. Presumably, the co-researcher would look at the scene or phenomenon from different theoretical viewpoint. At this stage, the consistency of the findings or dependability of the data was promoted by having multiple researchers independently code the data and then meet to arrive at a consensus on the emerging codes and categories. In theory, triangulation was expected to occur naturally for the reader. Data obtained from each researcher provided different theoretical viewpoints to compare and contrast data for analysis, and then to find new emerging patterns to enhance data quality for understanding and interpretation (Stake, 1995). Overall, it was suggested that the use of triangulation would increase confidence of the interpretation and finding of this research.

As in all research, consideration must be given to construct validity, internal validity, external validity, and reliability (Yin, 2003). Yin suggested that using multiple sources of evidence is a way to ensure construct validity. In this study, I use multiple sources of evidence with the use of archival data, therapist's observations, and researcher's observations. Internal and external validity is established by the exploration of data collection and analysis to compare and contrast patterns across three case studies

Finally, case study methodology was used to investigate the development and implementation of this unexplored phenomenon. Because case study research is not routinized (Yin, 1994), I have selected my own collection of data and analysis method. I used the ethnographic technique of layered account as a method of presenting my findings (Ronai, 1995, 1997). The therapist's observations and CELW data were used to identify patterns from the therapist's propositions pertaining to important meaning and significance of the phenomenon being studied. The researchers used cross-case analysis to achieve understanding and reflection of how CELW may be used in ongoing therapy relationships. Six tables and a summary provided a display of the progression and understanding of the development of the phenomena being studied. According to Yin (2003), "Such an observation can further lead to analyzing whether the arrayed case studies reflect subgroups or categories of general cases-raising the possibility of typology of individual cases that can be highly insightful" (p. 135).

In conclusion, the goal of the researcher was to seek out and present multiple perspectives for exploration, and to portray different views (Stake, 1995). The researcher recognized that her observations and propositions for understanding the phenomena are subjective; therefore, she offered the reader ample opportunities to understand the

phenomenon being studied from the perspective of the therapist, client, and co-researcher. Data collection and analysis by the researchers is expected to provide more accurate but limited understanding, and to provide the reader with a naturalistic, descriptive report that offers a variety of new opportunities for interpretation of each case study.

CHAPTER IV: RESEARCH FINDINGS AND ANALYSIS

The purpose of this research study was exploratory. As the researcher, I sought to gain insight into the use of collaborative email letter writing (CELW) in therapy relationships with clients who exhibit self-injury behavior (SIB). I was curious as to how social technology could be used as an additional therapeutic technique in therapy relationships with those clients who experience difficulty with verbal expressions of emotion.

I began using CELW in the summer of 2006, shortly after returning to Nova Southeastern University as a doctoral candidate in Marriage and Family Therapy. Previously, I had been influenced and informed by traditional therapeutic methodologies. However, in my doctoral studies I became exposed to newer therapy approaches, such as social constructionist, narrative therapy, and strength-based therapy, which soon enhanced and, in some cases, supplemented the traditional therapeutic models and theories that I have used for many years. In addition to this evolution in my own belief system and in keeping with this new knowledge, my clients became collaborators in their own therapeutic process and changes. At the same time, my private practice began to receive an influx of adolescents and young adults who presented with self-injury behavior (SIB). Working with individuals who exhibited SIB prompted me to seek new avenues for therapeutic communication. Since my focus was to find an alternative form of communication that might be useful for clients who struggled with verbal expression in live therapy sessions, CELW seemed ideal.

I employed CELW as an auxiliary form of communication with certain client populations. This social technology technique promoted continued client connection,

expression, and alliance when the client was not attending a therapy session. I selected clients who presented with SIB for my research, because I noticed that this population struggled significantly with verbal expressions of emotion during live therapy sessions. I also learned that many of these clients were eager to participate in research that included communication using social technology. As a result, I decided to conduct my research study on how CELW can be used in therapy relationships with individuals who struggle with SIB.

In this research study, I explored the phenomenon of CELW with clients who entered treatment experiencing SIB. I selected a case study methodology because it matched my idea for how I wanted to structure the study, especially the process of investigating an empirical topic by following a set of procedures. These procedures began with a strategy whereby the researcher explained three stages of logic. This is unique to this case-study research design and is expected to assist the reader arrive at a natural generalization with understanding of the phenomenon being studied (Stake, 1995; Yin, 2003).

The qualitative case study researcher, "seeks a collection of instances, expecting that, from the aggregate issue—relevant meaning will emerge" (Stake, 1995, p. 75). In an effort to understand and find meaning from the ongoing therapist-client collaborative email letter writing (CELW) exchanges collected during therapeutic treatment, which were voluminous, I focused my data collection on nine propositions:

1. curious, respectful questioning and the client's use of language;
2. the client as the expert concerning her or his own life;
3. deconstructing problem-saturated stories;

4. externalizing problems;
5. highlighting and promoting absent but implicit unique outcomes;
6. changing the relationship to the problem;
7. one-person family therapy;
8. developing autonomy and creating possibilities for the future;
9. retelling the client's preferred story in writing.

These nine propositions narrow and bind the numerous segments of CELW collected during therapeutic treatment to provide pertinent examples.

I used the ethnographic technique of layered account to assist the reader in understanding the multiple perspectives of the process of CELW, and to invite the reader to become an objective participant in the natural generalization of the propositions defined in this study, as well as to provide commentary related to the researcher's perspective as it pertains to "the act of writing about people" (Chenail, 2011, p. 1182). In addition, the technique of layered account was selected to address the therapist's bias and delineate more clearly the role of the researcher. This technique was added to guide and assist the reader to make her or his own meaning of the multiple interpretations from the collected data (Fry, 2010).

The collected data revealed assertions and observations for each case study. A co-investigator was employed during the third stage of the logic of this study. The co-investigator assisted the researcher to discover new insights, and to provide a less biased view into elements of each individual case study. The researcher utilized the co-investigator's findings in hopes that new patterns for comparison across each case study would emerge. Each case study was treated as a separate entity (Yin, 2003). The

researcher developed a final comprehensive cross-case analysis, matrix, and summary, thereby triangulating the data and research investigation for the reader. This final analysis shows how cross-case analysis syntheses can become more complex and cover broader issues than simply analyzing a single case study (Yin, 2003).

Collaborative Email Letter Writing (CELW)

For this research study, I selected three cases from my private practice of clients who displayed repetitive, nonsuicidal self-injury behavior (SIB). Each client case received a suicide assessment at the time of therapeutic intake and was assessed by the therapist to be not suicidal. Although each of these clients faced an assortment and degree of other problems along with SIB, such as anxiety, depression, and eating disorders, I considered them to be "similar" in criteria for this study. Common to all individuals selected, however, was marked discomfort with verbal self-expression of emotions during live therapy sessions, struggles with social situations, and feelings of shame, distrust in caregivers, and a fear of judgment from others.

I used the CELW social technology technique in three case studies by using elements of narrative letter writing (Freedman & Combs, 1996; White & Epston, 1990) to map alternative story themes, externalize problems, and identify unique outcomes from my client's entrenched negative identity conclusions. By adding letter writing as an additional pathway for collaborative communication in previously established therapy relationships, I was able to provide an auxiliary form of communication to build our therapeutic relationship. My email letter exchange added an additional way for me to attend to what my client might be doing differently. In each of my responses with the client, I used my client's language and metaphors to derive new themes for reflection. I

created my email letters by first reviewing the client's session notes and from these notes identifying unique outcomes. By using these unique outcomes as an extension of our counseling sessions, I was able to document the client's life stories (White, 2007), as well as to identify alternative themes separate from her or his SIB. Together, the client and I discovered new themes that were not under the influence of SIB, and new opportunities emerged filled with independence, strengths, and courage. These new themes provided new opportunities for my clients to define their own positions relative to their experience with SIB. Previous norms and expectations were rewritten into a new story of strengths, values, and ways to cope with ongoing life stressors.

Each client email letter was composed specifically to aid the therapeutic process, content, and progress of my client. I expressed my desire and appreciation for the opportunity to communicate with my client outside of our therapy sessions. In my first email letter, I explained to my client that I did not have expert knowledge of her or his life experiences and that we would learn about their experiences with self-injury together, which might lead us towards a path of understanding about the presenting problems. Moreover, I explained in detail that email letter writing is not something that my client should feel compelled to do. I explained to each client that this technique was to be used without attention to form. In fact, I advised clients to respond only to the questions or content that they felt was useful. In addition, I advised each client who participated in CELW that I check my email communication daily and that I would respond within 24 hours. However, if an emergency situation arose that demanded my immediate attention, I encouraged each client to reach out by phone. I found that clients usually responded to

my email communications. In many cases, my client spontaneously wrote an email letter during the week that expressed ongoing ideas, feeling, and thoughts.

Research Findings

I present my findings as the role of the researcher in the form of a summary at the end of each individual case study. My aim is to step away from the data to discover a new perspective and to facilitate the composition of a narrative that included the multiple perspectives of the therapist participant-observer, client CELW, and the therapist CELW. I then than apply the nine guiding proposition collected for analysis to the researchers summary. These propositions, which yielded insight into meaning and understanding from multiple perspectives, are explored after each case study illustration in the Researcher's Summary. I used the ethnographic technique of layered account to present the findings to the reader and to provide additional possibilities for filling in the gaps that naturally occur when interpreting each writer's personal narrative.

In the following case studies I have changed names and details to protect the anonymity of each client. However, although such identifying details have been deleted, I have attempted to retain the essence of each case and its essential veracity.

Case One: Val

My first experience working with CELW began in 2006, when I worked with Val and her parents for over one year. Val attended weekly sessions in my office and participated in ongoing collaborative internet communication with me. Val's family attended six therapy sessions over the year that she was in my care. In our first session, Val reported that she began to cut herself as a way to deal with her emotional pain and difficult past experiences. She explained that she, her biological parents, and her siblings

emigrated from another country when she was 11 years old. Shortly after her family moved to the U.S., her mother became depressed and her parents placed a large part of the responsibility for care of her siblings on Val. In addition, Val had difficulty assimilating into American culture and hated her new school. Val's parents were of different ethnicities.

In our third session, Val explained that her parents were from different cultures. She told me that her father had been an alcoholic with frequent angry outbursts for as long as she could remember. She said that he stopped drinking two years ago, when he was diagnosed with ADHD, for which he began taking medication. She described her mother as always struggling with depression, but never expressing any type of emotion. She explained that she felt that she had been uprooted from her grandparents and her larger family system, as well as from her home of origin. Val described this move as a very stressful and difficult event for her entire family. In the next five years, Val explained that she had a horrible time in high school. The first major problem was adjusting to American culture, learning the language, and becoming a parent to her parents and siblings. As a result, she learned the English language before her mother and siblings. Val declared that her responsibilities were enormous. She felt that she did not have time for herself because she was always taking care of someone else. She explained for the first few years of school she felt like she did not belong. In addition, coming home was often unpleasant, because her mother was depressed about leaving her country of origin, her father traveled a great deal for work, and she was responsible for taking care of her three brothers and sisters.

Val reluctantly informed me that during her first year in high school she was repeatedly gang raped by three older boys who attended her school. Val told me that the rapes occurred many times over 6 months and finally stopped by the end of that school term. Val felt that her overwhelming fear at the time and her concern over creating additional problems for the family prevented her from telling anyone else about what had happened to her. Val did report her abuse to her physical education teacher several years later, who then reported the incident to the principal of the school.

Val had been referred to three prior therapists who defined themselves as SIB experts. She had been hospitalized for a month at SAFE (a program in Texas for adolescents who exhibit SIB), and she had made several emergency room visits for treatment of her cutting wounds. Also, she had been on a variety of medications, all of which she reported did not help her SIB. During our therapy treatment, she continued to seek treatment from her psychiatrist and received medication for depression and mood swings It was necessary in our first meeting to focus on making sure that Val was safe and not in danger of seriously hurting herself. We collaborated on a verbal contract that described all of the options related to seeking help if it were needed. This plan addressed health and safety issues, and Val agreed to make contact with me by phone if she had injured herself and was in a dangerous situation. Otherwise, she would use the internet to communicate with me during the week as a forum for self-expression and support.

Val had very few friends that she spent time with after her last year in high school. She considered herself a loner, but wished that she had more friends. She was cognizant that many of her behaviors had a negative effect on other people. She claimed that she preferred spending time with older people. Val did not drink alcohol, smoke pot,

or date boys. She explained that she did not have an interest in this lifestyle at this time. She reported that she believed that this made other people feel strange. In a sense, she believed she was too controlled, which made most teenagers feel uncomfortable around her.

Our CELW process proved to be a powerful vehicle for Val's change. In one of our sessions, Val explained that she loved writing letters to me and that when I responded it helped her to feel better about herself, which promoted a more trusting therapeutic relationship. In addition, she explained that during the weeks that she had difficulty with cutting, self-expression, or food issues, she would write letters or reread some of the letters that had been sent to her, which provided a positive, supportive voice to propel her behavioral change. She also acknowledged that writing became a friend and a way to test out her expression of emotion. Val wrote, "It is like putting my toe in the water and I do not have to go into completely." Writing seemed to help her to learn to express and test out many of her new expression of feelings. These resulted in a feeling of less isolation and the connecting of other around her. A pivotal point in our therapy was when Val wrote in one of her letters that her voice on paper created a change in the way she expressed her frustration, anger, and feelings about herself.

Curious, respectful questioning and the client's use of language. In one of my first internet letters with Val, I used curiosity and respect when writing my first letter to her. I did this purposefully, hoping that my attention might spur her interest in any return internet communication that she might decide to send me. I never challenged her position or questioned what or when she would decide to respond to my letters. I respected and supported Val's decisions throughout all of our email communications. In addition, Val

used the term that she would like "to get back on track." In many of her email responses, she discussed how she planned to get back on track. I followed her lead and used this metaphor throughout our email communications.

Dear Val,

I feel honored that you feel comfortable talking to me. I understand that it was not easy for you to come to a counseling session. I am pleased that you are excited to communicate with me by email. Please know that it is your decision regarding what you select to respond to.

Therapists may also write therapeutic letters as a way to honor client language and stories (O'Hanlon & Weiner-Davis, 1989; O'Hanlon, 1994; Pyle, 2006) in narrative therapy (White & Epston, 1990), and as an extension of counseling sessions that document and privilege a person's lived experience. In this internet response, by using Val's language, I documented her lived experience and her emerging new unique outcomes:

Dear Val,

I noticed from our conversation on Tuesday in session that you made the decision to stop school for a short while and look for work. You also told me that you are looking into moving out of your parent's home and into your own apartment and that you thought this would help you with your thoughts about cutting.

Therapeutic letter writing can encourage clients to move forward in time. The therapist and the client can enter into a search for new meaning and new possibilities, where new questions emerge that challenge problem-saturated stories (Freedman &

Combs, 1996; White & Epston, 1990). "Alternative stories are derived from the discovery of past, present and new unique outcomes that are contradictory to the dominant story" (White & Epston, 1990, p. 127).

The client as the expert concerning her own life. Val was the expert of her own life; therefore, in our conversations, I demonstrated my expertise in the area of process, rather than content. It was equally important for me to validate and to honor the narratives that Val brought into question during our therapy encounters. I encouraged her to revisit elements related to past, present, and future. In my letters to Val, I commented on specific parts of these narratives. At times, I chose to discuss elements of her stories in our therapy sessions for further discussion and reflection. Although my goal was to collaborate with her throughout our written exchanges, I always honored Val as the authority of her own life narrative. In the following segments, I encouraged Val to narrate her own story without having to think or edit any of the content of her writing.

> *Dear Babette,*
>
> *This is going to sound weird, but when my arms are clean with no wounds just scars, I think they look ugly. I hate the way they look and the stress I get from people. So, I get urges to cut because I want them to look the way I feel. I guess I sometimes can't handle what is happening in my head emotionally. I can deal better with the physical pain and it actually relaxes my body. I know that's not a good thing but that's how it is. I wish I understood myself better*.

Dear Val,

It seems that you have the need to be honest about your feelings and your writing appears to reflect many of your struggles. Telling me about the stories from your point of view is very important to me. Thank you for trusting me with you true feelings. I look forward to hearing more about what happened over the last five years and how we can find new ways for you to relax your body without harming yourself. Please feel free to write anytime you feel that you need to express these emotions.

Dear Babette,

I've been thinking about our last session, I never really thought about how I felt about my parents giving me so much responsibility when I came to this country and with my siblings. I guess in a way, I resent them for doing that to me. I had a conversation with them last night about them doing this to me.

Dear Val,

I am so appreciative of all of your stories because it helps me learn and understand better how you feel. You seem to be working so hard to understanding the past and how it relates to the present. Talking to your parents was such a big step towards letting others know what has happened and how you feel. Trying to understand yourself and these behaviors will help you to understand the struggles you have endured and how to move forward in spite of these concerns.

Deconstructing problem-saturated stories. Deconstructing problem-saturated narratives is a process whereby the therapist acknowledges, challenges, and questions previous assumptions (that is, the dominant discourse). I sought to accomplish this by challenging Val to review, revisit, and then revise some of her past negative socially constructed narratives. Val explained to me in her second office visit that she struggled with SIB for five years and received harsh, disrespectful, and inhuman treatment from many of the caregivers with whom she has had appointments. In this email letter, Val describes the dominant discourses that have taken ownership of her personal identity.

Dear Babette,

I can't do anything right. My mind is constantly preoccupied with how much I hate myself. I'm so tired of trying to be good and not cutting or abusing food. I had a flashback over the weekend. This made things much worse. I don't want xxx to think that I am a bad person and be scared of me. It is no ones fault but my own that I get these flashbacks. I am exhausted.

Dear Val,

Thank you for letting me know how you really feel. I imagine that you have struggled with many of these thoughts over the years. Thinking about and trying to change these behaviors can be tricky, and as you said exhausting. Last week in session, you explained that there are days when you feel lousy and days when you feel pretty good. It must be difficult having your friends and family feel fearful of your behavior. I was wondering when are the times or days that feel less fearful?

My position was to continue to assist Val in the co-creation of new narratives by asking respectful questions that open up doors for her to invent new solutions that might assist her in coping with her continued struggles that contributed to the ongoing disturbing thoughts and social discourses.

Externalizing problems. Externalization creates a separation between persons and their problems. This, in turn, may open up space for new preferred ways of relating to the problem (White & Epston, 1990, White, 2007). Val initially had a difficult time changing her behavior because she had mixed feelings about discontinuing a behavior that was both friend and enemy to her. She explained that cutting was a type of survival mechanism and something she liked to do, although at other times, she hated it and wanted it to stop controlling her life. In this example, Val explains to me that she highlights her mixed feeling with giving up self-injury:

Dear Babette,

I do not want cutting to control my life, it just ruins everything. Even though I have to admit sometimes I do not mind it. I try so hard not to cut.

As Epston contended, "it is important for therapists to find out what the person is doing differently so that the problem can be disavowed" (Personal communication, 2010). I continued to find ways to point out that Val is able to disavow the problem:

Dear Val,

I hope that others can learn to push their self-harm behavior as far away as you are doing.

Dear Val,

When you told me in session that you had several good weeks, how did you manage to keep cutting from taking control?

As Val's letter writing evolved, she began to see firsthand how SIB had benefited her and why she had struggled to change the behavior without success over the last five years. She contended that this awareness made her feel less "damaged" and "crazy." While I intended to help Val externalize her problems, I also attempted to help her voice her past, present, and future unique outcomes. I believed that voicing these unique outcomes would help Val see that her problems only played a small role in her personhood.

Highlighting and promoting absent but implicit unique outcomes. Finding "unique outcomes" often enables persons to locate and embrace their own unique story of struggle, and to identify alternatives to those unitary knowledges (White & Epston, 1990). Val was able to identify alternative themes that helped her to challenge the unitary knowledge and find subordinate storylines to give expression to her experience of trauma (Denborough, 2006; White, 2006). In this letter, Val found alternative narratives towards her preferred identity. Val explained that her past trauma did not define who she was and that she could combine her past narrative with her new alternative story away from the normative social discourses that had told her that she was a bad person:

Dear Babette,

I think that my cutting does not make me a good or bad person. I think what matters is how I handle any situation and that even with the trauma

of my past, I have made it through and it has made me stronger. I am finding new ways to deal with my emotions.

Dear Babette,

I had a great weekend. The cutting and food issues were not even a part of me. I was able to allow myself to have fun with my family.

Val's letter writing contained a host of new meanings, feelings, and thoughts, some of which she found she could use to propel herself forward generatively. Val was convinced that she was not normal because many of the people in her life had been the judge and jury regarding her SIB. This recurring theme was perpetuated by her conversations with family, friends, and some of the professionals whom she had trusted with her medical and therapeutic care. In our written communications she began to challenge her previous negative identity conclusion:

Dear Babette,

I feel good that I shared a lot with my parents and xxx this week. I am able to share more with my parents these days because I am not so concerned with what they think.

Dear Val,

Not keeping your feeling in and sharing your thoughts and feelings with your parents and xxx seems to be very helpful. How have you managed to make this change?

Changing the relationship to the problem. Val's ability to separate herself from her problems resulted in her having a different relationship with them, as well as having a different relationship with the other people in her life that had at one time connected her

to these problems. Other themes became more predominant, which generated a new preferred story related to independence, making new decisions, and taking care of herself. In Val's final letters, new narratives and relationship dynamics were noticeably different from her dominant story as it existed before our therapeutic relationship began.

Dear Babette,

I am choosing friends that do not judge me. I feel like a weight if lifted off my shoulders because the more people I talk to like xxx and xxx and the more I write and talk to you…I feel like I am not so crazy.

Dear Babette,

I heard this quote, "damaged people are dangerous because they know they can survive" I now relate to that! Everyone in life gets hurt or damaged in one way or another. but I now believe that those who experience trauma, no matter how significant or insignificant, gain confidence of knowing they can survive curiosity, respectful questioning, and the client's use of language;

One-person family therapy. Val participated in most of her therapy sessions without any of her family members. Initially, with significant reluctance from Val, I encouraged her parents to join several of our first family sessions. The time spent in family sessions appeared compromised. In fact, Val sat silently during the two family sessions that her parents attended. Val later confessed to me privately that when her parents were not in the room, she felt more comfortable expressing her emotions, feelings, and thoughts. Therefore, I decided early in our therapy relationship that it would be more useful for me to see her parents separately for therapy sessions.

Dear Val,

Thank you for sharing your thoughts with me. It seems that you have been thinking a great deal about how you feel about your role in your family. We discussed in therapy last week responsibility that you had as a young person was overwhelming for you at times. It is also interesting how you described to me that that same role has helped you to be responsible today and accomplish many things.

Dear Babette,

I realized that when my parents first found out about my cutting, they made things much worse. I wish they would have not freaked out and reacted differently. I feel that they do not understand that this is the way I have learned to deal with my problems. I think my parents should learn about this with other parents

Selekman (2002) suggested that it is important to help clients find new avenues of communication and also to help them have the wisdom to bring their parents' voices into therapy in such a way that they (both parents and clients) can learn to do things differently. In these segments, I brought Val's parents' voices into our therapy sessions and acknowledged her struggles, while encouraging the communication with her parents and other significant persons in her life. Occasionally, I asked her if she would be interested in a family session, but she replied that she preferred to come in on her own. Because Val's parents were such an important presence in our therapy encounters, I brought the voices of her other family members into many of our face-to-face sessions and into our CELW exchanges. Val was able to explore how she felt about the past. She

also began to adopt a new leadership role in considering that she could help other parents with their children who might be going through similar problems.

Developing autonomy and creating possibilities for the future. In one of Val's last email letters, she continued to explore her relationship with SIB, but stepped into other new themes that developed and transported her position as having expert knowledge, while being able to now help others who may be struggling with SIB. Val openly challenged societal and social discourses that promoted the poor treatment of individuals afflicted with SIB. She was also able to comment on what she might see for her new future story as a leader of change for other adolescents with SIB. In this example, Val identified her own preventive measures that will provide information and benefit to parents and professionals when faced with these predicaments, as informed by White and Epston (1990):

> These letters encourage persons to find meaning around those aspects of themselves and/or of their relationships that they can appreciate, but that does not fit with the norms and expectations that are proposed by unitary knowledge's. In this process, persons are actively engaged in his redescription of their lives, and in the establishment of alternative knowledge's of personhood and of relationship. (p. 121)

In these three examples, Val professed not only to have become the expert about her SIB, but also that she could now teach parents and professionals about SIB:

> *Dear Babette,*
>
> *I feel like I have a six sense about which kids are cutting and I have been thinking about how I can teach other kids how to feel better.*

Dear Babette,

I hope I can help you learn how to tell parents and other counselors what to do when they find out that their child or a client is cutting.

Dear Babette,

If you want me to talk to any other clients about my experience with cutting, I think I can help you and them even some more. I have not cut for four and a half weeks.

Retelling the client's preferred story in writing. Email letter writing was an avenue for Val's creative expression that allowed her to express her most intimate feelings that had in the past been self-censored because of her fears of being judged. Although I never asked Val directly about the benefits of our internet communication, the following are three examples of how she believed that writing letters became helpful, as well as a creative practice that she looked forward to:

Dear Babette,

My writing has been a good decision because it helps me to slow down and feel less confused.

Dear Babette,

The more I write the less crazy I feel. Your responses have helped me with that.

Dear Babette,

I think you should encourage people my age to write their feelings down in a letter.

In all of our written communications, Val was selective regarding what she chose to respond to in the letters, and therefore, defined her own path of inquiry and change. This made an important distinction from the other traditional therapies in which she had participated in the past. Val did not follow a preplanned format that determined how she needed to make behavioral changes; instead, she orchestrated and implemented her own treatment plan and change.

Dear Babette,

It felt good talking to you yesterday but I am not used to a counselor who does not tell me what to do, I am learning and feeling good about taking charge of how to handle my life.

Val's progress in making her own decisions and her new participation in her own self-care and independence continued to emerge throughout our therapy experience. I also continued to highlight that Val's relationship with the problem was transformed into a new alternative story away from the discourses that previously had power over her (White, 2007). White (1995) suggests:

> that within the process of this therapy, I provide a safe place for remembering and build a context within which our client's story could be written and rewritten, thereby allowing them to make a distinction between the past, present and future. (p. 146)

In the final CELW exchange, Val redefined her relationship with SIB.

Dear Val,

It seems as if you have figured out how to get the upper hand on self-injury and want other people your age to know about how you have learned to do this?

Dear Babette,

In the past, I thought of cutting as a form of self-expression (on my arms and legs) and for a long time I didn't care what happened to me. Since I started seeing you I realized that I can move on with my life even if I feel out of control. I now see my writing as a way to tell you and others what has happened to me.

Researcher's summary. The collaborative nature of CELW brought a new avenue and form to thoughts about this client's trauma, self-image, and her fear of trusting other people. The implementation of CELW promoted new meaning and understanding between therapist and client, as well as a new level of trust and therapeutic alliance. A safe therapeutic environment was considered essential for clients to be able to explore alternative stories without therapist control and judgment (Hoffman & Kress, 2008; Stone & Sias, 2003; White, 1995, 2007; White & Epston, 1990; White et al., 2003). In this particular case study, the client validated the belief that many of the topics that were discussed during her live therapy conversations were easier for her to express in writing. In this sense, and following Freedman and Combs's (1996) notion of therapeutic letter writing, the client developed—with her therapist—multiple new themes for reflection, re-authored new stories by externalizing the problems, and enhanced her ability to develop a new relationship with the problem. In this case study, the client was

able to take a stand about issues that were important to her view of herself as abnormal, and that challenged the dominant discourses of her problem-saturated story. She was also able to identify new themes that fit with her preferred story, which helped her to worry less about the judgment of others. In some of her email letters, she explained that she could finally have healthy and open relationships with her family members, as well as being able to establish new support systems.

Clients who struggle with verbal self-expression, judgment, and shame, may benefit from using this alternative form of communication to supplement live therapeutic encounters (L'Abate, 2001; McDaniel, 2003). This client stated in several of her email letters that she was more comfortable writing email letters to her therapist than in face-to-face therapy. This freedom of expression appeared to help her overcome the difficulty she had with verbal expression, and provided a new level of comfort during her therapy sessions. The client explained, "I feel I can write anything to you and you will not judge me…this helps me when I come into session". This written exercise created an avenue for the therapist to build trust, alliance, and the ability to ask questions that would highlight important outcomes from the client's therapy sessions. Freedman and Combs (1996) suggested that a therapist use letters as way to summarize therapy sessions and offer an edited version of therapy sessions. The therapist followed this format: first, she carefully selected what was attended to in written form; and second, had the client's progress notes in front of her when she wrote her letters. Performing this exercise with the client's progress notes in hand further facilitated the therapist's use and understanding of the client's language and metaphor.

By adding CELW, this client developed an ability to control her anxiety, slowed down her physical and emotional reactions, and found clarity in how she saw her future. She began to see herself as a leader in the knowledge of her life, and she believed that she could help others who struggled with SIB and their parents. Written expression also enabled her to generalize this expression to other areas of her life, and although some of her fears still lingered, she was able to wake up every morning and recognize how far she had come and how far she wanted to go.

Case Two: Tess

Tess, age 25, entered my private practice at the request of a friend. Tess attended weekly sessions in my office and participated in on-going CELW. I offered Tess the option of using this alternative form of communication to augment her live therapy sessions for the purpose of creating new space for the expression of difficult emotions. It became clear to me early in our therapy relationship that Tess might benefit from an alternative, safe, and creative form of communication.

In our first session, Tess described herself as the only female sibling in her family, with two brothers, one older and one younger. After many conversations and emails with Tess, I began to understand elements related to my client's position as an African-American woman growing up with two brothers. Tess believed that in her culture female children were viewed as less important within the family system. Tess provided many examples of how this made her feel badly about herself, and how it had a significant effect on her self-esteem. In one of her email letters to me, she wrote that the only time she could remember feeling supported by her parents was when she received a scholarship for volleyball to attend college. Even with this accomplishment, she felt that

her parents regarded this success less important than when her brothers had participated and succeeded in any athletic activities.

Tess confessed during one of her first sessions that she did not trust therapists, and only agreed to attend one session as the result of a promise that she made to a friend. Tess related that she had attended therapy on two other occasions that resulted in negative experiences. The first therapy experience occurred at the request of her coach when he became aware that she had been struggling with binging and purging of food on a regular basis during her second year of college. Tess explained that after her first therapy session, the therapist contacted Tess's parents to disclose the content of her conversation. As a result, Tess decided never to return for another appointment. Tess attended two sessions with a second therapist at the request and recommendation of a good friend at her university. She reported that this experience was not helpful because she felt that this therapist was misinformed and lacked compassion related to her self-injury and food issues.

Tess was living with her parents when she began therapy in my office. Her return to south Florida was the result of not having a job or being able to afford to move out on her own. Tess explained that she never felt close to or supported by her parents in most of her life endeavors. As a result, she did not want her parents to attend any of her therapy sessions. Although we discussed that there could be possible benefits to her parents attending a few sessions, she was confident that her parents would have little interest in any type of participation in her therapy sessions. In general she believed that her parents had little understanding regarding her emotional problems or physical wellbeing. This became evident to Tess when she explained to her parents that she was struggling with

emotional issues in college, and her parents became angry at her and judged her harshly for her problem behaviors. Over the two years that Tess attended therapy sessions, I offered the option of emailing her parents to provide them with information regarding her progress in therapy. Tess preferred that her parents were not included in any aspect of her therapy treatment. In these situations, and because of Tess's age, my desire was to follow my client's lead and respect her position. By using Selekman's (2002) idea for one-member family therapy, I was able to bring the voices of other family members into our live therapy sessions and to augment those sessions with CELW, thereby enhancing systemic therapeutic progress and change.

Tess's struggle with SIB surfaced after she had been in therapy for 8 months. Tess explained that she hid this behavior from everyone because she was extremely ashamed and felt that everyone would judge her harshly. As a result, she could not recall exactly when her SIB began. Her estimate was that it began in her last year of college. When I learned of Tess's SIB, it became necessary in our therapy session to focus on making sure that Tess was safe and not in danger of seriously hurting herself. We collaborated on a verbal contract that described all of the options related to seeking help, if it were needed. This plan addressed health and safety issues, whereby Tess would make contact with me by phone if she had injured herself and was in a dangerous situation. Otherwise, she would use the internet to communicate with me during the week as a forum for self-expression and support.

In Tess's email letters, she wanted me to understand that her eating habits and cutting behavior were a coping mechanism for stress, anxiety, and fear. By writing down many of her past experiences, she discovered that her family never encouraged her to

express her feelings. As a result, she learned at an early age how not to express negative emotions. In her last year at USF, she believed that her cutting became a repetitive habit because it was her, "quick way to deal with any emotional pain and feelings of inadequacy and failure."

Tess often used a free-association form of writing in her email letters. Most of her email letters were self-orchestrated. I used curious inquiry to respond to Tess's emails. This created a collaborative way to assist her in the deconstruction and retelling of the many problem-saturated themes that filled her earliest email letters. By adding CELW, I was able to promote a positive, supportive new voice to propel Tess in her quest to become less reactivate during times when she felt out of control. A turning point in our therapy was when Tess wrote to me that, "She did not need to cut herself anymore because she felt she was able to deal with her pain and sadness differently."

When Tess stopped therapy in the winter of 2012, she reported that her SIB had stopped completely. She still admitted to having issues from time to time with her self-image, but she felt that she had learned many new tools to deal with these feelings. Writing and journaling had also become a new friend that she could call upon as a new resource during times of difficulty.

Curious, respectful questioning and the client's use of language. In this segment, I created a context where Tess felt more comfortable expressing her life experiences in writing. I invited Tess, by validating and acknowledging the difficult process, to begin our CELW exchange. I used language as an activity in which we engaged with others to create our realities, and one in which we invited others into written dialogue together (McNamee, 2004).

Hi Babette,

Part of me did not want to send this letter to you because then you will think that I am not doing so well. I have not sent a letter back because I am afraid to tell you what is going on in my head. There is this other part of me that said just write it and send it.

Hi Tess,

Thank you for sharing your thoughts with me even if you are not doing so well. I will welcome any feelings or thoughts that you may have no matter what is going on in your head. Please share only what you are comfortable sharing. By the way how did your trip to Tampa go?

Tess explained that she struggled with putting her thoughts into an email response. Therefore, I invited her to respond, while also being cautious to honor and respect her concerns. In an effort to help Tess move away from the problem, I asked a question about her trip to Tampa. By asking a question, I attempted to encourage a conversation away from the problem-saturated narratives. In addition, my desire was always to use the client's language in my email exchanges, as well as during our therapeutic encounters. Smith and Nylund (1997) suggest that meeting the other person within their language is effective because it offers therapists understanding of how the person thinks about or talks about his/her situation.

The client as the expert of her own life. A collaborative conversation is not possible when the therapist assumes the position of the expert of the client's life (Anderson & Goolishian, 1988). In my CELW exchange, I sought to be "less hieratical, more egalitarian, mutual, respectful and human" (Anderson, 1993, p. 21). My goal was to

create a therapeutic environment that allowed Tess to explore her life experiences from her perspective as the expert of the knowledge of her life.

Dear Babette,

I am not motivated to do anything at all these days. I feel if I had a passion or a hobby I could feel better. I feel like I am always doing so much and not getting anything accomplished. I'm also having really bad body issues this week. I feel as if I am so overweight. When I touch one of my body parts, I want to cry. I just want to wake up and be 30 pounds thinner.

Dear Tess,

It seems hard to be patient with yourself when you are trying so hard to make changes. As we discussed in your session, reaching out to others may be helpful when you are feeling lonely. You explained to me that when you reached out to one of your friends this made you feel much better. I was wondering are there times when you feel better about your body? When are those times?

My therapeutic position was to facilitate the cocreation of new meaning with Tess. This placed me in the position of a collaborative conversational participant. I asked Tess questions in an attempt to create new ideas and meaning for an alternative strength-based story. According to Anderson (1993), "In this process, both the therapist and the client have expertise to engage in dissolving the problems" (p. 325).

Deconstructing problem-saturated stories. I used deconstructive questioning to address past and present problem-saturated narratives. This technique allowed me to focus on challenging previous dominant discourses. I sought to collaborate with Tess to

review, revisit, and the revise many of her socially constructed narratives (Freedman & Combs, 1996; White & Epston, 1990).

Tess,

I am always happy to hear from you. I remembered some of your thoughts from our session, and I thought that many of them make perfect sense. When you share all of these thoughts is it possible that you let them go free? Do you think that when you express your thoughts they can become free? I was equally interested when you told me about telling yourself not to be discouraged that change takes time.

Hi Babette,

Sometimes the voices will not stop in my head. The negative things that I say to myself is overwhelming sometimes. I do want my thoughts to go away or be free but this is something I have to learn to do. Sorry for going on and on.

Hi Tess,

Your responses are welcomed and I never feel that you go on and on. Would you mind answering a have a few questions? How often are the negative thoughts giving you a hard time during the day? What would you have to say to yourself to cut these thoughts in half are magically disappear for a day… that they would leave you alone to think about some of the accomplishments that you have worked hard to achieve?

Over time, Tess and I deconstructed many elements of her problem-saturated stories. In one of her responses to my questions, she explained that her parents never

celebrated her accomplishments. Tess began to realize that her successes went unnoticed, so we coconstructed a new story of how to celebrate her superior strength, courage, and exceptional talent.

Dear Tess,

It was so interesting how you never realized that you never celebrated the successes in your life. I was wondering if you were to explain to your best friend what those accomplishment where…what would she say and how would you celebrate?

Dear Babette,

She would be very proud of me and we would go out for dinner to celebrate.

Externalizing problems. Externalization creates a separation between the person and the problem and opens doors for an individual to find preferred ways to relate to their problems (White & Epston, 1990). In these CELW exchanges, I invited Tess to open space to explore new opportunities and stories, while at the same time, I encouraged her to separate herself from her previous problem-saturated stories. By using the technique of externalization, I created a foundation for Tess to see herself as separate from the problem story (White & Epston, 1990).

Hi Tess,

I was thinking about you this morning and was wondering how you managed to take care of yourself so well in the last few weeks? When you are taking care of Tess, is it easier to keep self-injury and your food issues

at bay? How did you know to start looking for a new job and was this a way to take care of yourself?

Hi Babette,

I am not sure how I take care of myself? I know I'll take myself to a movie and dinner. I try to give myself a full day (Sunday) off where I am doing absolutely nothing. When I take care of myself it is easier to not cut or eat badly. I still have urges and it can be exhausting, but I guess that makes sense.

Dear Babette,

I have been doing some thinking lately about how I do not use the vices that I normally use to feel better like food and cutting. I can't believe my mind is somewhat clear. I have been trying to figure out what I want to do with my life.

In these email letters, I wanted to inquire about the problem becoming less overwhelming in Tess's life. I believed that by asking specific questions, we could coconstruct new narratives filled with elements about how she was learning to take care of herself differently.

Highlighting and promoting absent but implicit unique outcomes. Locating "unique outcomes" often enables clients to embrace their own unique story of struggle, and to identify alternatives to those unitary knowledges (White & Epston, 1990). Tess and I collaborated to identify alternative themes that helped her to challenge the unitary knowledge and find subordinate storylines to give expression to her problems (White, 2006). In these CELW exchanges, Tess found alternative narratives to her new preferred

story. Our CELW exchange offered her an opportunity to separate herself from the stories that had become fixed in the knowledge of her life.

Dear Tess,

When I read your email you wrote, "for once I am thinking for myself and now I like what is happening in my life now". It seems you are feeling better and carefully taking steps to make certain things better in your life. Could you tell me more about how you are doing that?

Dear Babette,

Thanks so much for your email, it meant so much to me. The progress is happening in most of my relationships. I am able to take myself out of a situation and look at it differently. I am not allowing myself to get to the point of being paralyzed like I used to.

Changing the relationship to the problem. When the therapist's main emphasis is on promoting a safe, respectful, conversational context in which clients feel free to express their thoughts freely without judgment or shame, the client is able to make transformative changes (Selekman, 2002). O'Hanlon and Weiner-Davis (1989) contend that the use of consolidating questions invites members to make distinctions between old and new patterns of behavior and describe the future reality that they would like to have. In these CELW exchanges, Tess appeared to be making a distinction where she was ready to take action to find resolve and a new strength-based future.

Hey Babette,

When I see you next week I'm going to bring in a list of fears that I feel hold me back, and a list of things I feel that I can't forgive myself for

because I feel those thoughts are holding me back. I think if I talk about them to you they will not be so strong or go away.

Hi Tess,

I am looking forward to learning more about the things that have been holding you back from becoming who you truly want to become. Bringing your list into session will allow us to work together to see how far you have come.

Hi Babette,

I feel as though I'm not stuffing my feelings anymore. This is helping me to realize things about myself that I like and things that I want to change. I don't like being uncomfortable, but I know I need to be in order to grow, so I'm ready. I'm nervous and scared, but ready.

By asking Tess several questions, we created a new context for change to occur. In these examples, I promoted and encouraged her to continue to reach out to other support systems that she has already experienced as useful tools and coping mechanisms. She acknowledged that when she spoke to her friends she judged herself less and felt less isolated.

Hey Tess,

As you continue to make changes and grow in your life, how will others be helpful to you during that this process"?

Hey Babette,

I need people in my life that I can be open and honest with. That has helped me tremendously, especially talking to you. Taking to you has

helped be to make changes because I feel you do not judge me and you have let me be open with my feelings. I need to know that I am not less than, but a part of.

Hey Babette,

I have decided that I need Tess time. I am figuring out what I want. I have so many ideas. I am realizing things about myself. I know I want to change jobs and find a new relationship.

Tess explained that she was more than ready to take action to implement change in her life. Although these email letters were written to me during her last 6 months of therapy, she was able to identify that she was afraid of moving forward. Gergen (2006) suggested that clients alter or dispose of earlier narratives, not because that do not apply anymore, but because they become less important in the client's new life story.

One-person family therapy. Young adults who feel disconnected from their parents are at a higher risk for developing symptoms such as SIB and eating disorders (Selekman, 2002). Early in our therapy relationship, I asked Tess if she wanted to invite her parents to attend one of our therapy sessions. Tess always answered that she did not feel comfortable with her parent's participation in her therapy. Therefore, I respected Tess's wishes and encouraged discussion pertaining to her family relationships. In this example, I used curiosity in my inquiry to find out more about the voices from her family system.

Dear Tess,

Most parents want the best for their children and try hard although they may miss the mark. If your parents had hit the mark better and they were

here right now, what might you explain to them that they could have done differently?

Dear Babette,

They would have been more supportive. We would have talked more and spent more time as a family. They would have spent more time asking how I was. I do not want them to be like that now. I just want them to leave me alone because it is all that I know from them. I feel that I have other people in my life who fill that role because they did not know how.

Family member attendance is optional in most therapy relationships. When family members did not attend client sessions, I brought the voices of family members and significant others into the therapy conversations and into our CELW exchanges. I believed that Tess was the active agent of change for her entire family system (Selekman, 2002). In this last segment, Tess explained that she has learned how to apply new coping strategies to her previous narrative. In doing so, she explained that she has developed a healthy reliance on outside support systems, while creating autonomy outside of the family system.

Developing autonomy and creating possibilities for the future. In several of Tess's last letters, she continued to explore her relationship with herself, but she has developed new themes that have encouraged a new position of possessing expert knowledge (Anderson & Goolishian, 1988), while also challenging the societal discourses related to why women are forced to have certain body-image expectations. Tess wrote about her struggles with her body image. She also commented on how she has made this change now, but expected it to last into the future.

Dear Babette,

I have gotten so much better these days that when I am going out I get dressed up and look and feel more put together. When I do this, I do it for myself. I worry less about what other people think or if I feel like a fat ass.

Dear Tess,

That must feel great. If you were to focus on a part of you that you liked the best…what would that be? By the way where did you get this idea about being a fat ass?

Dear Babette,

There are parts of my body that I love. I love my eyes and my hands. I also have a nice complexion. I feel much more comfortable in my own skin these days because I am starting to feel ok with myself.

Retelling client's preferred story in writing. In all of our written communication, Tess was selective regarding what she chose to respond to in her letters, and therefore, she defined her own path of inquiry, communication, and ultimate change. Tess never followed a preplanned format that designated how she needed to make changes happen or responded during our CELW exchanges. Tess used free association for most of her emails letters to me. I encouraged her to be the director of her written email exchanges and followed her lead with curious inquiry. In one of my last email exchanges, I proposed the question of whether writing had been helpful to her in therapy. Her response spoke for itself.

Dear Babette,

Writing has helped me tremendously. There are times when I want to talk about things and I'm too ashamed or embarrassed to in person. Not because I think you are going to judge me but I am ashamed sometimes still that I have these thoughts in my head and I feel the way I do.

Dear Babette,

Writing helps me get my head on straight. I write to you because it helps me feel calm and clears my mind.

Tess wrote that this technique had a calming effect on her. In addition, she described that when she wrote email letters to me, it allowed her to take time to put into words what was going on in her head, which helped her to gain a better perspective on her thoughts and feelings. In this segment, she recognized that writing can be a useful outlet for others.

Dear Babette,

When I write my thoughts down I am able to put a lot of things into perspective. It is nice to know that I have another outlet because sometimes things happen during the week and I know I can communicate with you. Everyone should use this outlet.

Dear Babette,

Sorry for writing to you so often, but it really helps me to clear my head and let you know what I am thinking when I am thinking it!

In this example, Tess openly announced that CELW has been very useful in her process of clearing her head in therapy. She explained that this form of communication

helped her to find a new perspective on life. In addition, she reported that she was grateful to have had the outlet of CELW.

Researcher's summary. This client claimed that written structure and form promoted a new way to understand her problems and to think about them differently, which allowed her to write a new story that would include celebrating her successes, experiencing healthy social relationships, and searching to find a satisfying future career. Freedman and Combs (1996) suggest that therapeutic CELW may encourage multiple new themes for reflection, re-authoring of new stories by externalizing the problems, and enhancing the ability to develop a new relationship with the problem. White and Epston (1990) suggest that therapeutic CELW can encourage clients to move forward in time, and that the therapist and the client can enter into a search for new meaning and new possibilities. It is during this search that new questions that challenge problem-saturated stories emerge. Such stories were important for the client to challenge her self-view as abnormal, and to see firsthand how the dominant discourses had taken hold of her life.

This client continued to identify new themes that promoted a new preferred story, which enabled her to worry less about the judgment of others, to find healthier support systems, and to begin to highlight new resources and opportunities towards her future goals and aspirations. In this case study, it is clear that the client preferred to work towards many of her personal goals without the presence of her family system in the therapy room. The therapist was able to work with her client to bring family member voices into therapy sessions, which encouraged the exploration of present and past difficulties. Many of these difficulties are related to her inability celebrate her own ability and successes. In these CELW exchanges, the client acknowledged the need for taking

care of herself, and for having significant support systems outside of her immediate family system.

This client professed to have received enormous benefit from the alternative use of CELW communication. Examples of this benefit can be viewed in several of the client's email letters, where she reported, "that writing was a more comfortable form of expression during times that she felt ashamed, embarrassed, and fear of being judged." Therapeutic change can also be seen as the client's written text changed over time. In her earliest email letters, she felt a need to apologize for writing long email letters to the therapist, and often explained, "I am sorry for writing such long letters." However, as CELW became a more comfortable form of expression for the client, she expressed only her appreciation and gratitude for having both live and CELW therapy sessions.

Writing became a revered technique for this client to soothe herself and to slow down her physical and emotional reactions. In fact, writing became a new outlet for the client to communicate negative thoughts and feelings. She identified in many of her email letters that she has always had profound issues in regard to letting go of the negative aspects of her body image and the need for perfection. In several of her last email letters, she described how the use of written expression proved to be a powerful way for her to explore new aspects of herself to appreciate and love. In addition, she was able to explain that she no longer had a need or desire to exhibit self-injury behavior.

Case Three: Jon

Jon, age 16, was referred for therapeutic services to my private practice for SIB and depression in 2009. Jon attended the first two therapy sessions with his mother. After meeting with Jon's mother, I was informed that the family's pediatrician insisted that Jon

attend therapy sessions for the problems he had been facing. However, upon inquiry, I was told by Jon's mother that he would only be attending appointments to fix his problem and that her husband would not attend therapy because he was angry at Jon for having shamed his family system.

After Jon's second appointment he was dropped at my office or he drove himself to sessions at my office. According to Jon, his family believed that counseling was only for crazy or sick people. Jon explained that his parents became extremely angry with him over the last year when his grades began to decline. At one point, Jon described that both his parents became angry and aggressive with him when he brought home a bad report card. This reaction terrified him to such an extent that this was the first time, he reported, that he began to practice SIB. From that point on, Jon described that he continued to have problems concentrating in school and, as a result, his grades continued to decline. Jon believed that his poor concentration and SIB led to his depression, isolation, and lack of motivation to participate in activities that he had enjoyed in the past. Jon's major complaint pertained to his mood swings, during which his depression might last days and he had experienced dissociative episodes.

Jon described such feelings of overwhelming depression and severe lack of motivation that after our first few sessions, I referred Jon and his family to a psychiatrist for medication evaluation. The psychiatrist put Jon on a low dose of a mood stabilizer. It was also important that I made sure that Jon's parents were not psychically abusive and that Jon would be safe in his home environment. Finally, to ensure that Jon was not in danger of seriously hurting himself, he and I collaborated on a verbal plan to address

health and safety issues. Jon agreed that if he injured himself or was in a dangerous situation, he would immediately contact me by phone.

Jon is the oldest of three siblings with a younger sister and brother. Jon's family immigrated to this country when he was 10 years old. The move to this country was overwhelming for both Jon and his family. After moving to this country, Jon reported that his parents had to work two jobs to support their family, and at 10 years old, Jon described that he had excessive responsibilities. As the oldest sibling, he was responsible for most of the household chores, as well as having to take care of his siblings while his parents worked. Jon explained that having excessive responsibility overwhelmed him and often made him feel alone, isolated, and uncared for by his parents.

When Jon came into therapy, he claimed that his grades had declined over the last year because of his SIB and his lack of concentration in school. As a result, his parents began to physically punish him for his academic decline. In addition, he reported that he stopped participating in many of the activities that he had once enjoyed. He stopped playing the guitar, ceased several sport activities, and became less social with friends. In one of Jon's first email letters to me, he stated that he was having such disturbing thoughts that they would lead to what he explained was his withdrawal and out of control behavior. He explained that he had never told anyone that he had these thoughts and feared that his parents and friends would not understand. In addition, he related that he believed that his parents disliked him and that most of the time his siblings thought he was strange. Jon told me that his mother had told him on many occasions that he was not smart, and that he should have never been born because of the problems he created for his family.

After several months in therapy, Jon reported that he wanted to attend sessions because he believed that attending appointments and writing to me was helpful. He explained that he finally could get the thoughts out of his mind through writing, and that he did not feel that I judged him. Furthermore, he explained that I was the first person who could understand why he behaved the way he did. Jon began to notice, after several months in therapy, that he was beginning to become more social with a new group of friends and that he had reunited with a girl that he had liked at one time. In addition, he described that the hours that he spent visiting SIB websites decreased significantly and that he tended to only contact friends that would be helpful to his struggle with SIB. As time in therapy and CELW progressed, Jon stopped visiting SIB websites entirely.

Although Jon explained his struggles over the year before he attended sessions in my office, I also learned that he loved participating in ROTC at his school and found this activity helped him to feel in control and better about himself. Jon explained that he had received a relatively high-ranked position in ROTC over the last few years. In one of Jon's email letters he explained that, "he loved being in ROTC because it was routinized and provided a structure and a need for order that was not imposed by him." He believed that ROTC was a safe place for him and, therefore, he spent most of his free time participating in this extracurricular activity. He confessed to having several friends in this organization, but now he stated that he had been seriously considering spending time with some of his ROTC friends outside of school.

One afternoon, Jon came into his session and explained to me that he was going to stop his cutting behavior completely. He had decided that he would no longer allow this behavior to control him. He explained that to become a member of the Marines (a dream

he had for many years), he would need to stop cutting completely. Apparently one of his superiors noticed his cuts and spent time with him discussing his options regarding going into any type of military service. Prior to this, Jon had always worn long-sleeve shirts, which concealed his wounds from his superiors and teachers in high school. Jon had made the decision to wear a uniform that displayed his scars, and he explained to me that the act of exposing his scars was a new step towards overcoming his problem with SIB.

After a 3-month follow up session and several emails with Jon, I learned that Jon's SIB had stopped completely. He explained that he still has some bad days along with mild mood swings. However, in most of Jon's last email letters to me he explained that he was excited to face his future and was now thinking about becoming a psychiatrist if he did not go into the Marines.

Curious, respectful questioning and the client's use of language. In my first email letters to Jon, I express my desire to communicate by CELW exchange. As a collaborative therapist, I always respect and support any type of response that my client might provide via CELW. In the following segments, I invited Jon to respond to my email letter writing exchange.

Dear Jon,

Thank you for responding to my email. I feel very appreciative that you feel that writing might be a way that we can keep in touch during the week. Your writing emails will help me to understand you better.

Dear Babette,

I feel as if I am bothering you by sending you my problems by email communication. I have had a terrible week and I am not sure that you

would really want to hear what really goes on in my head when I am at this very low place. I want you to understand that there is this part of me that wants to stop cutting and get better. It is all so confusing.

Dear Jon,

Thanks for coming in yesterday and sharing your honest feelings and thoughts with me. In your last email letter you explained that you did not want to bother me with your difficulties. You also shared with me in session that you did understand why you would need to go to a therapist and share your deepest thoughts and concerns. I respect that you told me that there are things that you are not comfortable sharing yet.

In Jon's email response, I realized that he was questioning his desire to participate in therapy or any type of CELW. I responded to him with compassion and understanding. I wanted to encourage him to shift his perspective regarding the possibility of the auxiliary use of CELW. I was also aware that most SIB clients reported feeling alienated and have difficulty making meaningful connections with others (Selekman, 2002); therefore, my response was inviting, but I continued to explain that I would honor any decision that he might make.

The client as the expert of his own life. Jon is the expert of his own life. My expertise is in the area of process rather than in the area of the content of our conversation. It was equally important for me to validate the narratives that Jon expressed to me in each email exchange. In the following segments, I encouraged Jon to feel free to discuss the narrative that he brought into our therapy relationship.

Dear Babette,

I feel so lost in my life. I feel sad, afraid, angry, hopeless, pain, empty, and alone. I hate feeling alone, because that is when my anxiety starts acting up. Sometimes I feel all of those feeling all at once. I do not know what is wrong with me or why I feel this way, I just do. I do not understand myself for why I feel this way I hate it. Also, when I was a kid, I had problems controlling my feelings so I would push my friends away because I was afraid they would hurt me or abandon me.

Dear Babette,

I hate my mood swings. One day I can be feeling depressed and wanting to cut. Then for several days, I am filled with energy, productive and energized. Then suddenly my mind starts racing and the energy is so great. I hate this so much. I feel out of control!

Dear Jon,

Thanks for sharing your true thoughts and feeling. After reading your email, I can really get a sense how you have tried to understand your emotions and how they relate too many of your struggles. Perhaps writing down these feelings may be one way to help get out what you are thinking and feeling and move on.

Collaborative conversation is not possible when the therapist assumes the position of the expert of the client's life (Anderson & Goolishian, 1988). In my CELW exchange, my goal was to create a therapeutic environment that allowed Jon to explore all of his feelings and life experiences from the perspective of him being the expert in the

knowledge of his life. My position was to validate his difficulties and then to offer collaborative questions that promoted my role as a conversational participant (O'Hanlon & Weiner-Davis, 1989).

Deconstructing problem-saturated stories. The deconstruction of client stories can facilitate the reevaluation of sociocultural messages, which allows clients to discover for themselves those ideas that best fit their preferred story (White & Epston, 1990). Deconstructing problem-saturated narratives is a process whereby the therapist acknowledges and challenges previous assumptions. In the following email exchange, I inquired through deconstructive questioning when his problems have less of a hold on him.

> *Dear Jon,*
>
> *In response to your question, I agree that some individuals struggle more with mood swings and negative thought. We also discussed how someone's self-concept can change. We talked about how people may view themselves or their self-concept as a result of what has been told to them by parents, teachers, or friends. You and I agreed that parents, TV, and the internet can have an effect on how many of us feel about ourselves at any given moment.*

I sought to challenge the dominant discourses that had taken hold of Jon's problem narratives. In this email segment, Jon described the social stigmas that had taken ownership of his personal identity. Deconstructing these narratives involved carefully selecting questions that highlight new ideas and knowledge of my client's preferred story.

Externalizing problems. Clients may find that talking about their problems as separate from their personhood gives them greater hope for change. These conversations can also encourage clients to reexamine the messages that they have received from others about the problem (White & Epston, 1990). When clients begin to challenge these messages, a new story can be coconstructed. In the following CELW exchanges, I used externalization to help Jon separate himself from the problems and to develop new empowering narratives away from the problems.

Dear Jon,

It was so interesting to me how when you played guitar you felt like you became lost in the many types of music that you played. I am also very interested in your love for ROTC and how your feelings of hatred eventually turned into something that you loved.

Dear Babette,

Since I was a kid, I wanted to be a marine. It has always been my dream and something that I loved. I hated ROTC at first actually, and I really did not like being told what to do. However, I did what I was told, and I made sure that I did the best that I could do. Next thing you know, I'm the first person to hold the highest position after only one year; which normally takes 3-4 years. Moving up so quickly made me realize that there is something that I am good at!

Dear Jon,

When you shared your thoughts with me in session, I learned that cutting is something that you hate to love. I was wondering how if cutting once

served a purpose and that was the part that you loved. Is it possible that you are beginning to hate it because you are realizing that you would prefer to control it rather than it control you? *When are the times that you feel that you control it*?

Jon began to separate himself from his problem-saturated story. In so doing, he began to identify strengths and hobbies that had gone unnoticed. I believed that these CELW exchanges could lead Jon towards feeling more empowered, which would then allow him to begin to contemplate the reunification of parts of his person that once felt joy and happiness. The act of separating from his problem-saturated story encouraged new emphasis on the successes that have been a large part of his personhood.

Highlighting and promoting absent but implicit unique outcomes. As a narrative, strength-based, collaborative therapist, I became curious about unique outcomes by asking questions about some of the behaviors that may have been trivialized or diminished in the past. Unique outcomes became building blocks for new contrasting stories (Freedman & Combs, 1996). The process of cocreating and exploring unique outcomes from Jon's dialogue in session, as well as what I learned from his email letter writing, became new information for exploration in these email exchanges.

Dear Babette,

I'm not sure how my role in ROTC turned into something that I loved. I guess it had a lot to do with being and feeling in control. In the beginning, I hated it because every few minutes I had someone telling me what to do. As time went on, I learned to take charge and I became a leader. As a

leader I became able to change my mind. I learned to pretend that everything was okay, and I am pretty good at doing so.

Dear Jon,

That is so interesting how you learned to take charge and become a leader even when it was difficult to do. How did you manage to change your mind?

Inquiry from our therapy sessions and email exchanges tended to highlight unique outcomes. Many unnoticed elements became written text, and thus Jon was able to discuss these unique outcomes in his live therapy sessions. This type of inquiry encouraged Jon to pay attention to some of the unnoticed elements and to incorporate this new knowledge into a new alternative strength-based story moving forward.

Changing the relationship to the problem. Unique outcomes began to emerge, which elicited a new preferred story that included reconnecting with friends and musical enjoyment.. In Jon's final letters, new narratives and relationship dynamics were noticeably different from his dominant story before our therapeutic relationship began. Finally, he explained that he had asked a friend to become his girlfriend and was feeling better about himself.

Dear Babette,

I have not harmed in a while now. The urge is still unbearable. All my cuts are healed, when there are not fresh cuts…that's when I feel I have to do it the most. I can't stand to see them fade away.

Dear Jon,

Thank you for taking the time to share your feelings with me. I am interested in how cutting became something that you no longer need to do and that you only have urges? I understand the urges are very strong, but how have you managed to keep them in check?

One-person family therapy. Jon was 16 years old at the time of therapeutic intake. I believe that family participation, in most cases, is helpful for therapeutic process and change; however, Jon's mother only attended a portion of Jon's first two appointments. In fact, Jon's mother came into session to explain her concern and lack of understanding. I encouraged both of Jon's parents to participate in therapy with or without Jon present, but they declined my invitation. I felt it was vitally important to include Jon's parents in our therapy. Also, Jon was eager for me to include his parents in our CELW as well. Therefore, I sent a series of emails that described Jon's progress in therapy to Jon's email address and requested that he deliver them to his parents.

Dear Jon,

As we discussed, I spoke to your parents today requesting that they come in for a family session. Unfortunately, they have declined. Would it be alright if I send them emails to keep them abreast of our therapy progress?

Jon explained to me in therapy that week that he would be comfortable with my sending his parents an email to report his ongoing change. I explained that I would send all emails to his address first. He could then forward or give the emails to his parents. In the following segments, I included my email letter to Jon's parents.

Dear J & J,

I wanted to let you know that I have been honored to have Jon attend sessions in my office. Jon and I believe that he has been making some significant changes. Last week, Jon wrote to me and we discussed in his session that he would not be participating in self-injury behavior anymore. Jon has had a great month and believes that he will be able to stay injury free in the months to come. As I have explained to you, many self-injuring adolescents perform this behavior as an effort to self-sooth, cope, or perhaps take away the emotional sadness or pain that they may feel. Young people who self-injure do not do this to hurt others or their parents. This is why have noticed that Jon had become isolative and unhappy for the last year.

Dear J & J

Jon has been working hard to make changes in the direction of honest self- expression, finding other avenues for dealing with his frustration, and learning how to handle his mood swings when they occur. I hope you will join me in celebrating Jon's successful changes along with providing assistance towards Jon's decisions for his future career and independence in the future. I appreciate your assistance in working with me to help Jon make all of these wonderful changes. Please free to contact me by email or phone at any time.

Jon's parents decided not to participate in our live therapy sessions. In my email letters to Jon's parents, I included his parents in my therapy encounters with Jon. I sent

several email letters to Jon's parents, with his permission, in an effort to obtain continued family support and transparency of therapy progress. My position was to assist all family members to help Jon attain a preferred identity. By including this minor's parents in our CELW exchange, I provided them with important information regarding Jon's therapy treatment outcome.

Developing autonomy and creating possibilities for the future. As Jon externalized his relationship with SIB, identified new themes that developed, and supported his newfound position of possessing expert knowledge, he also described how SIB now played a smaller role in his life. Furthermore, Jon described how a new alternative story replaced his old problem-saturated story. In the following email letter exchanges, he also commented on what he would actively do to perform his new future story.

> *Dear Babette,*
>
> *In the past cutting helped me to find a solution to my feelings. It would slow down the racing thoughts and emotions. The urges used to happen continuously, now this only happens once in a while. I wanted to let you know that I am taking a psychology class and it is going very well, and I am now working at my parent's restaurant. I am saving money at work to get myself a car and am so excited for that. My girlfriend and I celebrated our anniversary this month.*
>
> *Dear Babette,*
>
> *I am dealing with my negative feelings by remembering times when I felt good and by reassuring myself that I will get over what I'm feeling. I tell*

myself that time is the ultimate medicine. I tell myself that things do eventually get better. Although I know it will take time, every second that goes by I feel better. If the feelings are very intense, and I can't reassure myself, I'll do something to absorb my attention fully, and soon I forget what I was feeling and/or why I was feeling that way in the first place.

Jon explained that he was feeling happier and was managing his problems better. He was able to step away, slow down, and contemplate why and how he was able to do this. Jon stated that the urges to self-injure were still present, but he recognized that they had lessened, and that he was able to control many of these urges. These responses made it clear that Jon was well on his way to feeling better, independent, and confident, and that he would continue to make changes.

Retelling client's preferred story in writing. Live therapy sessions and CELW became a collaborative effort between the therapist and the client to cocreate, orchestrate, and implement a treatment plan that was specifically tailored towards his change. Jon expressed in the following email exchanges that the process of CELW was extremely useful for him. He confessed to having difficulty with certain expressions of emotion during live therapy sessions, and in one of his last email letters to me, he explained that he preferred the option of email communication when he needed to discuss difficult topics in therapy.

Dear Jon,

Thank you for responding yesterday to my email. I am so pleased that you are feeling better these days. I was wondering how our live session

compare to our collaborative email communication. If you prefer both, what did you like about each one and what did you not like?

Dear Babette,

I preferred our email communication. Often when I do try to talk, I can never get out what I want to say. Emailing gives me time to think about what I want to say and how I want to say it. Our live sessions require an immediate response. I think I have gotten better talking to you our sessions. It has helped me to understand myself better and has provided a safe place to talk about things I never talk about. Also, emailing you helped me to say things that normally I would be nervous to say in person.

Researcher's summary. When CELW is used as an additional therapeutic technique, it can elicit a reflexive process that fosters the exploration of multiple meanings (Penn and Frankfurt, 1994), which can also promote additional experimentation that affords the client time to take action to solve problems for new possibilities (France et al., 1995; L'Abate, 2001; Selekman, 2010). In many of this client's email letters, the addition of written structure and form for new understanding promoted new meaning for narratives that were related to present and future change. By adding CELW, this client was able to develop the ability to control his anxiety, minimized his physical and emotional reactions, and found clarity in how he would like to proceed with his future career goals. In this case study, the therapist did not have a planned CELW format. Many times, CELW exchanges were orchestrated by the therapist after therapy sessions. Frequently, CELW exchanges were used as a tool to check in with the client between the live therapy sessions. At other times, the client wrote spontaneously to the therapist about

problems, life events, and other general issues that were important for him to communicate prior to or after therapy sessions. Overall, the client appeared to control the pacing, response, and format of most email exchanges.

Unique to this case study, however, the therapist wrote a series of emails that were sent to the client for him to give to his parents. The parents decided not to participate in his live therapy sessions. The therapist wrote a series of emails that made transparent the client's progress in therapy, that highlighted the client-therapist alliance, and that acknowledged—in writing—Jon's achievements related to his career, academics, and cessation of SIB.

In the last CELW segments, the client identified a multitude of new themes that fit with a more preferred story, which ultimately encouraged the client to reevaluate, challenge, and find new outlets to deal with the disturbing mood swings and SIB urges that had previously consumed a large part of his life. Although the client acknowledged that he still struggled with many of these feelings, he was able to write about the unique outcomes that continued to surface, as well as the monumental change that occurred during his therapeutic participation. The use of CELW in conjunction with live therapy sessions created an avenue for the client to identify unique outcomes and externalize many of his problem behaviors. This was exemplified when the client wrote that his alternative story was now filled with goals for independence, excitement for career options, and the ability to maintain and nurture healthy social relationships. Lastly, this client expressed in writing that he received numerous benefits from the use of CELW, which he ultimately ranked as of higher importance for his therapeutic change than his experience during live therapy encounters.

Case Study Analysis

Qualitative case study analysis offers a means of investigating complex units that consist of multiple variables each of which are of potential importance in understanding the phenomenon being studied (Stake, 1995). "Types of qualitative case studies are distinguished by the size of the bounded case, such as whether it is one individual, several individuals, a group, an entire program, or an activity" (Creswell, Hanson, & Clark, 2007). This qualitative case study analysis used a multiple case study design for which I selected three nonrandom case studies that met the criteria for this study from my private practice. By using a multiple case study approach, I attempted to understand comprehensively multiple perspectives related to the phenomenon being studied. Multiple case study design is specifically useful when the researcher wants to identify which features are unique to a particular case study and which are common across cases.

This section details the analyzed and interpreted evidence related to the pre-established propositions, units of analysis, logic for linking the data to the propositions, and application of set criteria for interpreting the findings (Yin, 2003). Then, this section concludes with an analysis for the reader of the following four sources of data evidence:

1. therapist direct participant-observation, in the form of client case study vignettes;
2. exemplary segments from the client's perspective of collaborative email letter writing (CELW);
3. the therapist's perspective as explored in email segments;
4. a summary of overarching CELW themes that emerge in each of the three case studies.

The intention of this section is to explore how the relationship between the unit of analysis and each case study is conflated and how it can be further understood across a series of cases to find patterns for comparison. The data analysis began with the researcher developing and identifying common words, ideas, and themes from the four areas of data collection. Once the researcher completed this primary phase of identifying themes and ideas for each case, the co-investigator was given the data and was instructed to conduct a separate analysis to arrive at her own understanding of the four areas of data collection. The next phase of analysis was to incorporate the co-investigator's findings of the phenomenon being studied with the researcher's findings. After the researcher compared, contrasted, and combined her findings with the co-investigator's codes and themes, broader themes and patterns emerged that made a more comprehensive analysis of each case study possible. In this way, the researcher intends to provide the reader with the tools to formulate her or his own understanding of multiple perspectives on the phenomenon being studied. This technique of allowing the reader to identify broad themes is called natural generalization (Stake, 1995). In the following section, Tables 1, 2, and 3 illustrate the emerging facts and themes of each of the three case studies. Table 4, *Researchers' Findings*, displays the facts and themes that emerged from the combined findings of the researcher and the co-investigator.

Table 1
Case One: Val

Therapist Observation Participation	**Therapist CELW**	**Client CLW**
Problem family issues: Depression (mother and father). Drinking and ADHD (father). Father travels for career. Immigration and cultural issues.	Individual pace and decisions of what to respond to.	Writing thoughts and feeling down is useful.
Client issues: Oldest of four siblings. Lacks parental nurturing. Anxiety, depression, mood disorder, social isolation. Difficulty adapting to U.S. culture. Thinking of others before self. Child becomes parent	Use of the client's language.	Identifies that problems do not define the person.
Therapeutic issues: Mood disorder/psych evaluation medication. Lacks trust in caregivers. Multiple therapists over 5 years. Client's need for control. CELW helps therapist-client alliance, trust, verbal expression of feelings, frustration, and enhances self-esteem.	Validation of feelings, thoughts and narratives about past and present.	Expert of content and problems.
	Expert of process.	Communicates feelings to parents and other support systems.
	Externalization of problem.	Expresses mixed emotion about change.
	Revisits stories to retell and develop alterative meaning.	Moves into a leadership position of helping others.
	Encourages emotional expression of thought, feelings, and need for control.	Becomes more confident about decisions and social relationships.
	Facilitates shifting to strength-based alternative stories.	CELW provides clarity and safe way to express difficult emotions.
	Looks for what was different during weeks in which problem behaviors were not present.	
	Recognizes mixed emotions pertaining to problem behavior cessation.	
	Challenges the societal discourses that have been learned to foster change.	

Table 2
Case Two: Tess

Therapist Observation Participation	**Therapist CELW**	**Client CELW**
Problem family issues: Only female with two brothers. Lacks parental trust, nurturing, and emotional support. Cultural issues: females unequal to males.	Validation of writing about emotions.	Initial difficulty writing about emotions.
	Use of the client's language.	Client is expert of life experience.
	Client is expert of content.	New narratives emerge for alternative story of behaviors that client can change.
Client issues: Accomplishments not appreciated. Difficulty expressing emotion and feelings in writing. Feels out of control, unstable. Lacks direction. Struggles with food issues and SIB, which are coping mechanisms	Slow deconstruction of meaning.	Clarity of thoughts, feelings and emotions.
	Nonjudgmental and supportive to allow for change.	Unique outcomes taking care of self, engaging in relationships, career change, and finding healthier support systems.
	Cocreating new narratives related to unique outcomes and an alternative strength-based story.	Expresses mixed emotions about change.
Therapeutic issues: Lacks trust in caregivers. Lacks compassion and support from caregivers. Writing becomes essential to therapeutic process and trust building. Writing creates avenue for expressing difficult emotions and becomes outlet for thoughts and feelings. Uses writing and when frustrated and confused. Writing helps cessation of SIB and control of food and body issues.	Externalization of problem behaviors- Problem is not with the person. SIB and food issues are separate.	Controls thoughts and behaviors.
	Validating client's belief system.	Prefers therapy without other family members.
	Obtaining information about influence of family members through curious questioning are integrated into therapeutic process.	Challenges societal issues.
	Autonomy and independent new support systems are organized and created outside of the family system	Writing facilitates better perspective on family, looking to the future, and ability to take control of food and SIB issues.
		Writing helps to calm her emotionally and clear her mind.

Table 3
C*ase Three: Jon*

Therapist Observation Participation	**Therapist CELW**	**Client CELW**
Problem Family issues: Oldest of three siblings. Immigrant parents angry about client's problems and need for therapy. Overwhelming family responsibility. Lacks parental nurturing, support, and care.	Validation of difficulty of writing about difficult emotions.	Initial difficulty writing about emotions.
Client Issues: Difficulty adapting to U.S. culture. Disturbing thoughts and mood swings (began in puberty). Academic decline occurred with isolation. Lacks parental understanding of client's problems. Client becomes parent	Discussion of societal influences on feelings.	Externalization of problems about hating self and mood swings.
Therapeutic Issues: Psychiatric evaluation for medication. SIB websites for therapeutic reasons, writing becomes an avenue for expressing shameful, disturbing thoughts, feelings, and ameliorated mood swings	Externalizing problem behavior.	Unique outcomes of emerge about leadership and self-control of emotions.
	Providing support by identifying the problems are not necessarily internal, but external and can be malleable.	Struggle with letting go of problem behavior.
	Validation of emotional struggle and mixed emotions to move forward.	Identifies that behaviors are changing outside of self.
	Creating safe, non-judgmental and respectful format to communicate honestly.	Discourse changes surrounding problem.
	Deconstructing problem narratives to move toward alternative strength-based narrative.	New narratives emerge of relationships, successes, interests, and the future.
	Recognizing multiple unique outcomes of leadership.	Client identifies his struggle with urges to self-injure.
	Brings in parents in email letter writing.	Identifies that CELW provides safe avenue for expressing feelings, understanding himself better, gives him time to respond.

Table 4
Researcher's Findings

Case One: Val	**Case Two: Tess**	**Case Three: Jon**
No preplanned CELW format. Therapist followed client's lead.	No preplanned CELW format. Therapist followed client's lead.	No preplanned CELW format. Therapist followed client's lead.
CELW created alliance, trust, and better communication between therapist and client.	CELW first step in trust with therapist, created alliance, trust, and better communication, between therapist and client.	CELW created alliance, trust, and better communication between therapist and client
CELW promoted expression of trauma, exploration of emotions, and encouraged reflection and reauthorization.	CELW helped client to focus on strengths and create new resources, while challenging past problems and negative social discourses.	CELW allowed client to control pacing of writing and allowed therapist to check with client.
Client reported CELW more useful than face-to face therapy sessions. CELW facilitated clarity of emotion, control of anxiety, slowing down of reactivity, and helped client feel less judged.	Client reported CELW provided clarity of thoughts and feelings, a useful outlet for the expression of negative emotion, a way to visualize future goals	CELW helped client clarify emotions, reduction of anxiety, and control impulses
One-member family therapy.	One-member family therapy	One-member therapy where parents were included and sent separate summary email letters.
SIB and eating disorder under control.	Cessation of SIB and control of eating disorder issues	Cessation of SIB and reduction of anxiety and mood swings.

Cross-Case Analysis

Cross-case analysis was used to explore, understand, and identify relevant and irrelevant variables that translated into salient themes and patterns across each case study. A summary, obtained by amalgamating the three sources of information and meaning, also facilitates triangulation of multiple sources of the data (Yin, 2003). (See Tables 5 and 6.) The researcher used a cross-case analysis method to help the reader understand and examine the phenomena being studied. Ultimately, the observations of the researcher and the co-investigator, once synthesized, reveal conclusions that afford the reader an extraordinary understanding of these phenomena. From these conclusions, the reader and the researcher can build meaning pertaining not only to the therapist's observations, but also to the client and therapist CELW that may have facilitated change during the therapeutic process. Cross-case analysis allows for charting or mapping out a path that is consistent with the outcome, which generally takes the form of unfolding a theoretical story (Khan, 2008). The cross-case analysis tables display relevant patterns of information. By implementing these three stages of analysis, I increased the rigor and reliability of my research. Tables 5 and 6 illustrate for the reader a cross-case table and a summary of the similarities and differences.

Table 5
Cross-Case Analysis of Case Studies

Similarities across three cases	**Differences across cases**
Cultural or immigration issues.	Need for medication (2 cases).
Systemic family problems. Lacked nurturing & support.	Eating disorder issues in conjunction with SIB (2 cases)
Client responsible for family.	Never been to a therapist before (1 case); several bad experiences attending therapy (2 cases).
Client struggled with anxiety, depression, & mood issues.	Attended a 1-month program for SIB & eating disorders (1 case).
Thinking of others before self.	Parents attended several sessions With & without the client (2 cases).
Lack of trust, respect, & support with caregivers.	Cases varied in time of therapy attendance & ranged from 1 year to 2 years.
Internalization of negative feelings, thoughts, & emotions.	Ages of participants ranged from 16 to 24 years.
Need for control, autonomy, & independence.	
Socialization process compromised. .	
Poor self-esteem.	
Feeling judged & shamed for behavior.	
One-member family therapy.	

Table 6
Cross-Case Analysis of CELW

Similarities across three cases	**Differences across cases**
No preplanned format.	Took on leadership role to implement change in others (2 cases).
Created alliance, trust, safety, & communication alternative.	Used writing as form of expression outside the therapy relationship (2 cases).
Expression & clarity of emotions.	Included parents in series of email summaries when 18-year-old client's parents did not want to attend (1 case).
Facilitated control, pacing or writing, slowing down reactivity. Helped to calm anxiety.	Communicated better with family systems.
Enhanced communication & meaning between therapist & clients.	
Validated feelings, thoughts, & emotions about narratives related to past, present, & future.	
Promoted better perspective on family problems.	
Became more confident about decisions, goals for the future, & desire & ability to change.	
Client controlled content—what & when to respond.	
Validated past & present narratives.	
Promoted discussion of mixed emotions about change process.	
Externalized problem behaviors.	
Identified unique outcomes related to new support systems, behavior control, future career, autonomy, & independence.	
Challenged social discourses of behavior.	
Provided concrete, lasting form to identify change.	
Alternative strength-based story emerged.	

Cross-Case Analysis Summary

A cross-case analysis was conducted to obtain information regarding the similarities and the differences across the three case studies in an effort to explore how clinicians might use collaborative email letter writing (CELW) in certain therapy relationships. The researcher found that the similarities amongst the three case studies were significant, and that while the differences between cases were extremely limited, each case analyzed was considered a separate unique entity. Cross-case analysis revealed that the population examined in this study had an abundance of similarities in the areas of family systemic characteristics, client concerns, with little faith and trust in the therapeutic experience prior to this therapy relationship. Furthermore, implementing CELW yielded a multitude of benefits that appeared to expedite the therapeutic process, enhance the therapist-client alliance, build communication and trust, and provide an additional venue to express difficult emotional thoughts and feelings that these clients might not have explored if therapy consisted solely of face-to-face clinical sessions.

When comparing the similarities in family systemic characteristics, the integration and adaptation of cultural or immigration issues were significant in that each family's customs and traditions deviated from typical social discourses found in this country. As a result of these cultural and immigration issues, each client had to shoulder adult responsibilities at an early age, which led to a feeling of being uncared for by their parents, not feeling nurtured and supported while growing up. This premature responsibility culminated in each client—still really a child—becoming a caretaker of others, and thinking of others before themselves. Each client reported that there was no useful avenue for expressing negative thoughts, feelings, and emotions. They also reported that their support systems were limited. In addition, each client entered the

therapy process reporting fear of judgment, lack of trust, and overwhelming feelings of shame, while having little faith in the mental health process of therapy, either because of previous negative experiences or because of information gleaned from family system members. Finally, all three case studies resulted in one-member family therapy, in which most—if not all—face-to-face therapy sessions included only one client.

The researcher found minimal differences across the three case studies. These differences included the need for a psychiatric evaluation and medication with two of the case study participants. One case study participant attended a treatment program prior to entering this therapy situation, two participants exhibited symptoms of having an eating disorder in conjunction with SIB, and one case study participant had no previous experience with therapy prior to this therapeutic experience. The participants' ages were different and ranged from 16 to 24 years of age. The amount of time in therapy varied from 1 year to 2 years.

Nine propositions were applied to the CELW across three case studies. By binding the information analyzed to nine propositions, the researcher was able to narrow this study to focus on the pertinent elements of CELW. The collaborative nature of CELW brought a new avenue and form to thoughts, emotions, and feelings. Implementing CELW promoted new meaning, understanding, and validation of the client as the expert of the content and the therapist as the expert of the process. This collaborative exchange facilitated a new level of trust and therapeutic alliance, which also provided a safe therapeutic environment where clients were able to explore alternative stories without control and judgment on the part of the therapist. Clients developed an ability to externalize the problem and formulate a new relationship with the problem that

focused on new alternative strength-based stories. The externalization of problems and highlighting of unique outcomes promoted confidence in decision making, goals for the future, and the ability to change thoughts into action. Writing down thoughts, feelings, and emotions enabled clients to slow down their reactions, control unhealthy behaviors, and worry less about the judgment of others. Clients also reported being able to finally have healthy and open relationships with their family members, as well as being able to establish new support systems. CELW validated the belief that many of the topics that were discussed during live therapy conversations were easier to express in writing. In this sense, and following Freedman and Combs's (1996) notion of therapeutic letter writing, these clients developed multiple new themes to fit with their emerging alternative stories. By adding CELW, all three clients reported that they developed the ability to control their anxiety, mood swings, and desire to self-injure.

The differences in CELW across cases included two cases when the client took on a leadership role to implement changes with other clients or their families who were struggling with SIB. One case included emailing the parents to explain the therapy process and change. Two cases used writing outside of the therapy relationship, and one case had better control of her food issues and SIB. Finally, the other two cases experienced both cessation of SIB and better control of their food issues.

In the following final section, I discuss the differences that made each case a unique entity. My goal is to provide the reader with a comprehensive understanding of the differences that appeared to be the essence that created change within each case

study. In addition, I address some possibilities for needed additional therapeutic treatment that may have had an added effect on the overall therapeutic change process for each client.

In the first case study, Val, the use of CELW brought a new avenue and form to thoughts about this client's trauma, self-image, and her fear of trusting other people. By implementing CELW, I was able to promote new meaning and understanding between therapist and client, as well as a new level of trust and therapeutic alliance. In this particular case study, the client validated the belief that many of the topics that were discussed during her live therapy conversations were easier for her to express by writing email letters to her therapist. Furthermore, CELW promoted the identification of new themes for reflection, and the reauthorization of new stories that enhanced her ability to develop a new relationship with the problem. In addition, this client was able to take a stand about issues that were important to her view of herself as abnormal, and that challenged the dominant discourses of her problem-saturated story. This client stated in several of her email letters that she was more comfortable writing email letters to her therapist than having conversations during face-to-face therapy sessions. Unique to this case, the client stated that the freedom of written expression appeared to help her overcome the difficulty she had with verbal expression in social situations.

The client did not completely overcome her struggle with SIB. Although she experienced long periods of cessation of SIB during her treatment in my office, I learned at a three-month follow up session that she still continued to struggle at different times

with SIB. After our conversation, the client and I collaborated and agreed that we would work together to find a short term medical facility that specialized in SIB. Although this client had attended a program called "Safe," this admission was at the request of her parents and she was reluctant and felt that it was minimally beneficial. At a three-month follow up, my client expressed that she was eager to seek further help. As a result, she explained to her parents that she wished to find a facility that would help her overcome her SIB. In retrospect, I question whether my therapy treatment could have added some additional elements that might have provided benefit to this client. Perhaps if her therapy protocol incorporated group therapy and biweekly live therapy sessions, as well as some form of systemic therapeutic counseling, she may have been able to shift to a more permanent change in behavior.

In the second case study, Tess, the use of CELW provided a new written structure and form that helped her to understand her problems and to think about herself differently. By using CELW, this client was able to move forward in time, while the therapist's and client's interaction via email letters generated a host of new meanings and new possibilities for future change. Deconstructive questioning prompted new questions to emerge. These new questions challenged the client's problem-saturated stories. Unique to this case study, the use of challenging questions was important for the client to help her reexamine her negative body image in light of these new questions and how they might impact the problem-saturated dominant discourses. Also, these challenging questions allowed her to see firsthand how the dominant discourses had taken hold of her life. This client continued to identify new themes that promoted a new preferred story, which enabled her to worry less about the judgment of others, to find healthier support

systems, and to begin to highlight new resources and opportunities towards her future goals and aspirations.

In retrospect, it was a challenge to encourage this client to bring her parents into therapy session during the time of therapeutic treatment. Most of these client's difficulties were the result of her needing to still live at home with her parents. My decision to respect the client and bring family voices into the therapeutic process, without their actual presence, might have been reviewed and revisited more often. As a result, I might have been able to encourage the incorporation of some form of systemic family therapy, whereby sessions would have included the client's siblings or other close family members. It is true that even at a three-month follow-up session, this client had continued to make great strides, which continued after her treatment in therapy. This client also spent the longest time in treatment, when compared to the other two cases. It is plausible that if family members were present in some form of therapy, the change process may have been more expedient.

In the third case study, Jon, CELW was used as an additional therapeutic technique that fostered his exploration of multiple meanings, and promoted additional experimentation. CELW afforded the client time to take action to solve problems. In many of this client's email letters, the addition of written structure and form facilitated new understanding and promoted alternative stories to emerge pertaining to present and future change. By adding CELW, this client was able to develop the ability to control his anxiety, minimize his physical and emotional reactions, and find clarity in how he would like to proceed with his future career goals. The use of CELW served a multitude of unique purposes for this client, whereby the client was able to experiment with the

control, pacing, response, and format of all of his email exchanges. The use of CELW in conjunction with live therapy sessions created an avenue for the client to identify unique outcomes and externalize many of his problem behaviors. This was exemplified when the client wrote that his alternative story was now filled with goals for independence, and excitement over career possibilities. Finally, unique to this case study, the therapist wrote a series of emails that were sent to the client for him to give to his parents.

In retrospect, Jon's parents decided not to participate in his live therapy sessions or respond to any of the therapist's email letters. It is plausible that an attempt could have been made to have monthly phone conversations with Jon's parents. Perhaps if this option was offered, Jon's parents might have felt more comfortable with the participation in Jon's therapeutic process. In a three-month follow up email letter, my client reported still struggling with his mood swings, but was free of SIB and was continuing to progress nicely. Finally, an additional contract might be included at the time of client intake, alerting parents that if their child is a minor they will need to participate in the therapeutic process. They can be given several options that would include, attending a certain number of live therapy sessions with or without their child, or by working collaboratively over the phone to address the need for systemic family therapy.

In conclusion, all three case studies illuminate both the similarities and differences that can be gleaned from each case study as a separate entity, as well as a collective cross-case study. At first glance, the similarities appear to be more prevalent than the differences. However, once the researcher closely described the nuances of each case study as a separate entity, additional differences became significant. The goal of this research is to provide the reader with a comprehensive understanding of the differences

and similarities that appeared to promote the essence that created change within each case study. In addition, I provide a collective analytic understanding across cases of the phenomenon being studied.

CHAPTER V: DISCUSSION AND IMPLICATIONS OF THE STUDY

This chapter contains a discussion of the phenomenon being studied and a review of the limitations of this study, followed by the identification of potential areas for future research. In addition, this chapter includes some suggestions for how to organize and structure the use of collaborative email letter writing (CELW) in therapeutic relationships with certain client populations. Finally, this concluding chapter also contains speculations concerning the implications of this study as to areas of further understanding and the use of social technologies in therapeutic relationships.

Discussion

In this section, the researcher provides a discussion of how clinicians might incorporate the auxiliary use of CELW in private therapeutic practices with certain client populations who have difficulty with verbal expression in live therapy sessions. Data collection consisted of the therapist's participation in and observation of clients to create case study vignettes. To narrow the focus of CELW in these case study vignettes, the researcher used the nine propositions. (See chapter IV for the nine propositions.) By doing this, the researcher's analytic findings revealed themes and categories that illuminated important client characteristics. In addition, by using the nine propositions to narrow the focus of the study, the researcher was able to gain insights into CELW's practical applications and, in turn, shed light upon this underutilized potential resource for change. A cross-case analysis identified similarities and differences across the three cases. The first area of analysis pertaining to therapist participation-observation

discovered that the three case study clients shared similar client characteristics:

1. systemic immigration and cultural issues,
2. overwhelming responsible at an early age,
3. lack of parental support and guidance,
4. poor coping mechanisms and low self-esteem, and the
5. reoccurring internalization of negative thoughts, feelings, and emotions.

A cross-case analysis revealed numerous similarities in regard to the benefits related to the nine propositions applied to CELW. In all three case studies, for client populations that struggle with verbal self-expression, judgment, and shame, the use of CELW provided an alternative form of communication to supplement live therapeutic encounters. CELW created a new avenue for expression of all thoughts, feelings, and emotions, which afforded clients a new level of therapeutic comfort and safety. In addition, CELW not only created an avenue for the therapist to build trust and alliance, but also acted as a forum in which questions could be asked that highlight important unique outcomes from the client's CELW and from weekly live therapy sessions. By focusing on the nine propositions related to the CELW, the therapist used letters as way to validate, highlight, retell, and summarize client email letters.

When CELW is used as an additional therapeutic technique, it can elicit spontaneous responses that foster the exploration of new meanings and understanding between therapist and client. This technique encourages clients to experiment with the control and pacing of their return emails. It may not be coincidental that all of the participants in this study universally experienced a shift in their ability to control anxiety, mood swings, and urges to self-injure. These shifts also facilitated a decrease in their

previous physical and emotional reactions, and promoted clarity in their ability to make decisions and find multiple new narratives for new alternative stories of growth and change.

In all three case studies the therapist did not have a planned CELW format. In fact, many times, CELW exchanges were orchestrated by the therapist after therapy sessions. Frequently, CELW exchanges were used as a tool to check in with the client between the live therapy sessions. At other times, the client wrote spontaneously to the therapist about problems, life events, and other general issues that were important for her or him to communicate prior to or after therapy sessions. Although the therapist did not follow a preplanned agenda for her CELW, each email response was carefully composed.

The therapist decided what to attend to in written form by having the client's progress notes and email letters in front of her when she wrote her return email letters. Performing this exercise with the client's email letters in hand further facilitated the therapist's use and understanding of the client's language. Having the client's progress notes and email letters readily available made it simple for the therapist to summarize what had occurred during previous therapy sessions.

Limitations of the Study

The use of social technology continues to grow at a rapid pace. Although this study focused on the specific use of CELW in therapeutic relationships, a vast assortment of additional modern computer products and services are now more commonly used. At the completion of this dissertation in 2012, the use of email communication will soon be considered a less common form of interpersonal communication, and it is most likely that other social technologies will replace the use of email communication. Although email

communication offered a powerful vehicle for client communication in this study, I became aware in 2011 that as my clients were changing to alternative social technologies; email communication was becoming less significant. In order to adapt to this change, I needed to use a phone text at certain times to alert my clients to check their email address for my letter. Because of this new digital paradigm shift, clinicians will have to adapt to the new social computer technologies in their mental health practices (Scott & Thompson, 2009).

Some of these changes can be beneficial and can offer clinicians a host of useful alternatives that can offer an array of options for future change with certain client populations. Newer social technologies, such as synchronous chat rooms and videoconferencing, might offer therapists additional pathways to communicate with clients and their families outside of live therapy sessions. The use of new social technologies will also bring additional concern for ethics, confidentiality, client consent, and autonomy. With these concerns, therapists will need to constantly reevaluate how they use these practices in order to ensure that therapeutic care is not compromised. In addition, certain client populations may not have access to the use of computer resources, which will place a limitation on the implementation of computer assistance within certain groups. Finally, at this time, the research literature is limited in its scope of the understanding and effectiveness of these alternative social technologies (Scott & Thompson, 2009). However, the likelihood of these of new social technologies being used remains inevitable in clinical practices.

A case study design is also subject to limitations. According to Yin (2003), a case study does not aspire to universal methodology generalization. However, Yin suggests

that case studies lend themselves to comparing and contrasting cases, which makes possible tentative generalizations beyond the case itself. Analytic generalizations enable the researcher to expand the scope and understanding that guides or emerges from each case study. However, researchers must be cautious to treat each case as a unique and separate entity, even when using a multiple case study design and cross-case analysis.

Another limitation of case study design is to understand the researcher's bias towards verification of preconceived motives. This limitation can be addressed in an exploratory case study by the researchers immersing themselves in the context of each case study to such a degree that they have opportunities to also recognize the flaws in their preconceived notions (Tellis, 1997). In case study research, an additional limitation may also refer to the participant-observer and the small case sample as the researcher. Although this technique provides a unique opportunity for the researcher to become intimately close to the collection of data, it also may encourage the researcher to alter the course of events, which may not be helpful to the analysis of the case study (Tellis, 1997). Case study research is also recognized as having limitations because of the use of archival records or therapeutic documentation. When documents are used as a primary source of evidence in case study research, false leads can occur. Therefore, if documents are used in case study research, they should be used in conjunction with multiple sources of evidence to avoid such false leads.

Implications for Future Practice and Research

The findings of this research study present a compelling argument for including CELW as an effective additional communication technique in therapy relationships with certain client populations. However, the research also implies, by its relatively infrequent

use, that most therapists do not incorporate this technique into their therapeutic practices. In this section, I address my concern for the relative rarity of CELW inclusion in therapeutic relationships. I also address the need for an additional form of communication with certain client populations as a way to enhance client-therapist alliance, trust, understanding, and therapeutic change, as well as a host of other significant benefits.

The clients in this case study all reported that by adding CELW they were able to express emotions that might not have been expressed in regular face-to-face therapy sessions. Several clients reported that, "they loved writing and looked forward to a returned response," while another client explained, "that they felt that writing helped to clear her mind and stop them from reacting to the negative thoughts and urges in her mind." Coiera (2006) explains that there are still significant gaps in attention, challenges of reaching certain groups, and understanding of the role of communication services in support of healthcare delivery service systems. My focus became understanding and exploring how clinicians might be able to fill this gap by using CELW exchange as an auxiliary healthcare support system for certain client populations. At the time of this study, CELW exchange was one plausible form of electronic communication in therapy relationships with clients that exhibited self-injury behavior (SIB).

In exploring ways in which therapists may incorporate and restructure their clinical practices to accommodate the use of CELW, and after completing this study, several ideas suggest themselves. First, my advice to clinicians who are interested in this alternative therapeutic modality of CELW might be to start by receiving additional consent for social technology communication with one or two clients. This would serve as a way to explore, become familiar, and feel more comfortable with the technique of

CELW. In addition, I would suggest that a clinician use CELW with no more than five to six clients at one time, due to the time constraints of CELW and the need for therapeutic efficiency.

Second, clinicians using CELW should have their client case notes in front of them when returning email responses. In this way, pertinent client information would be available regarding the client's use of language. The client's use of language, in turn, would tend to highlight and promote insight into unique outcomes related to important strength-based narratives, knowledge pertaining to the type of deconstructive questions used, and finally, the ability to pay attention to the narratives that need to be revisited, restored, or summarized.

Third, an additional small fee might be added to the client's therapy cost for this additional therapeutic service. Fourth, the therapist and client should discuss how to use CELW. In certain cases, therapists may need to send their clients a phone text alerting them to a return response. Fifth, due to the growing concerns for client confidentiality and ethical considerations, extra attention will be needed on the part of the clinician to address ethical limitations when using email or any electronic technology. Sixth, clients need to be informed about the return policy of email exchange. Therapists should explain that email letters will be returned within two days unless the clinician is away on vacation or has an emergency, which would allow for extra time for an email response.

Today, most of our clients are communicating through a multitude of social technologies. It seems inevitable that this shift will infiltrate many therapeutic practices, which will create new opportunities for clinicians to experiment with new social technologies for communication. Therapists will need to take steps to become educated in

these new computer technologies in order to reach a larger variety of client populations. Further research may include an examination of these new social technologies, as well as the impact on cultural and socioeconomic groups, or countries, in order to have a better understanding of these practices. Finally, because little research exists on how to implement CELW in private clinical practices, it was impossible to compare the past analysis on the clinical use of CELW as an alternative therapeutic technique in therapy practices. It seems plausible that most therapists have not ventured into the use of these new social technologies, because of the demand on time and expense, which may be one of many presenting obstacles. One of the future goals for this research study would be to explore how CELW could assist a clinician and fit into a clinicians schedule to meet these demands.

At the end of this research study in July of 2012, it became evident that computer-mediated communication will continue to grow at a rapid pace. With this exponential growth, many more clinicians will most likely begin exploring the use of an array of new social technologies in their clinical practices. These new computer pathways will provide an additional way for the extension of communication between families, communities, and an assortment of other client populations. As with all therapeutic encounters, it will be necessary for practitioners to pay careful attention to the dynamics of appropriate client-therapist boundaries. Clinicians will need to address the appropriate use and implementation of these new communication technologies for clinical practice purposes. In addition, clinicians will need to be sensitive to the differences that may occur as the result of the use of each computer technology when compared to live face-to-face therapy sessions. These challenges include the need for establishing a creditable, trusting

therapeutic relationship, the inability to read nonverbal cues or tones of voice, the possible need for the immediacy of face-to-face contact, and to establish new guidelines for informed consent (Adler & Adler, 2008; McDaniel, 2003; Moules, 2003).

There is significant concern that the exponential growth of social technologies will continue to infiltrate the boundaries that separate self from others (Gergen, 1991). Gergen's theory questions the relationship between society and the individual, specifically, how the use of different communication technologies may have the ability to affect the individual's construction and perception of self. As social technologies continue to grow, practitioners will need to find alternative models to help clients maintain a sense of self in modern times, Gergen's theory brings to the forefront the importance and the many challenges that clinicians will be faced with in the future as they continue to explore the use of social technologies in their mental health practices. Ongoing research will help monitor this situation to ensure that the clients' sense of self is not compromised.

Summary

This study was designed to gather information regarding how one seasoned therapist used CELW as an additional therapeutic technique in clinical relationships with three individuals who exhibited SIB. Therapists may find that incorporating CELW into their therapeutic practices with different client populations, not included in this study, will allow for change to occur more expeditiously, as well as cultivating further alliance, trust, and safety in therapeutic relationships. In this study, in ongoing face-to-face therapy relationships CELW helped to establish an additional form of communication that significantly supplemented live therapy sessions. Furthermore, CELW promoted

additional nuanced communication for client-therapist understanding; meanings that enhanced the process of therapy and the experience for clients who exhibited SIB. The use of CELW or any social technology may not only create a more expedient conversation, but may also allow clients to more easily trace their change processes by tracking those changes through a very concrete form of evidence, such as email letters. The use of social technologies, such as email letters, can provide therapists and clients with a new method to hold on to important conversations that may illuminate accomplishments, highlight resources, and retell narratives filled with strength-based alternative stories. By using CELW, these alternative stories can be reviewed and revisited whenever the client needs reassurance and support—even after therapy has ended.

Regardless of the method of technology communication used, CELW exchange is a valuable and powerful vehicle for therapeutic change. In my research and in my private practice, I have experienced firsthand the enormous benefits that this technique represents and I believe that it is an underutilized resource within many clinical private practices. After exploring the benefits and risks of using CELW, I am also aware that it is necessary to use caution when using any form of social technology for clinical purposes. In conclusion, my goal for this research is to provide information pertaining to how therapists might consider incorporating CELW into their therapy relationships, as well as to prompt clinicians to consider using alternative social technologies when working with certain client populations.

References

Adler, P. A., & Adler P. (2008). The cyber worlds of self-injurers: Deviant communities, relationships, and selves. *Symbolic Interaction, 31*(1), 33-56.

Alleman, J. R. (2002). Online counseling: The internet and mental health treatment. *Psychotherapy: Theory, Research, Practice, Training, 39*(2), 199-209.

American Counseling Association (1995). *Code of ethics and standards of practice.* Alexandria, VA.

American Counseling Association (1999). *Ethical standards for internet online counseling.* Alexandria, VA.

Anderson, H. (1993). See and hear: And be seen and heard. In S. Friedman (Eds.), *The New Language of change* (pp. 303-322). New York, NY: Guilford Press.

Anderson, H., & Goolishian, H. (1988). Human systems as linguistic systems: Preliminary and evolving ideas about the implications for clinical theory. *Family Process, 27*(4), 371-395.

Austin, L., & Kortum, J. (2004). Self-injury: The secret language of pain for teenagers, *Education, 124*(3), 517-527.

Bacigalupe, G. (1996). Writing in therapy: A participatory approach. *Journal of Family Therapy, 18*(4), 361-375.

Bacigalupe, G. (2003a). Is there a role for social technologies in collaborative healthcare? *Family, Systems, & Health, 29*(1), 1-14.

Bacigalupe, G. (2003b). Letter writing in relational therapies. *Journal of Systemic Therapies, 22*(1), 1-2.

Bacigalupe, G., & Lambe, S. (2011). Virtualizing intimacy: Information communication technologies and transnational families. *Family Process, 50*(1), 12-26.

Bauserman, S. A. K. (1998). Treatment of persons who self-mutilate with dialectical behavior therapy. *Psychiatric Rehabilitation Skills, 2*, 149-157.

Baxter, P., & Jack, S. (2008). Qualitative case study methodology: Study design and implementation for Novice researcher. *The Qualitative Report, 13(4*). 544-559.

Bloom, J. W. (1998). The ethical practice of webcounseling. *British Journal of Guidance and Counseling, 26*(1), 53-59.

Brown, C., Weber, S., & Ali, S. (2008). Women's body talk: Feminist narrative approach. *Journal of Systemic Therapies, 27*(2), 92-105.

Carr, L. (1994). The strengths and weaknesses of qualitative research: What method for nursing? *Journal of Advanced Nursing, 20*(4), 716-721.

Chenail, R. J. (2011). How to conduct clinical qualitative research on the patient's experience. *The Qualitative Report, 16*(4), 1173-1990. Retrieved from http;//www.nova.edu/ssss/QR/QR16-4/chenail.pdf

Coiera, E. (2006). Communications systems in healthcare. *The Clinical Biochemist Reviews, 27*(2), 89-98.

Connors, R. E. (2000). *Self-injury.* New York, NY: Jason Aronson.

Conterio, K., & Lader, W. (1998). *Bodily harm.* New York, NY: Hyperion.

Craigen, L., & Foster, V. (2007). It was like a partnership of the two of us against cutting: Investigating the counseling experiences of young adult women who self-injure. *Journal of Mental Health, 31*(1), 76-95.

Creswell, J. (1998). *Qualitative inquiry and research design: Choosing among five traditions.* Thousand Oaks, CA: Sage.

Creswell, J. (2009). *Research design: Qualitative, quantitative, and mixed methods approaches* (3rd ed.). London, UK: Sage.

Crouch, W., & Wright, X. (2004). Deliberate self-harm at an adolescent unit: A qualitative investigation, *Clinical Child Psychology and Psychiatry, 9*(2), 185-204.

Darke, P., Shanks, G., & Broadbent, M. (1998). Successfully completing case study research: combining rigour, relevance and pragmatism. *Information Systems Journal, 8*(4), 273-289.

Deiteer, P. J., & Pearlman, L. A. (1998). Responding to self-injury behavior. In P. M. Kleespies (Ed.), *Emergencies in mental health practices: Evaluation and management* (pp. 235-257). New York, NY: Guilford Press.

Denborough, D. (2006). *Trauma: Narrative responses to traumatic experience*. Adelaide, South Australia: Dulwich Centre.

Denzin, N. K., & Lincoln, Y. S. (Eds.) (2005). *The handbook of qualitative research (3rd ed.).* Thousand Oaks, CA: Sage.

Derouin, A., & Bravender, T. (2004). Living on the edge: The current phenomenon of self-mutilation in adolescents. *The American Journal of Maternal/Child Nursing, 29*(1), 12-18.

DeSalvo, L. (1999). *Writing as a way of healing: How telling our stories transforms our lives.* Boston, MA: Beacon.

D'Onofrio, A. (2007). *Adolescent self-injury: A comprehensive guide for counselors and health care professionals.* New York, NY: Springer.

Dunne, A., Thompson, W., & Leitch, R. (2000). Adolescent males' experiences of the counseling process. *Journal of Adolescence, 23*(1), 79-93.

Epston, D. (2010). A new genre of working with the problems of young people and their families and communities. (Personal communication with author, June18, 2011).

Farber, S. K., (2005). Free association reconsidered: The talking cure, the writing cure. *Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry, 33*(2), 249-273.

Favazza, A. R. (1992). *Bodies under siege: Self-mutilation in culture and psychiatry* (2nd ed.). Baltimore, MD: Johns Hopkins University.

Favazza, A. R., & Conterio, K. (1988). The plight of chronic adolescents who self-mutilate. *Community Mental Health, 24*(1), 22-30.

Fox, R. (1983). The past is always present: Creative method for capturing the life story. *Clinical Social Work Journal, 11*(1), 368-378.

France, H., Cadieux, G., & Allen, G. E. (1995). Letter therapy: A model for enhancing counseling interventions. *Journal of Counseling & Development, 73*(3), 317.

Freedman, J., & Combs, G. (1996). *Narrative therapy: The social construction of preferred realities* (1st ed.). New York, NY: Norton.

Fry, S. W. (2010). The analysis of an unsuccessful novice teacher's induction experiences: A case study presented through layered account. *The Qualitative Report, 15*(5), 1164-1190. Retrieved from http://www.nova.edu/ssss/QR/QR15-15/fry.pdf

Gergen, K. (1991). The saturated self: Dilemmas of identity in contemporary life. New York, NY: Basic Books.

Gergen, K. (1999). *An invitation to social construction*. Newbury Park, CA: Sage.

Gergen, K. (2001). *Invitation to social construction.* London, UK: Sage.

Gergen, K. (2006). *Therapeutic realities*: *Collaboration, oppression and relational flow.* Chagrin Falls, OH: Taos Institute.

Gerring, J. (2007). *Case study research: Principles and practice*. New York, NY: Cambridge University Press.

Goldberg, D. (2000). Employment: Letter writing with troubled adolescents and their families. *Clinical Child Psychology and Psychiatry, 5*(1), 63-76.

Heath, N., Ross, S., Toste, J., Charlebois, A., & Nedecheva, T. (2009). Retrospective analysis of social factors and nonsuicidal self-injury among young adults. *Canadian Journal of Behavioral Science, 41*(3), 180-186.

Heinlein, K., Welfel, E., Richmond, E., & Rak, C. (2003). The scope of webcounseling: A survey of services and compliance with NBCC standards for the ethical practice of webcounseling. *Journal of Counseling & Development, 81*(1), 61-105.

Himber, J. (1994). Blood rituals: Self-cutting in female psychiatric inpatients. *Psychotherapy, 3*(14), 620-631.

Hoffman, P., Fruzetti, A., & Swenson, C. (1999). DBT-family skills training. *Family Process, 4*(38), 399-409.

Hoffman, R., Hinkle, M. G., & Kress, V. (2010). Letter writing as an intervention in family therapy with adolescents who engage in nonsuicidal self-injury. *The Family Journal, 18*(1), 24-30.

Hoffman, R., & Kress, V. (2008). Narrative therapy and non-suicidal-self injurious behavior: Externalizing the problems and internalizing personal agency. *Journal of Humanistic Counseling, Education and Development, 47*(2), 157-172.

International Society for Mental Health Online. (2000). *ISMHO/PSI suggested principles for the online provision of mental health services.* Retrieved June 1, 2001, from http://www.ismho.org/suggestions.htm

Keeling, M., & Bermudez, M. (2006). Externalizing problems through are and writing: Experiences of process and helpfulness. *Journal of Marital and Family Therapy, 32*(4), 405-420.

Klonsky, D., & Muehlenkamp, J. (2007). Self-Injury: Research review for the Practitioner. *Journal of Clinical Psychology, 63*(11), 1046-1056.

Koocher, G. P., & Keith-Spiegel, (1998). *Ethics in psychology: Professional standards and cases.* New York, NY: Oxford University Press.

Kress, V. (2003). Self-injurious behaviors: Assessment and diagnosis. *Journal of Counseling & Development, 81*(4), 490-499.

Kress, V., Gibson, D., & Reynolds, C. (2004). Adolescents who self-injure: Implications and strategies for school counselors. *Professional School of Counseling, 7*(3), 195-202.

L'Abate, L. (2001). *Distance writing and computer-assisted interventions in psychiatry and mental health.* London, UK: Ablex.

Leslie, R. (2002). Practicing therapy via the internet: The legal view. *Family Therapy Magazine, 1*(5), 39-41.

Levenkron. S. (1998). *Cutting: Understanding and overcoming self-mutilation.* New York, NY: Norton.

Lincoln, Y., & Denzin, N. (1994). *Handbook of qualitative research.* Thousand Oaks, CA: Sage.

Linehan, M. (1993). *Cognitive-behavioral treatment of borderline personality disorder.* New York, NY: Guilford Press.

Madigan, S. (2007). Watchers of the watched—self surveillance in everyday life. In C. Brown & T. Augusta-Scott (Eds.), *Postmodern and narrative therapy* (pp. 64-74). New York, NY: Sage.

Madigan, S., & Grieves, L. (1997). Re-considering memory. Remembering lost identities back toward re-remembered selves. In C. Smith & D. Nylund (Eds.), *Narrative therapies with children and adolescents* (pp. 338-355). New York, NY: Guilford Press.

Mann, C., & Stewart, F. (2000). Internet communication and qualitative research: A handbook for researching online. Thousand Oaks, CA: Sage.

McDaniel, S. (2003). E-mail communication as an adjunct to systemic psychotherapy. *Journal of Systemic Therapies, 3*(22), 4-13.

McNamee, S. (2004). Therapy as social construction: Back to basics and forward toward challenging issues, In T. Strong & D. Pare (Eds.), *Furthering talk: Advances in the discursive therapies* (pp. 253-270). New York, NY: Kluwer Academic/ Plenum Press.

Messina, E. S., & Iwasaki, Y. (2011). Internet use and self-injurious behaviors among adolescents and young adults: An interdisciplinary literature review and implications for health professionals. *Cyberpsychology, Behavior, and Social Networking, 14*(3), 161-168.

Miles, M. B., & Huberman, A. M. (1984). *Qualitative data analysis: A sourcebook of new methods*. Newbury Park, CA: Sage.

Miller, A. L. (1999). Dialectical behavior therapy: A new treatment approach for suicidal adolescents. *American Journal of Psychotherapy, 53,* 413-417.

Miller, A. L., & Glinski, J. (2000). Youth suicidal behavior: Assessment and intervention. *Journal of Clinical Psychology, 56*(9), 1131-1152.

Miller, D. (1994). *Women who hurt themselves. A book of hope and understanding*. New York, NY: Basic Books.

Miller, J. K., & Gergen, K. J. (1998). Life on the line: The therapeutic potentials of computer-mediated conversation. *Journal of Marital and Family Therapy, 24*(2), 189-202.

Morrissey, M. (1997). NBCC internet counseling standards unleashed intense debate. Retrieved February 29, 2002, from http://www.counseling.org/ctonline/sr598/Internetcounseling1197.htm

Moules, N. (2003). Therapy on paper: Therapeutic letters and the tone of relationship. *Journal of Systemic Therapies, 22*(1), 33-49.

Moya, A. (2008). The tip of the blade: Self-injury among early adolescents. *Dissertation Abstracts International: Section A. Humanities and Social Sciences, 68*(12), 329-534.

Muehlenkamp, J. J. (2006). Empirically supported treatments and general therapy guidelines for non-suicidal self-injury. *Journal of Mental Health Counseling, 28*(2), 166-185.

Muehlenkamp, J. J., & Gutierrez, P. M. (2007). Risk for suicide attempts among adolescents who engage in non-suicidal self-injury. *Archives of Suicide Research, 1*(1)*1*, 69-82.

National Board for Certified Counselors. (2001). The practice of internet counseling. Retrieved July, 22, 2002, from http://www.nbcc.org/ethics/wedethics.htm

Northey, Jr., W. (2005). Studying marriage and family therapists in the 21st century: Methodology and technological issues. *Journal of Marital and Family Therapy, 31*(1), 99-105.

Nylund, D., & Thomas, J. (1994). The economics of narrative. *The Family Therapy Networker, 18*(6), 38-39.

O'Hanlon, W. H. (1994). The third wave. *Family Therapy Networker, 18*(6), 18-29.

O'Hanlon, W. H., & Weiner-Davis, M. (1989). *In search of solutions: A new direction in psychotherapy*. New York, NY: Norton.

Penn, P., & Frankfurt, M. (1994). Creating a participant text: Writing, multiple voices, narrative multiplicity. *Family Process, 33*(3), 217-231.

Pennebaker, J (1990). *Opening up: The healing power of confiding in others.* New York, NY: Avon Books.

Pennebaker, J. (2004). *Writing to heal: A guided journal for recovery for recovery from trauma and emotional upheaval.* Oakland, CA: New Harbinger.

Pennebaker, J., & Seagal. J. (1999). Forming a story: The health benefits of narrative. *Journal of Clinical Psychology, 55*(10), 1234-1254.

Pierce, D. (1986). Deliberate self-harm: How do patients view treatment? *British Journal of Psychiatry, 149*(5), 624-626.

Pyle, N. (2006). Therapeutic letters in counseling practice: Client and counselor experience. *Canadian Journal of Counseling, 40*(1), 17-32.

Rasmussen, R., & Tomm, K. (1992). Guided letter writing: A long brief therapy method whereby clients carry out their own treatment. *Journal of Strategic and Systemic Therapies, 7*(4), 1-18.

Reynolds, D. (1976). *Morita psychotherapy.* Berkeley, CA: University of California Press.

Riordan, R. (1996). Scriptotherapy: Therapeutic writing as a counseling adjunct. *Journal of Counseling & Development, 74*(3), 263-269.

Robins, C. J., & Chapman, A. L. (2004). Dialectical behavior therapy: Current status, recent developments, and future directions. *Journal of Personality Disorders, 18*(1), 73-89.

Rombach, M. (2003). An invitation to therapeutic letter writing. *Journal of Systemic Therapies, 22*(1), 15-32.

Ronai, C. (1995). Multiple reflections of childhood sex abuse: An argument for layered account. *Journal of Contemporary Ethnography, 23*(4), 395-426.

Ronai, C. (1997). On loving and hating my mentally retarded mother. *Mental Retardation, 35*(6), 417-432.

Ross, S., & Heath, N. (2002). A study of the frequency of self-mutilation in a community sample of adolescents. *Journal of Youth and Adolescence*, *31*(1), 67-77.

Ryan, K., Heath, M., Fischer, L., & Young, E. (2008). Superficial self-harm: Perceptions of young women who hurt themselves. *Journal of Mental Health Counseling*, *30*(3), 237-255.

Selekman, M. (2002). *Living on the razor's edge: Solution-oriented brief family therapy with self-harming adolescents*. New York, NY: Norton.

Selekman, M. (2010). Collaborative strengths-based brief therapy with self-injuring adolescents and their families. *The Prevention Researcher*, *17*(1), 19-20.

Selekman, M., & King, S. (2001). "It's my drug": Solution-oriented brief family therapy with self-harming adolescents. *Journal of Systemic Therapies*, *2*(20), 85-105.

Shaw, H. F., & Shaw, S. F. (2006). Critical ethical issues in online counseling: Assessing current practices with ethical intent checklist. *Journal of Counseling & Development*, *84*(1), 41-53.

Shaw, S. (2002). Shifting conversations on girls' and women's self-injury: an analysis of the clinical literature in historical context. *Feminism & Psychology*, *12*(2), 191-219.

Simeon, D., & Favazza, A. (2001). Self-injurious behaviors: Phenomenology and assessment. In D. Simeon & Hollander (Eds.), *Self-injurious behaviors, assessments, and treatment* (pp. 1-28). Washington, DC: American Psychiatric.

Smith, C., & Nylund, D. (1997). *Narrative therapies with children and adolescents*. New York, NY: Guilford Press.

Smyth, J. M. (1998). Written emotional expression: Effect, sizes, outcome types, and moderating variables. *Journal of Counseling and Clinical Psychology, 66*(1), 174-184.

Stake, R. (1995). *The art of case study research.* London, UK: Sage.

Steinberg, D. (2000). *Letters from the clinic: Letter writing in clinical practices for mental health professionals.* Philadelphia, PA: Routledge.

Stone, J., & Sias, S. (2003). Self-injurious behavior: A bi-model treatment approach to working with adolescent females. *Journal of Mental Health Counseling, 25*(2), 112-125.

Sundqvist, A., & Ronnberg, J. (2010). A qualitative analysis of email interactions of children who use augmentative and alternative communication. *Augmentative and Alternative Communication, 26*(4), 255-266.

Tellis, W. (1997). Introduction to case study. *The Qualitative Report, 3*(2). Retrieved from http://www.nova.edu/ssss/QR/QR3-2/tellis1.html

Tomm, K. (1998). Externalizing the problem and internalizing the personal agency. *Journal of Strategic and Systemic Therapies, 8*(1), 54-58.

Trepal, H. (2010). Exploring self-injury through a relational cultural lens. *Journal of Counseling & Development, 88*(4), 492-500.

Trepal, H. C., & Wester, K. L. (2007). Self-injurious behaviors, diagnosis, and treatment methods: What mental health professionals are reporting. *Journal of Mental Health Counseling, 29*(4), 363-375.

Tubman, J., Montgomery, M., & Wagner, E. (2001). Letter writing as a tool to increase client motivation to change: Application to an inpatient crisis unit. *Journal of Mental Health Counseling, 23*(4), 295-312.

Walsh, B. W. (2006). *Treating self-injury: A practical guide.* New York, NY: Guilford Press.

Waitzlawick, P., Weakland, J. H., & Fisch, R. (1974). *Change: Principles of problem formation and problem resolution.* New York, NY: Norton.

White, M. (1995). *Re-authoring lives: Interviews & essays.* Adelaide, South Australia: Dulwich Centre.

White, M. (2006). Working with people who are suffering the consequences of multiple trauma. In D. Denborough (Ed.), *Trauma: Narrative responses to traumatic experiences* (pp. 25-86). Adelaide, South Australia: Dulwich Centre.

White, M. (2007). *Maps of narrative practice*. New York, NY: Norton.

White, M., & Epston, D. (1990). *Narrative means to therapeutic ends*. New York, NY: Norton.

White, V., McCormick, L., & Kelly, B. (2003). Counseling clients who self-injure: Ethical considerations. *Counseling and Values, 47*(3), 220-227.

White, V., & Murray, M. (2002). Passing notes: The use of therapeutic letter writing in counseling adolescents. *Journal of Mental Health Counseling*, *24*(2), 166-176.

Whitlock, J. L., Powers, J. L., & Eckenrode, J. (2006). The virtual cutting edge: The internet and adolescent self-injury. *Developmental Psychology*, *42*(3), 407-417.

Williams, K. A., & Bydalek, K. A. (2007). Adolescent self-mutilation: Diagnosis & treatment. *Journal of Pyschosocial Nursing & Mental Health Services, 12*(45), 19-24.

Wojcik, J., & Iverson, E. (1989). Therapeutic letters: The power of the printed word. *Journal of Strategic and Systemic Therapies, 8*(1), 77-81.

Yin, R. K. (1994). *Case study research: Design and methods*. Thousand Oaks, CA: Sage.

Yin, R. K. (2003). *Case study research design and methods.* London, UK: Sage.

Yip, K., Ngan, M., & Lam, I. (2002). An explorative study of peer influence and response to adolescent self-cutting behavior in Hong Kong. *Smith College Studies in Social Work, 72*(3), 379-402.

Zila, L., & Kiselica, M. (2001). Understanding and counseling self-mutilation in females, adolescents and young adults. *Journal of Counseling & Development, 79*(1), 46-52.

Zimmerman, T., & Shepherd, S. (1993). Externalizing the problem of bulimia: Conversation, drawing and letter writing in group therapy. *Journal of Systemic Therapies, 12*(1), 22-31.

Appendices

Appendix A

Consent for Participation

Dear former client,

Over the next few months, I will be conducting a research study on the use of collaborative email letter writing as an auxiliary technique in therapy relationships. I would like your permission to use your email letters that were written to me in the past.

Please note, that all letters and information used will be anonymous. In other words, I will de-identify your name and any pertinent information for this research study. It is very important that our relationship and your writing remain confidential.

Your letter s will be used to help explore in my research the use of collaborative letter writing when used in conjunction with live therapy sessions.

If you would prefer for me to not to use your email letters for my research, I will completely understand and find another avenue for my research. If you feel comfortable with me using your email letters in my analysis, please write back a brief response letting me know that I have your permission.

Sincerely,

Babette Rosabal

Appendix B

Consent for Email Communication

Consent Form for Email Communication

There are often times when it may be necessary or suggested that the use of electronic methods may serve to enhance the therapeutic process. It is for this reason, that I ask for a consent form to be signed by_____ in which I agree to have communication through email and text communication to augment therapy session with Babette Rosabal.

If I am a minor, my parent/guardian_____ will provide consent to allow communication with Babette Rosabal outside of therapy appointments.

These emails will be regarded as private communication, but may only be protected to the best of my ability. There may be cases where client confidentiality may not be protected due to the nature of undisclosed situations and technical problems with security. Although, client privacy through email and text will be of the highest priority and this office will require permission prior to the use of these services.

Sincerely,

Babette Rosabal

Appendix C

Co-Investigator Consent for Research

Co-Investigator Consent Form for Research

I_____ agree to be a co-investigator in a research dissertation study conducted by Babette Rosabal.

The researcher has selected me to participate in this dissertation project because of my research experience, and because I have never actively worked with the client population in this research study or with the phenomenon being explored.

As a co-investigator, I have been asked to provide new insight of the analysis of the nine propositions extracted from the collaborative client-therapist email letter writing (CELW) exchange. Although the researcher collected this data during treatment with clients from her private practice, data collection and analysis will be performed after client treatment has ended and IRB approval has been received.

My observations will further be used to obtain new patterns and themes across the three case studies, and for the development of a cross-case analysis, summary, and matrix.

The researcher has met with me for a 45 minute meeting prior to the analysis of this study to explain my role as a co-investigator. In addition, I have been told that all client records will be de-identified and are considered archival documentation.

Researcher signature_____

Co-investigators signature_____

Biographic Sketch

Babette Rosabal was born in New Rochelle, New York, to Norman and Harriet Abrams. She was raised in Scarsdale, New York. After receiving her Bachelor of Science degree from the University of New Mexico in 1981, Babette returned to New York to work where she was quickly promoted from customer service representative to store manager, and then to division manager for two major retail businesses. In 1986, she moved to south Florida and entered Nova Southeastern University where, in 1988, she received her Master's degree in Counseling Psychology. Upon graduation, Babette began working for Continental Insurance Company as a rehabilitation specialist. In this role, Babette counseled injured workers on their return to work. At the same time, she began to build her own private clinical practice and her family. While her two children were in middle school, she continued to build her practice and volunteered in various local public schools working with children and adolescents conducting social skills training, divorce and family issue groups, and grief counseling groups. In addition, Babette received extensive training as a comprehensive sexuality training specialist from the Unitarian Universalist Church, where she provided services for adolescents for many years.

Over the last 20 years in private practice, Babette has worked with children, adolescents, couples, adults, and families. In 2004, Babette purchased her first clinical office in Pembroke Pines, Florida. Babette returned to Nova Southeastern University in 2006 to pursue a doctorate in Marriage and Family Therapy. In 2011, Babette purchased her second clinical office in Davie, Florida, where she has developed a comprehensive team of collaborative healthcare professionals who specialize in providing therapy using state-of-the-art strength-based and a host of other therapy methodologies.

Babette is married to Orestes Rosabal and is the mother of two daughters, Shelby Rosabal and Kylie Rosabal, who are both attending college. She currently resides in Fort Lauderdale, Florida.