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Narrative Therapy to Reduce Self-Stigma: Empowering Children, Adolescents, and Their Families

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BY

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Abstract

The effects of self-stigma on children and adolescents with mental health diagnoses is a documented psychological issue in academic literature; however, no studies or articles to date present strategies for reducing its negative effects. Additionally, very few studies have connected the experience of parental stigma, or courtesy/affiliate stigma, and its effects on child and family well-being. Self-stigma has been conceptualized as existing on the opposite end of the spectrum from empowerment, suggesting that empowerment may serve as a promising approach to tackling self-stigmatization. This paper presents a novel therapeutic intervention for reducing self-stigma in children, adolescents, and their families through a narrative therapy approach, which serves to increase psychological empowerment.

Introduction

Self-stigma for those affected by mental illness is a well-documented phenomenon across research (Corrigan, Watson, & Barr, 2006; Ritsher, Otilingam, & Grajaless, 2003; Ritsher & Phelan, 2004; Yanos, Roe, Markus, & Lysaker, 2008). Whereas public stigma refers to the negative attitudes and stereotypes held by society about those diagnosed with mental disorders, self-stigma occurs when the diagnosed internalize those damaging stereotypes and experience negative consequences as a result (Corrigan et al., 2006). For example, in regard to public stigma, the diagnosis of Attention-Deficit/Hyperactivity Disorder (ADHD) is associated with several negative social stereotypes, including sloppiness, laziness, and underachievement (Justman, 2015). When an individual internalizes these stereotypes, believing that he is actually lazy and unable to succeed academically or professionally, he is experiencing self-stigma. Several studies have uncovered a range of negative effects associated with self-stigma, including

low self-esteem, reduced self-efficacy, poor quality of life, and reduced engagement in mental health services. (Fung, Tsang, Corrigan, Lam, & Cheng, 2007; Mittal, Sullivan, Chekuri, Allee, & Corrigan, 2012; Vogel, Wade, & Haake, 2006; Wahl, 1999; Yen et al., 2009).

Although most studies on self-stigma focus on adult mental health populations, a handful of studies have explored the harmful effects of self-stigmatization on children and adolescents diagnosed with mental disorders, as well as the effects of mental health diagnoses on their families (Kaushik, Kostaki, & Kyriakopoulos, 2016; Khalil, Gondal, Imran, & Azeem, 2020; Moses, 2009a, 2009b, 2010). Understanding the negative consequences associated with self-stigma, strategies to tackle the problem in this population should be an important area of research. Additionally, given the central role of caregivers in child development, it is important to incorporate the family's experience as well.

The following paper presents a novel approach to decreasing self-stigma in child and adolescent populations, incorporating caregivers as essential to the process. This paper uses the prominent conceptual framework of self-stigma developed by Corrigan and Larson (2009) to outline and uphold the conceptual framework which posits that increasing empowerment serves to reduce self-stigma. Narrative therapy is a postmodern psychotherapeutic model often used in therapeutic work with children and their families, and this paper argues that this therapeutic process will serve as an effective strategy to reduce self-stigmatization in children, adolescents, and their families.

Literature Review

Theory

Psychologist Patrick W. Corrigan is regarded as a pioneering researcher on the self-stigma of mental illness and theorizing strategies to reduce its influence. Corrigan and Rao

(2012) presented a stage model to outline the process of self-stigma development. First, they theorized that an individual diagnosed with a mental illness must have awareness of the stereotypes associated with that diagnosis. So, once again using the example of ADHD, the diagnosed individual must understand that society holds views that people diagnosed with ADHD are sloppy, lazy, and underachieving. Second, the individual must agree that the stereotypes are true about the group, i.e., he believes the public are correct that people diagnosed with ADHD possess those negative attributes. After agreeing with these stereotypes, the individual must then apply them to himself (i.e., "If I am diagnosed with ADHD, then I must be sloppy, lazy, and underachieving"). Lastly, to complete the process of developing self-stigma, the individual must then experience harm related to the self-application of the stereotypes. For example, the individual may experience low self-esteem and decreased self-efficacy (i.e., "I am lazy, sloppy, and unable to be successful because I have ADHD"). It is important to note that self-stigma does not cause harm until the individual actually applies the stereotypes to himself and adopts them as part of his identity (Corrigan & Rao, 2012).

Corrigan, Larson, and Rusch (2009) theorized even further that self-stigma, with accompanying decreases in self-esteem and self-efficacy, can lead to reductions in life goal achievement. The authors termed this construct the "why try" effect (Corrigan & Larson, 2009, p. 75). In essence, the model argues that reductions in self-efficacy and self-esteem associated with internalizing stereotypes may lead individuals to feel unworthy or incapable tackling the demands to achieve life goals. Using the previous ADHD example, an individual with this diagnosis who believes he is sloppy, lazy, and underachieving (self-stigma) will likely doubt his abilities to be successful and thus limit his attempts to achieve goals ("why try" effect).

A growing body of research has also explored a stigma phenomenon that is of particular interest to this paper: courtesy stigma. Coined by Erving Goffman (1963), courtesy stigma is defined as discrimination that is extended to people who are associated with a stigmatized person. In exploring self-stigma in children and adolescents, it is also important to investigate the effects stigma has on people in the child's immediate environment, namely parents, caregivers, and other family members. Given that parents have a significant amount of control and influence on a child's immediate environment, one can assume parental experiences of courtesy stigma will have an effect on the parent-child relationship and the children themselves. Research has suggested that society views parents as responsible for their child's mental health issues, with blame being attributed to bad parenting skills (Corrigan & Miller, 2004). In exploring the effects of courtesy stigma on parental well-being, Mak and Cheung (2008) found that the internalization of courtesy stigma (which is termed affiliate stigma) results in feelings of shame and embarrassment, self-blame, a tendency to avoid social contact, and attempts to conceal the child's mental illness. In a study on affiliate stigma of parents of children with ADHD, Mikami, Saporito, and Na (2015) found that greater affiliate stigma was associated with increased parent negativity and poorer social skills in the child.

Additionally, Moses (2010) found that in adolescent populations diagnosed with mental disorders, parental attitudes and actions were highly correlated with their children's self-esteem and self-efficacy. Parental hiding of their child's diagnosis was found to increase incidence of self-stigma. Children who felt their diagnosis was something to be concealed and not discussed were much more likely to internalize negative attributions associated with their diagnosis. Additionally, parental attitude toward the adolescent's control of their symptoms was also highly correlated with degree of self-stigma. Adolescents who believed their parents felt that they had a

sense of control and could reduce their symptoms through therapy and personal changes were less likely to experience self-stigma. Conversely, adolescents who believed their parents saw them as controlled by their diagnosis, helpless to change, and suffering from a "brain disorder" reported a higher degree of self-stigmatization. This research suggests that adolescents who believe their parents believe in their own self efficacy have better treatment outcomes, feel more empowered, and have more self-confidence (Moses, 2010). This research suggests that courtesy/affiliate stigma is a critical area of study when examining the effects of self-stigma in children and developing anti-stigma strategies.

Prevalence

Although there is an extensive amount of research discussing the presence and effects of public stigma and self-stigma in adult mental health populations, data addressing self-stigma in children is rather limited. This paucity of research is concerning, given that data strongly indicates the presence of stigmatization toward children and adolescents with mental health issues, perhaps even more so than adult mental health populations (Kaushik, Kostaki, & Kyriakopoulos, 2016). Studies have shown that children understand mental illness terms and associated stereotypes from a young age, and also suggest that children hold stigmatizing attitudes and view peers with mental health issues less favorably (Gale, 2007). Understanding that self-stigma develops as a result of public stigma, one would expect the high incidence of public stigma toward children and adolescents with mental disorders to have an effect on the children diagnosed themselves.

Although the data are sparse, a handful of studies have identified the presence and effects of self-stigma in children and adolescents with mental health issues. In a study of 60 adolescents ages 12-18 with a variety of mental health diagnoses, results indicated that adolescents who

reported experiencing higher levels of public stigma also reported lower self-esteem, heightened depression scores, and increased self-stigma. Additionally, results showed that earlier age at first treatment and severity of diagnosis were major risk factors for increased self-stigma (Moses, 2009a). A further study with the same group of adolescents found that participants who acknowledged and accepted their diagnostic label (self-labeling) reported higher ratings of self-stigma and depression and lower levels of personal mastery (Moses, 2009b).

Through testing and proving the validity of a self-stigmatization scale for school-aged children receiving mental health treatment, Kaushik et al. (2016) found that self-stigmatization was present in a significant number of the participants, with high scores in the areas of societal devaluation, secrecy, and self-stigma. Additionally, a study of children ages 8-12 receiving mental health treatment in Pakistan found a "…pervasive existence of self-stigma among the children diagnosed with emotional/behavior, neurodevelopmental and both emotional and neurodevelopmental diagnosis…" (Khalil, Gondal, Imran, & Azeem, 2020, p. 3). Although differences in culture between Western society and Pakistan are important to keep in mind when reviewing this data, the high prevalence of self-stigma found in this study is still concerning.

Another study by Moses (2010) highlighted the significant role of parental behavior and attitudes in the development of adolescent self-stigma. The study found that self-stigmatization was higher in children whose parents were more secretive about their child's mental health issues. Conversely, data indicated that parental optimism and greater confidence in the child's ability to control behavior were protective factors against self-stigma. Lastly, adolescents in the study who perceived less control over their mental health issues reported higher self-stigma (Moses, 2010). These findings highlight the importance of family variables in addressing self-stigma in children and adolescents.

In reviewing these data, it can be concluded that self-stigma affects a significant number of children and adolescents with mental health issues. Understanding the negative experiences associated with self-stigma, including low self-esteem, reduced self-efficacy, and poor quality of life, strategies to reduce self-stigma in this population should be an important area of research.

Anti-Stigma Approaches

How to battle the self-stigma of mental illness is a topic of debate, and research shows a variety of theoretical ideas and strategies aimed at reducing it (Mittal et al., 2012; Yanos, Luckstead, Drapalski, Roe, & Lysaker, 2015). With regard to adult mental health populations, the most common type of intervention strategy found in a review of the published literature was psychoeducation or psychoeducation paired with cognitive-behavioral therapy techniques (Mittal et al., 2012). The Healthy Self-Concept treatment program, which is designed for use with adults diagnosed with schizophrenia, uses a group modality and focuses on psychoeducation, peer support, and on identifying individual positive attributes (McCay et al., 2006). A randomized controlled trial showed that this intervention has a significant impact on self-stigma, hope, and self-esteem (McCay et al., 2007). The Ending Self-Stigma intervention is another group approach created for reducing self-stigma in adult mental health populations. This therapeutic model uses a highly interactional and flexible approach, with subjects over a nine-week period separating stereotypes from facts about mental illness and learning and practicing cognitive-behavioral techniques to change self-stigmatizing thinking. A small pilot study testing the efficacy of Ending Self-Stigma found that the approach significantly reduced internalized stigma, and also significantly increased perceived social support, empowerment, and recovery orientation (Luckstead et al., 2011).

Other self-stigma reduction approaches with adult mental health populations utilize complex multimodal interventions. One in particular, Narrative Enhancement and Cognitive Therapy (NECT), is a manual-based group approach that combines group support, cognitive restructuring, psychoeducation, and the development of personal narratives (Yanos, Roe, & Lysaker, 2011). Particular emphasis is placed on the fact that self-stigma is a social construction derived from public stigma. The participants construct narratives to gain new perspectives on their experiences, as well as receive feedback and support from other group members. A number of studies found that NECT is an effective intervention with regard to diminishing self-stigma and improving self-esteem and quality of life (Hansson, Lexen, & Holmen, 2017; Hansson & Yanos, 2016; Roe et al., 2014; Yanos, Roe, West, Smith, & Lysaker, 2012). The effectiveness of this treatment indicates that narrative approaches may be a useful strategy for reducing self-stigma.

In reading the literature, there did not appear to be any interventions specifically targeting courtesy/affiliate stigma, although one study by Wong, Mak, and Liao (2016) found that development of self-compassion may be a useful strategy for decreasing affiliate stigma and psychological distress in parents of children with Autism Spectrum Disorder. A review of the literature also found no interventions for reducing self-stigma in children and adolescent populations.

Mittal et al. (2012) also found that very few self-stigma interventions are based on a conceptual model. This is problematic, as theoretical underpinnings are needed in interventions to understand specific targets and desired changes in treatment. Of the few conceptual frameworks presented, preliminary empirical evidence suggests that interventions targeting

empowerment could be particularly effective in reducing self-stigma of mental illness (Brohan,

Elgie, Sartorius, & Thornicroft, 2010; Corrigan & Larson, 2009).

Self-Stigma and Empowerment

Building upon the previously discussed conceptual models regarding the stages and

consequences of self-stigma, Corrigan et al. (2009) found a paradox in the development of self-

stigma in those with mental illness. Although some individuals suffer the harm associated with

self-stigma, including low self-esteem and reduced self-efficacy, other individuals respond with

anger at perceived injustice and experience empowerment. Observing the positive effects of

empowerment, Corrigan et al. (2009) added to their conceptual model for self-stigma reduction,

theorizing:

> Empowering people seems to be an effective way of reducing self-stigmatization,
>
> encourage people to believe they can achieve their life goals, and circumvent further
>
> negative consequences that result from self-stigmatization. In a sense, empowerment is
>
> the flip side of stigma, involving power, control, activism, righteous indignation, and
>
> optimism (p. 466).

Youth empowerment models (Cargo et al., 2003; Chinman & Linney, 1998; Kim et al., 1998)

demonstrate the importance of empowerment for children and adolescents, particularly those

with mental health difficulties. Several scholarly articles from the United Kingdom also

acknowledge that mental health services need to be empowerment-orientated (DfES, 2003, 2006;

DH & DCSF, 2009; DoH, 2004). Grealish et al. (2016) demonstrated that empowerment

mediates the relationship between psychological processes and mental health, well-being, and

recovery in young people. A number of studies have also shown that empowerment is associated

with better quality of life, increased self-esteem, and more social support (Corrigan et al., 1999;

Rogers et al., 1997). Taking these findings into account, it can be concluded that promoting

empowerment in individuals with mental illness is a promising strategy for reducing self-

stigmatization across the lifespan.

Argument

Studies have shown that self-stigma negatively affects a significant number of children

and adolescents with mental health issues. Although strategies exist to battle self-stigma in adult

mental health populations, a review of the published literature did not reveal any interventions

designed for children and adolescents. Understanding the negative experiences associated with

self-stigma, including low self-esteem, reduced self-efficacy, and poor quality of life, strategies

to reduce self-stigma in this population should be explored. Additionally, given the central role

parents and caregivers play in children's lives and the interactional effects associated with

courtesy stigma, an anti-stigma approach for working with children and adolescents must include

the family to be optimally successful. Further, empowerment and a sense of self-efficacy may

very well be a protective process for children and adolescents that is promoted by their families

when confronting public stigma and the consequent experience of self-stigma. An intervention

that enhances empowerment through work with the child and family may prove useful.

Narrative therapy is a postmodern psychotherapeutic model often utilized in therapeutic

work with children and their families (Besa, 1994; Ghannadpour, Sams, & Garrison, 2018;

Hannen & Woods, 2012; Ikonomopoulous, 2015; St James O'Connor, Meakes, Pickering, &

Schuman, 1997). Building upon Corrigan et al.'s (2009) previously discussed conceptual model,

which theorizes that empowerment is the obverse of self-stigma, this paper argues that the

narrative therapy model increases empowerment and therefore serves as a promising anti-stigma

approach to working with children and adolescents with mental health issues. This approach

aims to promote a decrease in self-stigma in this population by providing a theoretical basis for

mental health practitioners to practice in an anti-stigma manner.

Tackling Self and Courtesy Stigma: A New Approach

Narrative Therapy

The narrative therapy model was developed in the 1980's by psychotherapists David

Epston and Michael White in New Zealand and Australia (Anderson, 2003). White and Epston

were influenced by a number of postmodern and post-structuralist ideas, with a particular

emphasis being placed on social constructionism. White and Epston sought to create a

therapeutic model that challenged the primary viewpoints of Western psychology that focus on

dysfunction and deficits. Taking information from social constructionism, they viewed diagnoses

as socially constructed concepts that have no value in and of themselves, but are rather

propagated by the "experts" of the time (i.e., physicians, psychologists, etc.) (Anderson, 2003).

Adopting the views of post-structural thinker Michael Foucault, they saw these socially

constructed "deficits" as problematic due to the power dynamics that followed (Foucault,

2001/1982). They observed mental health consumers becoming stigmatized and disempowered

by societal notions and sought to change this viewpoint through a collaborative therapeutic

relationship that supports clients in self-organizing and re-authoring their personal stories.

Drewery and Winslade (1997) stated the goal of narrative therapy as follows: "….to enable

clients to speak from subjective positions rather than as subjected persons" (p. 43). Although

narrative therapy contains many therapeutic techniques, the model is more a perspective for how

to think about clients and their problems. It can therefore be conceptualized as more of a

worldview or philosophy for working with individuals (White, 1995). Narrative therapy does not

follow a formula, but encompasses a set of techniques that facilitate the client seeing alternative

and preferred stories and perspectives, with the end goal being that the client develops a new relationship with himself and his story (Winslade, Crocket, & Monk, 1997).

Given that this paper places a primary focus on working with children, adolescents, and their families, it is important to discuss the efficacy of the narrative therapy model for these populations. Although empirical studies about the treatment are limited, a number of qualitative studies show promise for the effectiveness of narrative therapy in working with children and their families to tackle problems. In a pilot study of narrative therapy on a child and adolescent inpatient psychiatry unit, Ghannadpour et al. (2018) found the treatment led to a significant decrease in hopelessness and also improvement in parent-adolescent communication with fathers. Furthermore, research supports the effectiveness of narrative therapy with adolescent self-injurious behaviors (Hannen & Woods, 2012) and serious behavioral problems (Ikonomopoulous et. al, 2015). Besa (1994) examined the effectiveness of narrative therapy in reducing parent-child conflict, which was defined as defiant behavior, drug use, school issues, and other conduct problems. The study found that narrative therapy was effective in reducing-parent child conflicts. In a study investigating children and families' perceptions of narrative therapy, St. James-O'Connor et al. (1997) found that all family members reported some reduction in the presenting problem. Of particular importance to this paper's argument, the researchers also concluded that the results supported the view that narrative therapy empowers personal agency in family members. With regard to the appropriateness of narrative therapy as an intervention for children, Weston, Boxer, and Heatherington (1998) found that most children understand the concepts of interpersonal causality and multiple perspectives when approaching family conflict. These findings suggest that narrative therapy, as well as other constructivist based clinical approaches, are compatible for use with child and adolescent populations.

Empowerment

As mentioned previously in the literature review, in order to reduce self-stigma in children and adolescents, an anti-stigma intervention must increase empowerment (Corrigan et al., 2009). To make the argument for narrative therapy as an anti-stigma approach, this paper must first provide an understanding of psychological empowerment as a construct. Zimmerman (1995) stated that "empowering processes are those where people create or are given opportunities to control their own destiny and influence the decisions that affect their lives" (p. 583). He further defined empowerment theoretically as consisting of three levels of analysis which are interdependent with one another. These levels include psychological empowerment, which refers to the individual level of analysis, organizational empowerment, and community empowerment. For the purposes of this paper, the argument for narrative therapy as an anti-stigma approach for children and adolescents will focus on increasing psychological empowerment (PE). PE includes intrapersonal, interactional, and behavioral components (Zimmerman, 1995). The following paragraphs break down each component and argue how the narrative therapy model philosophically, theoretically, and practically serves to increase psychological empowerment, and therefore also reduce self-stigma. Specific narrative therapy techniques will be discussed in the context of how they increase empowerment in the individual.

Intrapersonal Domain

Intrapersonally, psychological empowerment refers to how people see themselves and their perceived level of self-efficacy, competence, mastery, and motivation to control (Zimmerman, 1995). Narrative therapy can then be viewed as an empowering treatment as it shifts clients' world view to one of control and competence rather than subjugation. Through the

therapeutic process, clients start to recognize strengths and capabilities, leading them to become

more confident in their perceived control over problems.

In many Western therapeutic and medical models, attention is given to labeling the child

with a diagnosis. Although diagnosing is meant to support the creation of the most appropriate

intervention plan, it also can have a stigmatizing effect, as the child takes on an identity saturated

with societal stereotypes associated with the diagnosis (Goffman, 1986). At the core of narrative

therapy, the social construction of dysfunction or deficit is conceptualized as being outside of the

individual. This process is coined "externalizing the problem" (Roth & Epston, 1996). For

example, instead of diagnosing and speaking of a child as "ADHD," a narrative therapist may

identify "energy and distraction" as problems that are influencing the child, with the child

maintaining an identity that is separate from the problems being discussed. Thus, if a child

diagnosed with a stigmatizing mental health diagnosis comes to perceive himself as separate

from the label and feels self-efficacy and competence in battling the problem, the child feels

empowered, reducing self-stigma associated with the label itself.

This process also opens the door for the child to recognize strengths and abilities that

were previously difficult to access. According to Zimmerman (1995), empowering processes

"…are inherently strengths based, focusing on strategies that create opportunities for promoting

agency, enhancing mastery, and exerting control…" Another technique that is central to the

narrative therapy process is identifying alternative stories, or "sparkling moments" (Monk,

Winslade, Crocket, & Epston, 1997, p. 44). Through an in-depth exploration of the client's

experiences, the clinician and client discover times when the problem was not so influential,

highlighting the client's already present strengths and abilities. For example, when working with

a child who presents with aggressive behaviors toward peers, the clinician and the child would

uncover times when the child felt power over aggression's influence. Times when the child walked away to calm down rather than becoming aggressive would be considered "sparkling moments", as those stories highlight the child's strengths and undermine his problem saturated identity. Enhancing these preferred narratives facilitates the child seeing himself as the change agent in life rather than a subjugated individual who has no control over his behavior, leading to a sense of empowerment.

In tandem with the process of identifying "sparkling moments," narrative therapists highlight the child's skills and encourage self-reflection through what White and Epston (1990) named landscape of action and landscape of consciousness questions, respectively. Landscape of action questions give the child opportunities to recognize and explore the strategies they utilized independently to tackle the problem. This emphasizes the child's abilities and competence, leading to feelings of empowerment. Landscape of consciousness questions promote self-reflection and positive identity development through asking the child what their success in tackling the problem means about him as a person. For example, after exploring a child's strategy to walk away instead of becoming aggressive, a narrative therapist may ask "What does your ability to walk away instead of becoming aggressive say about you?" These sorts of questions promote self-reflection about the child's abilities and strengths, undermining the self-stigmatizing and problem saturated identity of being the "aggressive kid."

Narrative therapy also promotes intrapersonal empowerment through positioning the child as the expert during treatment (Zimmerman & Beaudoin, 2002). Inherent to the therapy process across treatment modalities, the clinician holds a position of power over the child as both an adult and also a person being paid for "help." When a clinician views herself as a helper or expert, as is the case with many therapeutic models, the clinician can inadvertently push the idea

that the client is lesser than, incapable of independently managing life, and disempowered.

Narrative therapy seeks to undermine this power differential through creating a collaborative and

nonpathologizing therapeutic relationship (Anderson, 2003). Creating a collaborative

relationship rather than taking an expert stance places the child in a position of power over his

own life story. This equal and nonjudgmental stance provides an implication in the therapeutic

process that the child is capable and has the skills to approach the problem independent of any

expertise from the therapist. This leads to a sense of empowerment, and therefore a reduction in

self-stigma. Additionally, in viewing the child as the expert of his personal story, narrative

therapists are careful to utilize the client's language. Allowing the child the opportunity to name

the externalizing problem, (i.e., "the wiggles") gives the child a sense of control over his

narrative (Zimmerman and Beaudoin, 2002).

The narrative therapy model is also highly focused on the role of language in the

therapeutic process in general. According to Drewery and Winslade (1997), "How we speak is an

important determinant of how we can be in the world. So, what we say, and how we say it,

matter" (p. 34). Diagnostic labels generally emphasize deficit language and undermine individual

strengths. These labels can lead the client to develop a deficit saturated narrative (Nylund, 2000).

Through a social constructivist lens, when others see the child as the label, so does the child see

himself. The child internalizes these socially constructed stigmatizing attitudes, leading to low

self-esteem and a lack of self-efficacy. For these reasons, narrative therapists shy away from

using diagnostic language in therapy and are careful to use non-pathologizing and empowering

language to undermine socially constructed deficit laden narratives (Anderson, 2003).

Interactional Domain

The interactional component of psychological empowerment (PE) refers to the understanding individuals have about their community and related sociopolitical issues. Having a high degree of interactional empowerment suggests that the individual is aware of his behavioral choices and options to act as he believes appropriate to achieve personal goals. Facets of the interactional domain of PE include developing critical awareness of environmental context, understanding causal agents, skill development and skill transfer across domains, and resource mobilization (Zimmerman, 1995).

According to Zimmerman (1995), the process of understanding causal agents refers to identifying factors that may influence the client's surrounding context (i.e. people, objects, events) to either inhibit or enhance the client's efforts to exert control on his sociopolitical environment. At its core, narrative therapy encompasses a worldview and practice that unpacks and re-organizes the understanding of the client's environmental context. With regard to self, the narrative model recognizes that people have free will and decision-making capabilities, however it also argues that the concept of self is contextual and interactional. People cannot have full control over their circumstances due to the bidirectional nature of the individual interacting with their given context (DeKruyf, 2008).

Narrative therapy is inspired by poststructuralist, postmodern, and social constructionist ideas, which provide a theoretical understanding for the causal agents that are negatively affecting the client. Broadly, postmodernism is a group of ideas that challenge the concept of objective truth. Social constructionism, a particular postmodern theory, posits that the concepts of truth, reality, and knowledge are socially constructed through the vector of language (Anderson, 2003). Social psychologist Erving Goffman (1963), one of the pioneers of social

constructionism, contextualized problems and diagnoses such as ADHD and conduct disorder as
linguistic constructions, meaning that a mental health diagnosis and associated symptoms only
exist because society decided to construct the idea and label it For example, a diagnosis of
ADHD means nothing without the dominating experts in society who developed "knowledge"
about it and gave it a name. Unfortunately, these labels come to be associated by society with
stigmatizing attitudes, often leading to the diagnosed individuals stigmatizing themselves.

Given that the concept of self is contextual and interactional, the dominant discourses
about an individual's diagnosis and/or problems have a significant effect on that individual's
identity (Goffman, 1963). When working with children and adolescents, these dominant
discourses and causal agents become particularly powerful, as children's lives are very much
influenced and controlled by adults and other systems surrounding them. For example, if a
child's school is unable to see the child as an individual beyond his "ADHD" symptoms who is
capable of change, it will be very difficult for the child to adopt a more positive narrative and
become empowered because he is being limited by an environment that does not accept or
provide support for his preferred story. Through exploring a child's experience across contexts,
narrative therapists gain information on the people and stigmatizing attitudes that may be
hindrances to a child's empowerment and progress (Zimmerman & Beaudoin, 2002).

After understanding causal agents, the therapeutic dyad then identifies ways to mobilize
resources and obtain environmental mastery, which is termed critical awareness. The
interactional empowerment domain of critical awareness refers to one's understanding of the
resources needed to achieve a desired goal, knowledge of how to acquire those resources, and
skills for managing resources once they are obtained (Kieffer, 1984). Once again, this is
particularly important to keep in mind when working with children, as many of the decisions

made and contexts presented are put in place by parents, teachers, and other adults of authority.

There is therefore a constant tension between the external context and the self-efficacy of the

child (DeKruyf, 2008). Children in particular feel more out of control of their lives than adult

clients because the parents make decisions for them and use labels to describe them, such as "our

ADHD child."

Narrative therapists obtain critical awareness through identifying individuals who are

highly influential in the child's life and bringing them into the therapeutic process (Zimmerman

& Beaudoin, 2002). Although not always the case, typically the most important individuals in the

child's immediate context are parents and caregivers. When assessing the role of caregivers in

inhibiting or supporting the child in adopting their new empowering narrative, it is important to

keep in mind the effects of courtesy and affiliate stigma. Parental courtesy stigma occurs when a

parent is stigmatized for having a child diagnosed with a mental illness, (i.e., others believe the

mental illness is the result of poor parenting). When the parent internalizes and believes this

courtesy stigma, they experience what is referred to as affiliate stigma (Mak & Cheung, 2008).

In order to attend to the parent-child interactional problems associated with courtesy and

affiliate stigma, the narrative therapy model actively involves parents in the therapeutic process.

Narrative therapists invite parents to bear witness to their child's preferred narrative so that they

may see their child in a different light (Zimmerman & Beaudoin, 2002). When parents are able to

see their child as separate from the problem, they reduce the stigmatizing attitudes held for the

child. The more the child's immediate environment adopts the language of the preferred

narrative, the stronger that narrative will become for the child, as social constructivism tells us

how we are talked about greatly affects the way we see ourselves. As Moses (2010) found,

children who believe their parents trust in their abilities to tackle the problem experienced less

self-stigma, so facilitating a parental stance of support and confidence in the child's abilities

through bearing witness to the preferred narrative will lead to increased empowerment in the

child. Parental support then becomes a resource for the child to live in line with his preferred

narrative. This interactional process becomes cyclical in a positive way, as when the parent

views the child in line with the preferred narrative and is on the lookout for sparkling moments,

the child will feel more empowered to tackle the targeted problem and act accordingly. As the

problem becomes less influential on the child and the family, both the child's self-stigma and the

parent's affiliate stigma are reduced.

The clinician working with the child also becomes a valuable resource in increasing

interactional empowerment. As the clinician becomes a part of the client's social context and

views client as separate from the problem, the child receives new and different messages about

himself contradicting the dominating problem saturated story. Because the stigmatizing label

does not exist in this relational context and the problem is not seen as part of the child's identity,

the child begins to see himself in a more positive light. Additionally, through identifying and

exploring sparkling moments, the clinician gives the child the opportunity to uncover skills the

child already possesses to tackle the problem (Anderson, 2003). Although no skills are actually

taught, through this process the child heightens his awareness of his abilities and is able to utilize

those skills moving forward.

The use of "therapeutic documents" in narrative therapy can also be viewed as an

interactional empowering process. Although this intervention is carried out in different ways

depending on the clinician, in essence therapeutic documents provide summaries of sessions

which include identified strengths and skills, sparkling moments, and the developing preferred

narrative. These documents serve to emphasize the child's capabilities, giving him a physical

reminder of his accomplishments to view again and again (Anderson, 2003). Through therapeutic

documents, the child feels both intrapersonally empowered through developing confidence in his

own abilities and interactionally empowered through the non- stigmatizing and supportive views

of the clinician, which contradict his socially constructed problem saturated narrative.

Behavioral Domain

The behavioral domain of psychological empowerment (PE) encompasses actions taken

by the client to actively influence preferred outcomes (Zimmerman, 1995). Viewing this from

the lens of the narrative therapy process with children, the domain includes behaviors the child

directly engages in to reduce the influence of the problem and strengthen preferred stories.

PE is a process, and as such the intrapersonal and interactional domains directly affect the

behavioral domain and vise-versa (Zimmerman, 1995). For example, a child who feels

intrapersonal empowerment through developing a preferred narrative, externalizing the problem,

identifying sparkling moments, and recognizing personal strengths and abilities will show

behavioral changes by living in line with the preferred narrative. Externalizing the problem

removes blame from the child, instilling a sense of empowerment and personal agency which

drive the child to reduce the influence of the problem through behavioral means.

Additionally, bringing in an audience to hear the child's preferred narrative is both

interactional and behavioral, as the child is actively sharing his story while the audience is

listening and adopting that viewpoint. When sharing his story with parents, teachers, and other

important figures, the child is actively challenging the social constructed problem saturated

narrative that led to self-stigmatization (Zimmerman & Beaudoin, 2002). Through presenting the

preferred narrative, not only does the story become more solidified for the child, but he is also

able to potentially alter audience perceptions and create a positive change in his environmental context.

Another empowering therapeutic technique utilized in narrative therapy is the positioning of the client as a consultant. Once the child and his immediate environment have begun living in accordance with the child's preferred narrative, the clinician then invites the child as a consultant for other clients (Zimmerman & Beaudoin, 2002). This not only expands the client's audience of witnesses but reiterates the client's role as the expert and author of his own story. The client is given the opportunity to offer others support in tackling similar problems, thus having a direct effect on his environmental context and increasing his sense of empowerment.

Conclusion

Self-stigma of mental illness in children in adolescents is an overlooked psychological issue that warrants attention, given the persistent and harmful effects its presence is shown to have on child and family functioning. This paper served to address this problem through exploring the development, effects, and possible strategies against self-stigma through Corrigan et al.'s prominent conceptual framework. Self-stigma and empowerment have been hypothesized as existing on opposite ends of a continuum, meaning that an increase in empowerment will theoretically reduce self-stigmatization. In successfully arguing that narrative therapy promotes psychological empowerment across intrapersonal, interactional, and behavioral domains, it can be concluded that the therapeutic model is a promising anti-stigma approach to working with children and adolescents with mental health issues.

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