

11 - 28.11 Narrative Psychotherapy

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that remains, both inside and outside of the group, before the conclusion of treatment. Termination Phase. In the termination phase (sessions 16 through 20), the therapist discusses termination explicitly with the group members and begins to help them recognize that the end of treatment is a time of possible grief and loss. The therapist helps members recognize their own progress and the progress made by other group members. During this phase, group members are encouraged to describe the specific changes in their psychiatric symptoms, especially as they relate to improvements in the identified problem area(s) and relationships. Although it is common for group members to want to keep meeting on their own or to have frequent reunions, group members are encouraged to use this phase of the group to formally say goodbye to one another and to the therapist(s). The therapist(s) also uses this time to encourage members to detail their plans for maintaining improvements in their identified interpersonal problem area(s) and to outline their remaining work. POSTTREATMENT MEETING. The posttreatment meeting is scheduled within 1 week after the final group session. The therapist(s) uses this final individual meeting to develop an individualized plan for each group member's continued work on his or her interpersonal goals. The therapist(s) reviews the group experience and the changes the patient has made in his or her interpersonal problem area and significant relationships. REFERENCES Binder JL, Betan EJ. Essential activities in a session of brief dynamic/interpersonal psychotherapy. *Psychotherapy*. 2013;50(3):428-432. Bolton P, Bass J, Neugebauer R, Verdeli H, Clougherty KF, Wickramaratne P, Speelman L, Ndogoni L, Weissman M. Group interpersonal psychotherapy for depression in rural Uganda: A randomized controlled trial. *JAMA*. 2003;289:3117. Gilbert SE, Gordon KC. Interpersonal psychotherapy informed treatment for avoidant personality disorder with subsequent depression. *Clin Case Stud*. 2013;12(2):111-127. Huibers MJ, van Breukelen G, Roelofs J, Hollon SD, Markowitz JC, van Os J, Arntz A, Peeters F. Predicting response to cognitive therapy and interpersonal therapy, with or without antidepressant medication, for major depression: a pragmatic trial in routine practice. *J Affect Disord*. 2014;152-154:146-154. Markowitz JC. Interpersonal psychotherapy for chronic depression. *J Clin Psychol*. 2003;59:847. Miller MD, Frank E, Cornes C, Houck PR, Reynolds CF 3rd. The value of maintenance interpersonal psychotherapy (IPT) in older adults with different IPT foci. *Am J Geriatr Psychiatry*. 2003;11:97. Spinelli MG, Endicott J. Controlled clinical trial of

interpersonal psychotherapy versus parenting education program for depressed pregnant women. *Am J Psychiatry*. 2003;160:555. Swartz HA, Frank E, Shear MK, Thase ME, Fleming MA, Scott J. A pilot study of brief interpersonal psychotherapy for depression among women. *Psychiatr Serv*. 2004;55:448. Wilfley DE. Interpersonal psychotherapy. In: Sadock BJ, Sadock VA, eds. *Kaplan & Sadock's Comprehensive Textbook of Psychiatry*. 8th ed. Vol. 2. Philadelphia: Lippincott Williams & Wilkins; 2005:2610. 28.11 Narrative Psychotherapy

More than anything else psychiatrists do, they listen to stories. These stories so saturate the clinical encounter that it would be impossible to imagine a clinical encounter without them. In the very first meeting between psychiatrist and patient, the psychiatrist begins with an open-ended invitation to a story: "What brings you here?" or "What seems to be the problem?" Patients respond to these questions by telling psychiatrists about their lives, their troubles, when the troubles began, what seems to have caused them, how they create difficulty, and what kinds of problem solving they have tried. Such stories may be rudimentary, they may be only partially worked out, and they may even be baffled and confused. The patient may even be perplexed enough to answer "I don't know why I came" or "I'm not really sure what's wrong, my family sent me." Nonetheless, the patient's response to the psychiatrist's initial questions always involves a story. Narrative psychotherapy emerges out of this increased interest in clinical stories. The two main tributaries that lead to narrative psychotherapy come from the two different sides of psychiatry: narrative medicine and narrative psychotherapy. Narrative psychiatrists are psychiatrists who combine the wisdom of these two domains. Following the lead of narrative medicine, narrative psychiatrists recognize that psychiatric patients, like medical patients, come to clinics with intense stories to tell. Contemporary narrative medicine has developed from 30 years of work in bioethics and medical humanities devoted to humanizing the clinical encounter through a better understanding of patient stories. The term narrative medicine comes from Rita Charon, an internist and literary scholar, who used it to describe an approach to medicine that uses narrative approaches to augment scientific understandings of illness. Narrative medicine brings together insights from human-centered medical models, such as George Engel's biopsychosocial model and Eric Cassel's person-centered model, with research and insights from phenomenology, the humanities, and interpretive social sciences. Narrative medicine uses these resources to better understand the illness experience, "to recognize, absorb, interpret, and be moved by the stories of illness." As Charon argued, when clinicians possess narrative competency, they can enter the clinical setting with a nuanced capacity for "attentive listening. . . , adopting alien perspectives, following the narrative thread of the story of another, being curious about other people's motives and experiences, and tolerating the uncertainty of stories." She further argued that doctors "need rigorous and disciplined training" in narrative reading and writing not just for their own sake (helping them to deal with the strains and traumas of clinical work), but also "for the sake of their practice." Without such narrative competency, clinicians lack the ability to fully understand their client's experience of illness. For Charon and others in narrative medicine, narrative study is not a mere adornment to a doctor's medical training; it is a crucial and basic science that must be mastered for medical practice. A major task of narrative medicine, and therefore narrative psychotherapy, is to be a good listener and to connect empathically with the patient's story. A narrative psychiatrist, like a narrative physician, seeks to understand the patient first and foremost. This understanding brings patient and clinician together into a shared

experience of the patient's world. This narrative understanding is much more than a causal explanation of problem A or problem B that the patient might have. It does not simply abstract from the person's situation a categorical label that groups problems under a well-known abstract grid. Instead, narrative understanding tunes in to the uniqueness of the individual and the unrepeatability of the person's experience and difficulties. Narrative understanding, in short, is a deep appreciation of the person as a whole—what it feels like for this person, in this particular context, going through these particular problems. In addition to following the lead of narrative medicine colleagues, narrative psychiatrists also follow the lead of contemporary colleagues in narrative psychotherapy. The history of narrative psychotherapy goes back to Sigmund Freud's early work at the inception of psychoanalysis. At that time, Freud lamented about how his case histories sounded more like narrative fictions than hard science. Contemporary narrative psychotherapy's motivation for returning to the role of narrative comes partly from the broader turn to narrative in humanities, psychology, and social science and partly from the history of psychotherapy since Freud. The past century of psychotherapy has been a century of strife, with one faction after another splitting off from psychoanalysis. Leading alternatives to psychoanalysis included behavioral, humanistic, family, cognitive, feminist, and interpersonal, just to name some. All of these splits are characterized by further splits within splits, which has fragmented the field of psychotherapy to the point that there are now more than 400 active approaches to psychotherapy. Narrative approaches emerge at this particular moment as part of an important trend away from further fragmentation and toward psychotherapy reintegration. Narrative approaches are invaluable for psychotherapy integration because they provide a metatheoretical orientation from which to understand and practice psychotherapy. METAPHOR Metaphor performs this function by allowing us to understand and experience one thing in terms of something else. The metaphor selects, accentuates, and backgrounds aspects of two systems of ideas so that they come to be seen as similar: "Men are seen to be more like wolves after the wolf metaphor is used, and wolves seem to be more human." Understanding metaphor in this way connects to broader work in continental linguistic philosophy, and that work, as a whole, shifts standard ideas about truth and objectivity. It allows us to sidestep the usual binary traps between relativism (anything goes) and realism (there is only one correct or true way to describe the world). When the role of language is understood as a mediator between our concepts and the world, it no longer makes sense to think in these highly modernist either/or terms. Rather than using the rigid binary distinction between true and false, it becomes possible to think instead in a postmodern language of semiotic realism and pluridimensional consequences.

PLOT Plot works like metaphor in that it also orders experiences and provides form for narratives. Plot, or the process of emplotment, adds to metaphor two key dimensions: (1) it brings together what would otherwise be separate and heterogeneous elements, and (2) it organizes understanding and experience or time, or what could be called temporal perception. The critical function of plot for narrative is that plot creates a narrative synthesis between multiple individual events and brings them together into a single story. It allows an intelligible connection to be made between them. Remarkably, plot can create a synthesis between events and elements that are surprisingly incongruous or heterogeneous—events that do not seem to fit together. Plot also configures these multiple elements into a temporal order. This temporal order is of two sorts. First, each plot is comprised of a discrete series of incidents, of theoretically infinite nows. Second, each plot takes these infinite nows, proceeding one after another in succession, and organizes them into a humanly manageable experience. CHARACTER In narrative theory, the concept of character

connects directly to contemporary controversy surrounding the related and, some may argue, more basic concept of identity. The controversy around identity may be understood as a tension between essentialist and nonessentialist approaches. Essentialist notions of identity tell us that each person has a fixed personality, perhaps biologically stamped, that authentically belongs to that person and that is at the core of that person's being. This "true self" or "core self" may be distorted or covered over, but it is nonetheless there for the discovery if individuals apply themselves patiently and persistently to the task. Nonessentialist critiques, however, have deconstructed this ideal of identity and its notion of an integral, ordinary, and unified self. One of the most productive ways to navigate the tension between essentialist and nonessentialist understandings of identity is to draw a comparison between identity (in life) and character (in fiction). Rather than adopting a linear logic that understands identity as a more fundamental concept to character, this approach uses a circular logic to argue that people understand themselves in the same way they understand characters. Narrative approaches to identity allow people to navigate the tension between essentialist and nonessentialist identities because narrative identity allows for a kind of continuity over time, a relative stability of self, without implying a substantial or essentialist core to this stability. People's interpretations of themselves use the cultural stories with which they are surrounded to tell a story of self that escapes the two poles of random change and absolute identity. In this way, a narrative identity is also a cultural identification. A person's identification may seem original, but he or she narrates them with the resources of history, language, and culture.

NARRATIVE PSYCHOTHERAPY With this brief introduction into narrative medicine, narrative psychotherapy, and narrative theory, it is possible to draw out further the meaning of narrative for psychiatry. Fortunately, one of the most helpful aspects of narrative theory for psychiatry is that it provides an overarching, or metatheoretical, rationale for understanding how these many psychotherapies work. From a narrative perspective, all therapies involve a process of story telling and story retelling. No matter which style of psychotherapy one uses, the process of therapy involves an initial presentation of problems that the client is unable resolve. The client and therapist work together to bring additional perspectives to these problems, allowing the client to understand them in a new way. These additional perspectives vary greatly depending on which style of psychotherapy is used. It matters, in other words, whether the therapy is psychodynamic, cognitive, humanistic, feminist, spiritual, or expressive. From the vantage point of narrative theory, however, what these different approaches all have in common is that they rework, or "re-author," the patient's initial story into a new story. This new story allows new degrees of flexibility for understanding the past and provides new strategies for moving into the future.

FUTURE DIRECTIONS Recent work in narrative medicine, narrative psychotherapy, and narrative theory has opened the door for the development of narrative psychiatry. This development provides a critical corrective to contemporary psychiatric practice that helps to bring psychiatry back from its current obsessions with science and scientific method. This corrective is not a return to psychoanalysis nor does it demolish the progress of scientific psychiatry. When psychiatrists take a narrative turn, they do not throw out their other skills and knowledge. The shift to narrative is, as much as anything else, an attitude shift and an opening out to additional sources of information. It starts by bringing to the foreground that the clinical encounter is a human encounter, and it follows by opening out to colleagues in the humanities, interpretive social sciences, and the arts to help to better understand this human encounter. Most of all, narrative psychotherapy joins with other contemporary efforts in psychiatry—such as the recovery movement—to make clinical encounters much more client focused and collaborative. Narrative psychotherapy, at its core, recognizes that there are many

ways to tell the story of one's life. The choice among these different options is a key way in which people create their identity. These choices should not be reduced to expert choices or scientific choices because they are always also personal and ethical choices. In the end, they are choices about what kind of life one wants to live. Furthermore, clinicians must come to understand the value of biography, autobiography, and literature for developing a repertoire of narrative frames and options. In the end, narrative competency in psychiatry means a tremendous familiarity

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