CHAPTER 8

Supervision of Narrative-Based Psychotherapy

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NARRATIVE PSYCHOLOGY has become an important new integrative movement within the field of psychology, one that has spurred and shaped the development of narrative-based psychotherapies. Narrative psychology bridges what Bruner (1986) referred to as the *paradigmatic* and the *narrative* modes of thought, both of which are important to a full understanding of human experience. The paradigmatic mode of thought aims at deriving general principles and verifiable truths from observation of the world. Its emphasis on precision and quantification serves as the basis of empirical science. In contrast, the narrative mode of thought aims to construct believable stories about human intentions and their consequences. This mode of thought accounts for particulars rather than aiming to extract abstract generalities, and it is the way that humans seem to talk naturally about and make sense of their experience (Bruner, 1986; Sarbin, 1986). The narrative mode accounts for the traditions of mythology, storytelling, poetry and drama, and hermeneutic or interpretative analysis. As the language of subjective, particular experience, narratives give access to vivid imagery and emotion that other forms of thought do not make as readily accessible. Narratives are also a window into meaning making, giving insight into how individuals construct the world in their own manner. Narratives integrate emotion, cognition, and behavior, which makes them ideal vehicles for conveying the intersection of personality and social influence (Conway, Singer, & Tagini, 2004). Consider the following memory from a woman who had undergone a recent miscarriage:

> I was 27 weeks pregnant when I went into labor. When I arrived at the hospital, the nurse could not detect my baby's heartbeat. He was, in fact, dead. I delivered my son shortly thereafter and shortly after that, went into unexplained heart failure. At least that's what the doctor says. But I can tell you why—I lost my baby boy and my heart

ripped right in two. We spread his ashes on Thanksgiving Day at a mountain lake. My life has never been the same.

Her story makes her emotional experience palpable. Her attribution of her heart failure to her grief and her statement that her life has never been the same give a sense of the subjective enormity of her loss. The narrative hints at other ways that she sees the world. For instance, her story also suggests that there may be a sense of peace for her in the memory of laying her son to rest in the midst of nature—although the hint of peace is certainly not without overtones of terrible pain. In short, the story reveals, albeit incompletely, the phenomenology of her grief.

BACKGROUND OF NARRATIVE-BASED PSYCHOTHERAPIES

We can trace our contemporary emphasis on narrative as a vehicle for treating psychological suffering back to the writings of Freud and Adler. Freud (1900/1953) thought that through interpreting the symbolic or metaphoric content of dreams, memories, and free association, a psychoanalyst could bring to light the patient's unconscious conflicts. Adler (1930) regarded the *manifest* content of memories as shaped by and revealing of the rememberer's current goals and worldview, with the earliest memory having special projective value. Similarly, Rogers's (1951) client-centered therapy validated the client's voice and conscious presentation of concerns as opposed to seeing his or her narrated experience as simply a conduit to buried unconscious conflicts.

More recently, Bruhn (1990), in the tradition of Adler, proposed that a person's narrative memories are shaped by his or her current goals and worldview. Bruhn's cognitive-perceptual theory posits that a person's attitudes (views of self, others, and the world) provide a framework that shapes memory reconstruction and guides new perceptions to fit with existing memories. In other words, the autobiographical stories that people tell themselves and others have a powerful shaping influence on how they perceive the world. Bruhn developed a method of psychotherapy assessment by which a person's dominant concerns and interpersonal patterns may be discerned from collection of his or her memories, and his empirical studies demonstrated that the content and structure of early memories correlate with personality differences, diagnostic categories, and varying degrees of psychopathology.

Angus and McLeod's (2004a) handbook highlighted a range of contemporary narrative-based therapies including the most prominent of these approaches, White and Epston's (1990) narrative therapy. In the remainder of this chapter, we use the term *narrative therapy* only in reference to the specific type of therapy practiced by White, Epston, and their adherents. We use the term *narrative-based psychotherapy* to refer to the larger category of therapies that make narrative a central feature of their work. The following paragraphs highlight some, but certainly not all, of the narrative-based therapies currently being practiced.

CORE CONFLICTUAL RELATIONSHIP THEMES

The core conflictual relationship theme mode of psychodynamic therapy is structured to help patients achieve their desired outcomes in interpersonal situations through (a) identifying within their narrative memories sequences of relational events in which they do not act on their wishes because of an imagined (and feared) response from the other person, and (b) analyzing the sources of and disputing the accuracy of the feared response of the other (Book, 2004; Luborsky & Crits-Christoph, 1998).

PROCESS EXPERIENTIAL PSYCHOTHERAPY

Process experiential psychotherapy (Angus, Lewin, Bowes-Bouffard, & Rotondi-Trevisan, 2004) aids clients in thinking reflectively about emotionally charged narrative memories in order to coconstruct with the therapist a fuller understanding of life events and their meanings. Clients learn to identify different modes of thought in their narratives and learn to move from more discursive to more analytic ways of engaging with the stories they tell.

PERSON-BASED PSYCHOTHERAPY

Person-based psychotherapy (Singer, 2005; Singer & Blagov, 2004) integrates the collection of narrative memories with analysis of traits, goals, and defensive styles in order to obtain a comprehensive and holistic assessment of the client's personality and motivation. Narrative memories are explored as vehicles of self-definition in the context of dialogic relationships with intimate others in the client's life. In combination with analysis of the client's characteristic tendencies and long-term strivings, these self-defining memories may be interpreted for insight into interpersonal scripts and the client's systems of meaning making.

NARRATIVE THERAPY

Narrative therapy involves the close examination and deconstruction of clients' stories (Parry & Doan, 1994; White, 2004), with a focus on identifying and disputing dominant cultural assumptions that have shaped and limited clients' understandings of their lives while opening up possibilities for clients to narrate their lives in ways that are more expansive and liberating. Narrative therapy emphasizes movement away from internalization and self-blaming and toward recognition of community and collective empowerment in resistance to negative and destructive societal messages and practices.

COMMON PRINCIPLES OF NARRATIVE-BASED PSYCHOTHERAPIES

These narrative-based psychotherapies, along with others that share similar philosophies, may diverge in terms of the kinds of narratives they explore (some therapies help clients to articulate the social discourses that inform their narratives;

other therapies focus on tracking the scripts that clients learned from early childhood experiences). However, according to Angus and McLeod (2004b), all of these psychotherapies share some common tenets, including the following: (a) Narration is a fundamental process of self-construction and self-change; (b) narration is a basic therapeutic process and one that facilitates formation of the therapeutic alliance; (c) narratives contain reconstructive potential, because there is always more than one way to tell any given story; (d) effective therapists are experts in understanding narratives, such that they can identify and help clients capitalize on opportunities for narrative change; and (e) a major goal of narrative-based psychotherapy is the formation of a coherent, accessible, differentiated, and evocative narrative.

How might supervisors help their supervisees act on these principles in their therapeutic work? We elaborate in broad terms the kinds of therapeutic practices that these principles call for, and, where possible, we give examples from specific forms of narrative-based therapy. In reviewing past writing on supervision of narrative-based therapy, one should note that most published work up to this point has been contributed from narrative therapists. One of the goals of this chapter is to help expand supervisors' thinking about how to guide beginning therapists in adopting narrative-based principles that may be broader in orientation and technique than the one modality of narrative therapy.

TEACHING PRINCIPLES OF NARRATIVE-BASED PSYCHOTHERAPY

Principle 1: Narration Is a Fundamental Process of Self-Construction and Self-Change

Dan McAdams (1987, 1999; McAdams & Janis, 2004) has theorized that people construct an identity in the form of an evolving narrative that connects past, present, and future. McAdams (1988) identified four components in his life story theory of identity that are particularly interesting to look at as indicators of how people see the world: ideological settings, imagoes, generativity scripts, and nuclear episodes. The *ideological setting* is a person's general sense of whether the world and other people are good or bad, optimistic or pessimistic, just or unjust. An *imago* is a personal archetype reflected in different characters through the life story. Imagoes capture the repetitive characterizations that a person employs in his or her efforts to understand and engage with others in his or her life. A *generativity script* reflects a person's concerns with the ultimate meaning or purpose of his or her life. Generativity scripts reflect a person's expectations about how typical stories in his or her life will turn out. A *nuclear episode* is an autobiographical memory that is linked to the individual's most enduring concerns. It often expresses a turning point, peak, or nadir experience that continues to exert influence over the individual.

Because these aspects of life stories reflect and also shape clients' ongoing experience of the world and of themselves, supervisors might encourage supervisees to read McAdams and other narrative identity researchers (e.g., King, 2001; McAdams & Pals, 2006; Pals, 2006; Pillemer, 1998, 2001; Spence, 1982; Thorne, 2000). In addition to doing this reading, supervisees can follow the protocols for collecting

life story interviews and self-defining memories (McAdams, 1988; Singer, 2005). Through collecting and analyzing stories and memories, supervisees should become particularly sensitive to how the recurring plots and characters reflect interpersonal scripts and evocative metaphors that might be windows into ongoing relational struggles that clients may be facing. We address how self-defining memories may be used in this manner through a case study later in this chapter.

PRINCIPLE 2: NARRATION IS A BASIC THERAPEUTIC PROCESS AND ONE THAT FACILITATES FORMATION OF THE THERAPEUTIC ALLIANCE

Angus and McLeod (2004b) proposed that it is inherently healing for clients to be able to tell their stories in a supportive environment and, in so doing, explore and express their stance regarding events in their lives. The quality of therapists' and other listeners' presence makes a difference in the quality of the speakers' recall: In the presence of an attentive listener, speakers recall events in a more detailed and coherent way (Pasupathi, 2001). Supervisors can emphasize to supervisees that empathic attention and feedback is important for the purpose of helping clients to tell their stories in as full and uninhibited a manner as possible (Rogers, 1951).

When conducting narrative therapy, a supervisee is encouraged to maintain a compassionate, questioning stance vis-à-vis the client throughout the therapy and to remain open to new information about the client (Parry & Doan, 1994). The therapist should hold off from quick interpretations or reductive summarizing statements. Through open and empathic listening, the therapist gains a great deal of information about how the client sees the world. Therapist and client also build a sense of working as partners and sharing an experience, and the client builds trust in the therapist.

PRINCIPLE 3: NARRATIVES CONTAIN RECONSTRUCTIVE POTENTIAL BECAUSE THERE IS ALWAYS MORE THAN ONE WAY TO TELL ANY GIVEN STORY

If, as McAdams and Janis (2004) argued, narrative identity is a key part of personality, then the idea that narratives can be reconstructed in the course of therapy implies that therapy can indeed help people achieve significant personality change. To empower distressed clients to find other ways to tell their stories is to help them to effect significant changes in their lives.

The dialogical approach to narrative-based psychotherapy emphasizes the multiplicity of perspectives within the self from which stories might be told. This approach is based on a view of the self as a metaphorical theater of voices, containing multiple characters that relate to one another in any number of possible ways from cooperative to combative (Hermans, 2004, 2006). A therapist using this approach helps the client to identify dominant, problematic characters within the narratives—both internal characters (i.e., parts of the self) and external characters (i.e., other people in the clients' world)—while also keeping track of the situations in which these characters are prominent. The therapist assists the client in gaining distance from these dominant characters by adopting alternative and more flexible positions to reduce the characters' impact. In order to assist the client in taking other perspectives, the therapist enters into dialogue with the client's characters

by asking and inviting questions from the client. Additionally, therapist and client develop behavioral experiments to encourage the client to take on and strengthen different positions from his or her repertoire.

Principle 4: Effective Therapists Are Experts in Understanding Narratives, Such That They Can Identify and Help Clients Capitalize on Opportunities for Narrative Change

Research on the different types of narratives that clients tell in psychotherapy has been conducted in studies of process experiential therapy, a therapy in which clients are encouraged to tell significant, emotionally charged stories to induce emotional arousal that clears the way for the therapeutic construction of new meanings for the emotionally charged event (Angus et al., 2004). Angus et al. examined how three narrative processes that clients use in therapy contribute to productive therapy outcomes. These three modes of narrative processing are external, internal, and reflexive. *External narrative processing* is the mode in which a client describes what happened in a given sequence of actions. In the external mode, a client may articulate important and hitherto forgotten events. *Internal narrative processing* is the mode in which a client tells how he or she felt in a given situation. The internal mode is important because it helps a client to articulate and differentiate his or her emotional experience. *Reflexive narrative processing* occurs when a client considers what a given event means to him or her. This can lead to the development of new meanings and perspectives. All modes are valuable in telling complete stories in therapy, and the latter two modes are especially critical for bringing about therapeutic change. It is important, therefore, for supervisees to develop the skills to guide clients to further elaborate on their narratives in the internal and reflexive modes. Also, supervisees should learn when it is useful to guide clients from one mode to another. For example, good-outcome psychotherapy seems to occur when therapists guide clients to the internal narrative mode after clients are already telling stories in the reflexive mode (Angus et al., 2004).

Supervisors and supervisees together can review therapy transcripts, videotapes, or process notes from the supervisees' cases, and supervisors can help supervisees learn to identify points in the narrative at which the supervisee might help the client to sustain narrative processing in a given mode or make a transition to a different mode.

Principle 5: A Major Goal of Narrative-Based Psychotherapy Is the Formation of a Coherent, Accessible, Differentiated, and Evocative Narrative

McAdams (2006) and Singer and Rexhaj (2006) pointed out that good narratives need to be convincing not only to the self, but also to audiences. To seem lifelike to audiences, as well as to the self, a narrative should be differentiated and evocative; to allow audiences to follow the narrative, it should be comprehensible and not obscure in meaning. Incoherent and fragmented narratives may not only make little sense to audiences, they may even induce discomfort and anxiety in therapists and other listeners (Lysaker & Lysaker, 2006; Salvatore et al., 2006). Supervisors

should encourage their supervisees to be attuned to their own reactions to clients' narratives, as these reactions approximate how clients' narratives are received by others in their lives.

Supervisees should be aware that through listening and giving feedback, they inevitably serve as coauthors of clients' stories (Singer, 2005; Sullivan, 1953). As coauthors, they can suggest connections and linkages across different experiences, which may help the client to see more integration and coherence in the narrative. Also, as is practiced in narrative therapy (e.g., White, 2004), therapists can help clients see how their stories fit within the context of larger cultural narratives.

Singer and Rexhaj (2006) also highlighted the value of flexibility and complexity in narratives. As Book (2004) illustrated with his analysis of one client's core conflictual relationship theme psychotherapy, clients' narratives become more differentiated and flexible as clients learn to identify and preempt the relational scripts that have previously guided their actions. This increased flexibility may lead to new ways of fulfilling their heretofore frustrated wishes. Supervisees can help clients to increase the flexibility and complexity of their stories through a kind of sustained and empathic attention to the clients' experience in all its subtlety, including an understanding of the linkages between the clients' emotion and thought, an attunement to underlying meanings, and dedication to an ongoing process of narrative revision. Supervisors can model these skills of attention and discernment for their supervisees.

Having given a broad outline of the principles of narrative-based therapies and how supervisors might encourage their supervisees to implement these principles in their therapeutic work, we now outline more extensively one approach to the supervision of a narrative-based psychotherapy that integrates aspects of cognitive-behavioral, psychodynamic, and humanistic therapies.

PERSON-CENTERED APPROACH TO A NARRATIVE-BASED PSYCHOTHERAPY

The fundamental premise of the person-centered approach to therapy (Singer, 2005) is that individuals bring to therapy repetitive self-defeating thoughts and behaviors that take the form of familiar narrative sequences that may be discerned in several domains and specific experiences in their lives. This notion of repetition compulsion is traceable to Freud and other psychoanalytic writings (e.g., Freud, 1950), but a narrative perspective brings the insight that often the repetition of what defeats a person is more than a destructive response to a repressed dreaded impulse; it is rather the imposition on experience of a more elaborate meaning system that is encapsulated by a rigid narrative sequence of interpersonal interactions and corresponding emotions. Only narrative has the capacity to depict the complexity of these interpersonal and intrapersonal dynamics in a format that affords the opportunity for insight to both the individual involved and those others who would hope to understand this person's enduring conflict.

Tomkins's (1979, 1987) elaboration of Freud's ideas about repetition into a cognitive-affective theory of scripts anticipated much of the current interest in how individuals process information in narrative terms and how narrative memory may be an anchoring aspect of personality and identity (McAdams & Pals, 2006; Singer,

2004, 2005). The key contribution that Tomkins's script theory offers with regard to the practice of a narrative-based psychotherapy is that the therapist and client working together can identify from the client's past and current experience certain dominant affective sequences that are schematic expressions of repeated and often unresolved interpersonal conflicts in the client's life. These experiences or scenes have become linked by their shared affective patterns, for example a sequence of hope followed by disappointment followed by self-disgust and finally withdrawal and depression. Through psychological magnification, these sequences coalesce into a filter through which new affective experiences are processed and understood. Most critically, this filter or script becomes a template not only for making sense of the past but for structuring and rendering coherent, in a rigid sense, new interactions. With the script in place, individuals are all too likely to recreate the patterns of emotional behavior that have brought them previous conflict and frustration. These ideas clearly resonate with those of other important innovators in psychotherapy who emphasized cognitive and interpersonal rigidity (e.g., Beck, 1976; Ellis, 1985; Horney, 1950).

Person-based therapy, drawing on the insights of script theory and related cognitive-affective theories, seeks to do the following:

- Identify enduring conflicts that perpetuate clients' unhappiness.
- Identify narrative sequences that encompass these conflicts.
- Establish clients' awareness and understanding of these narrative sequences.
- Help clients overcome these sequences to reduce conflict.

Associated with each of these goals are specific strategies that help clients to make use of their capacity for experiencing the significant emotional struggles of their lives in the language of memories, stories, and metaphors (see Table 8.1). As detailed in Singer (2005) the first step of this approach is to conduct a comprehensive person-based assessment that allows for a thorough examination of clients' personality characteristics, overarching motivations, defenses, and relational dynamics.

Identifying Enduring Conflicts

Drawing on McAdams's (1995) three-domain framework of personality, the therapist assesses the client's traits (as measured by the NEO PI-R or other trait inventories), current motivations (as measured by Emmons's personal striving task, see Emmons, 1986, and Singer, 2005; or other motivation assessment procedures such as the Thematic Apperception Test), and narrative identity (as expressed through collection of a life history, autobiographical writings, and/or self-defining memories, see McAdams, 1987, and Singer & Salovey, 1993). In addition, drawing on the work of contemporary psychoanalysts such as Mitchell (2000) and Ogden (1994), the therapist also strives to assess the quality of the emerging relationship between the client and the therapist, including subtle intersubjective associations and emotions that the two may share (for a detailed account of how to track this intersubjective therapeutic dynamic, see Singer, 2005, chap. 5). In the course of this multitiered assessment, a clear picture of the client's most enduring and frustrating interpersonal conflicts is likely to emerge.

Table 8.1
An Outline of a Person-Based Narrative Approach to Psychotherapy

1. Identifying Enduring Themes and Conflicts
   a. Person-centered assessment
      i. NEO Personality Inventory—Revised (NEO PI-R)
      ii. Personal strivings
      iii. Life history and self-defining memories
      iv. Observation of relational dynamics in therapy
      v. Cultural influences
2. Identifying Narrative Sequences That Express These Core Issues
   a. In current life
   b. In self-defining memories
   c. In the therapeutic relationship
3. Aiding Client in Awareness and Insight About Themes and Narrative Sequences
   a. Learning contexts and triggers
   b. Developing a narrative language of metaphor and emotional handles for use in therapy and life
4. Changing Narrative Sequences and Overcoming Conflict
   a. Anticipating and preempting narrative sequences
   b. Reframing
   c. Role-playing
   d. Interpreting transference
   e. Recognizing and rewarding new endings
   f. Consolidating and reinforcing empowerment

IDENTIFYING NARRATIVE SEQUENCES

The narrative-based therapist then seeks to identify narrative sequences that encompass this conflict in three different modes:

1. Current relational experiences outside the therapy.
2. Specific narrative memories.
3. The current therapeutic relationship.

The paramount goal at this point in the therapy is to track and identify the most vivid and compelling narrative examples of how the self-defeating conflict plays out in the client's life. For example, a client, paralyzed by the prospect of choosing between a husband and a lover, told a compelling memory of her parents' divorce and how she had locked herself in her bedroom, fearful that she would have to choose one parent over the other. This memory and its affective sequence of confusion, fear of betrayal, and sequestered powerlessness eloquently telescoped the client's current relational struggle. By doing so, it provided a narrative-based therapy with a rich language of imagery and metaphor that helped the client to articulate her deepest and most subtle fears with regard to the choice she was confronting. This memory of the childhood bedroom and its walled-in terror fit the criteria of a self-defining memory (Singer & Salovey, 1993) in that it was vivid, frequently recalled, emotionally intense, linked to similar memories that shared its affective content, and conveyed an enduring theme or unresolved conflict (in this case a forced choice between two love objects).

As therapy progresses, both the therapist and client can increasingly identify the presence of the affective script across diverse current interpersonal situations and past experiences and within the therapeutic transference. As their facility in

detecting this pattern intensifies, the therapist and client can take advantage of their shared narrative vocabulary to highlight moments when the affective sequence appears to be unfolding. In the preceding example, the client eventually could say to the therapist "This is a locked door moment," and the therapist could immediately grasp that the client had gone into a emotional place of confusion and fear. The value of these *shared metaphors*, or what Leslie Greenberg (2004) called *emotional handles*, is that they convey affectively intense and complex relational dynamics in a short-hand and efficient fashion. The dyad working together can quickly know the place the client has reached and the risks associated with continuing to remain in that location. In both literature and therapy, metaphors are integrative units of the mind that bring together ideas, feelings, and physical experience within a single trope.

In addition to a shared language, the therapist and client can isolate the *contexts and triggering circumstances* in which the affective sequence is likely to take hold of the individual. Looking specifically at work situations, types of intimate discussions, family gatherings, and peer interactions can help the client find the commonalities, both externally and internally, that serve to energize the activation of narrative sequences. With memories, current experiences, and actual in vivo examples within the therapeutic dynamic to concretize the self-defeating pattern, the client can move from an abstract understanding to vivid and graspable incidences of repetitive and self-defeating conflict.

Helping Clients Overcome Sequences

Another advantage of the narrative sequence's tangibility is that it can become a practical tool for change. Therapist and client are united in an effort to move beyond awareness and institute a change in the self-defeating ending of the repetitive script. Because change in the individual's interpersonal patterns and self-understanding requires alteration in cognition, affect, and behavior, both psychodynamic and cognitive-behavioral strategies come into play. The imposition of the particular affective sequence involves a filtered interpretation of events, what cognitive-behavioral theorists would call a *faulty schema*. Accordingly, the therapist must help the individual to question assumptions about interpersonal interactions that hold strong similarities to previous experiences that have activated the narrative sequence. A similarity should not determine that the sequence and outcome of the new series of events must be identical to that of the previous ones or that the individuals involved harbor the same feelings or are likely to behave in the same fashion as previous participants in similar scenes have acted. This questioning of automatic assumptions is part of a general strategy of *reframing* the affective sequence that can include the use of automatic thought journals and the substitution of more constructive self-statements.

In combination with reframing efforts, individuals can become more adept at *anticipating and preempting the narrative sequence.* By knowing the contexts and triggers that are likely to release the sequence, individuals can engage in a variety of emotion regulation tactics (Gross, 1999) to avoid entering into the sequence's grip. By situation selection, avoidance, and response modulation, to name a few potential strategies, clients can limit their role in taking the potential sequence from spark to conflagration.

Another practical technique is to allow the client to act out a version of the affective sequence, imagining it unfolding at work or with one's partner at home. The therapist can play a coworker or the client's partner, or in a reverse role-play the client can take on the role of the primary other individual involved in the sequence. Reverse role-plays are particularly effective for helping to enlarge the empathetic horizons of the client and negating reductionistic assumptions about the other person whose role he or she has assumed (Singer, 2004).

Emphasizing narrative sequences in therapy also leads to real-time *interpretations of transference.* For example, Singer and Blagov (2004) described a client who returned from a school trip in high school only to find out that his father had wiped out his college savings account (which he had accumulated on his own from years of working a paper route) in order to buy a second car for the family. When the client protested that he would not have enough money for college, the father replied that he could have the car when he graduated high school. The client turned his anger on himself by withdrawing from the family and taking a series of low-paying factory jobs and giving up any ambition for college. This traumatic incident and similar encounters within his most intimate relationships crystallized into a script of distrust and expected betrayal that often caused him both to withdraw from and sabotage his closest bonds. As manifest in the transference, the client would often follow a session of more personal disclosure and deepened therapeutic alliance with disparaging comments about his progress in the previous week or the intervening days between sessions. He would express forgetfulness about the content of the previous session despite its emotional power and extent of insight; his comments and body language verged on indifference or scorn toward the therapist, minimizing the sense of connection and warmth they had achieved.

Using the client's narrative memories that captured this same pattern of intimacy and withdrawal as touchstones, the therapist and client were able to see this script in action and interpret it as a defense against his fear of dependency and betrayal. Linking this relationship pattern in the therapy to the emotional handles of the paper route and the client giving up on himself and his dream of college was a highly effective vehicle for making tangible how damaging his fear and self-destructive withdrawal could be to his attempts to build a more positive and trusting relationship with another person.

Whether one employs reframing, role-playing, or transference interpretations, the goal of a narrative orientation in psychotherapy is to help the client *recognize and reward different endings* to new situations that share many of the warning signals and triggers that are likely to set off the unfolding of the familiar narrative sequence. Part of what would be defined as a successful therapeutic outcome is the client's enhanced ability to build a delay into his reactions to situations and to use imagery to imagine where a particular interaction might head before actually engaging in emotional and behavioral responses. When the client is successful in this anticipatory response, the therapist and the client must take the time to acknowledge this victory over the tyranny of the repetition compulsion and enumerate the benefits that accrue from side-stepping this potential trap. In addition to explicit self-reinforcement, the client should clearly see improvement in relationships outside the therapy at home and work.

Building on the client's increased sense of autonomy and flexibility that has emerged from overcoming a previously frustrating narrative sequence, the

therapist has a unique opportunity *to consolidate and reinforce the client's more general sense of empowerment*. If we might borrow from the language of White's narrative therapy, clients have learned that by "externalizing a narrative," they need no longer be controlled by this script *or* by other "internalized narratives" that are not healthy or liberating for their growth and self-development. The best possible outcome is to see clients willing to question fundamental assumptions about the "oughts," "musts," and "shoulds" that too often limit their efforts at risk taking, change, and authenticity in their lives. Whether it is to take the risk of being vulnerable in a love relationship or to pursue an alternative career path or to finally stand up to an authority figure, a sense that one can step back from one's narrative patterns and direct them rather than simply act in them may be the most powerful offshoot of working with narratives in psychotherapy (see Hermans, 2006).

In order to illustrate how one might train and supervise beginning therapists in this application of narrative psychology to psychotherapy, we present the following case study. The first author (Jefferson A. Singer) served as the supervisor of the second author (Jenna Baddeley) for a client referred to her as part of an outpatient psychotherapy service at a Veterans Affairs (VA) hospital. Although therapies in this service are conducted in a cognitive-behavioral framework, the onsite supervisor of the second author (the third author of this chapter, Lisa Frantsve) permitted and assisted with the introduction of the more novel narrative approach in the treatment of this particular client. Once we had agreed to this arrangement, potential candidates for this narrative treatment were considered and this particular client was selected on the basis of his verbal fluency, his openness to participating in a research project, and the interpersonal focus of his presenting concerns. The client provided signed consent to participate in the supervised therapy, which included tape recording, and was aware that the therapy protocol might be further analyzed and written up for scholarly publication. This informed consent did not extend to a discussion of the specific components of narrative therapy or the larger theory behind narrative scripts and person-centered assessment and psychotherapy. Names and identifying details have been changed to protect the confidentiality and anonymity of the client.

Case 8.1

Phil, a 54-year-old married White male, was in the military service for 23 years and retired as an E6, after which he went back to college and earned his degree. He now works in the health field in a New England city. He and his wife are happily married and have two adult daughters. He speaks of his wife (and his daughters) with a great deal of fondness. The patient's father is deceased, and his mother, who is in her 80s, lives in Florida. The patient has been devoting a lot of time and energy to her care. For example, he recently moved her out of her house and into an assisted living facility and is working on sorting out her finances and coordinating in-home care for her. He has experienced his mother as short-tempered, ungrateful, and resistant to his efforts to help her.

He had previously sought treatment at a VA hospital for depression and had been diagnosed with Major Depressive Disorder. His current symptoms included dysthymic mood, poor self-image, worry and anxiety, weight gain, lack of exercise, and procrastination at work and home. He started on antidepressant medications (Celexa) at the

(continued)

same time as he began therapy. His therapy was defined as a relatively short-term treatment (in part due to the limited tenure of the therapist at the practicum site) and consisted of 14 sessions of weekly psychotherapy.

The therapist (second author) was a second-year master's student in psychology who was in the midst of a year-long practicum at the VA hospital. As part of the psychology outpatient service, she carried a small caseload (three to four clients) and also cofacilitated group therapies. The general context of her training at the VA hospital was cognitive-behavioral, but her master's thesis work and related projects with her thesis advisor (the first author) had familiarized her extensively with theory and research in narrative psychology.

The supervisor (first author) was a clinical psychologist who served as a professor of psychology at a liberal arts college and also maintained a private practice. With a background in personality research and training in both psychodynamic and cognitive-behavioral therapies, the supervisor in recent years had attempted to articulate a person-based approach to assessment and psychotherapy that highlights the integrative role of narrative psychology (Singer, 2005).

The site supervisor (third author) was a clinical psychologist who served as the director of the clinical health psychology section at the VA hospital. Trained in cognitive-behavioral and health psychology, she provided overall guidelines for addressing some of the more specific symptoms of depression but allowed the first two authors latitude to pursue alternative treatment approaches to the more long-standing intrapersonal and interpersonal conflicts that appeared to contribute to the client's dysthymic presentation.

Although the unique circumstances of this collaboration provide an example of an explicit integration of cognitive-behavioral and narrative techniques, the first author in his own practice has found that the weaving together of these two orientations is highly effective, though each approach can certainly stand alone.

EARLY WEEKS OF TREATMENT AND SUPERVISION

In any cognitive-behavioral treatment, early treatment focuses on problem assessment and goal setting. The therapist pursued these activities with the client, and they agreed to have the client work on an automatic thought log (Persons & Tompkins, 1997) that would chart potential dysfunctional thoughts that exacerbated the client's depressive tendencies or accelerated stress and anxiety.

The therapist understandably wanted to know what a person-based narrative approach would take as its focus in contrast to the cognitive-behavioral approach. Supervision discussions at this early stage highlighted the assessment of Phil as a unique individual rather than as the repository of symptoms or problems. Drawing on McAdams's (1995) three-domain framework of personality, the supervisor encouraged the therapist to collect data that would reflect Phil's most characteristic and general disposition (e.g., his particular profile of personality traits as assessed by the NEO PI-R; Costa & McCrae, 1992), his most significant and long-term goals as expressed in the major roles and contexts of his current life (e.g., his personal strivings; Emmons, 1986), and his most vivid self-defining stories that were reflective of his unique sense of identity (e.g., self-defining memories and life story; McAdams, 2001; Singer, 2005). In addition, the supervision emphasized the importance of a fourth domain of relational dynamics that could be monitored by carefully registering the experience of being with Phil and noting the affective quality of the dyadic interactions. The therapist was encouraged to be alive to all sensory, affective, and cognitive responses that Phil evoked in her, as well as to any possible thoughts, sensations, or feelings of countertransference (Singer, 2005).

The therapist proceeded to conduct assessments of each domain over the course of these early sessions. For the first domain, not only did the therapist collect Phil's

self-ratings on the NEO PI-R, but his wife supplied her ratings of Phil as well. With a little bit more struggle, Phil was able to provide a set of long-term goals in response to Emmons's prompt "In my life, I typically strive to . . . ." Within a therapy meeting, he was also able to provide a series of revealing self-defining memories in response to a request for memories that he considered highly important to the dominant concerns and conflicts in his life. He provided additional narrative memories in the course of the ongoing therapy sessions. Finally, the therapist made a special point of recording process notes that highlighted not only Phil's words but the moment-by-moment interaction between the two. These process notes allowed for open dialogue with her supervisor about the quality of her experience with Phil and the accompanying thoughts and feelings that emerged in her during and after their sessions. These process notes also helped the therapist to look for examples of when Phil deployed defenses in the service of emotion regulation and self-esteem maintenance (another critical dimension of the second domain in McAdams's framework).

Before discussing the results of this assessment, we should call attention to a critical question that the therapist asked of the supervisor—"Why bother with this extensive analysis of his personality? What are our goals in conducting these tests?" This is a question that the client might legitimately raise as well. The answer is that the therapist is looking for the linkage of cognitive schemas, the ways in which the client represents the self and others, to narrative representations of these schemas in past and current relationships. By knowing about traits, strivings, and memories, one is likely to see how the individual connects his or her episodic and semantic understandings of the world or, put in the simplest terms, how he or she makes sense of experience. Gaining insight into how an individual extracts a unique set of meanings from the world and translates those meanings into emblematic memories and stories provides a powerful opportunity for a series of effective interventions. These include the reframing, role-playing, and transference interpretations previously outlined. As one gains access to the touchstone narrative memories that a client describes as self-defining, knowledge about the client's characteristic traits and most ardent personal strivings is likely to clarify and confirm the themes that the therapist is able to extract from the memories. The overarching goal, then, of a person-based assessment in psychotherapy is to give therapist and client concrete access to the client's meaning-making and emotion-generating dynamic processes, which can then assist the client in gaining greater control over these aspects of his or her personality.

One should take note that questions about a client's overarching personality characteristics or Big Five domains (i.e., introversion vs. extroversion, degree of positive emotionality vs. negative emotionality, flexibility vs. rigidity, other vs. self-orientation, and conscientiousness vs. impulsivity) can be explored without the use of a formal personal inventory. Similarly, the therapist can probe about long-term goals and dominant motives without using a measure of personal strivings. The challenge of a person-based approach is not simply to quantify or record the client's personality, but to put the presenting concerns and symptoms of the client into the larger context of a complex and dynamic understanding of that particular individual.

PHIL'S INITIAL PRESENTATION

The therapist described Phil as talkative and eager to please. If not redirected, he was likely to digress into long monologues that reflected his current frustration and anxiety about his aging mother and her noncompliance with his financial and residential recommendations. Despite his stable employment and successful marriage, Phil conveyed a sense of coming up short and not living up to his potential. In responding to supervisory probes about the experience of being with Phil, the therapist stated that she liked his honesty and humor but also noted his discomfort

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with any positive feedback or praise. He seemed generally dissatisfied with himself and admitted to struggling with his mother's continued secretiveness regarding her finances, as well as her ongoing criticisms of his attempts to be helpful.

On the NEO PI-R, Phil rated himself as average in Neuroticism but did show elevated facet scores in Depression, Self-Consciousness, and Impulsiveness. Supporting the therapist's perception of Phil's tendency toward a more negative emotional tone, his wife rated him as very high in Neuroticism and saw him as very high in Depression and Impulsiveness, as well as high in all other facets of this domain, including Anxiety and Angry Hostility. Phil and his wife both saw him as average in Extroversion, though bordering on the higher side of the facet of Warmth. They also agreed that Phil was very high in Openness, particularly in his receptiveness to new activities, ideas, and values. His willingness to participate in this project was a good example of his interest in taking on new opportunities and alternatives. Phil saw himself as a bit more Agreeable than his wife did (high vs. average, respectively), but their biggest discrepancy was in the facet of Straightforwardness. Phil saw himself as high in this dimension, whereas his wife saw him as very low. This gap in their perception suggested that his wife may have seen Phil as not always being able to communicate directly his concerns and resorting to more strategic and muffled forms of expression. Finally, each partner saw Phil as low average in Conscientiousness, emphasizing some occasional difficulty with self-discipline and careful planning and deliberation.

Reviewing his personal strivings, we noted that he emphasized his efforts to fulfill his obligations to others at family and work while trying his best to stay positive and optimistic. In light of his NEO PI-R scores, as well as his initial presenting concerns, Phil's strivings reflected his ongoing tension about meeting these important work and family responsibilities in his life. His depressive cast may have been traced to his awareness that his efforts to stay positive and follow through on his responsibilities often fell short of the mark.

EXPRESSION OF DYSTHYMIC THEMES IN NARRATIVE MEMORIES

Once our attention turned to Phil's narrative memories and life story, the outline of his personality sketched out in the previous section came vividly alive in accounts of his lived experiences. Phil depicted his mother as a hard-nosed physical education teacher whose career lasted 35 years. In contrast, Phil was overweight and tended to be a little more emotional. His father was a military man who was scornful of Phil's displays of feelings. One of Phil's most defining memories of his mother, to which he returned more than once, was a time when he was gripped by a crab and became upset and tearful. As he tried to shake the crab loose, his mother watched him, laughing.

A second linked memory was of a time when his mother promised him a set of tools and then, for some minor infraction, withdrew the offer. He felt this reversal by her as a metaphoric "slap in the face."

A third linked memory was of a time in the service when he rallied his struggling department into shape for a major inspection. He managed to have the only department that passed the inspection, but when commendations were given out, the other departments received recognition and his department received none. In a fourth memory, he recalled winning a race against an arch rival but overhearing the rival's coach say, "You let that fat bastard beat you and I'll kill you."

In looking for themes across his larger life story, Phil zeroed in on the fact that he was eligible during his military service for 13 years in row to go up for promotion from E6 to E7 but "never finished that piece out." Similarly, in his current health services position, he could raise his status by taking an additional accreditation course but had procrastinated from taking action on this coursework.

When probed about more positive memories from growing up, Phil did recall two positive memories about his mother. One memory was when she reluctantly but ultimately agreed to go riding on a go-cart track. Once inside the cramped vehicle, she actually loosened up and laughed and smiled. A second memory connected to his mother's strong endorsement of education: One day an encyclopedia salesman came to the door, and, seeing Phil's interest in the books, she bought the set on the spot.

The goal of supervision in working with this narrative material is to encourage the therapist to become a kind of literary detective and critic. What patterns seem to emerge across the memories? Relying on Tomkins's (1979) concept of affective scripts, the therapist is encouraged to look for the affective sequence of emotions that are magnified across the diverse memories and become a template for organizing current and future experiences. In this case, the therapist was able to define the following pattern: Starting with a sense of shame for emotionality, weight, and disorganization, Phil is able to overcome this negative state, achieving a momentary sense of accomplishment and pride, but an authority figure withholds approval and even mocks his efforts, leading to a sense of humiliation and anger.

Such a memory script might be characterized as a "contamination script" (McAdams, Reynolds, Lewis, Patten, & Bowman, 2001), in which the narrative events go from good to bad. These affective sequences are associated with lower subjective well-being and greater susceptibility to depression (McAdams et al., 2001). In contrast, Phil's positive memories of authority seem to focus on moments in which authority figures acted spontaneously and let go of the control they more typically exercised over him.

The supervision then encouraged the therapist to examine these narrative sequences in terms of the other domains of the client's personality. The therapist made sensible connections between Phil's elevated facets of Neuroticism and his sense of falling short in areas of Conscientiousness and accomplishment. Similarly, the client's embracing of spontaneity as a great positive in his memories fit with his elevated scores on Openness.

Having used the self-defining memories to extract a narrative sequence that captured Phil's relational dynamics in an evocative fashion, we then turned to examining manifestations of this pattern in his current interactions with others in his life.

TRACKING THE NARRATIVE SEQUENCE IN CURRENT INTERACTIONS

Much of Phil's recapping of his concerns from his previous week as reported in therapy focused on his ongoing frustration with his elderly mother. He returned to this theme repeatedly, and in one of his final sessions he came to an emotional floodgate with regard to his resentment and frustration:

> I am shouldering a lot of responsibilities for her care, but not getting a word of thanks. She doesn't appreciate help that she can't control or dictate. . . . My wife and I had a session of psychoanalysis with each other. . . . We talked about why I'm getting angry and how my mom is not acknowledging me. I just want her to acknowledge that I'm doing work.

The therapist helped Phil put this frustration in the context of his larger pattern of doing for and giving to others but feeling that his contributions or accomplishments are overlooked. Phil admitted that this particular conflict was a repeated trap for him. With a dark humor he pointed out that he had made a printout of his days off in the past 4 years with a record of how each day was spent. He calculated that only 15% of his time off was used for anything recreational or pleasurable for himself. He began to laugh at the absurdity of this time-off record and continued to laugh until his face turned red.

The therapist once again linked his current feelings to the larger script from his past of trying hard, succeeding, but not receiving the recognition he craved, especially

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when his mother was involved. Phil responded by saying, "What I need from you is how to deal with not being appreciated." In asking this, he mentioned a physical pain in his stomach and his eyes began to water.

The therapist mentioned how Phil had taken steps to build up his own self-esteem and feel a self-generated pride. For example, he had been able to follow through with his goal of hiring a personal trainer and keeping weekly appointments over a number of meetings. He could see the results in his weight and health and was justifiably proud of this progress. As the therapist helped Phil to acknowledge this change, Phil recounted another recent episode that beautifully demonstrated how one can give a new ending to a previously troubling narrative sequence:

> Another thing that has happened is that when I would be at my mother's building and she would introduce me to her friends in the dining hall, I would not know what to say when they asked what I did. I would mumble something about working in health, but I always felt tongue-tied and inadequate. When I was last down there, I got to thinking about what we have been discussing and I changed how I describe myself. Now I say that I retired from the military after 23 years and have followed that career with one in health services with a focus on managing health benefits and claims at a VA hospital. Now her friends look impressed and go "Oh!" I have felt proud for the first time and like I deserve to hold my head high.

Phil's story of how he has altered his way of introducing himself highlighted how significant it was for him to make changes in the familiar narrative sequence that had dominated many of his past and current interactions. In subsequent sessions he was able to track this same narrative sequence at work in his relations with his supervisor and coworkers. In all cases his efforts to make the sequence explicit and to discuss it in therapy gave him more flexibility in thinking about his responses to these situations and in opening up the possibility of alternative responses. The supervision zeroed in on these moments from the process notes and highlighted the therapist's comments and interventions that supported Phil's efforts to see the linkages across his life domains and to free himself from compulsive repetition of this sequence.

TRANSFERENCE MANIFESTATIONS OF THE NARRATIVE SEQUENCE

Helping therapists in training to gain the third ear that allows them to track transference and countertransference dynamics in an ongoing therapy is one of the most challenging tasks of supervision. Less experienced therapists are often very task oriented and self-conscious. This makes it difficult for them to pay attention to subtle shifts in the therapy's relational dynamics and clients' more muffled expressions of feelings (positive or negative) about the process of therapy itself. For the most part, Phil's comments about the therapy were much in the vein of seeking to support and please the therapist. Well aware of both the age difference between the therapist and him (roughly 25 years to Phil's advantage) and the therapist's relative inexperience, Phil chose to offer encouragement and reassurance, taking on a more parental role at times in the therapeutic interactions. However, he also made several comments in the course of the therapy that conveyed a subtle frustration with himself for not meeting all the goals he had set himself at the beginning of treatment. Some of these comments might also have contained a kernel of discontent with the therapy's ability to provide him with the nurturance he desired, perhaps a repetition of the feeling of deprivation suffered at the hands of his mother. There were also moments in the therapy when the therapist made supportive and praising observations, which Phil in turn deflected or minimized, reflecting his discomfort with his own success.

Given the brevity of the therapy it may have been difficult for the relational dynamics of the therapy to reach enough depth and complexity to give the therapist a powerful real-time instance of the narrative sequence unfolding, but supervision allowed for

identification of these more minor examples. The supervisor encouraged the therapist to take more opportunities to discuss the therapy process with Phil and to assist him in seeing ways in which his struggles with withheld acknowledgment, unmet nurturance needs, and discomfort with praise were all repeated with variations in the therapeutic relationship.

SUPERVISING THERAPIST INTERVENTIONS AROUND NARRATIVE SEQUENCES

As the previous sections have demonstrated, much of the intervention in this form of therapy emerges from a teaching process about the role of self-defeating affective sequences in clients' lives. To make this point with impact and emotional force, the therapist relies on the imagery and metaphors that have emerged from the tracking of the narrative memories and current interactions. The supervisory process is an opportunity to brainstorm with the therapist on the most effective phrasing and timing of these allusive linkages.

For example, once Phil's key phrases or emotional handles had been identified, the therapist helped him to see potential repetitions as instances in which "the crab has got a hold of you again and you are wishing that your mother would do something more than laugh" or "that was a 'go cart' moment when your mother could let go of control and just relax" or "this time you could feel like you passed the inspection and others took notice of your accomplishment." The therapist increasingly gained confidence in developing this shared language with Phil. Phil in turn resonated to these allusions and could immediately experience these emotional linkages. By being able to locate current situations within this more integrated perspective, he could indeed step back and reframe his emotional responses and behaviors, freeing himself from reflexive and often self-diminishing reactions.

In addition to an enhanced awareness of patterns, the therapist also displayed an ability to help Phil see ways in which he was able to give new endings to what appeared to be the same old narrative sequence. We saw one example of this in his new style of introducing himself to his mother's friends. Another instance emerged in the therapist's and Phil's discussion of his personal trainer.

In the course of trying to praise Phil for using the trainer, the therapist found that Phil was returning to his old pattern of deflecting praise and seeing himself as a passive procrastinator. After all, Phil explained, he was only staying motivated because he had hired someone to motivate him. The therapist adroitly pointed out that Phil was indeed the one who had hired him and the one who was choosing to have him put Phil through the training regime. This reversal of Phil's self-image from passive to active lifted his spirits, and he was then able to comment on the pleasure he took from the trainer's positive feedback:

> Therapist: It strikes me that you're not only challenged by this guy but also get a lot of support and encouragement.
> Phil: Bingo!
> Therapist: It's like . . .
> Phil: Euphoria. . . . It's the kind of thing I'm not getting in a lot of venues.

There are other examples of interventions that we could draw on, but we would like to finish with an illustration of transference interpretation as an intervention. In our supervision discussions, we prepared for termination and the last sessions of the therapy. These supervisory meetings focused on the ways in which the therapeutic relationship had provided a "corrective emotional experience" (Alexander & French, 1946) regarding his pattern of trying to please authorities, having success, and then somehow feeling unacknowledged or sabotaged in his accomplishment. We agreed

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that it was critical for Phil to see the progress that he had made in the therapy in terms of tangible outcomes (e.g., improved mood, weight-training program, increased assertiveness with mother) and more subtle shifts in his self-understanding (e.g., identifying his self-defeating patterns that thwart his feelings of recognition and positive self-esteem). He had indeed made good use of his treatment and needed to receive the therapist's acknowledgment of this fact.

The last session did indeed achieve this end. As the therapist praised Phil for his work in treatment, Phil began to talk more willingly and openly of the positive accomplishments in his life and how he is slowly realizing that he needed to be more open about them and to celebrate them. Tearing up, he talked about his adult daughters and their continued closeness to him. He talked about the contrast in their upbringing to his own: For his daughters, there had always been an open exchange of feelings between parents and children, unlike in his own childhood. He talked about his pride in his work and recent recognition that he received for his achievements in his department. Most of all, he told the therapist how much she had helped him appreciate his own internal strength.

The ultimate goal of this last interaction was to provide Phil with a positive experience that could become an enduring narrative memory with a different ending from his previous set of self-defining memories. In this memory, he could see himself as working in collaboration with a nurturing figure, despite their mutual recognition of her relative youth, who took the time and showed the emotional openness to acknowledge his efforts and achievements. In feeling this validation, he was able to experience a self-validation that he had often denied himself in the past. This constructive and healthy narrative memory of his therapeutic experience could be an antidote to his residual tendencies to impose his old pattern on new experiences that involved questions of recognition and acknowledgment.

CONCLUSION

Narrative approaches in psychotherapy highlight the increasing importance of narrative psychology as an integrative perspective across all subdisciplines of psychology. The fundamental concept that human beings struggle to render ongoing experience into a storied form has proven to be useful in understanding phenomena in cognitive, developmental, personality, social, and industrial/organizational psychology. The narratives that individuals tell themselves and others are meaning delivery systems; they convey at both a personal and cultural level how people make sense of the world. The psychotherapist interested in tapping into narrative as a therapeutic resource must learn how to identify, analyze, and interpret the narrative sequences that clients disclose in therapy. Supervision of narrative approaches takes as its task the orientation of the therapist to this fledgling perspective and then the subsequent cultivation of narrative analysis and intervention.

Orienting new therapists to narrative psychology means encouraging them to read some of the seminal writings of the originators of this movement. Trainees should go over the work of Alfred Adler (early memories; e.g., 1930), Sylvan Tomkins (script theory; e.g., 1979), Jerome Bruner (narrative vs. paradigmatic thought; e.g., 1986), Donald Spence (narrative vs. historical truth; e.g., 1982), Theodore Sarbin (cultural influences in the construction of moral and emotional discourse; e.g., 1995), Dan McAdams (life story theory of identity; e.g., 1987, 1999), Ruthellen Josselson (use of narrative in qualitative research; e.g., 1995), Kenneth and Mary Gergen (postmodern view of the self; e.g., 1997), Katherine Nelson

and Robyn Fivush (development of narrative thought in children; e.g., 2004), among many others. Familiarity with these theoretical and empirical advances in narrative psychology helps therapists in training see memories and stories that clients recount as more than just conduits for the real information or facts. It helps them to recognize that the recounted narratives are themselves critical data for knowing the clients with whom they work. By looking at the narratives as vessels in and of themselves of self-understanding, meaning making, cultural expression, and moral discourse, therapists will listen to these memories and stories with a different level of intensity and acuity.

Besides teaching therapists about the profound significance of narrative in human thought and social interaction, supervisors must help trainees to assess and interpret narratives in ways that extract their full potential for therapeutic insight and intervention.

The challenge in this regard is to encourage the cultivation of Bruner's (1986) narrative mode of thought. Most graduate students are well versed in the paradigmatic forms of thought that are based on logico-deductive analysis, categorization, and quantification. In contrast, the narrative mode focuses on

> good stories, gripping drama, believable (though not necessarily "true") historical accounts. It deals in human or human-like intention and action and the vicissitudes and consequences that mark their course. It strives to put its timeless miracles into the particulars of experience, and to locate the experience in time and place. (Bruner, 1986, p. 13)

Therapists must come to their clients' memories, stories, and dreams in the same manner that they would approach a literary text. They must be sensitive to imagery, symbolism, and metaphor; they must enter into the feeling tone and texture of their clients' narrative. Listening to narratives in this fashion becomes an intersubjective process (Stolorow & Atwood, 1992) in which one's consciousness accesses and mixes with the narrator's consciousness (one might consider this a momentary Vulcan mind meld of the type that Mr. Spock used to conduct in the old *Star Trek* series). In the supervision of the case described in this chapter, the supervisor needed to give continued encouragement to the therapist to take imaginative risks in responding to the client's narrative material. Narrative truths are not captured in a cut-and-dried manner but through indirection and leaps of fantasy. Bruner drew on the words of the literary scholar Wolfgang Iser to elaborate this point:

> Fictional texts constitute their own objects and do not copy something already in existence. For this reason they cannot have the full determinancy of real objects, and indeed, it is the element of indeterminancy that evokes the text to "communicate" with the reader, in the sense that they can induce him to participate both in the production and the comprehension of this work's intention. (Isler, 1978, p. 61, as cited in Bruner, 1986, p. 24)

Clients' narratives require that therapists perform acts of meaning rather than simply recite the facts of their clients' lives and words. For supervisors to facilitate this skill in trainees (who might find this challenge quite daunting, given their social science backgrounds), they must send these beginning therapists off to the worlds of literature, art, and music. Reading and discussing poetry, theater, cinema, and music is ironically the best possible mental exercise for enhancing one's ability to

make associations across narratives, detect critical metaphors, and track sequences within narratives. Reading literary texts and viewing films and plays may seem intuitively obvious ways to enhance one's acuity in locating metaphors, dramatic structures, characterizations, and dominant themes, but how might listening to music help as well? All music, but particularly classical and jazz, is based in a theme and variation structure. Listening to chamber music or jazz improvisation will help trainees develop their skills in identifying a sequence of structural and emotional shifts (e.g., an opening theme or melody) followed by the variations and recapitulations of this initial sequence over the course of the work.

Even as therapists in training begin to explore this more integrative and creative way of thinking with regard to their clients' stories, they must also glean from supervision boundaries and restrictions on these imaginative flights. Invariably, therapists must seek additional evidence from the clients' memories, current experiences, or interactions within the therapy that align with the narrative sequence and metaphoric handles that they have chosen to highlight. The person-based assessment that draws on non-narrative information about the individual offers the opportunity for confirmation and/or revision of inferences drawn from the narrative material. In the spirit of any hermeneutic interpretation, there needs to be plausibility, coherence, and goodness of fit, as well as a sense of consensus between client and therapist, that this particular interpretive frame is accurate and helpful for greater understanding. For Michael White's narrative therapy approach, the extension of the therapeutic discussion to additional family members, friends, and community members allows the therapeutic formulation to bear the scrutiny of more than the therapist and immediate clients. The supervisor can certainly play a role in the evaluation of coherence and plausibility, but even therapists who no longer partake in regular supervision can still rely on peers to provide consultation about the appropriateness of their interpretive approaches.

As demonstrated in this chapter, narrative approaches in psychotherapy ideally integrate theory and techniques from cognitive-behavioral, psychodynamic, and humanistic therapies along with an acute sensitivity to the role that culture, gender, class, and race/ethnicity play in the narratives that people construct. Therapists with previous training in cognitive-behavioral therapy will find many overlaps in the uncovering maladaptive schemas; challenging overgeneralization; and encouraging reframing, role-playing, and more constructive self-statements. Psychodynamically trained therapists will be comfortable with concepts of repetition compulsion, transference analysis and interpretation, and corrective emotional experiences. The true challenge for trainees may be to step out of their comfort zones and allow the integrative aspects of the narrative-based approach to take them in new directions with their therapeutic thinking and practice.

In conclusion, narrative approaches in psychotherapy do not represent so much a new orientation in therapy as a shift in focus from more analytic and reductionist to more synthetic and integrative styles of thought. Sympathetic to humanistic perspectives, they certainly emphasize consideration of the whole person rather than a simple problem or set of symptoms. However, in addition to the humanistic stance, these approaches zero in on a unit of human thought—narrative structures created from experience—as a particular focal point in treatment. It is the conviction of those practitioners who employ narrative approaches that from clients' simple narratives can be woven much larger tales of suffering and redemption.

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