

1991 ✓

OPTIONS FOR RECIPIENTS OF NARRATED REALITIES

That phenomenon which we refer to when we say "self" presumes a narrative.

When people come for counselling or therapy they have a story to tell. In fact each of us has a story to tell--a better way of saying this is that each of us is a story-being--told--endlessly!! That which we try to indicate by the term "self" turns out to be patternings and organization of language, specifically sentences woven into texts or stories. Stories, metaphors, symbols, discourse, biographies, autobiographies--in short, all forms of narrative are increasingly taking on central significance in therapeutic work.

Therapy as a term needs to be uncoupled from its prefix "psycho" and from its long and unproductive association with pathology and deficit. A more useful formulation of therapy is that it refers to a **process of change and evolution within the self--a process of recursive identity formation. At best, therapy is a project undertaken by a reflexive self.**

This perspective on therapy is relevant to both counselling and "psycho-therapy", and most of all to the reflexive self as "self-therapy".

I will briefly outline three options which are currently open to counsellors. These options are: traditional-advisory; modernist; and postmodern. The postmodern option itself is comprised of four options.

1. Traditional advisory mode.

In this therapeutic mode, the story is received as is, and remains relative inviolate or unchanged. What the therapist is most interested in doing is to assist the client to find "efficient forms of action" under the circumstances as narrated. If a person is in grief, then the search is for forms of action to overcome the grief; if depressed, forms of action are sought to re-establish efficacy, and so on. The client's life story is taken as largely accurate and the problem is to locate ameliorative action within the story's terms and within the frame of cultural, traditional "sense".

2 Modernist mode.

This therapeutic mode is largely an outgrowth of the larger scientific community and shares most of the assumptions of science. The general belief is that the therapist should function as a scientist. With few exceptions, therapeutic theories (behavioral, systemic, psychodynamic, cognitive, or humanistic) contain explicit assumptions about:

- a. the underlying causes of deficit or dysfunction,
- b. the location of this cause within the client or the client's relations with others,
- c. the means for diagnosing and labeling,
- d. the means for eliminating the deficit or pathology.

In effect the trained, professional helper enters the therapeutic arena with a well developed narrative for which there is considerable support within the community of scientific peers. In this therapeutic modality the client's story is regarded as suspect--is it true, accurate or only a collection of misty and tangled recollections? The therapist's tack is to proceed to replace the client's flimsy account with a professional, scientific version. Thus the psychoanalyst replaces the client's story with a version of family romance; the behaviorist translates the client story into a model of inefficient, ineffectual behaviors; the Rogerian translates the received narrative into a

client's struggle with vulnerability and conditional regard; the RET therapist takes a client narrative and revises it into an amazing display of faulty thinking which is to be replaced by the therapist's superior mode of reasoning.

This modality has advantages. For one thing, the client may "get real insight"[insight matching the counsellor's]; the problematic narrative is removed and replaced with one which promises a more hopeful future. Basically, the client is invited to trade a failure story in for a well-advertised success story. The success story will likely include suggestions for alternative behaviors, forming or dissolving relationships, following a new regimen, submitting to therapeutic procedures and so on. By providing clients with scientific formulations, the therapist is carrying out a culturally approved role within a family of rituals in which the ignorant, the weak and the failing seek counsel from the wise, the superior and the strong. While there is little evidence that one school of therapy is more effective than any other, most schools exhibit a hegemonic attitude. Each school tends to advocate itself to the exclusion of all others, and in an ideal world, all other schools of therapy should succumb to the most scientifically "respectable" therapeutic approach.

3. Postmodern options of therapy.

In this modality, the shift is from trying to determine the truth of phenomena--client stories, for example, to the function of narratives as constitutive frames. How does this narrative in itself constitute a certain reality? If I believe X, then I will have justification for certain lines of action: if Y, then other lines of action become open to me. The focus is shifted from accuracy and truth to meaning and constitutive usefulness. A story represents reality as one kind of thing rather than another, as good or evil in respect to certain aspects as opposed to others. All narratives, including scientific narratives, justify[constitute], invite, rationalize, certain forms of life and not others.

The postmodern therapeutic option robs the therapist of his status as a scientific expert with more-or-less unquestioned authority on how life is lived and why. There simply is no basis for the therapist to take a "one right way" attitude toward client dilemmas and solutions. In the postmodern perspective the scientific knowledge of the therapist becomes another cultural mythology and must take its place amongst a myriad of other mythologies.

Postmodern options.

I will briefly describe four therapeutic metaphors which are contained in the postmodern conception of therapy and narrative.

1. **Language as lens.** This option holds that a narrative construction is a (language)lens through which the individual views the world. It is argued that it is on the basis of the world as seen, not as it is, that a person takes action. There are many arguments against this view, not the least being how on earth does the individual construct the lens. If there is no world outside of the lens, how could a lens ever be constructed in the first place?

2. **Internal model.** Here the narrative construction is construed as an enduring internal structure which informs, organizes and directs action. The client may have a picture of himself as a hero but come to realize that this image of himself is not a successful one. Through therapy he

revises or creates an alternative story and places himself in the narrative as a teacher rather than a hero and this story guides him to actions which are more satisfying. A danger of the internal model of narration is that it runs the risk of being static.

3. **Language(and life)games.** In this metaphor words gain their capacity to picture reality through their use in social interaction.

For example, what can be said about the emotion of fear is not determined by the "objective fact" of fear but by the conventions of emotion-talk in a specific culture. Of fear I can say that it is subsiding but not sultry, strong but not saline. How fear is for me is not due only to its physiological constituents, but rather fear is for me as I am able to talk about it in the language or languages which I have inherited and been inducted into.

Moreover, my language with its sentences is imbedded within broader forms of life. Consider, for example what it means for me to be angry. To count myself as angry, I must have recourse to certain words within the language games which I have learned. Beyond that however, I must be able to do certain body actions such as clench my fists, grit my teeth, and pound the table. Such actions constitute the forms of life within which my language is embedded. To engage in anger sensibly within my culture, then means that I must be able to perform a kind of cultural dance. If I am not able to take part in this dance, I fail at anger.

Stories are not just simply stories. They are performed in social situations--words are situated actions. A story acts so as to create, sustain, or alter worlds of social relationships(social reality). To me as an individual, stories have different meanings, uses and implications as my social embeddedness changes. If I tell my mother that I am feeling overworked and depressed, she may respond with sympathy, care and nurturance. If I tell the same story to my spouse she may reply with frustration and resentment--she has heard the story before and besides she is worried that I will not be able to keep on working so that we can put food on the table. If I tell my story to my doctor, he will reply with anti-depressant medication and if I tell my friend, he replies with an invitation to the pub and from my paramour my story may bring on an offer of intimacy and sex.

In therapy, it is not enough that the counsellor and the client negotiate a new meaning, a new narrative. The dance that really counts is not between counsellor and client. The question is whether or not the new meaning is serviceable within the social arena outside the confines of therapy hour. Narratives exist in the telling and tellings are constituents of relational forms, for better or for worse. To repeat, a story is not simply a story. What counts from the telling of a story is what forms of action are engendered, invited, promoted in the social context where the story is narrated.

4, **Stories that transcend.** Stories do not so much tell of specific achievements or happenings in life as they indicate a **life in process**. This means that narratives can be situated in the broader perspectives of dialogue and the generation of meaning. This stance toward story requires an attitude of indeterminacy--there are a multitude of possible stories and narrated meanings and there is no necessity to adhere to an invariant, "true" story or to search for the "definitive" story. The process of life does not yield definitive stories. **Therapy is a process during which meaning of experiences is transformed via collaborative dialogue between the participants(client and therapist).** Not only is there a fusion of the horizons of meanings of both participants but either or both may be awakened by seeing their own blindness. Counselling/therapy is **conversation or linguistic activity about a "problem" which generates(makes)new meanings.**

When we see therapy as linguistic activity (conversation) which a constitutive process, in which new meanings are made including alternative patterns of meaning and entirely new orders of meaning, then we can say that, all other things being equal, counselling is good when:

- a. the dialogue in counselling is transformative and in which new understandings are negotiated together with new sets of premises about meaning, and
- b. the evocation of an expectant attitude toward the as yet unseen, the as yet unstoried, the "meaning ahead of the text" (Ricouer, 1971) occurs.

Therapy moves from this "stories that transcend" perspective include:

- 1. A receptive mode of enquiry on the part of the counsellor.
- 2. Exploration of experience from multiple perspectives.
- 3. The search for exceptions to predominating experiences.
- 4. Recognition that one is often the prisoner of a culturally inculcated story which one did not create, but which one is living by; further, these stories can be re-authored and revised.

I will try

to fasten into order enlarging grasps of disorder, widening scope, but enjoying the freedom that Scope eludes my grasp, that there is no finality of vision, that I have perceived nothing completely, that tomorrow a new walk is a new walk.

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