



# Considering narrative therapy in palliative care practice<sup>✳</sup>

Craig D. Blinderman

Department of Medicine, Columbia University Irving Medical Center, New York, NY, USA

Correspondence to: Craig D. Blinderman, MD, MA, FAAHPM. Director, Adult Palliative Care Service, Department of Medicine, Columbia University Irving Medical Center, 601 W 168<sup>th</sup> Street Suite 38, New York, NY 10032, USA. Email: cdb21@cumc.columbia.edu.

**Keywords:** Narrative therapy; psychotherapy; palliative care; re-authoring conversations

Submitted Jan 19, 2023. Accepted for publication Jul 20, 2023. Published online Jul 28, 2023.

doi: 10.21037/apm-23-77

View this article at: <https://dx.doi.org/10.21037/apm-23-77>

Narrative therapy is a field of psychotherapy based on the writings and work of Michael White and David Epston. The basic idea behind this approach is grounded in the idea that stories constrain our understanding of ourselves and our ability to engage with the problems we face in life. While understanding traditional psychotherapy concepts, e.g., frame, formulation, transference, countertransference, clinical attunement, and attachment (1-7), is valuable for a “psychologically-informed” palliative care practice (8), a narrative therapeutic approach may provide the palliative care clinician with an additional framework to uncover our patients’ deepest values and guide them to re-author their stories and the problems they face.

Narrative therapy has a number of fundamental principles that differentiate it from other psychotherapeutic systems. First, our narratives are social constructions, made up of a “community of knowers”, i.e., a group of people who share similar beliefs, experiences, and shared values. Second, some narratives are better than others in capturing our lived experience and what comport to our true self or what we most treasure. Third, narrative therapy offers a “non-essentialist” approach to psychology. It is not based on essential truths of our psychological selves, but rather socially constructed selves that are deeply relational. In other words, talking about “human nature” outside of our social and relational histories are not terribly useful. Fourth, our stories about ourselves are developed in collaboration with others. We interact in local communities and our preferred stories can be bolstered by others. Lastly, narrative

therapy holds a “non-pathologizing” approach to therapy and care. This may be best expressed in an aphorism by White: “*The person is not the problem; the problem is the problem*” (9). Indeed, our problems exist in the context of the stories we develop in collaboration with others.

One important perspective of narrative therapy is the status or position of the clinician in the therapeutic relationship. The “dominant narrative” that exists in psychotherapy encounters is that the clinician has special access to, and use of, privileged knowledge (e.g., knowledge of psychiatric diagnoses, psychological theories, and therapeutic techniques). However, this knowledge may further pathologize and reinforce constructs like, normal/abnormal or healthy/unhealthy which may feel oppressive to patients, especially those facing a serious or life-limiting illness. To acknowledge and mitigate this “expert gaze” of the medical professional, a de-centered position is advocated. This de-centered approach allows the clinician to resist the dominant narrative of modern medicine and the ways in which we ourselves are recruited into this system of discourse. Narrative therapy instead offers a more collaborative framework of inquiry to approach conversations around the patient’s relation to their illness, other people in their lives, and the problems they face. The clinician is not passive in this process, but acts as an “influential” collaborator and directs the conversations with intentionality to promote new understandings. This approach can create space for new stories of hope, healing, and even mystery, regardless of the circumstances of the illness or its response to treatment.

<sup>✳</sup> Special series on Narrative Medicine in Palliative Care.

### Externalizing conversations: “the pain is not me”

White describes a practical approach to extricate the person from the problem, called “externalizing conversations” (10). This approach is largely informed by the writings of Michel Foucault. In particular, his observation that we hold ourselves to a kind of “normalizing judgment”. Foucault describes how modernity led to a new kind of power that binds society together, best understood as a panopticon, a pernicious means by which we are encouraged, or recruited, to maintain certain societal norms, as if we are watched by some external gaze of authority. We notice how we judge ourselves against other’s actions and to the norms of human society. Self-criticism is one way in which we internalize this “modern power” over us. For Foucault and White, normalizing judgment is a mechanism of social control—we internalize normalizing attitudes in our society and attach problems that we are facing with our own failures, limitations, pathologies, or need to reconcile inherent psychic elements. In this way, the individual becomes the problem, or the problem becomes part of one’s identity. Externalization is a process by which we can create some distance from the problem, seeing it not as a necessary condition of our existence, but as a problem outside of ourselves, a problem that may be “recruiting us” in all sorts of ways.

One example that comes up in palliative care is the way many patients identify with their pain—seeing it as something that is part of themselves, that should not exist, that is disrupting one’s life. This normalizing judgment can lead to the belief that the pain “should be fixed”, so the patient can become “normal” again. Even when pain occurs within the context of a serious illness, like cancer, we can see the extent to which this normalizing judgment can inflict additional suffering, in terms of shame, guilt, feelings of inadequacy, abnormality, etc.

Consider Stanley, a 90-year-old man with a history of multiple medical conditions, including a history of lymphoma, who suffers from chronic, debilitating pain in his lower extremities due to a peripheral neuropathy. When I first met Stanley, he complained of pain each day and had not found any relief in the multiple analgesics and non-pharmacologic approaches trialed. He believes that he is “a lost cause”. He limits his functioning as a result of terrible pain and finds it difficult to enjoy any aspect of his life. He believes that the pain is a constant feature of who he is and will continue in this way for the rest of his life. In addition, he believes strongly in the dominant narrative that medical

science should have a solution to the problem of his pain.

Given the difficulty in finding a medication that he could tolerate or that might decrease the intensity of his pain, I found that externalization conversations could be of benefit to Stanley (see *Table 1*). I began by helping Stanley rename his relation to his problem of pain, seeing the shift in his language of identification from being defined by his pain to “I have pain”. Over time, I helped Stanley to reframe his relationship with his pain, not as a problem that needed to be fixed, nor as a problem that could be ameliorated simply with “finding the right medication”, but rather as a problem that can be seen as part of living with an aging body that has experienced a number of illnesses; that the pain is not who Stanley is, nor does it need to define his life. Over the course of our conversations, despite his debilitating pain, he was able to focus his energy on being connected with his family and in particular spending time with his wife who had been placed in a nursing home in the setting of advanced dementia, which was another source of distress and pain for him. Focusing on his resources to endure pain and seeing it is a matrix of unpleasant sensations that he was able to endure allowed him to find some satisfaction with short walks, spending time with his adult children, grandchildren, and great grandchildren, and visiting his wife. He became less fixated on pain as a problem that is destroying his life, and instead saw his pain as something that could be lived with and endured. He started to experience himself as someone who valued things beyond his physical comfort, and this was deeply meaningful for him.

### Conversations that highlight unique outcomes: “calm feels good”

According to White and Epston, unique outcomes refer to “*aspects of lived experience that fall outside of the dominant story*” (9). In practice, this is like finding a thread of a story that is being told by one’s “preferred sense of self”. We allow our patients to find what is unique and then hover over this outcome to enrich or “thicken” their story - to add additional layers of meaning into what had previously been a “thin” telling of the problem. These conversations have several categories of inquiry. The first is that of negotiating a particular experience and naming the unique outcome. For example, consider Denise, a middle-aged woman who is terrified before every visit with her gastrointestinal (GI) oncologist to review her scans. Despite several recent scans showing no progression of disease, Denise is filled with profound dread and anxiety. However, on one occasion she

**Table 1** Adapting narrative therapy conversations in palliative care

Types of conversations	Examples of questions
Externalization conversations	<p>Does it help to call this problem by a different name?</p> <p>How have you been recruited into seeing ... as a problem that must be solved?</p> <p>How would you like to change your relationship to the problem (e.g., pain)?</p> <p>If you changed your relationship with the problem in this way, what new ways might you experience yourself?</p>
Conversations that highlight unique outcomes	<p>Have there been any other times when you have been able to resist ... grip on you and satisfy some other desire?</p> <p>Were you OK with these developments?</p> <p>Did this bring you delight or pleasure?</p> <p>How do you think you were able to do this?</p> <p>What do you think this says about you as a person?</p>
Re-authoring conversations	<p>Questions to explore the “landscape of identity”</p> <p>What does this suggest to you about what is most important to you? Or about what is precious to you?</p> <p>What does this story suggest to you? What’s your guess about what this reflects in terms of what you value?</p> <p>How does this instance or action shape or form a picture of you as a person?</p> <p>What does this history suggest about what you were aspiring towards?</p> <p>Questions to explore the “landscape of action”</p> <p>Are there any stories that you can tell me about your actions that would be a reflection of what is precious to you?</p> <p>How could you name this action? Could you use other words to name this action?</p> <p>Are there any other instances even more distant that confirms what you value?</p> <p>Is there anything that has happened in your life in more recent years that that fits into what you are learning about?</p> <p>How would you name this experience? How would you name this action?</p> <p>What sort of history is being constructed for you through all of these actions? What is the theme of this history?</p> <p>If you can draw support from this history, what would this make possible for you?</p>

reports that she managed to approach the visit with a sense of calm after hearing a spiritual teacher she had listened to on a podcast. This moment was unique and seemed different from the previous story she had told herself—that she would always be anxious and “that is just who I am, there is nothing I can do about it”. The second level of inquiry maps the effect of the unique outcome. How does it interact in her life and social relationships? Seen as a series of developments that unfold over time, we may ask whether she had ever noticed this before in other experiences. Denise reflected on how after one of her surgeries she

had noticed a kind of calm, peaceful feeling, and that this felt good to her. The third category of inquiry evaluates the unique outcomes and its effects. We may ask are these developments OK or not OK with you? Denise notes that she preferred feeling calm to feeling anxious, which often left her exhausted. She notices that when she is calm, even if things were difficult or uncertain, she did not feel as awful as when she is reacting out of fear. In the fourth category of inquiry, we may ask to justify the evaluation by asking “why” questions to develop other understandings. To help our patient re-author her story, we may ask, “Why is this

a benefit? Or why is this a bad outcome?”. Denise is able to articulate that when there is nothing she can do about the results, she would rather cultivate equanimity than be overwhelmed by anxiety and fear.

### Re-authoring conversations: “embracing my rebellious spirit”

Michael White cites Jerome Bruner’s work in literary theory as influencing his construct for thinking about re-authoring conversations (11). He notes that there are parallels between the activity of writing stories and therapeutic practice—both contain socially constructed, meaning-making activities. We can understand stories, including those of our lives, as having linear events that make up the plot (*sjuzet*) and the timeless underlying themes (*fabula*) that makes sense of the plot. Based on this, White describes two landscapes which can be mapped out in these conversations: (I) “the landscape of action”, i.e., the material of the story composed of the sequence of events that make up the plot (*sjuzet*) and the underlying theme (*fabula*); and (II) the “landscape of identity”, which can be understood simply as the reflections on the events in the landscape of action, e.g., intentional understandings, understanding about what is accorded value, realizations, etc. White writes, “... *it is the trafficking of stories about our own and each other’s lives that identity is constructed. The concepts of landscape of action and landscape of consciousness bring specificity to the understanding of people’s participation in meaning-making within the context of narrative frames*” (11). By bringing attention to these landscapes, we are able to help patients identify what they most cherish or treasure in life. Reauthoring questions (see *Table 1*) can help patients construct a narrative based on what they most value, as they renegotiate their identity in the face of serious illness.

Lucia had problems with relationships her whole life, she had been diagnosed with borderline personality disorder, had a hard time with jobs, money and family connections, and had been estranged by many in her family. At the age of 42-year-old she was diagnosed with metastatic breast cancer and that same year her long-term partner had broken off their engagement. Heartbroken and distressed about her future and cancer diagnosis, she put her energy becoming a strong public advocate for breast cancer awareness and women’s support groups, vowing to “fight the cancer” and show others that she was a strong woman capable of battling this deadly disease. She had done some modeling in the past and decided to go back to modeling following

her post-mastectomy surgery without reconstruction. This action seemed like a kind of rebellion. When we discussed her decisions to pursue this, she noted that she was allowing another identity to unfold—an identity rooted not in fear, but in self-expression, punk aesthetics, and rebellion to patriarchal and dominant narratives that she felt oppressed by in her life. In addition, we discovered that the challenges and discord she had with her relationships in the past, suggested how much she actually values friendship and connection. As her disease progressed, her old attitudes towards others, rejecting help and assistance, transformed into letting others back into her life. Together these relationships revealed how she could re-author a life of combativeness and distrust with appreciation and tenderness for these individuals who cared for her, while at times displaying a fiercely courageous and rebellious spirit.

### Conclusions

Narrative therapy is a de-centered but influential therapeutic approach of collaborative inquiry to address problems in our lives. The narrative therapy conversations survey may be useful when caring for patients facing a serious illness or at the end-of-life as they navigate and cope with a number of problems. Moreover, these conversations may be particularly valuable in considering health injustice in minoritized individuals and in marginalized communities, who themselves have been subjugated and at times mistreated under an “expert gaze” and other dominant narratives of race, gender, and sexuality.

As palliative care clinicians explore the psychological elements of their practice, narrative therapeutic approaches offer an additional framework to mitigate suffering, promote well-being, and empower agency by leaning into what individuals most cherish. Like the Japanese artform of repairing broken pottery, *kintsugi*, which embraces the transient or imperfect aspect of existence, we may re-author our brokenness, our losses, and the problems of serious illness, with another narrative—a preferred story—to connect us to what we most value and treasure, creating a new kind of wholeness, or what we may call healing.

### Acknowledgments

I would like to acknowledge Michael Davidovitz, PhD, LCSW, (Program in Narrative Medicine, Columbia University, New York, NY, USA) who introduced me to the writings of Michael White, David Epston, and others

in a course on Narrative Therapy in Columbia University's Narrative Medicine Program.

*Funding:* None.

### Footnote

*Provenance and Peer Review:* This article was commissioned by the Guest Editor (Eva Katharina Masel) for the series "Narrative Medicine in Palliative Care" published in *Annals of Palliative Medicine*. The article did not undergo external peer review.

*Conflicts of Interest:* The author has completed the ICMJE uniform disclosure form (available at <https://apm.amegroups.com/article/view/10.21037/apm-23-77/coif>). The series "Narrative Medicine in Palliative Care" was commissioned by the editorial office without any funding or sponsorship. The author has no other conflicts of interest to declare.

*Ethical Statement:* The author is accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

*Open Access Statement:* This is an Open Access article distributed in accordance with the Creative Commons Attribution-NonCommercial-NoDerivs 4.0 International License (CC BY-NC-ND 4.0), which permits the non-commercial replication and distribution of the article with the strict proviso that no changes or edits are made and the original work is properly cited (including links to both the formal publication through the relevant DOI and the license). See: <https://creativecommons.org/licenses/by-nc-nd/4.0/>.

**Cite this article as:** Blinderman CD. Considering narrative therapy in palliative care practice. *Ann Palliat Med* 2023;12(6):1475-1479. doi: 10.21037/apm-23-77

### References

1. Brenner KO, Logeman J, Rosenberg LB, et al. Referral Relationship: Illuminating the Ways Palliative Care Creates a Holding Environment for Referring Clinicians. *J Palliat Med* 2022;25:185-92.
2. Jacobsen J, Brenner KO, Shalev D, et al. Defining Clinical Attunement: A Ubiquitous But Undertheorized Aspect of Palliative Care. *J Palliat Med* 2021;24:1757-61.
3. Rosenberg LB, Brenner KO, Jackson VA, et al. The Meaning of Together: Exploring Transference and Countertransference in Palliative Care Settings. *J Palliat Med* 2021;24:1598-602.
4. Rosenberg LB, Brenner KO, Shalev D, et al. To Accompany, Always: Psychological Elements of Palliative Care for the Dying Patient. *J Palliat Med* 2022;25:537-41.
5. Shalev D, Rosenberg LB, Brenner KO, et al. Foundations for Psychological Thinking in Palliative Care: Frame and Formulation. *J Palliat Med* 2021;24:1430-5.
6. Shalev D, Jacobsen JC, Rosenberg LB, et al. (Don't) Leave Me Alone: Attachment in Palliative Care. *J Palliat Med* 2022;25:9-14.
7. Shalev D, Traeger LN, Doyle K, et al. Turning the Lens Inward: The Psychological Elements of Clinician Well Being. *J Palliat Med* 2022;25:349-54.
8. Blinderman CD. Psychologically Informed Palliative Care and Beyond. *J Palliat Med* 2021;24:1266-7.
9. White M, Epstein D. Narrative means to therapeutic ends. New York: WW Norton & Company, 1990.
10. White M. Externalizing of the problem and the re-authoring of lives and relationships. In: White M. Selected Papers. Adelaide: Dulwich Centre Publications, 1989:5-28.
11. White M. Maps of narrative practice. New York: WW Norton & Company, 2007.