CHAPTER 5

FILLING THE NARRATIVE ENVELOPE

DRAWING ON AN ANALOGY TO PLAYS AND NOVELS, to bring a narrative to life requires a context of time, place, and person—the who, what, when, where, and how of an event. Patients tell their story, however in whatever way they will or can and the task falls on therapists to build the narrative to a level of coherence for both. Therapists need to ask who someone is, what was happening in an event that was upsetting, how the patient felt about the choice she made, how old she was at the time, who else was involved, and all of the circumstances leading up to the event.

We all, patient and therapist alike, have a story to tell, but we are not all alike in our ability or willingness to tell it. Sylvia, the patient in chapter 4, was a willing narrator but told her story in brief statements so that she and her analyst developed a pattern of rapid frequent interchanges—a conversational dialogue. As is conventional, Sylvia was principally the teller of the story of sending her daughter to school, taking the steroids, fighting with her husband, and her way to deal with absences. The therapist asked her to tell him what happened, what she felt, what the funny place was like, what was it that she said, did she follow the pattern with her father, was she worried about people seeing her as cold, and did she use the “funny place” technique with the therapist’s own absence that summer. All of these questions were to encourage her to fill out the narrative and to orient her to significant issues the therapist believed needed to be expanded. Other interventions had more to do with his attempts to indicate that he heard and understood her, that is, his empathic success in sensing into her message from her point of view. At one point she asks him to be expansive: “Do you get it?” In response, they shift roles as teller, and the therapist fills in his narrative of what he has heard and understood. To his question, “Does that seem right,” she reassures him that it does, allowing her to resume being the principal narrator.

Sylvia and her therapist evolved a narrative style based largely on Sylvia’s proclivity to make brief statements and the value her analyst found in offering her frequent encouraging bridging questions and comments. Each patient-therapist dyad creates a unique dialogue based on the patient’s mode of communication when discussing different aspects of her problems and the therapist’s personal responsiveness and training. I am advocating an open therapeutic style in sharp contrast to the “silent” analyst of mythic caricature (who unfortunately did exist). It is not for therapists to chat rather than listen, but it is their charge to help their patients in every way they can to reveal the who, what, where, when, and how that is needed for each to enter the scene of the event, memory, dream, or reverie under consideration. This means that therapeutic technique shifts away from peering between the cracks of free association for a hidden message to elaborate more fully a coherent collaborative depiction of life experiences.

Narrative richness during therapy transcends mere storytelling. To reshape a patient’s problem with his identity, therapist and patient must be in touch with the patient’s biographic self. The symbolic world that a child forms and lives in is a world of stories. We build stories about going to the zoo, about being at grandmother’s apartment, about how father treats mother, about our sister’s love and treachery. Our mind is full of stories and, most of all, stories about who we are, who we have been, and who we are going to be. All our stories and scenes, our theater of the mind with our pretends and
pretensions, combine to be our autobiography, and our autobiography is coincident with our sense of self. A therapist's attention to a patient's narrative is thus a primary means of gaining entry into the patient's inner sanctum—his private collections of personal experiences, remembered and coconstructed with the therapist.

Attachment researchers discovered that adults asked to describe their experiences with respect to attachment revealed in the mode of telling the story important clues to the nature of these experiences and to strategies they adopted as children to achieve and preserve the greatest degree of security their attachment experiences allowed. The complex patterns of these behaviors involving approach and avoidance and overt or covert intense emotions often prove analogous to patterns of speech that adults employ when narrating their memories of attachment experiences. This remarkable analogy between a pattern of behavior followed by a preverbal one-year-old infant when seeking the security of attachment and an adult telling about remembered experiences indicates that patterns of narration contain embedded affective memories of presymbolic and symbolic intersubjective experiences. The mode of telling itself contains the story it is telling, at least with respect to attachment experiences and frequently when other motivated experiences are being described. Paradoxically, although the narrative style reveals an essential component of early attachment experiences, the style contributes to serious problems in filling the narrative envelope when the early behavioral strategies produced only an insecure attachment.

Many anxious-resistant infants adopt a strategy with their caregiver of approaching and pushing away. They adopt this ambivalent pattern in response to angry inconsistent parenting. As adults, they present their attitudes with respect to attachment in a form of speech that illustrates their continued preoccupation with the struggles that characterized their childhood attachments. Asked to describe his early experiences with his father a preoccupied speaker might say, "Well he was OK, the old man. He was strict and I was scared of him. My mother said I shouldn't sass him, but I couldn't listen to her because he was always pushing her around. Like when I called home last night and she answered the phone and I thought she had been crying and she told me my sister had called."

The speaker has lost track of the subject with rapid shifts from his answer to the initial question about his father to his mother and from past to present. Because of continued absorption in the troubled relationship he is describing, he sacrifices collaboration to an inner pressure that moves him anxiously away from one troubling topic to another. Narrative clarity requires knowing what was the mother crying about, did it have to do with the father, what role did the sister's call play? To get back to the original subject of the father's strictness and the patient's sassing would require an active effort both to note the moving away and to help the patient to reorient himself.

An example from the analysis of Nancy, recorded in The Clinical Exchange (1996, pp. 33–34), demonstrates a similar, less dramatic movement of approach and push away.

"Well, I was pretty mad yesterday. I come back, lie down, and I get mad again. I don't like to be mad. It's so overwhelming. What is going on in here is I take all the responsibility and you get all the fun [chuckling]. Getting so mad about taking all the responsibility destroys the possibility of my living at peace with the world. A fundamental injustice between men and women. I have two choices, deny that it's real, or if it is real, I have to accept it. I don't like the feeling of being manipulated, which is how I feel in here. Not only male–female but the way I see things in general. I feel like I have one foot nailed to the ground while I struggle to do things and the rest of the world moves about freely. [Mildly angry] I had a dreadful thought about you yesterday. My brother would examine things—pull the wings off a fly and watch it squirm, get pleasure—that's what you are doing! You're part of it. You can do nothing about it but make your living off it. I feel like a real misogynist. Before this when I got really angry with you, I could tie myself down [crying] by reminding myself you seem to be a decent man. It doesn't help now. You look benign."

Filling the narrative envelope in an interview requires an interviewer to be aware of what is being omitted and to have the interest and curiosity to request the information. Filling the narrative envelope with a patient immersed in an intensive therapeutic experience requires sensitivity to both the needed information and the affective state of the patient. Especially with a patient who has a preoccupied
style of relating her story, the principal theme will be embedded in shifting verbal complexity and more or less obscured as the sense of security in the dyad diminishes or rises. In Nancy's remarks opening the session, differing but interrelated themes abound. She begins and ends with her ambivalent relationship with her therapist. She introduces a central theme of responsibility and couples it with male–female issues (a common coupling for children who have experienced sexual abuse). She refers to her sense of entrapment (being nailed down) and couples it with her brother's sadism. She ends with her puzzlement about the therapist—is he benign and to be trusted or is he deceptive, seductive, and sadistic?

What is the therapist's task with a preoccupied speaker such as Nancy? To make the communication come alive as a dyadic sharing of meaning, the therapist must help Nancy recognize those themes that are salient in the dense, rapidly shifting moving toward and moving away of her narrative. The therapist helps the patient to bring into the foreground for their mutual exploration not omitted details as with a dismissing patient, but emotionally significant stories of self-with-other that are easily lost in the verbal overflow. In selecting themes to take up with patients, I give priority to affective expression, evocative metaphoric imagery, and newly emerging portrayals.

Comparing the response therapists have to preoccupied speech and dismissing speech, we can employ the clichés of “I couldn't get a word in edgewise” or “It's like pulling teeth.” More formally we can compare the filling of conversational space by the patient as being too much or too little to be collaborative. Sonya, whose treatment is detailed in A Spirit of Inquiry, was on the far end of the spectrum of avoidant patients. Raised in a household comprising a childlike mother who treated every response of Sonya as a repudiation of her own needs, an obsessive, duty-bound father insensitive to feelings, and a disturbed, abusive brother, Sonya entered treatment completely engulfed in depression and pessimism although functioning at a high level professionally. She offered nothing spontaneously, arguing that she had nothing to say and that if she did say something, it would accomplish nothing. Her answers to the therapist's questions were laconic and monosyllabic. Moreover, she averred that any depictions of past experiences were not memories but what she had been told. I believed that she regularly dismissed and disavowed the details and meanings of events in order to function. She sought security by locking herself in her room to keep others out and locking her feelings, thoughts, and memories in her mind, confining only in a small group of trusted female friends.

For a long time, the sessions followed an unrelenting pattern of long silences, pauses, and extremely sparse speech. Sonya would look at me with an expression of helpless despair and say nothing. I would ask, “How are you feeling?” She would answer “Same” in a flat voice. Remembering that she had described a previous treatment as a dreadful experience in which she had said nothing and the analyst had made no response, I decided to tread a thin line between asking questions to relieve the silence and respecting her aversion to demands to talk revealingly. After her “Same,” I allowed a silent interval and observed her with largely a peripheral gaze until I saw an indication of a readiness to be less avoidant. Her head or eyes turning to me, a restless movement of her foot, a change in facial expression would encourage me to ask a further question such as, “How are you sleeping?” “Not well” might be the answer, followed by another silence. After comparable intervals and indications, I might ask about her eating, her work, how she had spent her weekend, and what plans she had for the next weekend. She would respond with pertinent terse answers and would be unresponsive to my “follow-up” questions. I believed, and thought that she believed as well, that the content we exchanged was less important than the effort we were both making to reduce the stress of a tense, empty 45 minutes. My view was that I was tracking her responses as I would a traumatized infant with whom I was attempting to make and preserve a secure contact despite the child's avoidant–dismissive withdrawal.

Gradually Sonya began to add sparse spontaneous comments to her lament about being exhausted and unable to bear it much longer. My relief and joy at her greater involvement was shattered by my recognition that after a more communicative session, she boomeranged into a full-blown avoidant depression. Subsequently she very reluctantly agreed to antidepressant medication and became more able to sustain a narrative exchange. The avoidant–dismissive
tendencies now became less global and more embedded in the mode of speech, as in the following session a day after she had taken her professional boards.

Sonya entered and perfunctorily asked how I was, then looked away depressed and exhausted. I noted her tired, sad appearance. She said the boards had been awful, she didn’t know how she did, and she didn’t care. A dismissive silence followed. I asked, “Going back to work troubling you?”

**PATIENT:** I’m taking the day off. I couldn’t face work.
**THERAPIST:** I’m glad to see you are looking out for yourself. Last week you took over for others and worked late into the night.

**PATIENT:** It’s not work, it’s the boards. My work can give me a feeling of accomplishment; taking the boards gives me none. [This was a mixed message. It included a slightly arrogant negation of my suggestion, a helpful setting us on the right track, an extremely rare admission that her work gave her a feeling of accomplishment, and a bitter complaint about being forced to do something against her will.]
**THERAPIST** [Seeing an opportunity to fill the narrative envelope]: What was taking the boards like?

**PATIENT:** Two six-hour days of hell locked up in a room. A lot of questions, many of them stupid. Some were OK. Things I work with all the time. Others were antiquated and I had no idea, so I just put anything down. It was so stupid. It was as if you had to learn the names of all the state capitals in alphabetical order to pass medical boards. [This was a rare acknowledgment of my existence.]
**THERAPIST:** Oh.

**PATIENT:** It was stupid!
**THERAPIST:** A frustrating unnecessary exercise.

**PATIENT:** I called several friends and they were sympathetic, but it was my own fault—not taking the waiver when I could and transferring the boards I had taken (previously) and passed. I feel like I was hit by a stick. It’s all so stupid. Being asked a lot of stuff you don’t need to know. Being kept in a room for two days.

**THERAPIST:** It sounds like torture.

**PATIENT:** Um-hmm. [Looking away silently]
[Pause]
**THERAPIST:** Only you said, “Hit by a stick”—did you mean punished?

**PATIENT:** [With a burst of anger] What else would it mean?
**THERAPIST:** It could mean abuse.

**PATIENT:** Oh. Well, it was both—abuse and punishment—What are you smiling about? [I had smiled involuntarily, and she asked in a way that seemed genuinely curious as well as provocative.]
**THERAPIST:** I like it when you flare up. You come alive, you become animated, and for a moment you are out of your despair.

**PATIENT:** Well, maybe I should be a smartass more.
**THERAPIST:** I know you can be lively with your friends.

**PATIENT:** I try.
**THERAPIST:** Do you have to try or sometimes does your liveliness just flow?

**PATIENT:** Sometimes it flows, but mostly I try. [A silence followed in which I felt that her avoidance had resumed and I would await an initiative from her.]

**PATIENT:** I had a good experience with my mother. A surprise. She sent me flowers before the boards and called to wish me luck. She never calls me. I have to call her. It was nice of her.
**THERAPIST:** You were surprised and pleased.

**PATIENT:** I didn’t expect to hear from anyone. Of course, I didn’t tell my father.
**THERAPIST:** What went into your decision not to tell him?
PATIENT: I knew he'd say, "How many times did I tell you to apply for the waiver." I didn't want to hear it.

THERAPIST: You had been hitting yourself with the stick enough—your mother was thinking of your feelings, your father of his advice.

PATIENT: [Defensively] He doesn't know me. I was only a little kid [when her parents were divorced]. He'll ask me about it after a while.

As the session ends, through our exchanges about her mother and father Sonya introduces another theme: the ambivalence I have observed that children of divorced parents often feel. They are flooded with the criticisms that each parent explicitly and implicitly levels against the other. This criticism threatens the child with the loss of an attachment the child may wish to maintain. She can criticize a parent herself as Sonya did her father, but can become protective when someone else (the therapist) echoes the criticism. The ending of this session signaled the existence of another narrative envelope that would need to be opened later.

Mr. N presented another challenge to make communication come alive. He ground through session after session, talking in a tense, forced you-told-me-I-am-to-do-this-so-I'm-doing-it style. Unlike Sonya, who reluctantly provided any detail about her experiences, Mr. N described his life in great detail with the only affect being irritability and sarcasm. At times he would become more tense and constrained, lapsing into prolonged silences. He would hold his chin and have a look of intense, strained concentration—the pose of Rodin's *The Thinker* or of a child straining on the toilet. Efforts to encourage him to describe his feelings at these times failed to help. I became convinced that he lacked sufficient self-awareness of emotion to be more revealing. He experienced my asking him about his feelings as drawing attention to his inadequacy in introspection, rather than being helpful. I resolved to "listen" to the gap in his speech to try to help identify his inner state. After various periods of this "concentration" silence, he began to describe fantasies of blatant aggressive actions, such as being devastatingly sarcastic toward his boss or having people under his power hold a young girl while he sexually assaults and humiliates her. I could successfully take up with him how his rage fantasies arose in response to a specifiable narcissistic slight, but although he could be responsive to the connections I made, he could make no linkages on his own. Specifically, he was unable to process the implications of his fantasies and dreams through the use of analogy and metaphor. I found that when I actively used analogy mixed with a detailed explanation of the links, he readily appreciated and used the information. He began to understand humiliating criticisms, which he had received for years from friends, that he couldn't catch on to a suggestion or to humor based on metaphor.

Another important communicative gap remained. He avoided having and acknowledging a direct feeling or wish toward me as though his very being would be threatened. His conscious fixed placement of me was as a calm, successful man who had it all together and would use his professional skills to help him to get it all together. He was terrified that rage toward me would destroy the equanimity he strove to achieve in the reciprocal envelope of a calm but rigidly formal interaction with me. By focusing on his discontinuities in speech and linking the contents of his fantasies to occurrences between us during the session, I was able to help him appreciate his need to exclude me. A session late in the therapy indicates the progress made in animating this final missing element in Mr. N's ability to communicate his feelings to himself and to the therapist.

Mr. N began by stating with pride that, as a result of the treatment, he resisted a desire to go into a funk at work when he felt resentful. Yet he was disappointed that he still fretted over a minor criticism from his boss. Then, after a typical constrained silence, he reported a fantasy of saying good-bye to a woman colleague whose response was cold and perfunctory. He took a gun and killed her husband. After a further silence, he said he'd like to ignore his fantasy. I noted his wish to treat it as a waste product of his mind to be discarded and ignored as shameful. He agreed and said his action in the fantasy of killing the husband reminded him of his resentment toward his father for not being able to prevent his mother from her cold, cutting ways. I asked him to reflect on his having the fantasy at the particular moment in the session, and he answered that
he knew it had a meaning but he couldn't make the connection. I reminded him that, after telling me with pride of what he had accomplished, he had said that he was disappointed at still being upset by a small criticism. With feeling, he added, “Oh, I'm angry at you that after all this treatment, I still get upset.” He went on to say that when I wasn't responsive to him, like the woman in the fantasy, he gets distant and irritating. I said, “irritating.” After a brief denial, he acknowledged that he has long known, but felt too much spite to admit, that his silences, his ignoring me, his “self-anesthesia” must be frustrating and irritating to me.

Reappraising the theme of this chapter, communication comes alive when the narrative envelope is filled with the who, what, where, when, and how of an event. Much more than details are required, however. The vitality of the narrative derives from the expression of emotion, the me-to-you personal involvement of many of the interchanges and the creative use of spontaneity and metaphor. In any session the vitality of the narrative is subject to several factors: the degree of comfort and security patient and therapist feel in dealing with a particular motivation, the status of the comfort and security each feels about their immediate and underlying relationship, and the gains that have been made in the therapy in being open to explore a particular subject.

For example, Professor B had two areas of primary concern: his professional advancement and his troubled marriage. When discussing his problems in his profession, he was articulate, furnished considerable detail, and responded to my requests for additional information. He was relatively open to explore his emotions, although for him this was new territory. In contrast, any mention of his wife was terse and constricted. We had little opportunity to build a narrative beyond knowing of his strong disappointment, his reluctance to recognize how he felt, and how threatening the issue was for him. For a long time we made considerable progress in exploring his problems at work, but he had so compartmentalized his experience that the growth in one area did not extend into the other. Beyond Professor B’s aversion to discussing his marriage, a difference in the emotional feel of our working together presented another factor. His approach to our exploring his professional problems was cooperative and collaborative, whereas he responded to efforts I made to enter into a discussion of his marriage with a subtle hostility that I could sense but did not understand.

A crisis in their family forced his attention to focus on disturbances in their communication. I learned that in his wife’s presence Professor B was shut down in both speech and affect. She monitored everything he said, and with a critical glance from her, he became silent, withdrawn, and drowsy. In addition, for years she had served as his “psychological” advisor. This led to two influences on his narrative flow with me. First, the fear of loss of this dependence inhibited his willingness to open himself to the full extent of his dissatisfaction. Second, largely out of his awareness, he had set up a competition between his wife and me. This “enactment” (see chapter 7) of being played off against his wife as “counselor” was the source of the tension I felt but didn't understand. Now in the sessions, he expanded the narrative about their relationship and became as responsive to my efforts to fill the narrative envelope as he was and had been about his work. He began to apply the sensitivity, insight, and intuition that he had freed up in his relationships at work to his interactions with wife and their family crisis. Having entered couples therapy, he and his wife were helped to further repair their disturbed communication as he emerged from an emotionally costly, submissive dependence.

A further example illustrates changes in narrative flow occurring in a single session. I use excerpts from a session of the treatment of P reported extensively by James Fosshage (1990). P’s childhood had been traumatic with a fragile, explosively tyrannical father and a mother who couldn't cope with P’s ordinary needs and who developed a severe paranoid disturbance. In the preceding sessions, P had become very upset by an inadvertent discovery that she interpreted as evidence that her analyst was not the strong, confident person she had believed him to be. P begins the session describing her helpless feeling about being in a relationship “because I feel so threatened by anybody’s needs. And lots of human beings are around me—my son, my friends, my family . . .”
ANALYST: Your analyst.
P: My analyst...

ANALYST: And your reaction when we feel needy?
[The analyst fills the narrative envelope by including himself. This reference to himself might be a diversion were it not that his presumed neediness was directly under consideration as the source of P’s distress in the previous hour. At a prior time, the view of him as needy would not have fit at all. Now her omission of him in the list of needy people is an example of a momentary dismissive narrative.]
P: remains dismissive, stating (with a tone of disparagement), “It’s so extreme.” [Note the impersonal pronoun “it.”]

The analyst continues to try to help P with her depressive state and her constrictive narrative. He reminds her of the neediness and suffering around her during her growing up “and understandably you became fearful and intensely reactive when you sense neediness in others today.” P responds that she knows that, implying the analyst’s reminders about her past as a generalized communication can be experienced as more condemning than helpful. With a more open appeal, however, she asks, “but how am I going to change?” The analyst alters his narrative to become more specific. He suggests that as she reviews her experiences with him, she “will be able gradually to experience other’s neediness and pain as not so frightening and unmanageable.” He reminds her of her success in a dream of taking care of herself “by actively choosing not to take care of the other.” Encouraged, she asks, “You really think so?” and he answers, “Yes, I really do.”

P: pauses and then says, “It was very helpful for me [with a more energetic tone] to be able to tell you, to feel that I could tell you the things I despise about you. That I felt you weren’t strong enough. You see [emphatically] I don’t tell B [her husband], I don’t tell my father. I don’t tell people. . . . I think it is very helpful to tell you that and know you won’t fall apart. I was afraid I hurt you, but . . . that was a new thing for me actually to be able to tell you. And you’re still here and [with laughter] not dead.”

With only several uhs-huhs and a few words of encouragement from the analyst, P carries the narrative forward throughout the remainder of the session. She takes up an exploration of her present attitude, a traumatic experience at age three with her mother and her loss of the idealized view of the analyst. At times, the narrative flow threatens to falter as P momentarily becomes preoccupied with shifts in setting, time, and person. Through shared humor playfulness, however, and the analyst’s simple interventions, P maintains an openness to explore. After a reflective pause, she states, “I’m feeling I don’t know where things are going from here. I came in feeling they were not to go anywhere. Now, I’m just feeling that I don’t know and that’s sort of all right. I’m calm about that. . . .”

Once reflection enters a patient’s (or a therapist’s) narrative flow, the message is bidirectional: to the other and from and to the self. A narrative envelope that contains all the elements needed for both telling and reflection offers a richer, more vital quality to a story-being-told.

To state the obvious, all elements of a story-being-told are not of equal significance to therapists engaged in exploring meanings and motivation. In this chapter, I have taken up aspects of a narrative needed for a listener to enter into the mind state of a speaker. In the next chapter I will describe the importance of attributions patients make about their therapists.