The Narrative Nature of Clinical Reasoning

Cheryl Mattingly

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Narrative reasoning is a central mode of clinical reasoning in occupational therapy. Therapists reason narratively when they are concerned with disability as an illness experience, that is, with how a physiological condition is affecting a person's life. In this paper, narrative reasoning is contrasted with propositional reasoning, and two kinds of narrative thinking are examined. The first is the use of narrative as a mode of speech that can be contrasted with biomedical discourse, in which disability is framed as physical pathology. The second involves the creation rather than the telling of stories. Therapists try to "emplot" therapeutic encounters with patients, that is, to help create a therapeutic story that becomes a meaningful short story in the larger life story of the patient.

Many professions identify good thinking with a process that resembles the scientific method—an application in practice of empirically tested abstract knowledge (theories) and generalizable factual knowledge. Here reasoning involves the recognition of particular instances of behavior in terms of general laws that regulate the relationship between the cause and a caused state of affairs (see Mattingly, 1991, for a related discussion of this point). There are many debates within the philosophy of science about whether this model of objective knowledge characterizes even the hard sciences, such as physics (Kuhn, 1962; Putnam, 1979; Rorty, 1979). Also debated is whether the scientific method provides an appropriate model with which to characterize professional reasoning (Dreyfus & Dreyfus, 1986; Schön, 1983, 1987). I enter these debates in arguing that a narrative model of reasoning, as opposed to scientific reasoning in the traditional sense, is fundamental to the thinking of occupational therapists.

Therapists think with stories in two distinct, but equally important, ways—through storytelling and story creation. Storytelling constitutes an extremely important and underrated mode of discourse in occupational therapy. Recently, there has been a surge of interest in the health professions in eliciting stories from patients (Coles, 1989; Kleinman, 1988). It became clear in the course of the American Occupational Therapy Association/American Occupational Therapy Foundation Clinical Reasoning Study that therapists not only listen to the stories that their patients tell them, but also tell stories about their patients. Furthermore, an important part of this storytelling involves the therapist's understanding of the patient's way of dealing with disability and with puzzling about how to approach a problematic patient. The creation of clinical stories in clinical time is the second way in which occupational therapists use narrative in their reasoning process. I call such creation therapeutic emplotment.

Narrative Reasoning and Storytelling: Making Sense of the Illness Experience

What does it mean to say that occupational therapists think about their patients through the telling of stories and that this constitutes a primary form of thinking in their therapeutic practice? Jerome Bruner (1986, 1990), a psychologist noted for his studies of cognitive development, argued that humans think in two fundamentally different ways. He labeled the first type of thinking paradigmatic; that is, thinking through propositional argument and the second, narrative, that is, thinking through storytelling. The difference between these two kinds of thinking involves how we make sense of and explain what we see. When we look at something and try to understand it through propositional argument, we are trying to take a particular and see it in general terms, as an instance of a

Cheryl Mattingly, PhD, is Assistant Professor, Department of Occupational Therapy, University of Illinois at Chicago, 1919 West Taylor Street, Chicago, Illinois 60612.

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general type. For example, when we see a patient with a set of symptoms, we may note that we are seeing a severe case of Parkinson disease. According to Bruner, in linking the particular symptoms to a general disease category, we are thinking propositionally.

Conversely, when we are thinking narratively, we are trying to understand the particular case. Specifically, we are trying to understand a particular person’s experience. Narrative thinking is our primary way of making sense of human experience. We do this primarily through an investigation of human motives (Burke, 1945; Gardner, 1982). We think narratively when we want to explain not whether someone has Parkinson disease, but rather, why this patient’s wife is so unwilling to have her husband be discharged home. The difference between these two modes of thinking in occupational therapy is illustrated by the way in which therapists use storytelling to talk about their cases over lunch or to present cases to colleagues in weekly departmental staff meetings.

At University Hospital in Boston, where the Clinical Reasoning Study took place, the therapists drew on two modes of talking to discuss patients. Case presentations consisted of two distinct parts: “chart talk” and storytelling. The first, chart talk, involved a familiar biomedical presentation. When speaking chart talk, therapists focused on the pathology in general. The items ordinarily addressed were (a) key symptoms; (b) major typical physical impairments and primary needs, especially activities of daily living needs; (c) assessment goals and other ways of rating a patient’s extent of impairment; and (d) typical treatment modalities and strategies.

The second form of case presentation was through storytelling. Here the therapists shifted their focus from a discussion based on pathology to one based on the specific patients they had worked with and their experiences of disability. One example of such storytelling comes from a staff meeting in which an affiliating student was doing a presentation of a patient with Parkinson disease. After discussing Parkinson disease as a pathology, she turned to describing her problems with a specific patient with Parkinson disease, identifying a critical problem for clinical reasoning: What is she supposed to do with the patient’s wife? How should she best treat this patient, given his wife’s feelings? How does the wife really feel? What are this wife’s denial and anger about? Or is the wife displaying something that is being mistaken for denial or anger? These are all narrative questions whose answers require a kind of clinical reasoning that is fundamentally narrative in form. To return to Bruner’s (1986, 1990) distinction, when we think in propositional arguments, we try to transcend particulars and strive for abstraction (i.e., for truths that transcend any particular historical situation). But narrative is rooted in the particular. Whereas propositional arguments are concerned with understanding phenomena in terms of general causes, narratives are concerned with the likely connections among particular events. Bruner gave a simple example to illustrate the difference. The statement “if x, then y” belongs to propositional argument. An occupational therapist is relying on propositional reasoning when she says, “If you see these symptoms, then you probably have a case of Parkinson disease.” Such if-then statements are aimed at providing an abstract description of a causal relationship that holds up generally or, ideally, universally across concrete individual cases.

This genre of descriptive and explanatory statements can be contrasted with a very different mode of explanation. Bruner (1986) gave the following illustration, borrowed from E. M. Forster (1927). The statement, “The king died, and then the queen died” (pp. 11–12) is a narrative statement that not only concerns the particular, that is, some specific king and queen, but also, suggests causes that lead one to wonder about intentions. Did the queen die of grief? Was the queen murdered? We investigate the meaning of a narrative statement by trying out different motivational possibilities; we search for what guided the action that the statement reports. And human action, unlike a pathological process, is motivated. Narratives make sense of reality by linking the outward world of actions and events to the inner world of human intention and motivation. To ask in a narrative sense why something happened is to ask what motivated the actors to do what they did. In the philosophy of history, this mode of narrative explanation has been called “explanation by reason” (Dray, 1971, 1980). In a story, a person’s actions are accounted for—or explained—by their placement in some specific historical context that shows how and why they were begun, what other actions unfolded as a result, and how they evolved over time. So when we hear about a
particular patient with Parkinson disease whose wife complains that he does not do enough housework and we want to explain what is going on, we start asking the narrative questions enumerated earlier.

In moving between chart talk and storytelling, therapists present the clinical problem in different ways. The shift in presentation from an abstract discussion of Parkinson disease to a story of a patient with Parkinson disease who has an uncooperative wife involves much more than a move from the general to the concrete or from the objective to the subjective.

In chart talk, the focus is on a disease. The disease is the main character. But in storytelling, it is the patient's situation or experience with the disease that is the central clinical problem. The therapist might ask, What is the best way to treat the patient with Parkinson disease who is going home to this particular wife? The severity and nature of the patient's dysfunctions are still important, but they are only one part of the picture that the therapist has to put together with the unique features of one patient's situation.

Therapists often speak of expert practice as involving the ability to "put it all together" for a particular patient. I suggest that what they mean by this involves a thinking that is essentially narrative. The therapist takes what he or she knows in general of a disease process, appropriate theoretical frames of reference, and relevant experience with similar patients and applies all of this generalized and abstract knowledge to a particular case, such as that of the patient whose wife thinks he should be able to do household chores and resists having his bed moved up to the first floor where he will have access to the bathroom.

Medical anthropologists have made an extremely useful distinction in looking at health care by separating disease from illness experience (Good, 1977; Good & Delvecchio-Good, 1980, 1985; Kleinman, 1988; Kleinman, Eisenberg, & Good, 1978). Although traditionally medicine has focused on the diagnosis and treatment of disease, anthropologists argue that much more attention needs to be given to treatment of the illness experience, which involves the way in which the disease affects the person's life. Physiologically, the same disease can result in a very different illness experience, depending on the patient's particular life history and life possibilities. The patient with Parkinson disease whose wife lives all she can about the disease and welcomes her husband home is likely to have quite a different illness experience than the patient whose wife wants to relegate him to the basement.

What anthropologists have argued to the medical community during the last decade or two, occupational therapists have known for a long time: To effectively treat persons with long-term disabilities, one must treat the whole patient, which involves looking beyond the disease to how that disease is experienced by that particular patient. Treatment of a patient's illness experience is integral to good occupational therapy and it is where the heart of clinical reasoning lies; it is also where the thorniest reasoning puzzles present themselves. Reasoning about how to treat the illness experience is often the most difficult thing to teach the affiliating student or new therapist. How does a supervisor help a novice therapist to examine what is going on with this patient's wife and what therapeutic approach would best help this patient make the transition back home to this wife? Notably, when one addresses the illness experience, as opposed to the disease alone, it is often hard to establish who has the disease. Although a disease obviously belongs to one person—the patient—the illness experience, especially in the case of serious life-changing illnesses, is likely to be shared by the whole family.

Puzzling over how to treat a patient with Parkinson disease, given how his wife is responding to the illness, involves narrative reasoning, because it involves consideration of the disease from the patient's and family's points of view. The therapist must try to imagine how it feels to the patient and to various family members to have this disease, how they are experiencing it, and how it enters and changes the life story of a patient and his or her family.

Narrative Reasoning and Story Making: Creating Clinical Stories

Therapists create as well as tell stories. The narrative nature of clinical reasoning manifests itself not only in the work therapists do to understand the effect of a disability in the life story of a particular patient, but also in the therapist's need to structure therapy in a narrative way, as an unfolding story. This is perhaps the most interesting and subtle use of narrative reasoning in occupational therapy practice. Therapy can be seen as a kind of short story within the patient's longer life story. The therapist enters and exits the patient's life, playing a part for only a short time. Often, this part occurs at a critical juncture in the patient's life, a turning point triggered by the onset or downturn of an illness. Sometimes it occurs at a critical juncture in an entire family's life, as is often true in pediatric therapy when a family is learning to adjust to a newborn with a disability or when a child with a disability begins school. If disability is considered in narrative terms as something that interrupts and irreversibly changes a person's life story, then work with a patient can be seen as one chapter in that life story.

Although this narrative language is not a familiar way for therapists to describe their own practice, it serves to highlight how intensely therapists want to make therapy itself an occasion for patients to remake life stories that can no longer continue as they once did when a disability was absent or less serious. The therapist enters the life story of a patient and has the task of negotiating with the
patient what role therapy is going to play within the unfolding illness and rehabilitation story that the patient is living through. To be meaningful, occupational therapy must serve as a coherent short story within a larger narrative whole.

In each new clinical situation, then, the therapist must answer the question, What story am I in? To answer this question, the therapist must make some initial sense of the situation and then act on it. The process of treatment encourages, perhaps even compels, therapists to reason in a narrative mode. They must reason about how to guide their therapy with particular patients by imagining where the patient is now and where this patient might be at some future point after discharge. It is not enough for therapists to know how to do a set of tasks that have an abstract order based on a general or typical treatment plan; therapists must be able to picture a larger temporal whole, one that captures what they can see in a particular patient in the present and what they can imagine seeing sometime in the future. This picturing process gives them a basis for organizing tasks.

In her study of clinical reasoning among nurses, Benner (1984) noticed this narrative mode of reasoning in her subjects, although she did not focus on its narrative nature per se. The need for a narrative framework was suggested by a nurse quoted in Benner's study who worked in an intensive care nursery. She described what she considered to be the most essential kind of thinking she wanted her newly graduated students to evince at the end of their 3-month affiliation with her:

To my mind, moving the child from Point A to Point B is what nursing is all about. You have to perform tasks along the way to make this happen, but performing the task isn't nursing... I wanted to see a light going on—that OK, here's this baby, this is where this baby is at, and here's where I want this baby to be in six weeks. What can I do today to make this baby get along the road to end up being better? It's that kind of thing that's just happening now. They're the (student nurses) just starting to see the whole thing as a picture and not as a list of tasks to do. (p. 28)

This example emphasizes both the imagistic character of what the clinician needs to know, in contrast with the knowledge of tasks, and the context-specific nature of those images. Therapists in the Clinical Reasoning Study spoke similarly about picturing the patient and especially about having future images of who the patient could be. They believed that what they often held most vividly in mind when treating patients was not plans or objectives, but rather, pictures of the potential patient, that is, the future patient. For example, one of the pediatric therapists said, "You know, when I treat that 18-month-old child, I see the child at 3, then I see the child at 6, learning to hold a pencil. I have all these pictures in my head." The therapists described their difficulty when the patients or their families held different images of the future and their dilemma about the extent to which they should give patients or families their therapeutically based pictures, which were often more pessimistic. The therapists were frequently in the difficult position of trying to give hope to a patient while also having to let the patient know of his or her dark prognosis. The patients and their families could be extremely depressed about conditions that were even worse than they had imagined. The therapists spoke of these images as necessary but dangerous: necessary because the therapist and patient needed some guiding pictures, but dangerous because these pictures could blind the therapist or patient to what was realistically possible.

The therapists in the Clinical Reasoning Study were, like Benner's (1984) nurses, also conscious of the need to create specific images appropriate to a particular patient. General treatment goals devised from general knowledge of functional deficits and developmental possibilities were insufficient guides to practice, in the therapists' view. Instead, they worked with much more concrete guides, images, and stories, which were the "wholes" that allowed them to selectively choose what aspects of their knowledge base were appropriate to the situation. These images were organized temporally and teleologically, thus giving the therapists a sense of an ending for which they could strive.

Although these images of the future were often not formulated in words, unless there was some need to explicitly communicate them, they were part of what I call a prospective treatment story. In this prospective story, the therapists envisioned a possible and desirable future for the patient and imagined how they might guide treatment to bring such a future about.

The treatment approaches and treatment paths that the therapists tried to follow were often guided by such stories. These stories, derived from particular experiences and stereotypical (collectivized) scenarios, were projected onto new clinical situations in order to help therapists make sense of what story they were in and where they might go with particular patients. The therapists then attempted to enact their projected stories in the new clinical situations, working improvisationally to narratively pull in and build on whatever happened in a clinical session so as to add to the story's plot line. The therapists saw a possible story, which they recognized as clinically meaningful, and they tried to make that story come true by taking the individual episodes of their clinical encounters and treating them as parts of a larger, narratively unfolding whole. Prospective treatment stories were based on what therapists observed and inferred about the patient's larger life history, which involved both the patient's past and future. The therapeutic stories that the therapists imagined took their power and plausibility as part of a larger historical context that included a past that began before therapy started and a future that would extend after therapy had ended.

Notably, the prospective story cannot be equated with treatment goals and plans, although these will be incorporated into the story. Therapists try to create sig-

The American Journal of Occupational Therapy
significant therapeutic experiences and not simply reach a set of objectives in the most efficient way possible. They are concerned that the whole process of therapy unfold in such a way that patients will have powerful experiences of successfully met challenges; such challenges will motivate them to believe in therapy and work hard at it. In listening to therapy success stories, I found it rare for the success of therapy to have been measured by the reaching of the final goal. Rather, most of the therapists counted success as the generation of therapeutic experiences along the way, in which patients developed increasing confidence and commitment to take on challenges. The whole treatment story mattered.

Therapists in the Clinical Reasoning Study also worked to create significant experiences for their patients, ones worth telling stories about, because if therapy was to be effective, then the therapists had to find a way to make the therapeutic process matter to the patient. Each therapist faced the problem of constructing therapeutic activities that were meaningful enough to elicit the patient’s active cooperation. The patients had to see something at stake in therapy. Otherwise, why should they bother to try? If the patient did not try, therapy did not work. This was partly because the therapists required the patients to do things in therapy that the patients did not necessarily feel ready to do or believe to be worth the effort. But more important, the patients had to become committed because they had to take up the therapeutic activities. Therapists were often with patients only a short time—just a few weeks or less. They might teach a few skills or improve the patient’s strength a bit, but generally, their effectiveness depended on the use of therapy as a catalyst to help patients begin to see how they might do for themselves even when the therapist was no longer present.

For example, a therapist is working with a spinal cord-injured patient, teaching him to move checkers pieces with a mouth stick. It is not enough for this patient to learn to move these checkers pieces for the therapy to be successful; he must also take up a point of view that comes with being committed to the tremendous concentration needed to perform this previously trivial task. He must absorb a vision about why he should work so hard at something that was once so easy. This is just as critical as the skills he acquires. The therapeutic time together itself must provide a kind of existential picture of how he might live his life in the future with his disability. Therapy will not ultimately work, not in any catalytic way that patients will take home when they leave the hospital, if they are not strongly committed to the process. Without experiencing treatment activities from a committed stance, they will not see any future in them. They will not see the point.

If the patient is to become committed to the therapeutic process, then both the patient and the therapist must share a view about why engaging in any particular set of treatment activities makes sense. Coming to share such a view requires that both the therapist and the patient see how these treatment activities are going to move the patient toward some future that he or she can care about. Such a view is not reducible to a general prognosis or even to a shared understanding of a treatment plan. The therapist and patient must come to share a story about the therapeutic process; they must come to see themselves as in the same story. This is a kind of future story, a story of what has not yet happened, or has only partly happened—an as yet unfinished story.

How is such a story constructed? Generally it is not constructed through any explicit storytelling, but rather, through the sharing of powerful therapeutic experiences that point to a prospective story—a path that therapy will take. Clinical reasoning requires that the therapist (a) see possibilities for creating important experiences in which the patient will be staked, (b) make moves to act on those possibilities, (c) respond to the moves the patient makes in return, and (d) build on the experience by showing the patient a future in which this therapeutic experience becomes one building block. In the language of narrative, the experience becomes one episode in a much longer story. The therapist tells the story not in words but in actions that create an experience the patient can care about.

I follow the work of the philosophers Ricoeur (1984) and White (1987) in describing this therapeutic work as “emplotment.” The clinician’s narrative task is to take the episodes of action within the clinical encounter and structure them into a coherent plot. A plot is what gives unity to an otherwise meaningless succession of events. Quite simply, “emplotment is the operation that draws a configuration out of a simple succession” (Ricoeur, 1984, p. 65). What we call a story is precisely this rendering and ordering of a succession of events (e.g., a series of treatment activities) into parts belonging to a larger narrative whole. When a therapeutic process has been successfully em­plotted, it is driven and shaped by a sense of an ending (Kermode, 1966). To have a single story is to have made a whole out of a succession of actions. These actions then take their meaning by belonging and contributing to the story as a whole. A story, Ricoeur wrote, “must be more than just an enumeration of events in serial order: it must organize them into an intelligible whole, of a sort such that we can always ask what is the ‘thought’ of this story” (p. 65).

Narratives give meaningful structure to life through time. The told narrative builds, to borrow from Ricoeur’s (1984) argument, on action understood as an as yet untold story. Or, in Ricoeur’s provocative phrase, “action is in quest of narrative” (p. 74). Therapists are in a quest to transform their actions and the actions of their patients into as yet untold stories.

This can be translated into more familiar clinical language through a narrative reading of treatment goals. When an occupational therapist makes an assessment of
the patient, the outcome is a set of treatment goals. Goals, according to Ricoeur (1984), are not predictions of what will happen; rather, they express the actor’s intentions and preferences. These goals express a therapeutic commitment. They capture what the therapist intends to accomplish over the course of therapy. Treatment goals are an expression of what the therapist has committed himself or herself to care about with a particular patient.

As occupational therapists have argued (Rogers, 1983; Rogers & Kielhofner, 1985), a primary task of clinical reasoning is the individualization of treatment goals. Narratively, individualization involves the construction of a particular story of the treatment process rather than reliance on a generic line of action that strings together standard goals and activities.

Therapeutic Emplotment: A Case Example

A wonderful illustration of this process of narratively structured treatment is given by O’Reilly (1990), who, as part of the Clinical Reasoning Study, described her work with a head injury group. O’Reilly recounted a situation in which she was asked to take over a failing head injury group that was poorly attended. The first thing that bothered her was its name—the Upper Extremity Group. She described her first visit to the group, “I enter the large OT/PT treatment area where I see several residents scattered about at tables and exercise equipment. . . . At one table, a resident diligently puts small pegs into a pegboard. . . . What is most memorable is the silence. Except for the clang of the pulley weights, a dropped peg or the therapist’s quiet voice, there is not a sound in this room” (p. 2).

O’Reilly noticed that several of the group members were not present, and when she went to inquire, they told her, “That [expletive deleted] group is a waste of time.” She tried several strategies to entice members back, but nothing worked. She puzzled:

1. wonder, “What’s wrong with this group?” I make mental lists: 1. The name—I’ll talk to the residents about that. 2. The activities—no meaning, no purpose, no life-related goals, no goals that belong to the patients. 3. No interaction among members with the therapist. 4. Nobody is having fun—the residents are bored and the therapist is bored (and boring?). 5. Is there any progress that the residents experience? 6. What are the reasons for attending or not attending? And there is no direction—no theme. (O’Reilly, 1990, p. 2)

Although O’Reilly did not use the language of story to describe the problems she noticed, this list could easily be restated in narrative terms. Her statement that the group has no direction and no theme could be recast to say that there is no plot to this group; there is no story for which the group members are a part. The group is not going anywhere, narratively speaking. Any particular group activity is not an episode in an unfolding story that members share. The activities of the group are focused on broken body parts, as the group name (Upper Extremity Group) implies. Although the exercises may help improve body functioning, they carry no intrinsic meaning to the group members, because group activities are in no sense a short story in the larger life story of the patients.

The therapist pondered what to do by beginning to think about individual group members. Her mode of puzzling represents a shift from a biomechanical framing of the members’ disability to seeing their disability as having personal meaning in their lives. She described her reasoning in this way: “I think about the people. What do they want? What do they need? They are all so young; so far from home. They want to get out. They want to go home. HOME! They’re all from New York. That’s it! NEW YORK! I have a theme with which to begin” (O’Reilly, 1990, p. 2).

O’Reilly was reasoning in narrative terms. She was not telling a story, but she was beginning to envision a prospective story that all the group members could be a part of. She wrote:

1. have a theme with which to begin, but I don’t know a thing about New York. The Program Director is from New York . . . I dash to her office. “New York,” I blurt. “The Upper Extremity Group, they’re all from N.Y. Tell me something about N.Y., anything, everything.” She lists: “Empire State Building, Statue of Liberty, Long Island Ferry, the subway.” Laughingly, “You could have a New York Subway Group.” I reply, “We could be on the subway. They can take me to New York. What does it look like—is there graffiti? We can do graffiti. I need a new room, away from the big treatment room. Can we use the small meeting room?” Program Director replies “yes” and adds that she has a map of the N.Y. subway and will bring it in. “I’ll be the conductor . . . I have a blue blazer.” She says, “I think I have a funny little hat that will pass for a conductor’s hat.” We laugh through all the possibilities of this activity. This is going to be FUN!” (O’Reilly, 1990, p. 3)

In deciding to create a therapy group around a New York theme, O’Reilly could not only locate therapy in the relevant past of these patients, but also locate it within the future that they desire. This study dealt with young people in a chronic long-term care facility in Massachusetts, one that residents rarely ever leave. These patients wanted to go home.

O’Reilly invented the ingenious idea of turning a therapy room into a New York subway station. She also devised a way of generating some interest in the group:

I go straight to Mike’s room and ask him to make sure everyone comes to group today. “I have a different type of activity planned, and I’d really like to talk to everyone so that we can make some plans together.” Mike states that he loves the [expletive deleted] group. I tell him that I understand that and that perhaps he could gather everyone for me, and come for awhile. “Then, if you are really unhappy with the activity, you can leave.” He agrees. I hand him a small bag containing poker chips and ask him to give one to each group member on the attached list and have them bring the chips to the group. “Okay, but what do we do with these?” He asks. “That’s it! We’ll do graffiti. We can do graffiti. I need a new room, away from the big treatment room. Can we use the small meeting room?” Program Director replies “yes” and adds that she has a map of the N.Y. subway and will bring it in. “I’ll be the conductor . . . I have a blue blazer.” She says, “I think I have a funny little hat that will pass for a conductor’s hat.” We laugh through all the possibilities of this activity. This is going to be FUN!” (O’Reilly, 1990, p. 3)

Notably, in announcing the group, she introduced a key narrative element critical to any dramatic story—the element of suspense. In any good story, the reader will want to know what will happen next. To prepare for the meet-

The American Journal of Occupational Therapy

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The therapist had begun a story that spawned additional episodes. She set a therapeutic story in motion. The first group session that O'Reilly described in her case not only had a coherent plot, that is, a beginning, middle, and end (making graffiti), but also, because of her success, that session became just one episode in an unfolding therapeutic story in which patients became a cast of characters in the New York Gang. Even the name of the group came from the group members themselves. Specific biomechanical interventions were integrated in a meaningful way as activities that allowed group members to act their part in this drama, and the task of writing things on the wall allowed each person to express an individual voice as well. When O'Reilly initially devised the idea of doing something with a New York theme, the prospective story that she had begun to envision (and that she had concretely begun when she fixed up a room and donned a conductor's uniform) was much more than a set of treatment goals. Specific goals were incorporated in the narrative plot that she started. The success of this therapeutic intervention was ensured when the patients themselves took the story up and began to create new episodes that the therapist could not have imagined.

Narratively speaking, the shift of names from the Upper Extremity Group to the New York Gang represents a shift from a series of interactions in which therapeutic time is treated as a mere succession of activities, that is, as a procedural movement not grounded in context or in a picture of the patient, to narrative shaping of the therapeutic interaction in which therapeutic time has been emplotted by the clinician's picture of how to create an important therapeutic experience for the patients. The therapeutic efficacy of this intervention is about much more than meeting specific treatment goals. It is about creating an experience that gives the participants a vision of themselves as actors in the world, that is, as more than just patients.

**Conclusion**

Narrative thinking is central in providing therapists with a way to consider disability in the phenomenological terms of injured lives. Narrative thinking especially guides therapists when they treat the phenomenological body; that is, when they are concerned with their patients' illness experience and how the disability is affecting their lives.

In this article, I examined two kinds of narrative thinking. One is narrative as a mode of talk that therapists rely on to consider certain kinds of clinical puzzles. Because narratives are predominantly about human actions,
they provide a particular vantage point from which one can view the nature of clinical practice and pose clinical problems. The stories that the therapists told portrayed disability from an actor-centered point of view. They were personal, even individualistic, built on the structure of actors acting. Disability itself shifted from a physiological event to a personally meaningful one, that is, to an illness experience. General physiological conditions were shadowed as background context. What was brought to center stage were the ways that particular actors, with their own motivations and commitments, had done things for which they could be praised or blamed.

The second form of narrative thinking, which occurs in occupational therapy in a more subtle way, is story making, which involves the creation rather than the telling of stories. The telling of stories is always retrospective—a way of considering past events—whereas story making is largely prospective, playing out images that therapists have of what they would like to happen in therapy. Story making as therapeutic emplotment concerns the way in which therapists work to structure therapy narratively, thus creating dramatic therapeutic events that connect therapy to a patient's life. Often, the search for a meaningful therapeutic story appears to be triggered by resistance or alienation of the patient to the initial therapeutic activities offered, as in the case of the members of the Upper Extremity Group. Whatever the impetus, therapists try to create clinical experiences in which there is a significant occurrence or event for the patient in therapy, one in which the therapy itself is a meaningful short story in the larger life story of the patient. ▲

References


