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Chow, Esther O.W.

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Narrative therapy an evaluated intervention to improve stroke survivors’ social and emotional adaptation

Esther OW Chow

This series of articles for rehabilitation in practice aims to cover a knowledge element of the rehabilitation medicine curriculum. Nevertheless they are intended to be of interest to a multidisciplinary audience. The competency addressed in this article is to help practitioners to understand the importance of language and narrative in the therapeutic alliance and to apply language- and narrative-based principles in counselling and psychotherapy.

Abstract

Objective: To describe a theoretical and practical framework of using a train metaphor in narrative therapy for stroke rehabilitation in group practice.

Background: There is a paucity of literature on the application of narrative therapy in meeting the psychosocial-spiritual needs of stroke survivors in rehabilitation. In the current article, the use of narrative therapy being evaluated in a formal randomized study in stroke survivors is described in detail. The metaphor may be of practical interest to those working with populations confronted with unpredictable life challenges. Method: Narrative practice using the metaphor of ‘Train of life’ is an alternative practice to psychopathology, which provides a means for the participants to deconstruct from the illness experience, re-author their lives, and reconstruct their identity with hopes and dreams. This therapeutic conversations, primarily using questions, can be divided into six steps: (1) engaging participants to a Concord station; (2) unfolding the experience with Stroke: where each of the participants are coming from; (3) dialoging directly with Stroke; (4) co-constructing the train carriage; (5) planning for a future life journey with Stroke; and (6) celebrating the unlocking of a new journey. Along with the train of life metaphor, therapeutic documents and outsider witness conversations are used to strengthen the preferred identity, as opposed to the problem-saturated identity of the participants. Discussion: This metaphor poses an alternative methodology in stroke rehabilitation by reconnecting the survivors’ inner resources, skills, and competencies. Eventually, it could re-author the survivors’ identity developed from previous life challenges and reconstruct their purpose in life.

Keywords

Narrative therapy, use of metaphor, train of life, stroke survivors, psycho-social-spiritual intervention, meaning making, meaning of life

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Introduction

Stroke is the leading cause of disability worldwide,¹ and most survivors live with some degree of permanent disability.²³ As the physiological processes, meanings, and relationships link the outer social world recursively to inner experience,⁴ the
residual physical and cognitive impairments from stroke likely totalise the stroke survivors with problem-saturated life events, and adversely affect their sense of self and their identity after a stroke. Yet, the current focus of rehabilitation received by stroke survivors is primarily on physical recovery, whereas psychosocial and emotional needs have not been fully addressed.

Narrative therapy may offer a viable treatment approach in handling the psychosocial and spiritual hardships of the survivors. In stroke rehabilitation, a therapist helps a patient to deconstruct his or her problem-saturated story, co-construct inner strengths and beliefs, and reconstruct meaning and purpose in life that would align with his or her preferred identity. While various studies in the past two decades have demonstrated the effectiveness of narrative practice on the psychological needs of chronically ill patients, no attempt has been made to apply narrative therapy to stroke survivors.

A narrative therapy intervention in group practice has been developed for after stroke recovery, and is now being evaluated in a randomized controlled trial involving up to 100 survivors. This article gives a brief review of the nature of narrative therapy, and concentrates upon describing how the narrative therapy is delivered to these participants.

**Significance of applying narrative therapy in stroke rehabilitation**

Stroke survivors often experience a sense of profound personal failure owing to the sudden, debilitating experiences resulted from stroke. Social stigmas embedded in the Chinese-dominant culture further construct a problem-saturated identity as being sinful in one’s earlier lives that made them suffer from disabilities in older age as a punishment. Together with social isolation and spiritual distress, they feel as if they are ‘trapped’ in their ‘problem-saturated condition’. If no therapeutic rehabilitative treatment is provided, they become overwhelmed by a strong sense of hopelessness and helplessness.

Narrative therapists believe that, even if stroke survivors are afflicted with a problem-saturated identity, they can reconnect with their strengths and life wisdom, which will enable them to reduce the effects of the problems and rebuild their lives within the limits of disability. Through narrative therapy, people will be able to make sense of the illness experience and restore meaning of life and a sense of self-worth.

**What is narrative therapy?**

Narrative therapy, which emphasises personal experience and elaboration of meaning, has been gaining considerable momentum in the practice of psychotherapy. Building on the post-modern tenets of social constructionist school of thought, it was initially developed during the 1970s and 1980s, by Michael White and David Epston. The primary focus of narrative approach is people’s expression of their sequence of experiences or events in life. Such expressions are units of meaning and experiences, engaging people in narrative acts. In narrative therapy, people construct their life stories to make sense of their lives. However, in view of illness narrative, these stories are regularly constritive and blaming. In these cases, narrative therapists believe that multiple realities can serve as a means to help people reconstruct their lives from a more positive and appreciative perspective.

Narrative gerontology sheds light on new ways of responding to the stories of identity of older people. With the growing interests in use of one’s life narratives, it is essential to delineate the backbone of the narrative with research on autobiography, life review, and reminiscing to distinguish their uniqueness, before narrative therapy can be further considered and applied. While autobiography is referred to as one’s written introspective report of life, reminiscence is a recall of memories, which is usually a pleasurable experience of the narrator. Life review is a critical analysis of one’s life history; by examining each developmental stage, it helps to resolve past conflict and overcome unsuccessful earlier life events in achieving ego integrity. Through collaborative conversations, narrative therapists engage people in the process of re-authoring their life stories to accommodate transitions and challenges, preserving their preferred identity and reconstructing their future.
Narrative therapy is a respectful approach to counselling and community work. It views problems as separate from the individual, and assumes that everyone has various skills that could help in reducing the impact of challenges in their lives.\(^2\) In short, narrative therapy includes three core components: deconstructing problem-saturated stories, co-constructing alternative stories and thickening alternative stories with the aid of therapeutic documents and outsider witnesses practiced throughout the therapeutic conversations.

This article reports on a first attempt to apply narrative therapy in group practice with stroke survivors. By exploring recovery narratives, stroke survivors and caregivers in the study had the opportunity to make sense of illness experiences, to reconstruct the meanings and purposes of their lives and to review the strengths and resources that can help them overcome personal and environmental challenges.

**Deconstructing problem-saturated stories**

With the disabilities, biomedical discourse and social stigma, many stroke patients have come to believe that their eating habits and lifestyle are the causes of their problem.\(^4\) Participants often perceive themselves as ‘useless’ and ‘worthless’ after experiencing multiple losses from stroke, and believe they have become a ‘burden’ on their family and society.\(^4,5\) The enduring impact of the problems and slow recovery may cause them to ‘internalise’ the problem, as if it represents their identity and their ‘inner-self’.\(^12\) Narrative therapists seek to separate a person’s identities from the problem by deconstructing the problem-saturated stories and opening space for the person to view his or her life from a different perspective using ‘externalising conversations’\(^2\) (see Table 1 in the appendix, available online).

**Co-constructing alternative stories**

To co-construct alternative stories, narrative therapists first help people to identify some of the neglected but potentially significant events that are ‘out of phase’ with their problem-saturated storylines.\(^2\) In narrative therapy, these events are considered as ‘unique outcomes’.\(^2\) Afterwards, two types of question — ‘landscape of action’ and ‘landscape of identity’ — are asked to co-author an alternative story.\(^13\) ‘Landscape of action’ questions involve inquiries into events and actions, so as to assist people in linking these events to an alternative storyline. ‘Landscape of identity’ questions invite people to reflect on the identities of themselves and others, in order to relate the alternative storyline to the person’s understanding of his or her preferred identity.\(^2\)

**Thickening the alternative stories**

Once an alternative story is co-constructed, narrative therapists find ways to thicken the story by conducting re-membering conversations, inviting an outsider witness group and performing definitional ceremonies.\(^13\)

Narrative therapists believe that identity is founded upon an ‘association of life’. Re-membering conversation provides an opportunity for people to revise their memberships in their ‘associations’ and to describe the alternative stories that have been cogenerated in their relationships with others.\(^2\) In the outsider witness practice, narrative therapists invite an audience to witness and acknowledge the alternative stories and identity of the persons.\(^2\) Lastly, definitional ceremonies provide a context to celebrate significant steps in the journey and transitions from the problem-saturated story to the alternative story.\(^13\)

**Therapeutic documents**

Throughout the therapeutic conversations, therapeutic documents can be used in the form of documents, letters, certificates, videotapes, pictures, or other formats. They contribute to the thickening of the alternative stories by providing reflections that one can refer to at any time.\(^13\)

**Rationale of using metaphor in narrative therapy**

According to the *American Heritage Dictionary of the English Language*,\(^2\) a metaphor is ‘a figure of
speech in which a word or phrase that ordinarily designates one thing is used to designate another, thus making an implicit comparison' and 'one thing conceived as representing another'. Metaphor is used in psychotherapy for various functions. For example, metaphors can serve as a way for the therapist and the participants to develop and access their goals collaboratively. Moreover, while using metaphors, participants may begin to appreciate their strengths and capabilities, develop problem-solving skills and create outcome possibilities.

Metaphors have been commonly used in narrative therapy. For instance, ‘life as a journey’ and ‘ill-body as a dilapidated house’ emerged from the collaborative conversations; they served as collective narrative methodologies to engage people who consult a therapist and facilitated the therapeutic process. Some other examples are the ‘tree of life’ for vulnerable children in South Africa, ‘team of life’ for former child soldiers from Sudan and ‘kite of life’ for people experiencing intergenerational conflict.

Why use train as a metaphor?

The metaphor used in the therapy has to build upon people’s ordinary and everyday life to create resonance and connections between the therapist and those who come to consult the therapist. Like the most of major cities, Hong Kong has a highly developed transport network in which trains play a vital role. As people in Hong Kong are familiar with trains, the ‘train of life’ emerged as a metaphor in therapeutic conversations of this study. Moreover, life is like a train journey: different critical events in life symbolise unique experiences at each train station. Life goes on and passes from one station to another. Although there may be gains and losses at each station, the train of life carries on. When people reach the station altered by stroke, they may have lost physical functioning and health to different degrees, and their career and social life may be affected. However, their situation provides a space to call on ‘love and care’ from their families and peers, and to testify the care from families and their inner resources, such as perseverance, as the ‘fuel’ for the train engine to continue their life journey with stroke. As a result, a train seems to be an appropriate metaphor for this context.

This article aims to provide a detailed description of the application of a runaway train as a narrative metaphor, which was adopted and being evaluated in 15 narrative therapy groups with 101 stroke survivors compared with 15 psychoeducation groups (comparison group; n = 92) in the context of a randomized controlled trial.

Participants

The study included people who suffered a stroke within the last two years who had completed any rehabilitation, did not have an active psychotic mental illness and had the cognitive and communicative ability to participate.

Metaphor of the ‘train of life’: introduction

The train of life is a metaphor that is agreed by the therapist and the participants collaborating on the storyline development. The therapist first invites participants to construct a train journey, which consists of different stations – events from participants’ past and present experiences. During the therapeutic conversations, therapists and other participants listen to the problem-saturated stories, externalise these problems, and deconstruct their experiences with stroke by leaving the previous stations and co-constructing new stations for the future. These new stations, which are other ways of living close to their preferred storylines, align with their renewed purposes in life through meaning reconstruction.

Preparation prior to practice

Building up rapport, the relationships and interactions between participants and the therapist are the most important activity at the beginning of a group therapy. Engagement of individual participants begins through pregrou interview to receive their background information and brief them about the details, such as what to expect, address concerns and contract with the participants. Questions that
are useful for pregroum interview are listed in the Table 1 in the appendix, available online.

**Application of the train of life metaphor**

**Step 1: beginning from a Concord train station**

Collective engagement is often the first step in a group setting. Thus, we begin using the metaphor by creating and naming a joint train station, which represents the place where the therapist first meets the participants in therapeutic conversations. This joint train station also helps to establish an equal starting point between the therapist and the participants, as both will develop the metaphor together.

The therapist may begin by illustrating his or her pathway leading to this Concord station:

1. Here is the ‘ABC’ Centre. Let’s call it the ‘ABC’ station, where we meet and begin our journey.
2. Let me share the reason why I came. I come from XYZ (a district) and work to understand the effect of stroke on individuals. I call stroke a ‘trouble’ that has imposed many limitations on older adults and their loved ones (and share a personal experience in caring for a stroke survivor). This ‘trouble’ has indeed paved my pathway in working with stroke survivors. I would describe my experience with stroke as my ‘service’ to those I care about and respect. Therefore, I came from this ‘Service’ Station.

**Step 2: unfolding the experience with stroke: where you are coming from**

After the initial engagement, ‘externalising conversations’ aims to reveal participants’ problem-saturated stories and the effects of stroke on their lives, as well as to externalise the effects of stroke from the participants.

‘Externalising conversations’ involves five components: (1) defining and exploring the effects of stroke on participants’ lives; (2) evaluating participants’ relationship with stroke; (3) giving a name to stroke; (4) giving a name to the station that symbolises the period of stroke; and (5) giving a collective name to this specific stage of the life journey/experience as a group.

In the first two components, participants’ experiences with stroke are defined and evaluated. Giving a name to stroke offers an opportunity for participants to objectify it and give closure to the nature of stroke. Creating a ‘life station’ connected with the Concord station, which represents the place where the participants met with stroke and their past lives with stroke prior to the narrative therapy group, to further externalise the effect of stroke. After all members have created their own stations with stroke, the therapist invites members to give a name to this specific stage of the collective train journey with stroke. This collective naming process represents a conclusion to the past life experiences with stroke for all participants.

A list of externalising questions can be found in Table 1 of the appendix, available online.

All in all, ‘externalising conversations’ allow participants to witness and acknowledge the effects of stroke on their lives. Below is an example of an ‘externalising conversation’.

**Therapist:** What is it like for you living with stroke?

**May:** It [Stroke] has totally changed my life, as I have become physically dependent on my spouse for personal care. I am not able to move around by myself – I have to walk with aids and cannot even go to toilet by myself at some point of time. My family members worry about me, and they don’t allow me to go out alone.

**Therapist:** It’s like taking away many things from you, and it seems to have confined you in many ways. Do you like this Stroke?

**May:** I don’t like it! I am not able to cook for my family, lost my self-care abilities and freedom and am confined to home most of the time.
Therapist: How would you describe this Stroke?
May: It’s like a ‘rope’ [naming of Stroke] that holds me back at home and restricts my life. I have become a prisoner and a useless person [a person with problem-saturated identity].

Therapist: If you have to name this specific experience with stroke as one of your life stations, what name would you choose for this station?
May: I would call this life station as ‘Restriction’.

Other examples of names given by group members for ‘Stroke’ include: ‘typhoon’, ‘tsunami’, ‘theft’, and ‘a bad person’. All these names present stroke as an unpredictable force that swipes away their valuables swiftly. The therapist then invites each member to externalise his or her experience with stroke by ‘naming a train station’ individually. Group members came up with names such as, ‘Station for waiting to die’, ‘Station of darkness’, ‘Unlucky station’, and ‘Station of an unhappy life’.

Therapist: Now we know where we came from. As a group, we share a life experience with stroke. If we have to designate this stage of life experience together as part of our life journey, how would we name it?
Group: A Bumpy Railway Line… Tunnel of Despair… Rehabilitation Railway Line…

Sharing stories to others who have been through similar experiences allows stroke survivors to externalise their problems, overcome isolation and seek refuge. Furthermore, collectively naming their ‘shared stage of life experience’ strengthens the cohesion among participants – as if the group has undertaken rite of passage or placed a significant marker in their shared journey.

Step 3: intimate dialoguing directly with stroke
In order to further externalise the problem of stroke from the participants, a medical practitioner – a doctor or a nurse – is invited to personify stroke and conduct a conversation with the participants through role playing. This process not only conveys health-related knowledge, but also serves as a channel for participants to regain their sense of personal agency and re-position their relationship with Stroke. Previous literature has shown that this form of direct discourse or narrative theatre could empower participants.

At first, participants’ questions to Stroke are related to its symptoms, preventions and rehabilitation methods. Progressively they also touch upon sensitive topics, such as the fears and terrors that may accompany Stroke. In this dialogue, participants are often assured that they are doing the right things, and become grateful for their caregivers’ unfailing and loving care. Both stroke survivors and their caregivers’ sense of personal agency is significantly enhanced and they agree to work collaboratively in facing Stroke. Additionally, conversations with Stroke invite participants to cherish what they still have, despite their losses. Selected sample-structured questions for Stroke, modified from Wingard and Lester, are listed in Table 1 of the appendix, available online.

Based on the principle that the ‘person is not the problem, the problem is the problem’, externalising practice helps to separate the problem from the person and to open up opportunities for the exploration of one’s the knowledge, skills and ways that he or she addresses the effects of stroke. After externalisation, participants are in a better position to redefine their relationship with the problems; they feel empowered to make a closure of the period being controlled by problems associated to stroke.

Step 4: co-constructing the train carriage
The group then seek to co-construct alternative storylines through ‘re-authoring conversations’, which involves discovering unique outcomes, landscape of actions, landscape of identity questions and re-membering conversations.

Knowing participants’ determination to leave the past life journey (the ‘Tunnel of despair’), they are invited to share with the group the characteristics
of his or her ‘train carriage’. The ‘carriage’ represents each person’s unique beliefs, qualities, abilities, purposes and commitments, which are components that provide them with the power to carry on to other ways of living their preferred storylines.28,29

To identify their ‘carriage characteristics’, the therapist invites members to explore their forgotten yet exceptional life events that could contribute to a renegotiation of identity.25 The participants are invited to trace the history of some of the neglected but potentially significant events that are ‘out of phase’ with their problem-saturated storylines – their unique outcomes.26 As more and more unique outcomes are traced and given meaning, an alternative storyline of identity starts to emerge. Re-authoring this alternative story involves zigzagging between ‘landscape of action’ and ‘landscape of identity’ questions and re-membering conversations.35 Below is an example of a therapist discovering the unique outcomes of a group member.

**Therapist:** What helps you to pass through the life station where you meet Stroke? Tell us the characteristics of your ‘carriage’ that makes you stronger?

**Peter:** My train carriage is made up of hard work and persistence … through observing diet control and doing exercises regularly … it carried me away from the ‘Devil Station’, where I was stuck with Stroke, and where my life was altered. Also, determination is the fuel that has taken me this far …

**Therapist:** You have mentioned being hardworking, persistent, and determined is your main source of energy. When did you become being determined? Please tell us a story about your ‘determination’.

‘Landscape of action’ questions enquire ‘what,’ ‘where,’ ‘why,’ ‘when,’ ‘who,’ and ‘how’ participants are coping with their problems.23,35 On the other hand, the ‘landscape of identity/intention’ questions elicit the commitments, principles, hopes, values, and purposes, which might have led to their past actions.29 Some examples of the questions related to ‘landscape of action’ and ‘landscape of identity’ are listed in Table 1 of the appendix, available online.

Below is an example of ‘landscape of action and identity’ questions that emerged in the process of discovering unique outcomes.

**Peter:** I got to know ‘determination’ when I was ten. I promised my father to take care of my younger brother and sister when he was chronically ill.

**Therapist:** What have you done to know ‘determination’ more?

**Peter:** I know if I persevere and work hard, I will reach my goal one day. That was how I worked full-time to help my mother to raise a family of four and how I completed my high school education on a part-time basis [landscape of action].

**Therapist:** You had to take up such a heavy responsibility when you were very young?

**Peter:** Being the oldest son, I knew that I have to support my mother to raise the family. We had already lost one parent. I know that if I work faster and harder, it would make a great difference [landscape of identity].

**Therapist:** Being a good son and a caring brother were important to you since the early stage of your life. It seems that ‘determination’ has helped you to achieve these identities and to fulfill these roles.

As shown in the example above, the discovery of unique outcomes using landscape questions may help participants to reconnect with their personal values and beliefs from the past.23 Other examples of group members’ ‘carriage characteristics’ include ‘hope’, ‘prudence’, ‘kindness’, ‘courage’
and ‘perseverance’. These characteristics represent their core qualities and commitments that are deeply rooted in them since early years. They also point out role models, such as their family members and peers, whose strengths and abilities deserve great respect.

It is believed that the sense of self is socially constructed and that it exists in relationship to other people. Re-membering conversations, therefore, helps to thicken group members’ preferred storylines by connecting their alternative stories of identity to others’ stories. Re-membering questions are listed in Table 1 of the appendix, available online. Below is an example of a re-membering conversation.

Peter: I learned this from my mother, who had a hard life after my father passed away when I was only ten. She was determined to ‘stand on her feet’ and to raise the three of us all by herself, holding on to these values and beliefs. Also, I know that my family needs me, so I have to stand on my feet and take up my responsibilities as a husband and a father.

Therapist: If your mother knew that you have been holding onto these beliefs during these challenging years, and that they have helped you in maintaining a distance from Stroke and cherishing your family, what would she say?

Peter: I think she would feel very proud of me (in deep thoughts with tears).

Participants begin to revive a sense of personal agency and worthiness through re-authoring conversations. Coming out from the ‘Tunnel of despair’ and the ‘Bumpy rehabilitation railway line’, they are ready to co-construct their possible futures and their preferred identities.

**Step 5: planning for a future life journey**

The stroke survivors are now ready to have a conversation about their ‘Future life station’, the beginning of their preferred ways of living.

The therapist may ask the re-authoring questions as listed in Table 1 of the appendix, available online. Following are examples from the group.

**Therapist:** We are now planning for a future life journey. At what station do you want to build in your new journey with stroke?

**John:** A station of ‘health’.

**Therapist:** A station of ‘health’. What kind of health do you want?

**John:** All kinds of health – social, psychological and spiritual. However, the most important is physical health.

**Therapist:** How can you maintain and optimise physical health?

**John:** I need to stop smoking and drinking, and eat healthily [landscape of action].

**Therapist:** Why do you want to be healthy?

**John:** I want to regain my freedom, to have a wonderful life and to spend more time with my wife and my family.

**Therapist:** I see that being a good husband and a good father [landscape of identity] is important to you.

Other examples of future life station include ‘hope’, ‘prudence’, ‘kindness’, ‘courage’ and ‘faith’. After all members have individually created their new stations with stroke, the therapist invites the group to name their new journey with stroke collectively. Examples of the new life journey are: ‘Changing for the better’ line, ‘Silver lining’ line and ‘Healthy and happy’ line.

**Outsider witnesses practice**

The significant others of the participants are invited to join a specific session as witnesses. As participants identify the unique outcomes, strengths and beliefs that they have rediscovered in previous stages, these witnesses give feedback. The outsider witnesses practice questions are listed in Table 1 of the appendix, available online.
Tom, who is also a stroke survivor, is invited to be an outsider witness for one of the narrative therapy groups. Below is an example of outsider witnessing.

**Therapist:** Tom, what do you think about Joe’s story? What expressions or images resonate with you?

**Tom:** The expression of ‘I’ll always Stand by You’ and experiences of Joe and his wife resonated with me.

**Therapist:** Why did their experiences draw your attention?

**Tom:** I learned from their loving care and mutual support as a couple and the way they used their life wisdom to tackle the illness experiences. Now, I understand my wife’s complaints are actually utterances of love, and I’m grateful that I am not walking alone … I feel that I am treasured by my family and friends, who have been walking and supporting me all along …

Conversations with outsider witnesses help to thicken the participants’ stories of coping and preferred identity.\(^{20–23}\) Moreover, participants’ testimonies are greatly valued by, and helpful for, outsider witnesses as well. At this point, the participants’ sense of capability and worthiness are greatly treasured.\(^{27–29}\)

At the same time, through participants’ renaming of the problem, their change of perspective on stroke and its influence is evident. Examples are from ‘No.10 typhoon [Unable to predict and control]’ to ‘No. 5 typhoon [Able to control when it occurs again]’, from ‘evil spirit [casting bad curses]’ to ‘theft [stealing]’. They also seem to view themselves differently; for instance, one member changes his self-description from being a ‘useless’ person [problem-saturated identity of having no abilities and as a burden to others] to a person with ‘gratitude’ [a person who is being valued by the spouse and respected by the children; a person who uses one’s life experience to help others], from being a ‘hopeless [with no sense of future]’ person to a person with hope and dreams.

**Step 6: celebrating the grand opening of a new railway line**

Definitional ceremonies are performed to consolidate their alternative ways of life with their preferred identity.\(^{22–23}\) An opening ceremony of the new journey is conducted at the end of the group therapy. It is a celebration of group members’ transition from a problem-saturated story to the new alternative story.\(^{13,22–23,28–29}\) The therapist may introduce the opening of the new railway line by saying:

> We would like to have a grand opening for our new train journey, to witness the beginning of ‘Rekindling the light of life’ line as from today.

Then, the therapist invites participants to cut the ribbon together and start the opening ceremony as a group.

**Therapeutic documents**

Throughout the eight sessions of the group process, therapeutic documents are prepared when participants make important commitments, or when they are ready to celebrate important achievements.\(^{13,22–23,28–29}\)

In this study, the therapist draws out the train journey and takes notes on a large piece of paper. This not only helps to keep track of important things that are being mentioned, but also to guide the therapeutic conversations.\(^{13,28–34}\) Additionally, participants are given a booklet to document their specific milestones on the ‘Train of life’. Throughout the group therapy, there are therapeutic letters that record the thoughts and reflections from the outside witnesses, and/or therapist to the group or a particular participant. These further thicken the alternative stories and provide reflections that can be referred to at any time.\(^{13,28,34}\)

**Practical considerations**

There are some practical considerations in application of practice, including: finding ways to help participants in the naming process (externalising conversations), being cautious not to re-traumatise the participants and securing appropriate transportation and facility support in light of the participants’ special needs.
Naming of the problem

Some of the participants may find it difficult to rename ‘Stroke’ and their ‘experience with Stroke’. Oftentimes, they repeat the names that other participants suggested. An alternative approach is to engage the participants in externalisation of the problem during the pre-group interview instead. If participants chose the same name in the group setting, the therapist can probe further, such as asking about their difference in severity of the same name. Moreover, the therapist may provide more time for participants, if they could not come up with a name at the moment.13

Traumatising the participants

For some participants, the experience of stroke may be too traumatic for them to talk about in front of the group.36 Therefore, it is crucial for the therapist to meet with the participants beforehand, in order to evaluate the readiness of each participant in disclosing his or her experience with stroke. In the earlier group sessions, the therapist may invite those who are more ready to share their experience with stroke first. Alternatively, the therapist may start by focusing on the participant’s support before talking about his or her experience with stroke.

Location of venue, and other support

As most of the stroke survivors have some degree of disability, the location of the venue should be safe, wheelchair accessible, within their district and convenient enough for them to get on and off transport.31 The furniture should be safe to hold onto, so as to prevent participants from falling. Therefore, folding tables and chairs are not recommended. It would be helpful if provision of transportation allowance is secured to attain full participation.

Discussion

This article describes a practical framework for the use of metaphor in narrative therapy in stroke rehabilitation. The metaphor is designed to be a collective narrative methodology29 in meeting the psycho-social-spiritual needs of the stroke survivors and their caregivers. Compared with methodology in contemporary health and social services, the use of metaphors in narrative therapy put forward another viable rehabilitation of practice. Stroke rehabilitation is different from the contemporary health and social services, which primarily rely on, and are significantly influenced by, the medical model that places emphasis on disease, illness and pathologies.36 In the conventional medical practice model, the professionals often appear to know more than the patients themselves. The treatment modality stemming from the psycho-educational approach intends to teach people about their problems, with the hope to transfer skills that helps to recognise and control signs of relapse, to problem-solve and to cope.31 Yet, when the emphasis is mainly on the deficits or weaknesses, it may further give the idea that people are the cause of the problem.37 The use of language and diagnostic deficits may disempower people to become saturated with pathologies.38–44

By contrast, in narrative therapy, those consulting the therapist are regarded as the experts in their own lives, instead of the therapist.13,22–23,29 Using a ‘Train of life’ metaphor, the therapist could encourage the use of survivors’ naming and descriptions of ‘stroke’ as an alternative dialogue rather than using medical discourse.40 This would facilitate the creation of a new perspective in the one’s understanding of ‘stroke’ and the effect of stroke, as opposed to a deficit approach from the traditional problem-focused model that restricts their vision.38,41

Moreover, narrative therapists view problems as separate from people.13 In the metaphor, ‘Stroke’ is seen as an entity or substance outside the survivors, which can be understood and referred to,42 not embedded as part of their personality or being, and not as survivors’ personal fault and failure.37 Therefore, survivors are treated with personal agency and could be free from self-blame and guilt.39 While using a journey metaphor, the therapist also encourages survivors to rename ‘stroke’, to help them externalise the problem20,29,42 at different phases of the journey, to regain power and control over it40 and to move closer to their hopes and dreams.

In addition, the narrative therapist assumes that people have many skills, competencies and abilities.13,23,29 Through re-authoring conversations, ‘unique outcomes’ are found, instead of disabilities
and limitations. Hence the survivors’ sense of self according to their abilities and worthiness has become more obvious and is greatly enhanced.

There are some practical limitations in the use of metaphor. Although the metaphor of ‘Train of life’ offers an alternative methodology, it is probably demanding to apply for survivors with aphasia or with lower cognitive ability, as they may not be able to tell their stories and engage in the discourse of the metaphor. Furthermore, some participants are hesitant to create their own ‘Train of life’ station. There are various explanations, such as having difficulty in understanding the symbolic meaning of the metaphor, lack of imagination and other cultural or personality-related factors. Thus, the therapist in the current study provided examples and allowed individuals to create the station later.

**Clinical messages**

- By separating the problem from the stroke survivors, new perspectives can be co-constructed to make sense of the stroke experience and its effects.
- Instead of focusing on the disabilities and limitations, narrative therapy reconnects the survivors’ inner resources, skills, competencies, and abilities.
- By building on their inner strengths and achievements from previous life challenges and co-constructing a meaningful purpose in life for the future, it helps to re-author the preferred identity of individuals for psychosocial and spiritual healing.

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**Conflict of interest**

The author reports no conflict of interest concerning the materials or methods used in this study or findings specified in this article.

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