Reading the Patient's Mind:

Irvin Yalom and Narrative in Psychiatry

Thesis

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Abstract

In this thesis, I use a close reading of two memoirs by existential psychiatrist Irvin Yalom to develop a narrative approach to psychiatry. This approach treats each patient's story as a unique work of literature. It involves the psychiatrist's listening for literary elements such as tone, incongruity, and figurative speech in patient stories. It also requires the psychiatrist's engagement in cooperative acts of storytelling and interpretation, which, I suggest, provide insight into the patient's inner and outer life. This insight helps the psychiatrist to understand the patient's needs, whether these needs are psychosocial, neurobiological, medical, or otherwise. Ultimately, I argue that this approach prepares psychiatrists to respond creatively to the complex challenges of mental illness.

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Part I:

Introduction

In this thesis, I argue that we can better understand the needs of patients with mental illness by receiving their speech as we would receive a work of literature. In other words, rather than merely labeling the speech of psychiatric patients as "disordered" or "disorganized," I suggest that we should listen to their speech with an ear to the presence of figurative language, including metaphor, analogy, personification, hyperbole, and so forth. Indeed, I believe that all patients, even those with severe psychiatric illness, have something important and intelligible to say. When these patients struggle to communicate in conventional ways, we must work even more diligently to decipher the messages they are trying to send us.

To illustrate, consider a person who, while hospitalized involuntarily on an inpatient psychiatric unit, calls his physician "the devil." Does this patient literally believe that his physician is the malevolent deity of Judeo-Christian mythology? To countenance a more likely possibility, perhaps the patient is expressing anger and fear at being held against his will ("damned") in an unpleasant place ("Hell") for an indefinite period ("eternity"). Following this religious imagery, perhaps the patient feels that he has been placed in the psychiatric ward due to an unfair judgment of his moral character, or as punishment for some misdeed he has wrought. Perhaps he resents the physician's power over him. Perhaps he feels that his hospitalization is akin to demonic torture. Only by considering these interpretive possibilities, I argue, can we as physicians fully understand the perspectives of our psychiatrically ill patients. To fully appreciate these possibilities, we must first consider that our patients may be communicating with us in ways that are figurative and indirect rather than linear and literal.

The presence of figurative language in a patient's speech does not, however, imply that the patient *realizes* that she is using figurative speech, or that she intentionally sends coded messages. Rather, the patient's speech may simply "come out" as figurative, and she may not be able to provide us with more literal clarification of her meaning. In these cases, it is up to the physician to interpret the patient's speech to the best of his or her ability. I will not attempt to elaborate a theory that would explain from a neurobiological perspective why people with mental illness often struggle to communicate in direct or conventional ways. It is my experience that nearly everyone uses figurative language in everyday speech; however, we each have varying levels of control over and awareness of this figurative language, depending on several variables including educational background and mental health history.

My interpretive strategy for psychiatry draws inspiration from literary theory, person-centered care, and the narrative medicine movement. Beyond the task of recognizing figurative language in the verbal accounts of our patients, I posit that figurative language often serves as a proxy for narratives that the patient uses to explain his or her own life. These narratives may be original to the patient (e.g., "After the car accident in '97, things started going downhill…") or may borrow to varying degrees from myths and narrative forms present in the prevailing culture (e.g., "I went to Hell because I sinned; when I got there, the Devil punished me and never allowed me to leave"). Part of the job of a psychiatrist, I believe, is to unpack the narratives implied by the patient's figurative speech.

To show how a psychiatrist may interpret figurative speech and unearth life narratives latent within a patient's verbal accounts, I will discuss excerpts from two memoirs written or co-written by Irvin Yalom, MD, an American psychiatrist with expertise in literature and existential therapy. In *Love's Executioner* (Yalom 1989), Yalom writes of his treatment of Marvin, a middle-aged accountant

who suffers from anxiety, depression, and debilitating migraines. In *Every Day Gets a Little Closer* (Yalom and Elkin 1974), Yalom and his patient "Ginny Elkin" each reflect on their experiences at weekly therapy meetings. Through these excerpts, I will show how physicians can use attention to figurative language to better understand the needs of their patients and to further their therapeutic relationships. As well, I will show how a physician's interpretation of figurative language is different from the reading of literature in that the patient is not a static text to be explicated, but rather a dynamic human being who can challenge and sway the physician's interpretations of her stories.

Part II:

Listening for narrative meaning in *Love's Executioner*

In his memoir *Love's Executioner* (1989), Dr. Irvin Yalom showcases a form of critical listening that I hope to use as a blueprint for my approach to psychiatry. Yalom recounts in this memoir several memorable courses of therapy with patients in his psychiatric practice. The final chapter centers on Dr. Yalom's visits with Marvin, a seemingly "prosaic" 64-year-old accountant who seeks Yalom's expertise because he recently has begun experiencing sexual problems and severe migraine headaches, neither of which he has ever encountered in the past (Yalom 235).

In their first consultation, Marvin introduces himself by handing Dr. Yalom a color-coded chart documenting the events of his life over the past several weeks. He directs Yalom's attention to the fact that all his migraine headaches have immediately followed episodes in which he has experienced premature ejaculation or has been unable to maintain an erection in sex with his wife. ("Every migraine… was coded in blue. Every sexual rush, colored red, was reduced to a five-point scale according to Marvin's performance…" ibid. 230.) Marvin shares that his mental wellbeing has hinged on his sexual performance, and that, since his sexual performance has suffered of late, his mental health has been poor. For the majority of his 41-year marriage to his wife, Phyllis, Marvin reports that he rarely has experienced any sexual difficulties. Now that he has been struggling with erectile dysfunction, however, his mood has been swinging between euphoria and desolation, depending on whether he is physically able to have sex with his wife. When he fails at sex and becomes "depressed," Marvin experiences migraines so severe that he must take himself to the emergency room (ibid., 231-233). In sum, Marvin's life has begun to revolve around his ability to have sex with his wife. Despite having been married to her for 41 years without any previous sexual

problems, he has suddenly developed erectile dysfunction and premature ejaculation followed by days of despair and intense pain.

In receiving Marvin's self-disclosure, Yalom notes his feeling irritated with Marvin's way of speaking: "Marvin spoke in a deliberate, pedantic manner. Obviously he had rehearsed this material beforehand… [his] commentary was precise but stingy, slightly abrasive, and larded with clichés… Although he brought up details of his sexual life, he expressed no embarrassment, self-consciousness, or, for that matter, any deeper feelings" (ibid., 232-234). Puzzled by Marvin's dry, impersonal delivery, Yalom attempts to use more direct questioning to elicit the patient's true feelings about his sexual problems, "to get beneath the forced 'hale fellow' heartiness" (ibid., 234). Unfortunately, these attempts go nowhere. Marvin denies having any problems in any aspect of his life, including in his marriage. Citing his longtime distrust of psychiatrists, he declines to engage with Dr. Yalom on any level deeper than simply describing his symptoms in more elaborate detail (ibid., 234).

After the meeting ends, Yalom continues to reflect on his lingering feelings of distaste towards Marvin. In doing so, he identifies two possible sources of his irritation, namely, Marvin's outward haughtiness and his attempts at controlling the flow of the visit:

> Was it his superficiality, his needling, his wagging his finger at me…? He took over the first hour… with his determination to stick that chart in my hands whether I wanted it or not. I thought of tearing that chart to shreds and enjoying every moment of it (ibid., 234).

Still, Yalom continues to wonder at the ferocity of his aversion to Marvin, doubting that these aspects of the initial visit could fully account for his strong emotional reaction. To better

understand the reasons for his discomfort with the patient, Yalom reformulates Marvin's story in his own terms, isolating the facts of the case from the psychiatrist's poor first impression of the patient.[3] In doing so, he seems to home in on the discrepancy between Marvin's glibness and the painfully intimate issues for which he is seeking help:

> … I thought more about him, the two Marvins – Marvin the man, Marvin the idea. It was the flesh-and-blood Marvin who was irritating and uninteresting. But Marvin the *project* was intriguing. Think of that extraordinary story: for the first time in his life, a stable… previously healthy sixty-four year-old man who has been having sex with the same woman for forty-one years suddenly becomes exquisitely sensitive to his sexual performance. His entire wellbeing soon becomes hostage to sexual functioning. The event is *severe* (his migraines are exceptionally disabling); it is *unexpected* (sex never presented any unusual problems previously); and it is *sudden* (it erupted in full force precisely six months ago)…" (ibid., 235).

In reconstructing Marvin's story in this way, Yalom also realizes that the timing of Marvin's symptoms ("precisely six months ago") may be important. Whereas Marvin never had experienced migraines or impotence in the past, these symptoms appeared suddenly, as if from thin air, around six months before the initial consultation. Perhaps, Yalom infers, Marvin's symptoms could be related to some triggering event, such as a major life change or a new medical issue that Marvin may have neglected to mention.

[3] Whereas conventional psychiatric practice might involve reformulating a case in the standard format of "Subjective, Objective, Assessment, and Plan" (Podder et al. 2021), outlining sequentially the patient's symptoms, the physician's findings, her professional assessment of the patient's problems, and her plan for treating those problems, Yalom retells Marvin's clinical presentation using the methods of creative writing (cf. Charon and Marcus 2017, 273).

Following this intuition, Dr. Yalom presses Marvin at the next visit to reflect on whether any changes or events of significance have transpired in his life over the past year. After initially denying any such changes, Marvin eventually admits that he decided about six months ago to sell his accounting firm and retire (ibid., 235). He rejects, however, the idea that his decision to retire has affected him psychologically: "Problems about retiring? You've got to be kidding. This is what I've been working for – so I *can* retire" (ibid). Yalom privately doubts Marvin's rebuttal: "How is it possible for retirement *not* to evoke deep feelings about the passage and passing of life, about the meaning and significance of one's entire life project?" (ibid.). But further interrogation on the matter does not elicit an emotional response from Marvin, nor does it reveal any obvious connection between Marvin's retirement and his sexual symptoms. Rather, Marvin reiterates that he feels confident about his retirement, declaring that his work as an accountant has never held any special meaning to him: "My work is about money… What retirement really means is that I've made so much money I don't need to make any more" (ibid., 236).

Feeling stymied, Dr. Yalom turns the conversation to Marvin's early career. He learns that Marvin studied mathematics in college, and that, after earning his bachelor's degree, Marvin began work as a high school teacher, foregoing the opportunity to attend graduate school due to his having married Phyllis young and with limited financial resources. After he had spent several years teaching high school mathematics, Yalom discovers, Marvin switched careers to become an accountant so that he could make more money. Over the ensuing decades, Marvin used his position as an accountant to become personally wealthy, channeling his income into real estate investments and amassing a considerable fortune (ibid., 237).

Having learned about the trajectory of Marvin's career, Dr. Yalom asks Marvin about his vision for life post-retirement. "That brings us up to now, Marvin. Where do you go in life from

here?" (ibid). Marvin responds to Dr. Yalom's query in a tentative manner that departs from the superficial confidence he has projected up to this point. Yalom notices the change in Marvin's tone: "'Well," Marvin ambles, "as I said, there's no point in accumulating any more money. I have no children' – here his voice turned gray – 'no poor relatives, no desires to give it to good causes'" (ibid.). Marvin is at a loss. When Yalom attempts to probe this apparent sense of uncertainty about the future, however, Marvin yields little more, and Yalom believes that he has reached a dead end. "I was struck… by Marvin's lack of wonderment at his own story. Where was his curiosity that his life had changed so dramatically, that his sense of direction, his happiness, even his desire to live was now entirely dictated by whether he could sustain tumescence in his penis?" (ibid., 238).

As the two move to conclude the meeting, Marvin mentions offhand that he has written down a few of his recent dreams as Dr. Yalom instructed at their first meeting. This development surprises Yalom, who has harbored low expectations for Marvin: "I had suggested he keep a writing pad by his bed to record his dreams, but he seemed so little inner-directed that I doubted he would follow through" (ibid., 239). At Dr. Yalom's invitation, Marvin shares several of these recent dreams, which prove to be rich in imagery and emotion. One dream especially catches Yalom's attention:

> The ground under my house was liquefying. I had a giant auger and knew that I would have to drill down sixty-five feet to save the house. I hit a layer of solid rock, and the vibrations woke me up (ibid., 239).

While Marvin recites this dream straightforwardly, expressing no obvious valence towards its content, Dr. Yalom immediately suspects that the dream holds symbolic meaning. Taking into

consideration Marvin's decision to retire and his subsequent onset of sexual problems, Yalom offers something resembling a literary analysis of the dream. "The dream about the giant auger could not have been more clear: the ground under Marvin's feet was liquefying (an inspired visual image for groundlessness), and he was trying to combat that by drilling, with his penis, sixty-five feet (that is, sixty-five years) down!" (ibid., 240). Thus, Yalom interprets Marvin's dream as evidence that Marvin's decision to retire has brought him in direct confrontation with his impending old age and the end of his working life, stirring up feelings of disorientation and "groundlessness," and that Marvin has been attempting unsuccessfully to mollify these feelings using sex. Scintillated, Dr. Yalom instructs Marvin to continue recording his dreams and to bring them to future therapy sessions.

At the next session, Marvin tells Dr. Yalom about a nightmare he has had:

> The two men are tall, pale, and very gaunt. In a dark meadow they glide along in silence. They are dressed entirely in black. With tall black stovepipe hats, long-tailed coats, black spats and shoes, they resemble Victorian undertakers or temperance workers. Suddenly they come upon a carriage, ebony black, cradling a baby girl swaddled in black gauze. Wordlessly, one of the men begins to push the carriage. After a short distance he stops, walks around to the front, and, with his black cane, which now has a glowing white tip, he leans over, parts the gauze, and methodically inserts the white tip into the baby's vagina (ibid., 242).

Guided by Dr. Yalom's questioning, Marvin conveys that the most frightening part of the dream was the macabre atmosphere, "the silent footsteps, the blackness, the sense of deep foreboding" (ibid., 243). Rather than intensifying the horror of the dream, however, the insertion of the cane into the baby's vagina has a slightly calming effect for Marvin: "that part seemed almost

soothing, as though it quieted the dream – or, rather, it tried to. It didn't really do it. None of this makes any sense to me. I've never believed in dreams" (ibid.).

Once again applying his interpretive powers, Yalom identifies the mood of the dream as one of dread. Dread of what? As Yalom reasons, the darkness of the landscape, the grim atmosphere, and the centrality of the undertakers signifies the fear of death (ibid., 245). For Marvin, the insertion of the cane into the baby's vagina lessens but does not extinguish this dread. Yalom interprets the insertion of the cane as a symbolic representation of sex, or, more specifically, of Marvin's having sex with his wife. "I thought," Yalom divines, "of the sexual act that was not sex but merely a futile attempt to dispel the dread" (ibid.). In parallel with the dream about the giant auger, therefore, Yalom concludes that the dream of the undertakers represents Marvin's using sex to allay his anxiety about senescence and death. "I was certain," Yalom postulates, "that my first impression had been close to the mark: that his impending retirement had stoked up much fundamental anxiety about finitude, aging, and death, and that he was attempting to cope with this anxiety through sexual mastery. So much was riding on the sexual act that it was overtaxed and, ultimately, overwhelmed" (ibid., 240). In analyzing Marvin's dream, therefore, Yalom comes up with an explanation that connects the patient's decision to retire with his mood swings, migraines, and sexual dysfunction. Marvin has been experiencing intense anxiety due to an as-yet unrecognized fear of death. Sometimes Marvin can use sex to quiet these anxious feelings. When Marvin is unable to use sex in this way, however, he experiences the full force of this death-anxiety in the form of headaches and depressed mood.

Reflecting on this interpretation, Yalom feels amazed that he has gained such insight from Marvin's dreams, especially considering that he has learned so little about Marvin from direct conversation. To help himself conceptualize this strange disconnect, Yalom imagines that these

dreams have issued from some anonymous "dreamer" other than Marvin. "Buried somewhere within Marvin's walls," as Yalom visualizes, "was a dreamer tapping out an urgent existential message" (ibid., 245). Following this mental construction, Yalom reformulates the dream of the undertakers using what he imagines to be the voice of this mysterious dreamer. "I wondered, If disguise were unnecessary, if the dreamer could speak to me without guile, what might he say?" (ibid.). His reformulation goes as follows:

> 'I am old. I am at the end of my life's work. I have no children, and I approach death full of dread. I am choking on darkness. I am choking on the silence of death. I think I know a way. I try to pierce the blackness with my sexual talisman. But it is not enough' (ibid., 245).

For Yalom, the dream of the undertakers and the dream of the auger converge on a fundamental truth of human existence: the certainty of death and our struggle to reconcile our mortality with our will to live (ibid., 4 – 5). Indeed, this tension forms one of the axioms of existential psychotherapy, a school of therapy of which Yalom is a founding member (see also May and Yalom 1989). In short, existential psychotherapy is a form of therapy meant to help people cope with challenges inherent in the human condition. Among these challenges are "the inevitability of death for each of us and for those we love; the freedom to make our lives as we will; our ultimate aloneness; and, finally, the absence of any obvious meaning or sense to life" (Yalom 1989, 4 – 5). It appears, therefore, that Yalom's commitment to the tenets of existential psychotherapy figures centrally in his interpretation of Marvin's dreams.

As the two continue their regular therapy sessions, Yalom continues to hold in mind his imagined distinction between Marvin and the Dreamer, eliciting Marvin's dreams and retelling them

in the Dreamer's voice. "While Marvin and I strolled and casually conversed at superficial levels," Yalom relates, "the dreamer drummed out a constant stream of messages from the depths" (ibid., 248). For example, Marvin shares with Dr. Yalom a dream about a boy in school:

> The teacher in a boarding school was looking around for children who were interested in painting on a large blank canvas. Later I was teaching a small, pudgy boy – obviously myself – about it, and he got so excited he began to cry (ibid., 249).

"No mistaking that message," Yalom remarks, rewording the dream thusly:

> [He] senses he's being offered an opportunity by someone – undoubtedly you, his therapist – to start all over again. How exciting, to be given another chance, to paint his life all over again on a blank canvas (ibid., 249).

This mental construction of the "dreamer" seems to help Yalom engage in a therapeutic relationship with Marvin even though he does not initially enjoy the patient's company. It also enables Yalom, as we have seen, to gain insight into Marvin's mental life when direct conversation reveals little. Marvin, for his own part, continues to attend therapy sessions. Despite his skepticism about psychiatry, Marvin's migraines seem to improve as he meets regularly with Dr. Yalom, even though he cannot explain why exactly therapy has been helpful.

Over the ensuing months, Yalom learns more about Marvin through both dream interpretation and direct conversation. "I grew acquainted with the characters who peopled Marvin's mind," Yalom narrates, including Marvin's wife Phyllis, his absent father, and the overbearing mother of his childhood. Marvin begins to reveal that his marriage with Phyllis is not as harmonious

as he initially had let on. He admits that he has experienced mood swings related to his sexual performance for twenty years, rather than the six months he initially claimed (ibid., 241). Related to his sexual issues, he shares frustration that his wife Phyllis seems to mete out sex only rarely, and to withhold sex as a punishment (ibid., 247).

In time, Marvin opens up with Dr. Yalom about Phyllis's social anxiety, which is so extreme that the woman virtually never leaves the house. As a result of this social anxiety, Phyllis has forbidden Marvin from having friends or family over to the house to visit. She has discouraged Marvin from traveling, as she does not wish for him to leave her home by herself. Indeed, many years earlier, when the pair had been unable to conceive a child naturally, Phyllis refused to leave the house to see a reproductive specialist. Hence, the couple remained childless (ibid., 243 – 244).

As Yalom continues to learn more about Marvin, his mental representation of Marvin expands, growing more sophisticated as it incorporates each new piece of information about Marvin's inner and outer life. Marvin, in turn, becomes gradually more aware of his own inner mental state and more invested in uncovering the meaning of his own dreams. As his participation in therapy deepens, Marvin appears increasingly to experience the strong feelings communicated by the "dreamer," spurring him to reexamine his own life. In one poignant therapy session, Marvin cries for the first time in years when he realizes that he has never allowed himself to grieve his mother's death (ibid., 256). At later meetings, Marvin begins to understand that he has suppressed his emotions for many years, and that he has not at all lived the life he wanted (ibid., 258 – 259). He mourns his life spent without children and without the closeness of family or friends; he mourns the potential he has squandered by focusing his career solely on making money. Marvin shares a dream emblematic of this regret:

> I am taking an examination. I hand in my blue book and remember that I haven't answered the last question, I panic. I try to take the book back, but it is past the deadline. I make an appointment to meet my son after the deadline (ibid., 258).

According to Yalom's retelling, this dream means the following:

> I realize now that I have not done what I might have done with my life. The course and the exam is over. I would have liked to have done it differently… Maybe if I had taken a different turn, to have done something else – not a high school teacher, not a rich accountant. But it is too late, too late to change any of my answers. The time has run out. If only I had a son, I might through him spew myself into the future past the death line (ibid., 258).

Thus, Yalom interprets this dream as representing Marvin's regret for having lived an unfulfilled life, and his anguish at the fact that he cannot go back and live differently. The "exam" is over, as it were; Marvin has reached retirement age. This realization seems to bring Marvin intense grief. "He grieved," Yalom laments, "for his past and impending losses. Most of all, he grieved for the vast empty spaces of his life: the unused potential within him, the children he had never had, the father he had never known, the house that had never brimmed with family and friends, a life work that might have contained more significance… Finally, he grieved for himself, the imprisoned dreamer…" (ibid., 259). On the other hand, Marvin's new insights on his life prompt him to begin speaking more openly with his wife Phyllis (ibid., 260). Though Phyllis previously had refused to participate in couple's therapy, Marvin's renewed candor and liveliness convince Phyllis of Dr. Yalom's exceptional skill, prompting her to leave the house to join Marvin for therapy sessions.

In couple's therapy, Marvin comes to understand that he has been using sex for a very long time to quiet his own anxiety, rather than simply enjoying the activity. Phyllis, on the other hand, confesses that she has used sex to maintain a measure of power in her relationship with Marvin (ibid., 265). "I guess I had to have *something* that Marvin wanted," Phyllis laments. "Often I feel I don't have much else to offer. I wasn't able to have children, I'm afraid of people, I've never worked outside the home…" (ibid.). The two begin to speak more openly about their relationship. With guidance from Dr. Yalom, Phyllis becomes emboldened to leave the house more often. Most of Marvin's presenting symptoms dissipate, and Marvin ultimately learns to approach old age with greater openness and acceptance.

As I have shown here, Yalom demonstrates how careful attention to the patient's story, especially in the early stages of the therapeutic relationship, can reveal far more about the patient's inner life than may be obvious at first glance. To this end, I would like to highlight several aspects of Yalom's approach that I believe are worth emulating. Most importantly, Yalom attends closely to the patient's verbal account, listening for meaning beyond the surface level. More than simply taking the patient's words at face value, in other words, Yalom remains vigilant for verbal and nonverbal clues that may hint at deeper meanings in the patient's presentation. These clues point Yalom towards future lines of inquiry for therapy. In my observation, Yalom uses several key types of information as clues to uncovering more about the patient:

(1) Apparent incongruities in the patient's story. Early in their course of therapy, Dr. Yalom suggests that Marvin invite Phyllis for couple's counseling. At the next visit, however, Marvin reports with exasperation that Phyllis has refused to participate in any therapy whatsoever. For Yalom, this course of events belies Marvin's initial claim that he and Phyllis have an outstanding marriage (ibid., 243). Yalom begins to suspect that the pair has more serious issues than Marvin has

been willing to admit. This suspicion informs his lines of inquiry with Marvin over the course of many therapy sessions; indeed, further exploration reveals that Marvin and Phyllis harbor a great number of unaddressed resentments and frustrations. Many of these unspoken dissatisfactions, including Marvin's frustration with Phyllis's need to control sex, turn out to be related to Marvin's presenting symptoms (see also below).

To give another familiar example, recall that Marvin initially denies feeling any strong emotions about his decision to retire. This denial contradicts Yalom's experience as a psychotherapist and his fundamental beliefs about the meaning of life's milestones ("How is it possible for retirement *not* to evoke deep feelings about the passage and passing of life…?"). In identifying this apparent incongruity, Yalom homes in on a crucial issue behind Marvin's suffering, namely, the way that retirement has forced Marvin to confront his fear of death, his disappointment about the trajectory of his life, and his many years of suppressed emotions.

(2) Elements of figurative speech, such as symbolism and metaphor. Yalom's attention to figurative speech is especially apparent in his interpretations of Marvin's dreams. Consider, for example, his claim that the "giant auger" symbolizes Marvin's penis, that the undertakers in the dark landscape signify Marvin's fear of death, or that the feeling that the "exam is already over" represents Marvin's disappointment that he has reached retirement without living the life he wanted to live.

We might observe that Yalom not only *pays attention* to figurative meaning in the patient's verbal account. Rather, he *actively courts* figurative meaning by requesting that Marvin record his dreams when surface-level conversation does not prove therapeutically fruitful. In other words, when the patient cannot express himself in a direct way, Dr. Yalom invites him to express himself

indirectly through his dreams, which, when compared against facts that Dr. Yalom knows about the patient's waking life, provide insight into the Marvin's inner state.

(3) The patient's delivery of the story. In their first meeting, Marvin discusses his overwhelming sexual and emotional distress with little outward expression. The way Marvin delivers his verbal account strikes Yalom as forced, insincere ("Marvin spoke in a deliberate, pedantic manner. Obviously he had rehearsed this material beforehand… commentary was precise but stingy… larded with clichés"). This delivery seems for Yalom to hint at something odd about Marvin, whether it is a guardedness towards psychiatrists, a lack of self-awareness or self-insight, or merely an unpleasant personality. Yalom considers each of these possibilities in turn. As well, he carefully weighs his own private irritation at Marvin's insincere manner of speaking (see below).

(4) The physician's emotional reactions to the patient. As we have seen, Yalom leaves his first meeting with Marvin feeling profound distaste for the patient. In appreciating his own emotional reaction, Yalom challenges himself to figure out why he does not like Marvin, reflecting on what exactly has bothered him about the visit. He identifies several sources of discomfort, including Marvin's haughty, controlling way of interacting, as well as the discrepancy between Marvin's overconfident manner of speaking and the sensitive subject matter of his verbal history (see above). In response to his frustration with Marvin's persona, Yalom seems to dive more eagerly into dream interpretation, bypassing a level of conversation that he believes will not be illuminating, either because of the patient's superficiality, because of the therapist's lack of openness to the patient's self-presentation, or both.

These aspects of the patient's story provide Yalom indirectly with information about the patient's inner life and about the interaction between patient and psychiatrist. Yalom, in turn, uses these indirect clues as guideposts for further inquiry. Following these lines of inquiry, the physician

gains more information about the patient with each meeting. As the physician learns more about the patient through both interpreted clues and direct conversation, he builds an increasingly sophisticated mental model of the patient, mapping the patient's inner state and social environment. As this mental model becomes more sophisticated, the psychiatrist, in turn, becomes better able to provide meaningful interpretations of the patient's verbal accounts. In other words, as Yalom learns more about the patient's life, he is better able to decipher and contextualize the meanings of each new utterance by the patient.

Consider, for instance, the elemental simplicity with which Yalom interprets Marvin's first dream about the giant auger: "he was trying to combat [his groundlessness] by drilling, with his penis, sixty-five feet (that is, sixty-five years) down!" Showing his psychoanalytic background, Yalom interprets this dream in a way that is straightforwardly phallic. This dream interpretation is simple, I suggest, because Yalom knows relatively little about Marvin in the early stages of their therapeutic relationship. Yalom must use his training and what little he knows about Marvin – essentially, Marvin's age, sex, and symptoms – to make sense of the dream. As their relationship grows and Yalom learns more about the patient, he can interpret Marvin's dreams with greater personal specificity. With regard to the dream of the completed examination, for instance, Yalom draws from what he has learned about Marvin's life trajectory, including his childlessness and money-oriented career, to offer a fuller, more insightful analysis: "Maybe if I had taken a different turn, to have done something else – not a high school teacher, not a rich accountant. But it is too late, too late to change any of my answers. The time has run out. If only I had a son…" (ibid., 258).

Thus, we might say that Yalom follows uses a *recursive* interpretive process to extract maximal meaning from the patient's verbal accounts. Each therapy session, each conversation, and each reported dream provides material for the psychiatrist to interpret. Each interpretation, in turn, allows

the psychiatrist to build a more complete understanding of the patient's circumstances and inner life. To bring the process full circle, this more complete understanding allows the psychiatrist to better contextualize any new information he learns about the patient.

In addition to the recursive nature of Yalom's approach to Marvin, I would also like to draw attention to the way that Yalom tests hypotheses about Marvin's inner life by rephrasing the patient's verbal accounts.[4] More specifically, notice how Yalom creatively retells the patient's reported dreams in an imagined third voice, that of "the Dreamer." These creative retellings allow Yalom to consider a wider range of possibilities about Marvin's life, especially because the psychiatrist's first impression of the patient is that he is "prosaic." By attributing the intense emotions of Marvin's dreams to a separate "Dreamer," Yalom gives himself a medium to consider the emotional meanings of the dreams in a way that is distinct from his nascent therapeutic relationship with Marvin. As well, this activity seems to help Yalom conform the meaning of the patient's verbal accounts more directly into his mental representation of Marvin. In other words, these retellings allow Yalom to convert the narrative "raw material" of Marvin's dreams into explanations of the patient's inner life that cohere with the psychiatrist's overall mental representation of the patient.

So far, the observations we have made about Yalom's approach to Marvin match with the interpretive strategies I am proposing in this thesis. Each aspect of Yalom's approach that I have discussed up to this point – its attention to incongruity, its focus on figurative meaning, its creative retelling of the patient's stories, its reflectiveness on the patient's manner of speaking and the psychiatrist's response to it, its recursively building a mental model of the patient – represents a core

[4] cf. Charon and Marcus 2017, 271-273.

element of my own account. Now, I would like to point out some areas where my approach differs from Yalom's.

The main difference between my approach and Yalom's is in the level of commitment to specific ideas about the causes of psychological suffering. As we have seen, Yalom is a founder of existential psychiatry, a subfield of psychiatry whose stated aim is to help people cope with the difficult realities of human existence, especially "death, freedom, isolation, and meaning" (May and Yalom 1989). As such, Yalom's approach as a practitioner turns on his ability to recognize and address the existential concerns that may be causing a patient's anguish. "In my therapy," he propounds, "my primary clinical assumption… is that basic anxiety emerges from a person's endeavors, conscious and unconscious, to cope with the harsh facts of life, the 'givens' of existence" (Yalom 1989, 4).[5] Notice how Yalom commits to an existential interpretation of Marvin's symptoms early in their course of therapy. "How is it possible," Yalom petitions after his first meeting with Marvin, "for retirement *not* to evoke deep feelings about the passage and passing of life, about the meaning and significance of one's entire life project? For those who look inward, retirement is a time of life review… a time of proliferating awareness of finitude and approaching death" (ibid., 235). From this point forward, the majority of Yalom's work with Marvin centers on addressing the patient's fear of death and his regrets about dreams unlived. In a sense, then, Yalom has used his interpretive skills to find the deep existential meanings behind Marvin's dreams and verbal accounts,

[5] As we have already seen, Yalom's commitment to existential therapy involves assumptions about the way that existential concerns unfold across the lifespan, e.g., "when people retire from work, they reflect on the meaning of their life," "when people get old, they begin to think about death." Notice how these assumptions are most naturally expressed as archetypal narrative forms; indeed, it is challenging to imagine that claims about the evolution of life's meaning could be expressed in any way *other than* narrative forms. In this manner, Yalom's approach to therapy relies on a finite number of core scripts that describe the way that people struggle with aging, growth, meaning, and life milestones as they move through time. In other words, Yalom's approach depends on a small number of "origin stories" about the kinds of issues that may lead to mental suffering. My approach, as I demonstrate here, can accommodate an indefinite variety of stories about the causes of suffering. Indeed, I believe that suffering comes not only from existential concerns, but also from more immediate causes such as medical, social, sexual, and financial problems, among many other origins.

to identify the existential anxieties that underlie Marvin's symptoms. Once Yalom singles out the existential crisis that he believes is responsible for Marvin's suffering, namely, Marvin's fear of death, he uses this issue to help Marvin gain self-understanding and to open new conversations about ostensibly smaller but nonetheless significant issues in Marvin's life, such as the dynamics of his marriage to Phyllis. We might represent with a schematic diagram (*Figure 1*) Yalom's use of the axioms of existential psychiatry in therapy with Marvin.

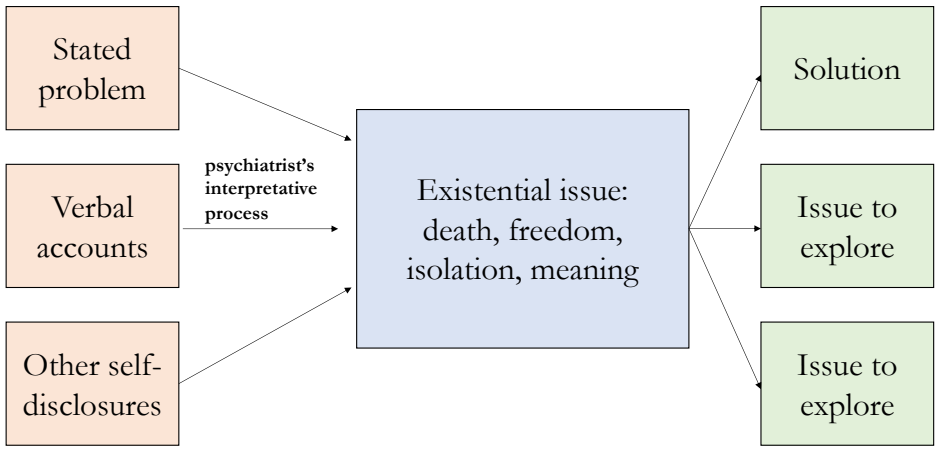

Figure 1: Diagram representing Yalom's use of existential psychiatry in his course of therapy with Marvin.

Thus, Yalom demonstrates an *a priori* commitment to the idea that psychological suffering stems primarily from discomfort and uncertainty around life's deepest existential truths.[6] This commitment strongly guides Yalom's approach to therapy. In my approach, by contrast, I seek to

[6] To give Yalom credit where it is due, the psychiatrist does recognize, if only cursorily, that Marvin's case admits of multiple levels of interpretation (e.g., Yalom 1989, 253). However, he gives near-exclusive attention to the existential perspective, mentioning only in passing the potential for Freudian and relationship-centered interpretations of Marvin's case.

assume as little as possible about the causes of each patient's suffering, at least at the outset of therapy. I hold no *a priori* commitment to any one model or theory of mental illness. Rather than begin each new course of therapy by working to identify the cause of the patient's problems from a limited menu of possible solutions – e.g., death anxiety versus freedom anxiety, depression versus bipolar – I envision remaining open to many alternatives, including possibilities I may not have initially imagined. There are no foregone conclusions in my approach to therapy.

To view this matter another way, we might say that Yalom's approach is *prescriptive* in that it involves seeking narrative evidence for a particular form of distress, namely, existential anxiety. Identifying existential anxiety sets the stage, in turn, for existential therapy: helping the patient to reckon honestly with the unchangeable truths of human existence. In this way, therapy with Yalom "funnels" towards the existential, towards existential interpretations of, and solutions to, the patient's suffering. In listening specifically for existential sources of suffering, however, Yalom risks disregarding many other forms of narrative information. In my approach, by contrast, the psychiatrist strives to synthesize disparate aspects of a patient's clinical presentation, using these varied pieces of information like tiles in a mosaic to make a new story that explains who the patient is and what the patient needs. Freeing ourselves from strict adherence to a single paradigm, we recognize that a patient's needs may take any of an endless variety of forms, encompassing not only the existential, but also the medical, marital, neurologic, financial, psychopathologic, and beyond.

By eschewing the need to quickly narrow in on the cause of the patient's suffering, moreover, the psychiatrist frees mental space that she can use to gain more intimate familiarity with the patient's life stories. As she learns more about the patient's inner and outer life, the psychiatrist will begin to pay attention to literary elements that stand out in the patient's verbal and nonverbal communications: tone, topic, mood, theme, motif, metaphor, allegory, character, and so forth. These

literary elements allow her to construct a mental representation or "map" of the patient, which, as we have described, gradually deepens her ability to interpret future conversations with the patient. The psychiatrist devotes special focus to those aspects of the patient narrative that strike her as *off-kilter:* that, in the broadest sense, surprise her expectations, whether because they seem to depart sharply from the mental model of the patient she has been developing, because they are self-contradictory, because they make her feel uncomfortable, because they defy social norms, etc. These off-kilter aspects of the patient narrative serve as guideposts for further therapeutic exploration. I imagine that, in many cases, investigating these surprising or seemingly incongruous elements of patient stories will lead us to unexpected conclusions. Rather than attempting to find the prefabricated model of psychological suffering that best fits the patient, therefore, this approach strives to explore each patient's verbal account on its own terms, appreciating it as one might address a unique work of literature.

Of course, we must be sure to give credit to Yalom where it is due. His existential approach to psychotherapy seems to provide a great deal of healing for Marvin and for many other patients, as memorialized in *Love's Executioner*. I do not dare purport that my approach would produce superior results in Marvin's case, nor that it would necessarily change the case's outcome at all. It is my view, however, that Yalom's existential approach to therapy causes him to gloss over a few potentially important themes in Marvin's personal narratives. By settling on an existential interpretation of Marvin's symptoms and dreams so early in their course of therapy, Yalom misses opportunities to consider other meanings behind Marvin's verbal accounts. Here, I would like to follow some of these loose threads that seem to "stick out" of the therapeutic relationship between Dr. Yalom and Marvin.

To begin, let us return to Marvin's evocative dream of the undertakers. As we have shown, Yalom interprets this dream as representing Marvin's use of sex to distract from his fear of death: to prove his vitality, to soothe his own anxiety, or something along these lines. Some of the main elements of the dream are its mood of overwhelming dread; its setting in a dark meadow; a baby in a black carriage, swaddled in black gauze; two gaunt men dressed in black, whom the dreamer suspects are undertakers; and the white-tipped cane that one of the men inserts into the baby's vagina.

I would like first to consider the dream's mood, which Marvin describes as "soaked in fear," pervaded by a "deep sense of foreboding" (ibid., 243). Yalom interprets this ghastly mood as representing Marvin's fear of death, which would seem consistent with the presence of the undertakers and the funereal connotations of a baby swaddled in black gauze. It is possible, however, that the dream's mood of dread could represent something vaguer. Perhaps Marvin suffers from a general sense of anxiety about his current life situation. Or, considering that Marvin's presenting symptoms include anxious feelings about sexual performance, perhaps the dream's mood represents Marvin's dread about sex, which, according to this interpretation, would be allegorized in the dream by the insertion of the cane into the baby's vagina.

In my view, there is another, more plausible interpretation for the dream's macabre mood, which I will discuss below. Before we discuss this alternative possibility, I would like to draw attention to the discrepancy between the dream's fearful mood and the flat tone with which Marvin narrates the dream. Yalom, as a firsthand observer, seems to have trouble reconciling these aspects of Marvin's dream story. As we have discussed above, the psychiatrist conceptualizes this divide by attributing the invention of the dream to a "Dreamer" who is separate from the narrator, Marvin. While this conceptualization proves useful to Yalom, it also obscures the fact that every aspect of

the dream, including its dark characters and aura of doom and grief, belongs to Marvin. In considering this fact, we naturally wonder why Marvin retells this dream in a way that makes him appear "unmoved" (ibid., 242). As I see it, there are two major possibilities. On one hand, Marvin's unemotional tone at the beginning of therapy could be an affectation. In other words, Marvin could be pretending to be unmoved by his troubles as a way of saving face with the therapist or attempting to shore up his wounded self-image. On the other hand, Marvin might seriously lack access to or awareness of his own emotions. This possibility would seem to cohere with a story that Marvin later tells Dr. Yalom about a time that he attempted to grieve the loss of his parents but found himself unable to cry (ibid., 256). In either case, this discrepancy between mood and tone reveals a serious glitch in the way that Marvin relates to himself and the world around him. If I were Marvin's psychotherapist, I would be curious to explore this issue in greater depth.

Now, to bring this reading of the glitch together with our reexamination of Marvin's nightmare, let us consider anew the insertion of the cane in the baby's vagina. As Yalom posits, this aspect of the dream seems to have sexual connotations. We might wonder, however, why a dream that is putatively about sex would involve a baby. Leaving aside the unlikely notion that Marvin is a closeted pedophile, there are several intriguing possibilities. To deepen Yalom's original interpretation, perhaps Marvin feels that he is attempting to "plumb the fountain of youth," as it were, in his sexual endeavors. In other words, perhaps Marvin's recent decision to retire has stirred an overwhelming anxiety about his impending old age and death, of which he has tried to remain in denial through youthful feats of sex, which would be caricatured in the dream by a sex act with a baby.

My strongest suspicion, however, is that the baby and the insertion of the cane represent something that Marvin grieves. Consider again that the baby lies in a black carriage, swaddled in

black gauze, and is attended by two undertakers. In a sense, the dream's basic images suggest the baby's funeral or interment. (Could the "dark meadow" be a cemetery?) Now, in direct conversation with Dr. Yalom, Marvin has already shared that he and Phyllis were unable to conceive a child when they were young. Marvin brushes off his disappointment at this fact, but his dismissal feels transparently disingenuous: "That's past history. I was disappointed then, but that was a long time ago, thirty-five years ago" (ibid., 237). I suspect, therefore, that the dream of the undertakers represents Marvin's anguish and grief that he has never fathered a child. By this interpretation, the ineffective insertion of the cane would represent the couple's inability to reproduce, to create a baby through sex. The dream's mood of fear would express Marvin's horror at the realization that he will never father a child, as he and his wife are now too old. His childlessness is irreversible. Marvin's dream of having a child is dead.

To add evidence for this interpretation, recall that the first break in Marvin's blustery, unemotional narrative tone occurs when he mentions that he does not have any children. "'I have no children' – here his voice turned gray" (ibid.). That this topic of conversation bursts Marvin's emotionally disconnected persona attests, I suspect, to the strength of Marvin's sadness and disappointment at his childlessness. Indeed, as the course of therapy continues, Marvin brings to Dr. Yalom numerous dreams that allude to his unborn children. Consider Marvin's dream about meeting a woman:

> I am at a wedding, and a woman comes up and says she is my long-forgotten daughter. I'm surprised because I didn't know I had a daughter. She's middle-aged and dressed in rich brown colors. We had only a couple hours to talk. I asked her about the conditions of her life, but she couldn't talk about that. I was sorry when she left, but we agreed to correspond (ibid., 249).

Yalom, for his part, interprets this dream as evidence that Marvin has been discovering the "feminine, softer, sensitive side of himself," implying that the daughter in this dream symbolizes a neglected part of Marvin's soul (ibid., 249). In my view, however, this scene plays out in a more literal way Marvin's wish for a child.[7] Notice that the daughter in this dream is "middle-aged," which, perhaps not coincidentally, is approximately the age that Marvin's daughter would be if Marvin and Phyllis's reproductive efforts "thirty-five years ago" had been successful. Because Yalom has already decided to interpret Marvin's dreams through an existential lens, he misses this possibility, reaching for a seemingly deeper insight as he passes over the dream's more straightforward interpretation.

Similarly, consider again the dream of Marvin's running out of time on an examination. "I make an appointment to meet my son after the deadline" (ibid., 258), the dream concludes. In keeping with his hypothesis that Marvin's psychological problems issue from his fear of death, Yalom suggests that Marvin's plan to see his unborn son "after the deadline" reveals a desire to defy his own death, "to spew [himself] into the future past the death line" (ibid.). Again, I wonder whether Marvin simply wishes that he had a son, yet he has missed the "deadline" to produce one with Phyllis.

In considering the theme of childlessness in Yalom's course of therapy with Marvin, I would like to point out the way that I have narrowed in on this theme: by noticing many isolated mentions of unborn children and reproductive failures throughout the course of therapy. Marvin and Dr. Yalom never talk at length about this subject, nor does Yalom spend a great deal of time reflecting

[7] I'm suggesting here that the dream is a "wish-fulfillment dream" in the manner described by Freud, a la *The Interpretation of Dreams.*

on it. As a reader, however, I have seen the idea come up again and again, scattered across many different conversations between the two. In this way, I mean to demonstrate that my approach does not always require the listener to dig for the "deeper meaning" behind a conversation. Sometimes, a psychiatrist's attentive listening may also involve noticing surface-level utterances that come up repeatedly, even if they have not yet opened a longer conversation. "This idea keeps popping up," the attentive psychiatrist might think to herself. This aspect of my approach contrasts with Yalom's existential approach, which prominently involves the psychiatrist's listening for the deep existential concerns underlying the patient's symptomatology.

There is one more theme from this course of therapy that I would be interested to explore: Marvin's need for control and his frustration when he cannot achieve it. In a similar manner as I have just demonstrated, I noticed this theme recurring across many different conversations between Marvin and Dr. Yalom. Recall that Marvin's domineering attitude is one of the first aspects of the patient that Yalom notices and dislikes. As we have seen, Yalom resents Marvin's bullying his way through their first meeting: pointing his finger at the psychiatrist, demeaning his profession, wresting control of the conversation by thrusting a chart into the psychiatrist's hands. The theme of control reemerges towards the end of therapy when Phyllis joins for couple's sessions. Marvin admits to using sex to quell uncomfortable feelings, and, accordingly, to feeling frustrated when Phyllis is not readily compliant with his "need" for sex as a means of anxiety control. Phyllis, on the other hand, admits to strategically denying Marvin sex to wrest control back from him. In this way, Marvin's sexual issues reveal a power struggle between the two. Marvin tries to use Phyllis for anxiety relief via sexual gratification; Phyllis retaliates by withholding sex. Predictably, this power struggle creates a great deal of mutual resentment, which the couple had never explored until meeting jointly with Dr. Yalom.

Reviewing this course of therapy in its totality, I believe that Marvin's resentment towards Phyllis is stronger than Yalom realizes. To show why, let us synthesize a few of the propositions we have made about Marvin's clinical presentation. Recall that Marvin was never able to raise children, in part because Phyllis refused to leave the house for fertility counseling. Further, recall our hypothesis that much of Marvin's suffering issues from his childlessness, or from the realization that he and Phyllis probably will never have children now that they have reached old age. Taking these observations together, we can see how Marvin might feel, as he reflects on his adulthood, that Phyllis has exerted wide-ranging control over his sexual and reproductive faculties, from his ability to have sex when he wants it to his ability to create offspring. For an authoritarian person like Marvin, we might imagine that this sense of being controlled has caused decades of fury.

Indeed, when we look closer at Marvin's course of therapy with Dr. Yalom, we notice that he voices significant frustration with Phyllis across numerous meetings. Yalom generally does an excellent job of directing conversation back to Marvin, challenging him to take responsibility for his feelings and behaviors rather than simply blaming his wife. On one occasion, however, Marvin reveals the frightening intensity of his resentment towards Phyllis. This revelation occurs when Marvin tells Yalom about a recent occurrence in which he and Phyllis were having sex, but Phyllis ruined Marvin's orgasm by blurting out suddenly "There are other reasons to make love than to get rid of tension" (ibid., 246). Yalom, unaware of the ferocity hiding under Marvin's bland exterior, invites him to practice telling Phyllis why he is dissatisfied with the timing of her statement. Marvin responds that he cannot attempt this activity, citing that "I'm afraid of my impulses – my murderous and sexual impulses" (ibid., 247). Perplexed, Yalom asks Marvin what this caveat means. Marvin's response surprises the psychiatrist, as well as perhaps the reader:

> Do you remember, years ago, a news story of a man who killed his wife by pouring acid on her? Horrible thing! yet I've often thought about that crime. I can understand how fury toward a woman could lead to a crime like that (ibid., 247).

Unsure how to respond to this shocking admission, Yalom avoids the topic altogether, opting to change the subject. "Remembering I hadn't wanted to take the lid off such primitive feelings – at least not this early in treatment – I switched from murder to sex" (ibid., 247). For reasons he does not explain, however, Yalom never returns to Marvin's statement or what it might mean. Based on some of the observations I have made above, I would like to offer an interpretation. I posit that Marvin's hidden acrimony towards Phyllis issues from a perception on the patient's part that his wife has total control over his sexual and reproductive faculties, and, by implication, over his mental wellbeing. Of course, Phyllis's control over Marvin would exist largely in the latter's mind, as the former reveals herself in couple's therapy to be a rather timid person. Nonetheless, this interpretation would explain why Marvin's violent rage surfaces in the context of Phyllis's disrupting his orgasm with an unexpected critique: the untimely interruption plays out in miniature the narrative that *Phyllis ruins my sex*. Otherwise, Marvin keeps this bitterness out of conscious awareness, apparently because he feels that it is "disloyal" (ibid., 248).

Marvin's comment about husbands killing their wives with acid seems to blindside Yalom. Beyond the gruesome nature of the comment itself, I suggest that Yalom's surprise also relates to the fact that he has narrowed in sharply on the existential aspects of Marvin's case from the beginning of therapy, leaving out of focus the power dynamics between the patient and his wife. As a result, Yalom perhaps has not considered that Marvin's marital issues have caused so much anguish, so much resentment, so much acidity (pun intended). Whatever the reason, Yalom chooses

at this juncture in therapy to leave "the lid" on Marvin's covert hatred for his wife. Instead of probing these feelings more deeply, Yalom continues his existential tack for several months (ibid., 248-263). When Yalom feels that he has exhausted the usefulness of the existential approach with Marvin, he renews his invitation for Phyllis to join them for couple's counseling (ibid., 260). Thus, Yalom eventually addresses the power struggle between Marvin and Phyllis, if perhaps later in therapy than I might personally have done.

When Yalom finally brings Phyllis and Marvin to hash out their marital issues, he helps them to better meet each other's psychosocial needs by suggesting an idiosyncratic exercise. Dr. Yalom instructs Marvin to call Phyllis from work every two hours during the daytime to repeat the following phrase: "Phyllis, please don't leave the house. I need to know you are there at all times to take care of me and prevent me from being frightened" (ibid., 267). Paradoxically, this exercise proves empowering for both partners. The messages' regular timing and authoritarian nature provide Marvin with a sense of control and predictability. In short, Marvin knows that he will get to boss Phyllis around multiple times per day. For Phyllis, on the other hand, these repetitive messages quickly become irritating. Before long, Phyllis gets tired of hearing Marvin tell her not to leave the house, and she begins, happily, to leave the house to do activities on her own. This change helps her to grow in independence and self-esteem. Marvin, in turn, is forced to find ways to manage his anxiety independently. Soon, his migraines disappear (ibid., 267-269). Thus, I believe that Yalom's success with Marvin and his wife exemplifies the type of psychosocial change that I would hope to foster in my patients.

To conclude this section, I would like to reformulate Marvin's clinical presentation in my own words, so as to demonstrate the insight I have gained using my open-ended, narrative-based interpretive approach to psychotherapy. Marvin's retirement, as we have seen, has stirred not only

his fear of death, but also many his many regrets about the life he has lived. In a particularly distressing turn, he now must confront the fact that he has never had children and now likely never will. He blames his wife, whose agoraphobia stopped her from seeking fertility counseling when the two were young enough to conceive. Marvin's anxiety skyrockets. For many years, he has grown accustomed to using sex with his wife to keep his anxiety under control. Now that he is old, however, his penis does not work as well as it once did, rendering the sexual act more difficult to complete. Compounding Marvin's erectile difficulties are his wife's strategically denying him sex as retaliation for his using her like an anxiety pill ("Perhaps you could say that she's my Valium," ibid., 237), or as a migraine abortive (pun not intended but seemingly relevant). *Vis a vis* Marvin's anxiety about his never having children, his difficulties with sex emphasize his reproductive powerlessness, which conflicts directly with his desire to be always in control. Desperately trying to copulate his way out of his anxiety – and perhaps, somewhere in his unconscious mind, to make a last-ditch effort at fathering a baby – Marvin fails. With no behavioral outlets left for this distress, Marvin unwittingly somatizes his anguish as a migraine headache.[8]

The retelling I have offered here makes use not only of the existential features of Marvin's case, but also of its marital, reproductive, medical, and power-dynamic aspects. In this way, I believe, my approach achieves a conceptual flexibility that Yalom's does not. Rather than committing to a limited collection of possible interpretations for each patient's suffering, e.g., "death, freedom, isolation, and meaning" (May and Yalom 1989), I commit to reconstructing and understanding well the stories that patients share about themselves, much as I would approach a work of literature. As

[8] "Somatization" refers to the expression of psychosocial stress as an apparently physical or medical symptom. This concept has gained increasing recognition in the mainstream of psychiatry over the past several decades; see Lipowski 1988.

with a great book, I leave open the possibility that my patients' stories may fall outside the scope of my personal life experience, pushing me, through curiosity and compassion, to learn more.

Ultimately, my approach to psychiatry seeks to use narrative techniques, such as the ones I have proposed above, to help the patient better flourish in life (cf. Nussbaum 2001). Because "flourishing" may look a little different for each patient, I anticipate that working to help patients attain flourishing will often involve the use of creativity and imagination (cf. Charon and Marcus 2017, 281-283). With respect to Marvin's case, of course, Yalom has already demonstrated considerable creativity in providing the patient and his wife with the paradoxical daily exercises we have discussed above. By comparison with Yalom's approach to psychiatry, however, I believe that the open-ended nature of my narrative approach provides even more room for creativity, making possible a wider range of approaches to patient suffering. I personally would like to help Marvin to introspect on the angst he feels about his childlessness. Why does it bother him so much? In doing so, I would expect to continue the recursive process of narrative exploration, learning more about Marvin by listening to the stories that this topic awakens in him. As well, I might help Marvin explore coping strategies for his anxiety that do not require him to control his wife's behavior. For example, I could have him try different kinds of physical exercises when he feels anxious. In doing so, I may also stimulate Marvin to explore why in the first place he believes that he needs to be in control to feel calm. As well, I might suggest that Marvin and Phyllis seek further couple's counseling; in the meantime, I would consider prescribing Marvin medication for erectile dysfunction. Thus, I acknowledge that each patient's psychiatric needs may differ, and, indeed, may be several, encompassing any of a wide range of potential areas including the psychosocial (e.g., need for belonging in a group), practical (e.g., need for stable housing), medical (e.g., need for antiparkinsonian medication), existential (e.g., need to cope with one's fear of death), and beyond.

In the next section, I will focus specifically on the ways that psychiatrists can use narrative to better understand the psychosocial needs of their patients, and to endow patients with the behavioral capabilities they need to fulfill these psychosocial needs. As we will see, this process requires narrative cooperation between psychiatrist and patient. It requires each party to tell stories, to interpret the other's stories, and to respond critically to one another's interpretations of stories. This multilayered dialectical process (cf. Phelan 2014) allows the psychiatrist, I argue, to gain insight into larger and larger portions of the patient's life, transcending the relatively narrow confines of the therapeutic relationship so as to better understand the patient in her totality.

Part III:

Narrative Co-Construction in *Every Day Gets a Little Closer*

In the previous section, we discussed some of the ways in which a psychiatrist can use interpretive skills to better apprehend the needs of patients. These interpretive skills resemble the mental operations involved in the study of literature: attending to figurative language, listening for motifs, analyzing diction, and so forth. In this section, I will argue that the interpretive processes involved in a physician-patient dialogue go both ways. It is not merely the psychiatrist who interprets the patient, but also the patient who interprets the words and actions of the psychiatrist, and who, in return, may scrutinize and challenge the psychiatrist's interpretations of her.

In a successful therapeutic partnership, I contend, the psychiatrist and patient work gradually towards mutual understanding. To accomplish this end, they must develop a shared repertoire of storytelling elements – characters, images, metaphors, allegories, metonyms, story-worlds – to describe recurring issues in therapy and in the patient's life. By negotiating the meanings of these storytelling elements, the psychiatrist and patient gain insight into the patient's psychosocial needs and determine their relationship to one another. This form of physician-patient cooperation is essential to the approach to psychiatry I am putting forth in this thesis.

We see similar forms of narrative cooperation at work in the memoir *Every Day Gets a Little Closer: A Twice-Told Therapy* (1974), co-written by Dr. Irvin Yalom and his pseudonymous patient "Ginny Elkin." This book features written reflections by both Yalom and Elkin on weekly psychotherapy sessions that the two shared throughout the early 1970s. It follows a serial format,

documenting chronologically the observations journaled by each party in the days following each week's therapy session.[9]

Relevant to my purposes, this memoir reveals many of the ways in which patients are active participants in the interpretive work of psychotherapy. Elkin's written accounts reveal how she interprets the behaviors and utterances of Dr. Yalom in therapy, and how she reflects these interpretations back to Yalom to gauge his reactions. As well, Elkin's sections of the memoir show how she critically appraises the interpretations that Dr. Yalom provides for her own utterances and behaviors, either accepting, rejecting, or modifying them as she finds appropriate. Thus, rather than Yalom controlling the therapeutic dialogue, Elkin influences how Yalom understands her and their shared therapeutic relationship. These efforts towards mutual understanding between Elkin and Yalom, in turn, deepen each party's self-understanding (cf. Charon and Marcus 2017). On my account, therefore, therapy is a bidirectional process.

To begin this section, I will provide a brief synopsis of the book, helping the reader to understand the relationship between Yalom and Elkin and the trajectory of their course of therapy. Then, I will narrow in on a few key interactions between Yalom and Elkin that demonstrate the dynamic, two-way nature of interpretation in a successful relationship between psychiatrist and patient. These bidirectional acts of interpretation help Yalom to guide Elkin towards behaviors that better address her psychosocial needs.

Yalom and Elkin first meet in the late 1960s when Elkin participates in one of Yalom's therapy groups at Stanford University. Elkin is an aspiring writer in her mid-twenties who has moved to California from the East Coast to enroll in a creative writing program. Though talented,

[9] The book's editor is professor of literature (and wife of the author) Marilyn Yalom. In her Editor's Foreword, Prof. Yalom describes the book as "a piece of literature… with two distinct characters and two recognizable literary styles, not unlike an epistolary novel" (Yalom and Elkin 1974, x).

she has seemingly struggled with the daily challenges of adulthood. She often finds herself unable to write due to self-doubt and paralyzing bouts of anxiety. To feed and shelter herself, she shuffles between disagreeable temp jobs and unemployment checks. Mired in shame, guilt, and self-effacement, she occupies timid and dependent roles in her personal relationships, unable to express her anger or even her displeasure with others. She cannot figure out how to enjoy sex with her emotionally distant boyfriend Karl.

Yalom, on the other hand, is a married man in his late thirties. A mid-career psychiatrist at a prestigious academic hospital, he seeks intellectual stimulation and personal renown through academic pursuits, in addition to enjoying the daily challenges of psychotherapy. Privately, Yalom wishes that he had become a writer instead of a physician, yet he does not seriously consider abandoning his medical career. Upon learning in group therapy that Elkin is a skilled creative writer suffering from "writer's block," Yalom offers to meet with her one-on-one, with the stipulation that Elkin provide written reflections on their weekly sessions in lieu of a fee. Although he does not tell Elkin until later in therapy, Yalom hopes covertly to help the patient develop into a successful writer, expressing vicariously his own desire to write.

When the two begin their course of therapy, Yalom regards Elkin as troubled, in need of urgent help. He feels daunted by the challenges that therapy with her will present:

> She has no sense of herself… She does not recognize or express her anger… She is consumed with self-contempt. A small voice inside endlessly taunts her. Should she forget herself for a moment and engage life spontaneously, the pleasure-stripping voice brings her back sharply to her casket of self-consciousness… I felt considerable alarm about Ginny. Despite many strengths – a soft charm, deep sensitivity, wit, a highly developed comic sense, a remarkable gift for verbal imagery – I found pathology wherever I turned… most clinicians

would affix to her a label of 'schizoid' or, perhaps, 'borderline.' I knew… that therapy would be long and chancy (Yalom and Elkin 1974, xii – xiv).

Elkin, by contrast, views Dr. Yalom warmly. She appreciates his wisdom, openness, and amiability. Nonetheless, she awaits therapy anxiously, as she feels that this activity will expose as merely illusory the few small successes she has achieved in her young life:

> … with him… I could talk straight; I could cry, I could ask for help and not be ashamed… All his questions seemed to penetrate past the mush of my brain. Coming into his room I seemed to have license to be myself. I trusted Dr. Yalom… [Although] I had replaced acting with tennis, looking for someone with being with someone, experiencing loneliness with trying to recall it… I had a feeling that I had skipped out on my problems and that they would all be waiting for me at the ambush of night (ibid., xxiii – xxiv).

At the outset of therapy, the reflections of Yalom and Elkin read nearly as separate monologues, as streams of consciousness with little overlap in content. They feature a great deal of internal chatter. Take, for example, Yalom's reflection on the third session (10/21/70), in which he worries about the purity of his motives as a therapist.

> It's almost as though I am performing in front of an audience. The audience that will receive this. No, I guess that isn't completely true – now I'm doing the very thing I accuse Ginny of doing, which is to negate the positive aspects of myself. I was being good for Ginny today. I worked hard and I helped her get at some things, although I wonder if I wasn't just trying to impress her, trying to make her fall in love with me. Good Lord! Will I never be free of that?

> No it's still there, I have to keep an eye on it… What do I want her to love me for? It's not sexual… Is it that I want to be known by Ginny as the person who cultivated her talent?... At one point I caught myself hoping that she would notice that some of the books in my bookcases were nonpsychiatric ones, O'Neill plays, Dostoevsky. Christ, what a cross to bear!... Here I am trying to help Ginny with survival problems and I'm still burdened down with my own petty vanities" (ibid., 11).

Similarly, Elkin's reflection on the first visit (10/9/70) reads as a mental inventory of her personal shortcomings.

> I have a long history of not answering or taking questions seriously. I never use my mind or cast it out further than the present, except when I use it to fantasize. I don't let it change or shape reality, just comment on its passing… Yesterday, like almost always, I was so self-conscious, glued to my surface, superficial structure of what I must say, what I must be. Reciting into a mirror. One mirror that wouldn't be bad luck if it were broken. But those aren't fighting words. Just more yap (ibid., 5-6).

As the two continue weekly meetings, they each begin attempting to understand the other and the nature of the relationship they share. In these attempts, the reader appreciates the use of figurative language drawing from the mainstream American cultural repertoire. For example, Elkin asks Dr. Yalom in apostrophe whether he sees her as a magazine in a doctor's office, as, the trope goes, a trite and banal way to pass time (10/21/70, reflection written in mid-November):

> I was looking at your way of treating me, like an adult. I wonder if you think I am pathetic or, if not, a hypocrite, or just an old magazine that you read in a doctor's office… You still seem to think that you can ask me questions that I will answer helpfully or with insight (ibid., 14).

This passage reveals much about how Elkin views herself, as well as about how she strives to understand her relationship to Dr. Yalom. By portraying their therapeutic situation in this way, Elkin engages in a form of perspective-taking, casting Yalom as a patient waiting to see the doctor rather than as the doctor himself. This analogy would seem to humanize Yalom, lowering him from the mythic heights of "doctor" to Elkin's level as a patient, as a fallible participant in life. When reconsidering their relationship in this way, however, Elkin still seems to think herself unworthy of Yalom's attention, describing herself as "pathetic" or infantile. Indeed, by objectifying herself as a "magazine" rather than as a person, the patient seems to deny her own vital power, representing herself as passive, as inert, as something that Dr. Yalom can pick up and put down at will. Elkin appears to believe that she, like an "old magazine," cannot truly dialogue with the psychiatrist, but is doomed eternally to repeat to him the same empty phrases. Dr. Yalom, on the other hand, occupies in Elkin's imaginative description a mildly interested but ultimately detached role. He serves merely as an onlooker to Elkin's tired old ways. Thus, Elkin's figurative language in this passage suggests that she lacks belief in her ability to change. It also suggests that she doubts Yalom really cares about her.

Yalom recognizes these feelings of futility in Ginny. In his own attempts to understand the patient, he personifies Ginny's sense of ineffectuality as a an "imp." As he writes on the session of November 12, 1970, "I then went on to talk with her about the little imp inside that strips all pleasure from every one of her endeavors, stops her from enjoying sex, enjoying her trip to Europe"

(ibid., 20). This personification conjures a hellish image akin to the demonic persecutors of Dante's *Inferno*. The reader imagines Ginny as a tortured soul, her joy siphoned away by a malicious devil that follows closely at her heels. Yalom's description here matches with Ginny's concept of herself as passive sufferer, though it imbues her with a larger measure of agency than the foregoing "magazine" analogy would imply. Perhaps, the reader imagines, Ginny may one day dispatch the imp. Based on the figurative language used by physician and patient, therefore, it seems that both parties recognize Elkin's sense of passivity, though the two may disagree about the possibility of her gaining more agency in the future.

As Elkin and Yalom continue to meet, their weekly reflections begin to coalesce around common themes, and, as they do, the reader senses that the two are synchronizing in some important way. Their conversations settle on a limited number of perceived issues in Ginny's life, including her rocky relationship with Karl, her emotional dependence, her childlike demeanor, her difficulties in expressing anger, her self-defeating attitude, her sexual foibles, her fear of abandonment, her unrealized potential in life, and her love of creative expression, as well as her relationship to Dr. Yalom.

In a few key moments, these issues collide with powerful imagery and figurative language. During their meeting on 11/19/70, for example, Yalom sternly reproaches Elkin for neglecting to write an entry on their previous therapy session, per their original agreement. This conflict leads to a broader conversation about Elkin's difficulties in approaching relationships with other adults as if she were a coequal partner, worthy of the same level of respect and responsibility that she attributes to them. Elkin, in reflecting on the fact that she has ignored her write-up, expounds her belief that she is hopelessly immature:

> … I saw that I was bundled up inside this wrapping, these leggings, this smile of a little girl. I think it's always when I feel this presence inside me that I start to cry. I feel like I have to drag this pitiful, but real, kid around in me. And the most important question was when you asked me, 'Do you think of yourself as a woman?' I knew, 'No, no.'… The landlady and I in our fights are not two women. It's a crank and a little girl who has done something wrong and wants to get on the good side of life… I just want to be bundled up and rocked by you (ibid., 24).

Here, Elkin describes herself as a "little girl," and, as the entry continues, she conjures an even more dramatic sense of regression by portraying herself as an infant who needs to be "bundled up and rocked." Perhaps, the reader reasons, Elkin habitually copes with adversity by reverting to a state of dependence, by begging others to care for her. These metaphors communicate that Elkin does not believe that she is mature enough for the challenges of therapy. Given that Elkin is in fact an independent young adult, however, we sense a tendency towards self-defeat, towards quitting before the game has even begun, as it were. In this way, Elkin's self-description as a "child" serves as a cop-out. Rather than owning up to her mistake or renegotiating the terms of the agreement, the patient seeks for the therapist to soothe her discomfort, to envelop her with the unconditional embrace of a parent.

Yalom seems to register the evasive and self-defeating nature of Elkin's insistence that she is best represented as a child. Indeed, he explicitly rejects this metaphor, insisting that Elkin is an adult and should behave like one:

> Only later in the interview was she able to talk about wanting to appear a woman in front of me (as she sat there like a child), that she wanted to appear attractive to me… I made it clear

> that although she says she wants to please me, she deliberately did something designed to displease me, i.e., not bringing in the written material… I also decided to help her test reality by pointing out that writing a summary of the previous interview is not optional – that's part of an adult (though I didn't use this word) contract she has made. What was unstated was the implicit threat, which I am perfectly serious about, that I will not see her without keeping this part of the contract. She seemed a bit subdued by this, said she felt like a young student in front of a teacher (22-23).

In these passages, we view Dr. Yalom and Ginny wrangling over the metaphor that the latter is a child, with the patient clinging to it and the physician denying it. This conflict has consequences for their therapeutic partnership. From a transactional standpoint, the two have agreed to work together on the premise that Yalom will provide Elkin with therapy if the latter provides the former with written reflections on therapy sessions. Elkin, however, attempts to wiggle out of this agreement by depicting herself as tiny and helpless. In order to maintain the integrity of their clinical relationship, Yalom must clearly disapprove of this self-portrayal on Elkin's part, combating it with reaffirmation that Elkin is, in fact, a capable adult.

Further, when Yalom prompts Elkin to juxtapose her description of herself as a child with the outward reality that she is a talented and attractive young woman, the psychiatrist and patient begin to explore some of the awkward social ambiguities of their relationship. Which of the archetypal roles of mainstream American culture will their relationship fit? Should the two relate to one another simply as doctor and patient? Or also as parent and child? As a teacher and his pupil? As two sexually potent adults? As friends? As transactors in the marketplace or litigants over a contract? Throughout the course of therapy, Yalom and Elkin negotiate the open-ended nature of their relationship, with Elkin addressing Yalom at turns as "doctor," "Papa Yalom" (ibid., 153), or

simply "you" (e.g., ibid. 79), and Yalom addressing Elkin primarily as "Ginny." While the two remain in a fundamentally unbalanced relationship, occupying the roles of doctor and patient, their relationship becomes increasingly complex and egalitarian as they "try on" aspects of these alternative roles over the course of several years. Thus, their dialogue about Elkin's figurative description of herself as a child serves as a venue for the pair to begin negotiating how they will interact with one another as partners in therapy.

As well, this dialogue provides an opportunity for Yalom to pursue therapeutic ends with Ginny. When Ginny describes herself to Yalom as infantile, she forces Yalom, in effect, to choose whether he will endorse or dismiss this description. In roundly rejecting Ginny's metaphor, Yalom achieves several ends. First, he affirms an obvious truth: that Ginny is an intelligent adult who can regulate her own behavior and keep promises. This affirmation, though it seems to deflate Ginny in the moment, provides her with needed encouragement and validation. Indeed, by standing firm on the pair's initial agreement, Yalom lends credence to his claims that he believes Ginny to be capable of withstanding the hard truths and boundaries of a mature partnership. The psychiatrist also supports the patient in persevering through a task she has set out for herself, namely, therapy, even though she evidently feels anxious, tense, and powerless. In this way, Yalom helps Ginny to practice moving forwards in her endeavors despite self-doubt.

A related piece of figurative language about which Yalom and Elkin discourse is the latter's recurring claim that she is a "lump." Elkin introduces this metaphor on February 24, 1971, following a night in which she had lain awake with anxiety because her boyfriend Karl had called her "a sexual lump" due to her failing to respond to his sexual advances (ibid., 55). Rather than repudiate Karl's name-calling, Elkin resigns herself to the notion that Karl must be correct, that she must truly be a "lump." Indeed, the metaphor of "lump" resonates with Ginny beyond the sexual context in which

it originated: Ginny accepts "lump" as an accurate characterization of her personhood in general. In Ginny's mind, "lump" seems to succinctly describe the ways in which she habitually fails to respond to provocation, whether positive (e.g., partner's invitation to have sex) or negative (e.g., partner's insults). In a profound way, the "lump" metaphor seems to represent for Ginny her own tendency towards inaction, towards responding to conflict by doing nothing. "Sometimes," she remarks during this session, "I feel desperate and tired. But I never really catch what has been biting and gnawing at the line. I just get calm again and it is gone, the terrifying feelings, the helplessness" (ibid., 57). As such, Ginny wholeheartedly accepts the notion that she is a "lump," believing that it captures her longstanding propensity not to act when she is in distress, even if action would ameliorate her distress.

Yalom, on the other hand, does not agree that Ginny is a lump:

> It seems that she had, earlier in the evening, perhaps unwittingly rejected his advances, and thus felt responsible for his reaction, and, in fact, totally accepted his definition of her as a lump. She began feeling like a lump in all aspects of her being despite the fact that Ginny is anything but a lump… Indeed, earlier that day she had gotten dressed in some outlandish spoof costume just to amuse Karl and later had gotten into a long giggling spree in a German class they had attended together. All this stands out in marked contrast to seeing herself as a lump. All I could do at this point was to question her willingness to accept another person's definition of her (ibid., 55).

In this passage, Yalom expresses private exasperation that Ginny does not stand up for herself when Karl insults her. Noting Ginny's passive acceptance of Karl's slights, Yalom recalls his earlier observation that Ginny struggles to express disagreement with others. Having identified this

area for improvement, Yalom spends the remainder of the session coaching the patient to communicate her ostensible disappointment with Karl. He asks Ginny to pretend that he is Karl, inviting her to say to him whatever she wishes to tell Karl about the way he has treated her. Ginny, however, is unable to defend herself against Karl's rude accusations, even in simulation. "… there was no way," Yalom remarks, "in which I could help her overtly experience any of her anger toward Karl, even in play acting… we had gotten into a really crucial area for her – one which we'll have to work on for a long period of time: her inability to express any anger… to assert herself and demand her rights…" (ibid., 56). For the remainder of their course of therapy, Yalom devotes a great deal of effort to showing Ginny how she can tell others when she feels angry or violated. Thus, by applying his interpretive powers to Ginny's acceptance of the metaphor that she is a "lump," Yalom identifies the patient's need for practice in asserting herself.

In the following months, Yalom helps Ginny practice expressing her anger by deliberately irritating her in small ways and providing a safe environment to vent her ensuing frustration (ibid., 229). For example, Yalom arrives to therapy ten minutes late and watches to see whether Ginny will rebuke him for it (ibid., 68). These covert exercises allow Ginny to become more comfortable acting out her anger rather than suppressing it. This skill, in turn, helps Ginny to assert needs and boundaries for herself.

When the metaphor of "lump" resurfaces in later therapy sessions, Ginny regards it with increasing scrutiny, demonstrating that therapy with Dr. Yalom has helped her learn to defend herself. For instance, in May 1971, Yalom decides to share with Ginny some of his written reflections on therapy, i.e., those eventually published in the book. The patient takes exception when she reads that Dr. Yalom often has felt dispirited by her self-defeating tendencies. On June 2, 1971, Elkin writes of Dr. Yalom's journal entries:

> The part that made me cringe and which I remember just now is when you talked about my self-pitying cycle and getting sucked into it. That's seeing me as a lump. The writings are horribly incriminating of me. I don't believe I am totally the way I am described by myself or you (ibid., 85-86).

Here, several months later, Ginny fights back against the notion that she is a "lump," rejecting for the first time this way of characterizing her. Thus, she has sensed a tacit endorsement of Karl's "lump" accusation in Yalom's descriptions of her. Rather than accept this metaphor, Ginny now challenges it, explicitly reversing her earlier view. Her change in perspective on this metaphor shows growth in her ability to defend herself. In refuting the metaphor, she clearly communicates a sense of betrayal, a sense that Yalom has let her down by thinking of her in such poor terms.

Despite these successes in therapy, Ginny continues to struggle for many months to express anger and disappointment with Karl. On June 15, 1971, Ginny begins therapy in a sullen mood because Karl once again has berated her as a "lump." As Yalom reflects on this session,

> It all began when she walked into my office crest-fallen and depressed saying, "We had another 'lump' talk last night."… The gist of this talk was that Karl had relentlessly criticized her because of her many failures… he was asking for some interaction with her, some spontaneity… She couldn't respond to him or responded as though she were someone else sans emotions. It was a total nightmare, she just waited until it was over so that she could be mercifully relieved of everything (ibid., 89).

In response to Karl's criticism, Ginny simply shuts down, allowing her boyfriend's frustrated outburst to go unaddressed. The progress she has made in therapy evidently has not yet generalized to other relationships. Indeed, rather than rebuking Karl for using the "lump" moniker, as she has just done with Dr. Yalom, Ginny reverts to childlike withdrawal: ".. she suddenly burst out crying and expressed the wish that she were a five-year-old child again, where she wouldn't have to worry about doing anything for anybody" (ibid., 91). Over the next year, Ginny continues to suffer in her relationship with Karl and begins to fantasize that he will leave her (ibid., 113). In therapy, however, she continues to make gradual progress in the realm of self-assertion. For the first time, she asks Dr. Yalom if she can reschedule a therapy appointment (ibid., 104). She expresses disappointment with Yalom when the psychiatrist judges her friend harshly for smoking marijuana (ibid., 139).

Recognizing, however, that Ginny will need more direct intervention if she is to apply her newfound assertive skills to relationships outside of therapy, Yalom welcomes Karl to their weekly sessions. Throughout May and June 1972, the three meet on several occasions for couple's counseling. In these sessions, Yalom coaches Ginny to communicate her anger and frustration to Karl. To the physician's surprise, Karl receives these exercises well, expressing relief that Ginny has finally offered her true feelings on their relationship (ibid., 188-189). In the months following these couple's counseling sessions, Ginny reports that she and Karl have begun speaking more openly about their strengths and rifts as a couple. As they do, the two slowly realize that they cannot find a way to both be happy in the relationship, that they are not compatible partners. They eventually break up (ibid. 237). Many months later, Ginny writes a letter to Dr. Yalom sharing that she has become happier without Karl, and that she has begun cultivating several close friendships in which she feels comfortable expressing disagreement (ibid., 243).

In the spring of 1974, after their final therapy session together, both Yalom and Elkin reflect on the trajectory of their relationship. Their remarks indicate that both parties harbor complex feelings about one another, but that they ultimately consider their relationship one of warmth and friendship. Yalom reminisces:

> And then she left the office, not a borderline character disorder, an inadequate personality, an obsessional psychoneurotic, a latent schizophrenic, or any of the other atrocities that we perpetrate daily. She left as Ginny and I will miss her (207).

Elkin, in slight contrast, seems to leave therapy with a sense of unrealized potential, a sense that the two have not quite seen eye to eye, yet nonetheless with a sense of fellowship:

> Our problem together is still defining what is real. So much of what you do and I say in session, I frown at in retrospect… At least you are my friend, and I envision the day when I can pound on your door (209).

Having outlined the course of therapy memorialized in *Every Day Gets a Little Closer*, I would like to expand on a few important narrative phenomena that I have noticed in the interplay between Yalom and Elkin, but that the psychiatrist does not explicitly address in his reflections. Namely, I want to discuss the way that the figures of speech shared between psychiatrist and patient – such as Ginny's self-descriptions as a "lump" or Yalom's personification of Ginny's depressive tendencies as a malicious "imp" – often serve as proxies or metonyms for collections of related narratives about the patient's life. Put differently, I suggest that these instances of figurative speech allow the patient and psychiatrist to conveniently "bundle" many thematically related stories about the patient's life.

By bundling these stories, participants in therapy may succinctly refer to a repeated pattern of thought or behavior on the patient's part. By giving a meaningful, original name to a pattern of thought that causes the patient suffering, physician and patient can, in turn, critically examine and potentially modify this pattern (cf. Hollon and Beck 2013).

To show what I mean, let us return to the passage above in which Elkin portrays herself as a child: "I saw that I was bundled up inside this wrapping, these leggings, this smile of a little girl…I feel like I have to drag this pitiful, but real, kid around in me" (ibid., 24). Elkin's figurative self-description as "child" unites several related stories about her life that she has told to Dr. Yalom. For example, Elkin alludes in the same passage to several episodes in which she has capitulated to many of her landlady's unreasonable demands, characterizing their interaction not as that of "two women," but as that of "a crank and a little girl who has done something wrong and needs to get on the good side of life" (ibid., 24). Elkin's developmental reasons for deferring to the landlady become clearer as the course of therapy continues and the patient shares with Yalom many stories about her mother, who is overbearing and difficult to please, and who has fostered a sense of inferiority in the patient since early childhood. As Elkin has reached adulthood, moreover, her mother has frequently voiced her disappointment that the patient has not achieved any of the things that she considers markers of adulthood, such as having a marriage or a steady career (e.g., ibid., 155). Elkin's feeling of perpetual immaturity is most literally represented by a story she tells about her first job following college graduation:

> After I graduated from college, I returned to New York. I couldn't find a job, in fact had no direction. My qualifications dripped like Dali's watch, as I was tempted toward everything and nothing. By chance, I got a job teaching small children. Actually none of the children

> (and there were only about eight) were pupils; they were kindred spirits and what we did was play for a year (ibid., xix).

Thus, the metaphor that Elkin is a child represents a variety of different experiences that underlie the patient's feeling that she has not achieved adulthood. At a level of abstraction higher than that of individual stories but lower than that of a figure of speech, we might hear in Ginny's reflections a general narrative that follows the form of *Though I have tried for several years, I cannot seem to figure out how to grow up. I remain clueless and dependent like a small child.* This narrative runs frequently in Ginny's mind, connecting many different facets of her life, contributing to her tendency towards self-defeat.

In a similar way, the metaphor that Ginny is a "lump" can be expanded into a general narrative form that goes as follows: *When people try to interact with me on an intimate level, I simply do nothing. I play possum. I do not engage.* This general narrative form unites many individual stories that Ginny tells about herself, including her time spent in college lying around in the grass rather than making friends ("I liked nothing better than to be a human sundial," ibid., xix), her non-response to Karl's sexual advances, her failure to respond to invitations to submit writing samples, her lack of engagement with group therapy, her reluctance to reply honestly to Yalom's interview questions, and so forth. These experiences have seemed to condition Ginny to expect that she will not respond if someone else attempts to engage with her. This expectation takes cognitive form as a set of core narratives about her personal tendency towards inaction, which Ginny uses as both an explanation of past behaviors and as a guide to future behaviors. In this way, her personal narratives about failing to respond to intimacy, as represented by the metaphor "lump," create a self-fulfilling prophecy. When Ginny fulfills this prophecy, reciprocally, she adds more evidence for the

prophecy's truth, further strengthening her belief that she is a lump. Thus, her figurative description of herself as a "lump," her repeated narrative descriptions of her behavior as lumplike, and her *actual* lumplike behavior form a self-reinforcing cycle.[10]

Yalom, however, knows that the stories we tell about ourselves can change. To help Ginny change these maladaptive descriptions of herself, he first counters them by returning to the patient stories she has told him that, whether she realizes it or not, demonstrate her exhibiting non-lumplike behavior. For example, Yalom reminds Ginny of the way she has dressed up in a silly costume and pranced around the house to entertain Karl, which works to great effect (ibid., 55). Then, as we have seen, Yalom embarks on a years-long effort to provoke Ginny into acting in ways that are not lumplike, e.g., needling her into anger by showing up late to therapy sessions, gently teasing her with the term "cyclotherapy," (ibid., 164), baiting her into criticizing Karl, and challenging her to give Karl the ultimatum that he gets serious about their relationship or else she will terminate it (ibid., 90). In this way, Yalom helps Ginny to break the cycle of thinking and acting like a lump. In a more

[10] There are many hypotheses about the evolutionary origins of the nervous system in animals, but one prominent hypothesis holds that the cells composing the nervous system (neurons, i.e., brain cells) emerged in invertebrates from electricity-conducting muscle cells that served to coordinate muscular contraction across many disparate parts of a body (Pasano 1963, Westfall 1973). In other words, this hypothesis considers neurons to be evolutionary descendants of action-oriented muscle cells whose function was to coordinate complex behaviors. Extending this hypothesis to human behavior, we might think of the brain as a "master system" for directing action via muscles. If this concept is accurate, then the stories we tell about ourselves habitually may not be mere abstract entities, mere words floating on a page in our mind, but verbal expressions that are inextricably tied at the neurobiological level to our behaviors. We see a parallel to this line of thinking in Aristotle's *Nicomachean Ethics*, which discusses, among other things, the way that a person's overall character arises from his or her habits of thought and action (see also Bernacer and Murillo 2014). "Excellences," Aristotle posits, "we get by first exercising them" (in Ackrill 1988, 376). Indeed, Aristotle explores the biological and phenomenological underpinnings of this observation in his *Parts of Animals* and *Movements of Animals* lectures (in Ackrill 1988, 220-240). "For sense-perceptions are at once a kind of alteration, and *phantasia* and thinking have the power of the actual things. For it turns out that the form conceived of the pleasant or fearful is like the actual thing itself. That is why we shudder and are frightened just thinking of something… That is why it is pretty much at the same time that the creature thinks it should move forward and moves, unless something else impedes it" (ibid., 235-236). Thus, we might conceive of personal narratives not merely as representations of action, but as *primers* for action, as "pre-actions."

general sense, he stimulates her to form new patterns of thought and action, to rewrite old life narratives hidden under the moniker of "lump" that are impeding her personal growth.[11]

Yalom's approach with Ginny provides a blueprint for my narrative-based therapeutic strategy. This strategy begins by recognizing that the figures of speech that people use to describe themselves, such as "lump" or "child," often have latent within them a collection of life stories that share a common theme. By unpacking the stories that underlie these figures of speech, the therapist can learn about the patient's repeated patterns of thought and action. Some of these patterns of action may be healthy and adaptive, e.g., exercising every morning. Other patterns may impede the individual's fulfilling her needs. In Ginny's case, for example, the metaphor "lump" describes her longtime pattern of not responding when others invite emotional intimacy; this pattern impedes her ability to fulfill her needs for acceptance and belonging. When the therapist identifies these maladaptive patterns, she can help the patient to change them by suggesting new behaviors, by providing safe opportunities for the patient to practice these new behaviors, and by helping the patient to view with skepticism the metaphors and stories attendant to old ways of thinking and acting.

Viewed in this way, I suggest that an important role of the psychiatrist is to recognize the figures of speech – the analogies, metaphors, hyperboles, personifications, and so forth – that the patient uses to describe her personhood and her behaviors, and to find the old stories hidden within these figures of speech. We can represent this process of narrative uncovering with a schematic diagram (*Figure 2*).

[11] Later in therapy, Ginny worries about a "lump" on her face that she believes is cancerous (Yalom and Elkin 1989, 160). Does this phenomenon represent her learning to see the metaphor of "lump" as foreign and harmful?

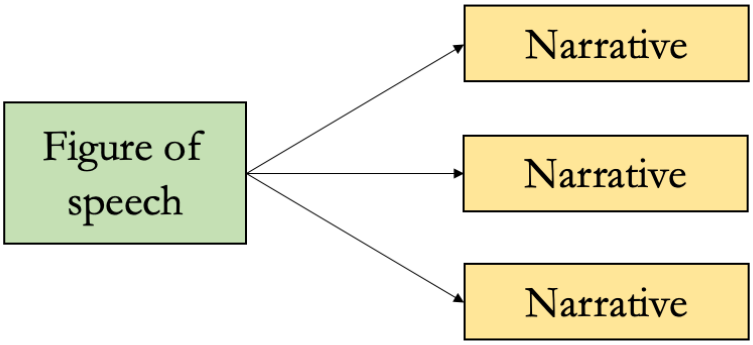

Figure 2: Exploring the life stories underlying a patient's figurative self-description.

As we have shown above, the stories underlying a patient's figurative self-description (e.g., "I'm Old Faithful") can occupy a range of levels of abstraction, from the most concrete ("My brother asked me to buy him garlic, so I went to the store and bought him a bag of garlic") to the most general ("When someone gives me a job, I do the job right, and I do it in a timely manner").[12] Thus, therapy can be viewed as a process of unpacking pithy self-descriptions into stories, and repackaging stories into new figures of speech, as it were. Rather than simply packing and unpacking, however, I posit that successful therapeutic interventions involve the psychiatrist's helping the patient sort through her life narratives once they are unpacked, allowing her to critique the harmful ones and preserve the healthy ones. Further, a successful approach involves helping the patient to write new life narratives in support of her psychosocial growth. Over time, the psychiatrist

[12] In our shared lexica, there are many such figures of speech that "stand in" for archetypal narrative forms. In American popular culture, for example, we use the phrase "jumped the shark" to mean that a once-great institution has entered a period of decline, and, in an attempt to restore itself to its former glory, has promoted a dubious stunt; this stunt, rather than reviving the institution, serves in the public eye only as further confirmation that the institution is no "longer what it used to be." (For those who are not familiar with the phrase's origin, it comes from public reaction to an episode of the sitcom *Happy Days,* which was widely popular in the mid-1970s. When the show's ratings began to decline in the late '70s, writers attempted to revive the show's cultural currency by having fan-favorite character Fonzie jump over a shark while riding water-skis. Rather than restore the show's popularity, however, this stunt served to confirm that the show's golden era was "officially" over.)

helps the patient to integrate healthier life narratives into new behaviors and figurative descriptions of herself (*Figure 3*).

In *Every Day Gets a Little Closer,* for example, Yalom helps Ginny to unpack the life stories behind the harmful metaphor that she is a "lump," examining the narratives that have contributed to her endorsement of this sobriquet, such as those describing times she has failed to respond to Karl's sexual advances. Yalom counters these narratives by returning Ginny stories she has told him about non-lumplike things she has done, such as convincing Karl to enroll in a German language class with her. As well, the psychiatrist intentionally provokes Ginny into anger, stimulating her to become outwardly upset with him.

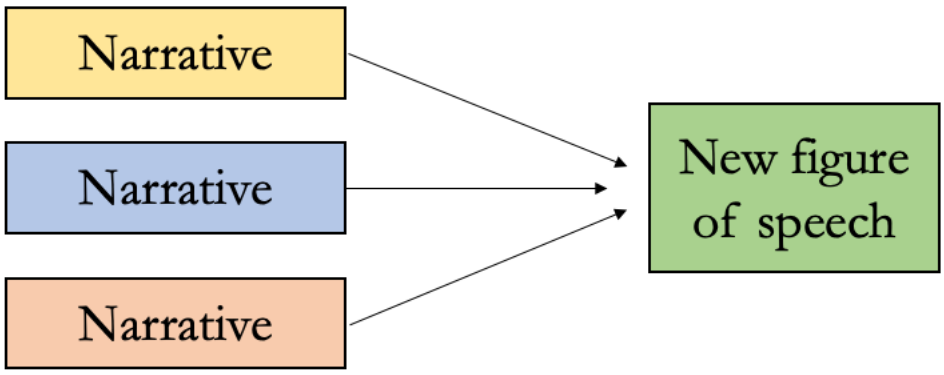

Figure 3: Repackaging healthy life narratives into a new self-description.

To give figurative expression to Ginny's newfound ability to get angry, Yalom creates an imaginary character, "Angry Ginny." He consolidates into this character several new stories about instances in which Ginny has stood up to the psychiatrist, in which she has voiced her dissatisfaction with Yalom's behavior. For example, Angry Ginny makes an appearance when the eponymous patient becomes upset that Dr. Yalom has rescheduled therapy at the last minute: "The most striking

part of the session was… when Ginny hurled two tiny Ginny bolts at me. First she said it seemed over the phone… that I hadn't really wanted to see her this week. Then she added that she was a little ambivalent about coming today since she could have gone to the races instead and this is the last day of the season" (ibid., 87). In a similar manner, Yalom catalogues the gradual emergence of the patient's fury as the "Ginny get angry series" (ibid., 89).

It is worth noting the dramatic contrast between Angry Ginny and Yalom's earlier description of Ginny as a "tortured soul," an eternal sufferer bedeviled by the "imp" of self-reproach. Rather than slowly succumbing the torments of hell, Angry Ginny is a powerful goddess, hurling thunderbolts like the Zeus of Ancient Greek myth. Thus, Yalom builds a case for an empowered Ginny, cataloguing her successes under the figurative heading of this new character. Angry Ginny represents both the progress that Ginny has made in asserting herself and the confident, agentic person that Yalom hopes for her to fully embody in the future.

To summarize, my strategy, as exemplified in large part by Yalom's course of therapy with Ginny, involves (1) identifying figurative language in the patient's verbal account; (2) uncovering life narratives latent within the patient's figurative descriptions of herself; (3) critically examining these life narratives in cooperation with the patient; (4) helping the patient to challenge unhealthy life narratives, to nurture healthy ones, and to invent new narratives that encourage growth; (5) helping the patient to repackage these healthier narratives into more uplifting, life-sustaining descriptions of herself; (6) stimulating the patient to act in ways that interrupt the harmful behavior patterns represented by old life narratives; and (7) giving the patient opportunities to practice patterns of behavior that match with her newer, healthier life narratives. As we have seen, this process does not issue solely from the psychiatrist. Rather, it is bidirectional. Indeed, in determining which life narratives are "healthy" or "unhealthy" in the first place, the psychiatrist will need to understand the

specific causes of the patient's suffering, as well as her goals for therapy. From start to finish, this process requires cooperation between psychiatrist and patient, a shared effort towards understanding the patient's inner states and outward behaviors.[13]

In many cases, as with Yalom and Elkin, I imagine that this shared understanding will emerge with a certain degree of spontaneity. When two people know each other for long enough, after all, they naturally develop a mutual understanding, as encoded in part by a shared repertoire of stories. These stories encompass both experiences that the two parties have shared together and experiences that they have had individually, but whose accompanying stories have been told enough times to produce a shared familiarity (e.g., *Tell these guys about the time you ran from the cops*). Sometimes, two friends tell a story so many times that they invent a verbal shorthand for it (e.g., *Tell the poop story*). In some cases, two people with deep mutual familiarity begin to see patterns in one another's stories and bundle similar stories together into a single description (e.g., *That's just Sarah being a mensch again*, or *There's my dad acting like a housecat*). In this way, many stories can be condensed into a single pithy description; these kinds of pithy descriptions, once formed, may be expanded back out into their constituent stories, as when, for example, an unfamiliar party joins the conversation (e.g., *Oh, you've never met Sarah? She's a mensch, I tell ya! This one time, we were driving to Florida*…). All these narrative phenomena obtain in the relationship between psychiatrist and patient, as we have observed well in the partnership between Yalom and Elkin.

[13] This need for cooperation becomes clearer, I would like to point out, when we remember the distinct epistemic situations of psychiatrist and patient. The patient knows herself better than anyone else. Indeed, she is the only person in the world who knows her own thoughts. Yet she seeks therapy because she is lacking some important higher-level perspective. The psychiatrist, on the other hand, is an expert at providing higher-level perspective, yet begins therapy as a stranger to the patient and can never really know the patient's thoughts. Thus, psychiatrist and patient each are epistemically limited, yet they are limited in a complementary way. Hence the back-and-forth process by which the psychiatrist offers an interpretation of the patient's behavior, and the patient, in response, either affirms or rejects this interpretation, depending on whether she believes that it fits with her life experience, e.g., as when Elkin denies Yalom's claim that she is a capable, attractive adult, or when Yalom, reciprocally, denies Elkin's claim that she has not yet reached adulthood. On my account, therefore, narrative co-construction is more than an ethical nicety: it is a requirement for effective therapy (cf. Effron et al. 2019).

In the partnership between patient and psychiatrist, however, the psychiatrist clearly has an added responsibility, i.e., to help the patient, whether that helping takes the form of healing, fixing a problem, facilitating a greater degree of wellbeing, or something else. To achieve a beneficent end, the psychiatrist must learn very quickly *who the patient is* so that she can understand *what the patient needs*. (A psychiatrist does not often have the luxury of allowing relationships to unfold at their own pace.) I suggest that psychiatrists can improve their ability to know the patient by adopting an exploratory stance towards each patient's figurative language, particularly the figurative language that the patient uses to describe herself and the people around her. When probed curiously, this figurative language often gives way to narratives that the patient uses to understand herself and her world.

By focusing on the narratives and figures of speech that a patient uses to conceptualize herself, therefore, the psychiatrist gains powerful insight into the patient's frame of mind: her thoughts, feelings, and baseline assumptions about herself and the world around her. As I have demonstrated in this section, attention to a patient's use of figurative language and personal narrative also helps the psychiatrist to understand the patient's behavioral patterns outside of the relatively narrow context of the therapeutic relationship. With this broader view of the patient's inner and outer being, of the contexts in which the patient thrives or suffers, the psychiatrist may devise strategies that help the patient to better meet her psychosocial needs.

I have indicated above that a major goal of my approach to psychiatry is to help patients develop life-sustaining ways of thinking about themselves. These new ways of thinking, as I have discussed, would be expressed in the patients' personal narratives and figurative descriptions of themselves. But what exactly does a "life-sustaining" description of oneself look like? The answer will depend to some extent on the patient's personality and goals. For Ginny, perhaps the greatest

triumph of her years of therapy with Dr. Yalom is that she has grown to see herself as courageous. In reflecting on life following her breakup with Karl, Ginny describes herself using the timeless metaphor of a tenacious fighter: "I didn't stay down for the full count of suffering" (ibid., 242). Rather than remain despondent, Ginny picks herself up and finds new relationships with which to fill her life, relationships which prove to be more open than any she has experienced in the past. "Maybe things will grow bad" again, she extends the boxing metaphor: "Then I can fight back" (ibid., 243). With Yalom's help, Ginny has kindled in herself a survival instinct, a courage, a perseverance that she did not possess before. These qualities have helped her to achieve a greater degree of flourishing in life.

In the final section of this thesis, I will return to the question of what exactly constitutes a "life-sustaining narrative." In doing so, I will also discuss some future research directions for the novel approach to psychiatric practice I have proposed here, as well as some of the approach's potential limitations.

Part IV:

Conclusion

In this thesis, I have used the writings of psychiatrist Irvin Yalom, in concert with the accounts of his patient "Ginny Elkin," to guide the creation of a narrative-based approach to psychiatry. Accordingly, my strategy shares many features with Yalom's approach to psychiatry, including his attention to incongruity, tone, and figurative language in the patient's narrative. As well, my approach shares with Yalom's a desire to help patients change the stories that they tell about themselves, to help patients adopt life narratives that sustain rather than impede their flourishing.

However, my approach also differs in important ways from Yalom's. Rather than centering my work on the axioms of existential psychiatry, whereby the ultimate origins of human suffering are "death, freedom, isolation, and meaning" (May and Yalom 1989), I center my work on the praxis of narrative theory and narrative medicine. This commitment entails a desire to understand each patient on his or her own terms, to appreciate each patient's story as I would appreciate a work of literature, lending each story a patience that assumes there is meaning to be found that may not be immediately obvious (Charon 2017). This patience extends not only to relatively literal stories like those of Yalom's patients Marvin and Ginny, but also to unusual narratives that mainstream psychiatric practice might deem as "disorganized," "tangential," or "delusional" (APA 2013, 99-102). For example, a patient with a historical diagnosis of schizophrenia may tell a story about how she is Jesus, and how God has sent her to Earth save the ecosystem from evil. My approach would treat this story not as mere fodder for diagnosis, but as an attempt at communication, as a message that requires interpretation in the context of the patient's life.

Unlike reading literature, however, our patients' stories may change over time in response to therapy. Patients can clarify their meaning, letting us know whether our interpretations of their stories are accurate to their life experience. Reciprocally, our interpretations of the patient's stories, as well as our perspective and encouragement, can help the patient to foster life narratives that better support her healthy psychosocial functioning. In this way, the changeability of patient narratives enables growth.

Developing further on Yalom's work, I have sketched in this thesis the beginnings of a conceptual framework for thinking about the ways that figures of speech often "stand in" for general narrative forms, or for collections of thematically related narratives, as exemplified by Ginny's describing herself as a "lump," a metaphor that summarizes a collection of limiting narratives the patient holds about herself along the lines of *I do not respond when people invite me to share intimate feelings* (Yalom and Elkin 1974, 58). These kinds of self-descriptive figures of speech can serve as doors to the psychiatrist's better understanding the patient's inner life. In a reciprocal way, the physician and patient can create new figurative descriptions for the patient (e.g., "Angry Ginny") that represent narratives describing the patient's exhibiting a desired behavior. Part of the work of a psychiatrist, therefore, is to work back and forth between figures of speech and the narratives latent within them.

Along these lines, I have also begun to sketch a conceptual framework for thinking about the ways that life narratives represent enduring yet changeable patterns of behavior on the part of the patient. I have suggested that there is a reciprocal, mutually reinforcing relationship between habits of behavior and the stories we tell about ourselves. To best help patients effect behavioral changes, therefore, I have argued that a psychiatrist must address both the behaviors and the life narratives that attend them.

To conclude, I will discuss potential critiques of my account and outline a few directions for future research.

Potential Critiques

First, I will address a potential critique of the method I have used in this thesis to sketch a new approach to psychiatry. Then, I will address a critique of the approach itself.

One may point out that Yalom's psychiatric memoirs *Love's Executioner* and *Every Day Gets a Little Closer* show only, as memoirs do, a limited (and carefully selected) view of the events depicted therein. That is to say, these memoirs communicate only small cross-sections of protracted, years-long courses of therapy. As author, Yalom picks out only those occurrences and snippets of conversation that he has found most salient, leaving the remainder inaccessible to the reader. We are not, therefore, receiving an unbiased view of what happened during these therapy sessions. While the serial format of *Every Day Gets a Little Closer* may bring the reader nearer to the actual events of therapy than does the retrospective format of *Love's Executioner*, still, any written account of therapy will inevitably select out an immense amount of detail. How, then, can we establish an approach to therapy using the work depicted in these memoirs?

In response to this critique, I would like to clarify that my goal in explicating Yalom's texts is not to scientifically deconstruct Yalom's approach to therapy as it is practiced *in vivo*. Rather, I believe that the aspects of Yalom's therapeutic approach *represented in his texts* serve as good (if not exact) models for my own approach to psychiatric practice. In other words, these two texts communicate certain of Yalom's approaches to the daily work of psychotherapy; I feel that the methods communicated within these texts provide an excellent "base model" for psychiatric

practice, to which I have made a few key modifications and conceptual additions. So long as Yalom has not intentionally misrepresented his therapeutic work (cf. Phelan 2017), the exact selection of historical details in these memoirs does not matter nearly as much as the practical methods and attitudes that the memoirs depict.

Now that we have addressed a critique of the literary method I have used to develop my novel approach to psychiatric practice, let us turn to a critique of the approach itself. I have claimed in this thesis that attention to narrative and figurative language can help psychiatrists to better understand their patients' inner lives, their thoughts, feelings, shames, hopes, and imaginations. One may counter, however, that a psychiatrist can *never* truly know these things about a patient. Only the patient can know the contents of her own mind. Perhaps, then, it is misguided to attempt to understand the patient's inner life, and the psychiatrist should focus instead on outwardly observable behaviors (cf. Wann 1964).

I would respond to this critique by first reminding the reader that there is clearly a connection between a person's outward behaviors and her inner life. Though I will not attempt a wholesale defense of phenomenological approaches to psychiatry and psychology, I will invite the reader to consider the way that we humans do not simply *produce* behaviors: we think about them, too. For example, we plan future actions. We may reflect critically on our past actions, using these reflections to modify our behavioral habits as we see fit. We imagine trying new activities that we have never done before, and then we do those activities. Moreover, while our suffering may often *result* from our own behaviors, this suffering exists in our thoughts and feelings. Thus, I argue that we cannot alleviate suffering without attending to the thoughts and feelings of patients.

Of course, in attempting to understand what our patients are experiencing, we inevitably will make many mistakes and misinterpretations. These mistakes, however, do not invalidate the

importance of *attempting* to grasp our patients' inner lives. In some cases, we may in fact accurately comprehend what our patients are "going through." When we succeed in this endeavor, I suggest, we put ourselves in a far better position to help the patient address the causes of her suffering.

As I have acknowledged above, the psychiatrist occupies an epistemically limited vantage point with respect to the patient's cognitive and emotional life. As psychiatrists, however, we offer something that most patients do not have: a perspective that comes from witnessing on an intimate level the suffering of hundreds and thousands of people. We can provide patients insight into their own lives that they are not able to provide themselves – or else why would they seek psychiatric help? Thus, psychiatrist and patient each are epistemically limited, yet they are limited in a complementary way that underscores the importance of a cooperative approach to therapy of the kind for which I am advocating here.

Directions for Future Research

1. Connection between personal narratives and behavioral tendencies. In Part III, I proposed that there is a deep relationship between the stories we tell about ourselves and our repeated patterns of behavior. I have not, however, given a detailed account of the nature of this relationship. Future research may explore at a social, psychological, or neurobiological level the connection between personal narratives and behavioral tendencies. See also Footnote 8, p. 52.

2. How to gain skill at expanding figures of speech into narratives, and condensing narratives into figures of speech. In Part III, I discussed the way that patients' descriptions of themselves often hold within them internalized narratives about their own behavioral tendencies. Part of the work of

the psychiatrist, I have proposed, is to explore the narratives behind each patient's figurative self-descriptions. Future research may investigate, from an educational perspective, how psychiatrists can become more adept at working back and forth between figures of speech and narratives.

3. The goals of this narrative-based approach to therapy. As I have discussed in Part III, one important goal of my approach to psychiatry is to help patients develop life-sustaining narratives. But what exactly does a "life-sustaining" description of oneself look like? Of course, as I have mentioned, the term "life-sustaining" may be relative, to a degree, to the individual patient and her specific needs. Nonetheless, my approach to psychiatry would benefit from a more general investigation of the types of personal narratives that promote mental health, versus the types of narratives that cause patients to suffer. As a start towards this more general investigation, I venture that life-sustaining personal narratives and self-descriptions are those that engender qualities like perseverance, optimism, social connection, self-awareness, and self-regulation – qualities that, in my view, allow people to flourish in life rather than languish (cf. Nussbaum 2001). For example, a narrative that promotes perseverance might go along the lines of "I go through hard times, but I always bounce back." To extend this line of reasoning, a life-sustaining personal narrative may be one that promotes the behavioral habits, the social and emotional capabilities, that support flourishing (cf. Cusimano 2016). In this vein, future research will investigate what kinds of narratives will support such social and emotional capabilities.

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