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Stories of Recovery: the Role of Narrative and Hope in Overcoming PTSD and PD

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Abstract and Keywords

I explore the role of narrative understanding in recovery from post-traumatic stress disorder (PTSD) and personality disorder (PD), and explain why self-autonomy and self-creation, as components of narrative understanding, are central to the recovery process. Drawing on a hypothetical clinical vignette, I show how narrative understanding can impede recovery if it is not harnessed to a patient's sense of agency for change and hope for the future. I suggest that this risk can be averted by focusing on how narrative is a form of understanding that can surprise us and defy expectations, allowing us to free ourselves from our pasts and treat our futures as open. I conclude by reflecting on the difficult balance that clinicians must strike in supporting patients to develop narratives that genuinely promote recovery: they must hold hope for their patients, yet temper their hope with realism about the genuine constraints and hardships their patients face.

Keywords: agency, freedom, hope, narrative, personality disorder, post-traumatic stress disorder, recovery

Exploration of the past and its impact on the present is a central component of many kinds of cognitive behavioral and psychodynamic therapies for a variety of psychiatric disorders. The therapeutic aim of this exploration is to help patients develop a better narrative understanding of their lives. Narrative understanding is sometimes heralded as crucial for a life of value. The unexamined life is not worth living, because it is by reflecting on our life, considering who we are and who we want to be, what we have done and endured and what we want to do or endure no more, that our life becomes *our own.* Much as a story-teller tells a story, we fashion and shape our lives, thereby embodying the values of self-autonomy and self-creation.[1] But this very general and abstract value in narrative understanding seems, at first glance, far removed from the reality of the clinic, where particular patients present with concrete symptoms and problems, which therapists and other mental health professionals try to treat. The development of narrative understanding is indeed pervasive in therapy, but it is unclear why in fact it helps psychiatric patients, many of whom live lives filled with so much suffering and impoverishment and chaos that the values of self-autonomy and self-creation seem, quite literally, a world away. Why, then, does narrative understanding help?

My aim in this paper is to explore the role of narrative understanding in recovery from two particular kinds of psychiatric disorder, namely, post-traumatic stress disorder (PTSD) and personality disorder (PD), and explain why self-autonomy and self-creation are central to the recovery process. Although my discussion focuses on these disorders and their standard forms of treatment, my conclusions generalize to some extent to all psychotherapeutic approaches that aim to understand present problems in light of past experiences and thereby enable patients to change problematic emotional and behavioral patterns. I argue that narrative understanding risks impeding recovery unless it is harnessed to what I shall call a patient's *sense of agency for change*. Only in conjunction with this sense of agency and hope for the future is narrative well placed to offer patients the help they need.

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The paper divides into six sections. First, I describe the nature of PTSD and PD, focusing in particular on the way both disorders are responses to trauma. Second, I explain how evidence-based treatments for these conditions employ techniques to develop narrative understanding to target specific symptoms and problems. Third, I offer a hypothetical clinical vignette of a patient with a dual diagnosis of PTSD and PD that illustrates how narrative understanding can impede rather than promote recovery. Fourth, I argue that this impediment occurs when narrative understanding is not harnessed to a patient's agency for change but instead functions for the patient as an excuse for why they cannot change. I identify this as a risk inherent to therapeutic approaches to treating PTSD and PD that develop narrative understanding. Fifth, I explore the feature of narrative that can avert this risk. I argue that, because narratives can surprise us and defy expectations, they offer a form of understanding that allows us to free ourselves from our pasts and treat our futures as open, and so can be effectively harnessed to a sense of agency for change. Finally, in the sixth section, I conclude by reflecting on the nature of the clinician's role in helping patients develop this form of narrative understanding in order to promote recovery. I suggest that, as part of good practice and care, clinicians must strike a difficult balance. They must believe in their patients' powers of choice and agency and hold out hope for recovery in order to support patients to develop such an attitude themselves, yet temper this hope with realism about the genuine constraints and hardships their patients face that stand in the way of a better future. They must have faith, yet face the evidence.

Post-Traumatic Stress Disorder and Personality Disorder: Diagnostic Criteria

Although precise comorbidity rates between post-traumatic stress disorder across the spectrum of personality disorders are as yet unknown, the overlap between them and the complication this creates for diagnosis and treatment are ubiquitous within clinical practice.[2] The reason for this overlap is, at least on the surface, clear. Not only are many of the symptoms and problems faced by patients similar, but so too is at least one part of the typical cause: past trauma.

PTSD typically occurs in response to a single traumatic event or episode in one's life, such as a severe or life-threatening assault or accident. The core symptom of PTSD is repeated and intrusive re-experiencing of this event, in the form of images, thoughts, dreams, or "flashbacks." Flashbacks involve the patient feeling and on occasion acting as if the event is in fact recurring: the experience is as of re-living the trauma, as if the past quite literally erupts into the present. These various forms of re-experiencing typically lead to severe psychological distress and physiological arousal for the patient. In addition, random sensory cues that have become associated with the trauma, in virtue of temporal co-incidence, can equally trigger distress and arousal. In response to these symptoms, patients typically engage in a range of unhelpful coping strategies, including but not limited to avoidance of all stimuli that could trigger re-experiencing the event, which greatly reduces their capacity to lead a normal life. In addition, they may also suffer from more general forms of cognitive and mood disturbances, such as difficulty concentrating and irritability (American Psychiatric Association 2000).

On the other hand, PD typically occurs in individuals who have suffered extreme and lasting forms of early psychosocial adversity. This can include being raised within severely dysfunctional families, where there is breakdown, death, institutional care, and parental psychopathology; a history of childhood sexual, physical, or emotional abuse; and social stressors, such as war and poverty (Paris 2001). PD is defined as an enduring and pervasive pattern of experience and behavior that deviates markedly from cultural norms, causes extreme psychological distress and general dysfunction, and is manifest in cognition, emotion, and behavior (American Psychiatric Association 2000). For patients with PD, their personality—the ways they are naturally inclined to think, feel, and act—is pathological. There is, of course, a genetic component to personality quite generally and personality disorder in particular (Jang and Vernon 2001). But people with personality disorder usually have been disadvantaged not only by nature, but by nurture. Just as PTSD is typically a response to a single traumatic event or episode, PD is in large part a response to extreme and lasting forms of early psychosocial adversity, in other words, to enduring childhood trauma.

It is not uncommon for patients with personality disorder to experience repeated and intrusive re-experiencing of childhood events, including in the form of flashbacks. Like patients with PTSD, they can find themselves re-living events in such a way that they lose touch with present time and place. But even patients who do not suffer from repeated and intrusive images, thoughts, dreams, and flashbacks nonetheless typically respond to the present through the veil of their past: the childhood trauma is with them, even if not in the form of such discrete, vivid

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symptoms as occur in PTSD.[3]

The past is present in the extreme and markedly culturally divergent emotions experienced by people with PD. To the outside, seemingly small and insignificant events can cause very high levels of, for example, anger and aggression, hurt and despair, or fear and anxiety. Although this may be partly due, over time, to the development and entrenchment of emotional habits or tendencies, the basic clinical understanding of the phenomenon is that, for patients with PD, something in the present is reminiscent of trauma in the past, which causes the present event to be unconsciously or consciously interpreted as possessing a similar valence, provoking extreme emotions. These emotions “belong” in the past, to use the language of the clinic, even though they occur in the present. They cause severe psychological distress to the patient, but also create dysfunction in their lives, due to the effect they have on relationships with others and general functioning.

This dysfunction occurs because, again as with PTSD, people with PD typically engage in a range of unhelpful coping strategies in response to these emotions. Due to early psychosocial adversity, people with PD have typically not only suffered trauma, but equally typically lacked the opportunity in childhood to learn healthy way of managing extreme emotions. Destructive coping strategies may have been modeled by carers, or simply developed over time within a patient’s individual history, in absence of the possession of alternative healthier strategies. These destructive strategies can include, for example, self-harm or violence towards others, recklessness and impulsivity, extreme forms of social withdrawal and avoidance, and substance abuse. Although these strategies typically offer short-term relief from emotional distress, in the long-term they not only cause further distress to the patient, creating a cycle from which it can be difficult to escape, but equally create severe problems in their social and occupational lives. In this respect, there is again overlap with sufferers of PTSD, who may use similar strategies to manage their symptoms, gaining short-term relief at the cost of long-term distress and dysfunction.

Post-Traumatic Stress Disorder and Personality Disorder: Treatment

For both PTSD and PD, treatment is complicated and must be multi-pronged in order to target all areas implicated in the disorders: cognition, behavior, and emotion. Cognitive behavioral therapy (CBT) is the treatment of choice for PTSD (NICE 2005). PD was long considered impossible to treat, but in the past decade, new evidenced-based treatments have emerged (NIMHE 2003), predominantly although not exclusively group-based, with therapeutic communities often considered the treatment of choice (NICE 2009). Recovery is now a viable aim for many patients suffering from these conditions, even if the scars of past trauma will never entirely fade.

Despite the complexity of problems and the diversity of therapies, the development of *narrative understanding* in patients is nonetheless pervasive within treatment for both disorders. The reason is that such understanding targets and aims to improve symptoms and problems where the past erupts into the present: in the case of PTSD, images, thoughts, dreams, and flashbacks; in the case of PD, extreme and intense emotions.

CBT for PTSD involves a process often called “cognitive restructuring” whereby patients re-live the trauma in the presence of the therapist, who actively encourages and helps them to put the experience into words, in such a way as to promote the elaboration and temporal contextualization of the trauma memory. Despite repeated, intrusive, involuntary re-experiencing of the trauma, patients with PTSD typically have poor voluntary recall of it: their memory is fragmented and disorganized, details may be missing, and they may not be able to remember the temporal order of events. Ehlers and Clark (2000) argue that this difference is due to the fact that there are two routes to the retrieval of autobiographical information. Retrieval can proceed via direct triggering by stimuli associated with past events. Or it can proceed via higher-order semantic processing which organizes past events according to thematic concepts and time periods. Ehlers and Clark suggest such semantic processing may both facilitate the retrieval of autobiographical information by structuring it in relation to themes and times, and, further, inhibit the triggering of autobiographical information by associated stimuli, as voluntary control over the memory is increased through semantic processing. In patients with PTSD, the autobiographical information seems triggered by associated stimuli but not semantically processed. The task of verbally elaborating and temporally contextualizing the event in therapy thus serves to create higher-order semantic retrieval strategies which may offer more scope for voluntary control of the traumatic memory. Simply put, creating a clear, coherent, and temporally ordered narrative of the traumatic event may suppress involuntary re-experiencing by providing a structure which allows it

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to be better voluntarily recalled and integrated into one's life story.[4]

Cognitive restructuring occurs de facto in many forms of therapy for personality disorder as well, when patients are asked to explore traumatic past events with the therapist or the group, seeking to understand the meaning of the event for them and its connection to other events in their life, so that a pattern can come into view. The same themes emerge at different times: understanding the past's repeated impact on later times is part of developing a narrative of one's life, which again brings clarity, coherence, and order. Patients become better able to recognize the features of the present that are reminiscent of the past and so provoke extreme and intense emotions. They come to possess a reflective understanding of their present emotions via an understanding of their genesis. Again, as with PTSD, this in turn can help them better regulate their emotions and tolerate the distress they cause. Rather than being overwhelmed by their present emotions, they can step back from them and reflect on their genesis in the past, thereby using their narrative understanding as a tool for improved emotional and behavioral management.

In both PTSD and PD, then, the development of narrative understanding of past trauma, whether this is a single event or a lasting pattern, helps patients deal with symptoms and problems where the past erupts into the present. They can understand aspects of their present experience as due to the past, and with this understanding, establish better reflective capacity and control in the present. Narrative understanding of course does not help with all symptoms or target all problems: negative core beliefs and processing biases still need to be modified, and unhelpful coping strategies need to be avoided and better ones put in place. But narrative understanding helps manage the distress of the past erupting into the present—it facilitates locating the real distress in the past where it belongs, as opposed to allowing it to color and distort the present.

Hypothetical Clinical Vignette

Martha is a middle-aged woman with a long history of engagement with mental health services. She was adopted into a large family as a child and always felt uncared for and different from her siblings: the black sheep within the family. When she was fourteen she was sexually abused by a family friend over a period of some months but did not tell anyone at the time out of fear of being disbelieved and blamed for soliciting the attention. She subsequently used drugs and alcohol as an adolescent and was promiscuous, putting herself at risk. Her first overdose was when she was sixteen, when she drank a bottle of vodka and took a package of paracetamol and three months of birth-control pills after breaking up with a boyfriend. In her early twenties she met her first husband. Both of them were unfaithful to each other on numerous occasions and they regularly drank heavily. Their marriage was not physically violent but was volatile and characterized by terrible arguments and repeated separations, although it lasted twelve years. They had three children together whom Martha stayed home to care for, while her husband ran a business. After they divorced, she then married again, to a man she believed to be different but with whom a similar pattern developed over time. Over the course of both marriages Martha overdosed a further five times.

Martha had a series of accidents when she was staying home looking after her children. The first occurred just after the middle child was born, when she trapped her shoulder in the oven when closing the oven door. She was badly burned and suffered long-term mobility problems and pain in her shoulder, which affected her capacity to physically care for her baby, causing her much distress. When her youngest child was born, the first time her husband was away on business, she fell down the stairs rushing to tend to her in the night, and broke her hip. On that occasion she lay helpless on the floor for some time, listening to the baby cry, until she was able to rouse her oldest child to come to her aid.

In the wake of both accidents, Martha felt blamed by her husband and guilty about the effect on her family of her physical disability and pain. After the second accident, she suspected her husband was having yet another affair and become depressed in mood. She then started experiencing intrusive images and flashbacks of having her shoulder trapped by the oven door, and lying on the floor helpless while her baby cried. These were regularly triggered by stimuli she could not, as a mother, easily avoid, such as cooking and interacting with her children. She withdrew from her children and allowed household duties to lapse, which further compounded her guilt. She started drinking even more heavily to numb the images and flashbacks and the feelings they aroused. It was during this period that she overdosed most frequently.

Martha was diagnosed with PTSD and offered two courses of intensive CBT to manage her symptoms. This involved not only re-living and cognitively restructuring the accidents, but linking the experienced meaning of these events

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to the larger course of her life. But the images and flashbacks did not significantly abate. At the end of the second course, the therapist suggested that, in light of her history, she be assessed and treated for personality disorder, and she was subsequently referred to a group therapy treatment programme.

Within the group, Martha displayed excellent narrative understanding of her life history. For instance, she was able to describe vividly the overwhelming feelings of inadequacy, anger, and despair that led to her overdoses. She could identify present triggers of these feelings, such as feeling rejected and blamed by her husband, and guilty herself, and connect these feelings to her early childhood experiences and her sexual abuse. She could tell the story, as it were, of how she came to overdose. But her perspective on this story was never one of an agent. Rather, within her narrative, she presented herself more as a passive victim.

Within Martha's narrative of her life history, overdoses where things that *happened*. They were the final event in a coherent and well-ordered sequence of events that made explanatory sense. But they were not things she *did*. For instance, when asked in group to describe the lead up to one of her overdoses, Martha eloquently explained how, feeling overwhelmed and like she could bear life no longer, she got into her car and went to buy alcohol and tablets before driving to a secluded place, only to conclude: "And then, there was an overdose." When the group questioned her about why she did not say that *she then took an overdose,* she became defensive and distressed, and rushed out of group. When she returned, she initially refused to speak to the group about why she left, but when pressed, reported that early childhood feelings of being the black sheep in the family had been triggered by the group's questioning, and that she had been scared of suffering flashbacks as a result.

PD patients are notoriously stigmatized for being "manipulative" and "attention-seeking."[5] When working with patients like Martha, whether individually or in group settings, it can be very difficult not to respond to such behavior in these ways. This, in turn, can create a temptation to invalidate the emotions the patient is experiencing as disingenuous—as part of a dramatic performance designed to have an effect on the audience. In this example, Martha's passive narrative of her overdose and subsequent response to the group's query may seem designed on the one hand to evoke pity by creating the impression of helplessness and victimhood, and on the other to silence the group's capacity to challenge this impression by invoking the threat of flashbacks. But it is important to be clear that, as difficult as it can be to effectively manage one's own responses in such contexts, this should not make us doubt the reality of Martha's report of her emotions.[6] It is perfectly conceivable that, although Martha is of course in fact the agent of her overdoses, her experience of herself in those moments is as of a helpless victim. Equally, it is perfectly understandable how and why the group's challenge could trigger early childhood feelings of being ostracized and isolated and make her feel frightened of experiencing flashbacks. Of course, everyone, including patients with PD, sometimes lies or behaves in a manipulative or attention-seeking fashion. But given the nature of PD, there is no reason to question that self-reports of this form are usually genuine.

Martha's story has a sad if not uncommon ending: she did not feel that any of the treatments offered had helped, and eventually dropped out of group therapy. She continued to struggle with her emotions and relationships, resorting to alcohol abuse and overdoses at times of crisis.

Narrative, Passivity, and Excuses

What is counter-productive about Martha's narrative to her prospects for recovery? We all distort the stories we tell in multiple ways, depending on our purpose in telling them (Tversky 2004). To make people laugh, we embellish and exaggerate. To convey information, we omit detail and normalize. Martha's narrative is no less an accurate or honest account of her experience than any of us is likely to tell. If it is counter-productive to her recovery, it is rather because of the use to which it is put. Martha's narrative understanding seems to function as *an excuse* for why she cannot change: it maintains her sense of self as a passive victim, rather than empowering her to be a responsible agent.

Treatment for personality disorder proceeds in part via reflection on one's own part in the development and maintenance of patterns of behavior that cement and heighten extreme emotions and the unhealthy coping strategies then employed to manage them. The reason is simply that these are what it is possible *to change*. For, put bluntly, we can only directly change what we ourselves do, precisely by choosing to do things differently (Pearce and Pickard 2010; Pickard 2011, 2013a, 2013b). Martha's narrative is not harnessed to any sense of her own agency for change with regard to her problematic patterns of behavior. For, although she is the protagonist

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and narrator of her story, the story she tells is one of fate and inevitability, where events unfold according to a recognizable and predictable pattern, which she is powerless to alter, even though able to recognize and eloquently describe. Her narrative understanding of the past's impact on the present is used to explain why she is as she is, but in such a way that defends against her taking responsibility for her behavior in the present, and working to change problematic aspects of it. Instead, it serves to further cement her fate—crises and overdoes are just what always happen to her, they are the story of her life.

The development of narrative understanding of past trauma, whether this is a single event or a pattern, can help patients with PTSD and PD deal with symptoms where the past erupts into the present and improve their capacity to cope, but only if they are motivated to deploy this understanding to that end by acknowledging their agency with respect to problematic behavior in the present. It offers the promise of better reflective capacity and control over emotions and behavior, but it does not guarantee it by any means. For, effective therapy for many forms of psychiatric disorder is typically hard and painful: in the face of a life already full of suffering, patients must not only face this suffering head on, but also face aspects of themselves and the choices they have made—and may indeed be continuing to make—about which they may feel terrible shame, guilt, self-blame, and self-hatred. For patients like Martha, who are perhaps not ready to meet this challenge, their narrative understanding of their life may be yet another obstacle on the path to recovery in offering a form of self-understanding that can serve to further entrench problematic emotions and behaviors.

Hence therapeutic approaches that promote the development of narrative understanding in patients with PTSD and PD carry a risk. Rather than narrative understanding offering a tool to empower patients to reflect on their life and become agents of their own recovery, it may contribute to their sense of passive victimhood, offering an explanation of their life as unfolding in a fatalistic and inevitable way, leaving little room for a sense of agency or any hope for the future.[7]

Narrative, Agency, and Hope: The Surprise of a Good Story

How can this risk inherent to narrative understanding be averted? The answer, of course, is that the narratives patients tell must be harnessed to their sense of their own agency for change. This requires patients to focus as much on the future as on the past: to make choices about the kind of person they want to be and how they want to live, and to see these choices through in the face of hardship, suffering, and the pull of habitual emotional tendencies and unhealthy coping strategies. It requires, in other words, that patients embody the values of self-autonomy and self-creation, working to make their life their own. Implicit in this project of *owning one's life* is the belief that one's future is *open*, in the sense that it is something one can create and shape through choice, resolve, and will. One's future is not something that one must resign oneself to—a predetermined fate predicted by one's past irrespective of one's actions in the present.[8] Rather, one is free to create it.

There is nothing about the capacity to reflect on who one wants to be and how one wants to live that demands a narrative understanding. Just as patients like Martha reveal that narrative understanding is not sufficient for improvement in symptoms and problems due to past trauma, so too it is unlikely to be necessary. The values of self-autonomy and self-creation may be promoted and realized in many forms, and may look forward without looking back. Nonetheless, despite the risk of passivity or victimhood inherent in narrative, it is a form of understanding that has the resources to cast us loose from our past. When properly developed, narrative may be particularly productive within the clinic.

Narrative is a form of understanding that typically possesses a diverse range of features, such as coherence and temporal order, explanatory power, and a sense of taking us on an emotional journey, with an ending or experience of closure or resolution.[9] But in addition to these features, stories are also typically *full of surprises.* Stories can take unexpected twists and turns, contain things we would never have imagined, things that never could be real, things magical and fantastical, things that defy the laws of nature and, importantly, the laws of psychology, even ceteris paribus as these no doubt are. In stories, *anything can happen*. Of course, in good stories, even when the unexpected happens, we can see how or why it is connected to and rendered intelligible by what led up to it, unexpected as it is. But it is part of our shared culture of stories that life can be unpredictable and really surprise us.

Self-autonomy and self-creation are general and abstract notions that, as I noted at the outset, seem a world away

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from the lives of many patients, whose suffering may feel unbearable, and whose problems may seem insurmountable. The kind of question, for instance, routinely faced by psychiatric patients is more likely to be how to manage to get up and get dressed and feed oneself and one's child, than what kind of life is ultimately worth living. If embodying the values of self-autonomy and self-creation is central to recovery, this embodiment must be present in the small practical choices and tasks that constitute daily problems of living. Because of the power of stories to surprise us, they can help bring these abstract values into contact with daily life.

A patient who has struggled every day of their adult life to get up and get dressed and function normally has overwhelmingly good inductive evidence that tomorrow will be exactly the same: this is how their life is, it will not change. In a scientific or sober mood, everyone should agree that that is the best prediction given the available evidence. Tomorrow will be the same as every other day has already been. In contrast, not only does this morose prediction not make a good story, but we can easily imagine a much better story that begins: *something was different this morning.* When we make up stories, we decide what happens, and we can decide to defy expectations and confound predictions. We can be spontaneous, playful, radical, and unpredictable. This ordinary and familiar feature of stories is part of the potential power of narrative in the clinic.

Patients with PTSD and PD face a double-bind on the path towards improvement and recovery. On the one hand, they must not deny the impact of their past on their present. For, if they do, they lose the resource such understanding offers to improve their capacity to manage their emotions and behavior in different and better ways. On the other hand, and at the same time, they must find a way to free themselves from their past. They must view their future as open and so themselves as agents, rather than believing their future is predicted by the past irrespective of their actions in the present.

Narrative is a form of understanding that promises a way out of this double-bind. On the one hand, it explores the impact of the past on the present, thereby securing the resource such understanding offers. But, on the other hand, because narrative can be full of surprises, because anything can happen in a story, it yet invites the possibility of freedom from the past and agency in the here-and-now so as to allow patients to author their future. It can therefore in its telling create a sense of hope: "Here is where I am and here is the story of how I got to where I am. I know my struggles and my weaknesses. But what comes next in my story? What shall I make happen?"

Narrative, Agency, and Hope: The Clinician's Role

If this account of the role of narrative in recovery from PTSD and PD is correct, then the clinician's role must involve supporting the patient to gain a narrative understanding of the impact of their past on their present while empowering them to employ this understanding to make changes in the here-and-now that are part of new patterns, leading to a better future. Good practice and care demands that clinicians do what they can to help patients to tell their own stories with hope, in order to best promote recovery. The most straightforward way of doing this is for clinicians to hold hope themselves for their patients: to believe in their patients' powers of choice and agency and their capacity to recover and lead a better life. Communicating this belief, persisting in it despite lack of good evidence and in face of their patients own resistance or despair, and trusting their patients even when their patients do not trust themselves, can help to engender hope in patients themselves. It is a truism that we are often only able to believe in ourselves if others believe in us.

Yet hope, like narrative, also has its potential pitfalls.[10] Isaiah Berlin (1969) famously distinguished negative and positive liberty, or the difference between freedom from obstacles and constraints, and freedom to control one's life and fashion or shape it as one wills. Patients may know what they want to be free *from,* without knowing what they want to use any new-found freedom *for*—without knowing how to live without their problems or struggles, or what goods or activities could replace them. The exhaustion and oppression of the imagination that can result from long-term suffering, together with a lack of self-belief and self-esteem, may impede the capacity to envisage a new, positive life for oneself, let alone the capacity actually to create it. And, in absence of a clear, credible vision of who one is, how one wants to live, and what realistically one needs to do in order to attain this, it can be all too easy to grasp for fantasies and unattainable ideals. Hope can be excessively wishful, representing a dream that is so divorced from reality as to be unattainable, dooming any attempt to realize it to failure. Hence the risk that patients contrive and cling to false hopes until, as everyone, patients included, might expect, their struggles and problems take hold and they end up despairing and reverting to negative past patterns.

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Clinicians must therefore balance hope with realism in order to help their patients do the same. The world is not ultimately a story—it is governed by the laws of nature and psychology. Patient narratives that are cast loose from the past, in so far as the future is treated as open, must not be cast loose from the reality of the world that the patient inhabits: the genuine constraints that lay upon them, both with respect to their external environment and their internal resources. Clinicians must help patients feel hope in telling their story and develop their capacity to imagine a new, positive life for themselves, but this hope and this vision must be tempered with realism, and so actively engaged in thinking through what changes really are possible in the here-and-now and what changes are not, and how they might best be tried and maintained over time and through hardship.

Hence, although hope and belief in a better future no doubt increases the likelihood that it will be realized, clinicians must nonetheless occupy two opposing stances that are difficult to rationally reconcile. They must have imagination and faith when using narrative understanding to support patients in recovery from PTSD and PD, and maintain belief in their patients' powers of choice and agency. Yet, they must face the evidence that suggests their faith is misplaced and their belief unwarranted, because only then can they help patients create a vision for a new, better life that is realistic to achieve. Even when clinicians and patients alike succeed in effectively striking this balance, their hopes for a better future are often dashed. But, not always. Harnessing narrative understanding to a sense of agency for change can at least sometimes make for a happy ending—it can be worth it to hope, even when it is not fully rational.[11]

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Notes:

([1]) For discussion of the connection between narrative and the self, see Dennett (1992), Flanagan (forthcoming), and Velleman (2005).

([2]) More is known in relation to combordidity rates between PTSD and borderline PD in particular: research suggests 68 per cent of patients with PTSD also suffer from borderline PD (Shea at al. 1999) and 56 per cent of patients with borderline PD also suffer from PTSD (Zanarini et al. 1998).

([3]) As Williams (1998) puts this point in her first-person description of what it is like to live with borderline PD: “For me, it was a reaction to being overwhelmed by present pain that reminded me of the past … The past and the present became one.”

([4]) Interestingly, Polya et al. (2007) found evidence that different linguistic forms of narratives of negative past events are associated with better or worse emotional regulation. Retrospective forms of narrative, which clearly distinguish the present time at which the narrative is being told from the past time at which the events occurred

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(e.g. through consistent use of the past tense), are associated with coherent regulation of emotions. Experiential forms of narrative, which represent past experiences as if they were occurring at the time at which the narrative is being told (e.g. through consistent use of the present tense), are associated with instability of emotional regulation.

([5]) For critical discussion of the idea and stigma of "manipulation," see Potter (2006).

([6]) Note that this point stands no matter one's view of the unconscious processes that may be driving Martha's behavior, for by definition these lie outside of her conscious awareness.

([7]) This risk to agency of narrative understanding may dovetail with the risk to self of diagnosis with a psychiatric disorder in the prevailing neurobiologically focused psychiatric culture, as articulated by Tekin (2011).

([8]) Philosophers often distinguish determinism from fatalism and argue that only the latter rationally warrants an attitude of resignation. Holton (forthcoming) argues that predictability, which is often confused with determinism, also warrants resignation. In what follows, I continue to speak of the need to believe that one's future is open, in the sense that it is something one can create and shape through choice, resolve, and will. Arguably, this is compatible with physical determinism; for discussion see Holton (2010) and List (2013). However, I doubt very much that the distinction between determinism, fatalism, and predictability is consistently tracked within folk psychological thinking, where the idea that one's future is determined by the past seems naturally paired with the idea that it is not within one's power to affect it through one's choices and actions.

([9]) For discussion of these features of narrative, see Velleman (2003).

([10]) For discussion of the pitfalls and power of hope, see McGeer (2004) and (2008).

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