Journal of Psychiatry
Psychotherapy & Communication

Haverkampf, C. J. (2024). Working with Stories in Psychotherapy: Narrative Identity, Meaning-Making, and Therapeutic Change. J Psychiatry Psychotherapy Communication, 2024 Mar 31;13(1):12-21

Working with Stories in Psychotherapy: Narrative Identity, Meaning-Making, and Therapeutic Change

Christian Jonathan Haverkampf

Narrative Clinical Review

Abstract—Stories matter in psychotherapy because they organize experience, identity, relationships, and anticipated action, but narrative methods are neither interchangeable nor inherently beneficial. This narrative clinical review distinguishes personal narrative identity, narrative therapy and re-authoring, life review and dignity therapy, expressive writing, and manualized trauma-focused narrative protocols. Evidence available through 29 February 2024 suggests that agency, autobiographical specificity, responsive listening, and elaborated exceptions can accompany improvement, while outcome evidence differs substantially across intervention families. Narrative therapy research includes promising but limited depression trials and process studies; reminiscence and life-review interventions show modest average benefits; dignity therapy addresses end-of-life meaning and legacy; expressive-writing findings are heterogeneous; and narrative exposure and written exposure are structured PTSD treatments rather than generic storytelling. The review organizes clinical work around four levers: selection, organization, positioning, and audience. A revised account matters clinically when it supports a safer boundary, clearer request, relational repair, behavioral experiment, or valued action, not merely when it sounds coherent or positive. Meaning-making effort can also become rumination, flooding, imposed redemption, or unsafe disclosure. Accordingly, narrative work requires permission, non-leading inquiry, attention to culture and power, monitoring of distress and function, and explicit separation of therapeutic meaning from factual or forensic verification. The listener is part of the intervention, but the patient remains the author and owner of what is told, withheld, recorded, or shared.

Index Terms—narrative identity, narrative therapy, life review, expressive writing, narrative exposure therapy, therapeutic communication

Christian Jonathan Haverkampf, M.D., LL.M., is a psychotherapist working in private practice in Dublin, Ireland. Correspondence: jonathanhaverkampf@gmail.com. Website: www.jonathanhaverkampf.com.

I. INTRODUCTION

A patient rarely brings symptoms alone. Distress arrives with an account of what happened, what it means, who is responsible, what others will do, and what kind of future remains possible. That account may be spoken fluently, offered in fragments, communicated through images and bodily reactions, or withheld because telling has previously brought disbelief, danger, or shame. Psychotherapy inevitably responds to these accounts. Even a treatment organized around behavior or physiology asks which events matter and how change will be recognized. The clinical question is therefore not whether therapy uses stories, but how it listens to them, how cautiously it draws inferences, and whether the resulting account enlarges or narrows the patient's choices.

Narrative language can make different practices look deceptively similar. An evolving sense of identity is not the same as narrative therapy; a life review is not dignity therapy; a private expressive-writing exercise is not a trauma-focused treatment; and a manualized exposure narrative is not simply an invitation to tell one's story. Each practice has a different task, dose, audience, evidence base, and risk profile. Treating them as interchangeable encourages broad promises that the evidence cannot support. It may also turn coherence, disclosure, or optimism into hidden requirements of a good patient.

This review takes a narrower position. A story becomes clinically useful when it increases agency, specificity, connection, and workable choice, not merely when it becomes more positive or internally tidy. Change may loosen a problem account's monopoly without replacing it with a wholly new identity. The listener matters because questions, pacing, acknowledgment, correction, and relational safety influence what can be said and what can be done afterward. At the same time, a compelling therapeutic account does not establish historical truth, and symptom change cannot serve as forensic corroboration. Narrative work is most responsible when

Haverkampf, C. J. (2024). Working with Stories in Psychotherapy: Narrative Identity, Meaning-Making, and Therapeutic Change. J Psychiatry Psychotherapy Communication, 2024 Mar 31;13(1):12-21

uncertainty remains speakable and when the patient retains control over disclosure, interpretation, documentation, and audience.

Core clinical propositions

- Clinical usefulness depends on agency, specificity, connection, and workable choice, not coherence or positivity alone.
- Story work can alter selection, organization, positioning, and audience without requiring a total rewrite of identity.
- Exceptions gain credibility when they are elaborated, witnessed appropriately, and supported by action.
- The listener's questions and responses shape the intervention, while authorship remains with the patient.
- Meaning-making effort can become rumination, flooding, imposed redemption, or suggestive certainty and should be monitored.
- Narrative change is strongest when it supports a safer boundary, clearer request, relationship repair, experiment, or valued action.

II. SCOPE AND REVIEW METHOD

This narrative clinical review used a literature-search cutoff of 29 February 2024, exactly one calendar month before the nominal issue date of 31 March 2024. Sources were eligible only when the article, book, or stable public record was publicly available by that date. The review searched combinations of narrative identity, life story, autobiographical memory, narrative therapy, re-authoring, innovative moments, life review, reminiscence, dignity therapy, illness narrative, expressive writing, written exposure, narrative exposure therapy, trauma memory, recovery narrative, therapeutic alliance, and psychotherapy process. Reference lists of major reviews and trials were checked for foundational and comparative work. The systematic review by Yeo and colleagues was published online on 23 August 2021 and was therefore cutoff eligible despite its 2022 issue assignment (Yeo et al., 2022).

Priority was given to systematic reviews, meta-analyses, randomized or controlled trials, longitudinal process research, and foundational conceptual work needed to distinguish intervention families. The inquiry was organized around three questions: what a narrative construct or intervention asks the patient to do; what outcomes and processes its evidence can support; and what clinical boundaries prevent an inviting metaphor from becoming coercive practice. The review does not treat frequency of citation as proof, nor does it infer a common mechanism merely because several methods use spoken or written accounts.

This is not a systematic review and no pooled estimate was calculated. Populations, comparators, narrative tasks, follow-up periods, and outcomes vary markedly, while some literatures rely on small samples or observational process measures. Temporal association between narrative change and symptom improvement does not by itself establish that narrative change caused the improvement; equally, a package trial cannot identify which element produced an effect. Conclusions therefore remain at the level of defensible clinical synthesis. They identify distinctions, decision points, and observable tests rather than asserting that one narrative form is universally therapeutic.

III. WHAT COUNTS AS A STORY IN THERAPY?

A story is more than a list of events. It selects some moments from a much larger field, arranges them in sequence, links them through implied causes, assigns roles and moral positions, anticipates an audience, and points toward a future. Two patients may describe the same visible event while inhabiting very different accounts. 'I left the meeting because I failed again' and 'I left when the conversation became unsafe' select similar behavior but position the speaker differently and imply different next steps. Therapy needs enough detail to distinguish an account that preserves a disabling prediction from one that accurately names constraint or danger.

Narrative identity refers to the evolving, internalized account through which a person connects remembered past, experienced present, and imagined future. It is a developmental and psychological construct, not a treatment protocol. Narrative therapy is a collaborative practice associated with externalizing problems, examining problem-saturated descriptions, developing exceptions or preferred accounts, and attending to cultural discourse (White & Epston, 1990). Life review and reminiscence interventions revisit experiences across the lifespan, often with older adults. Dignity therapy is a brief, structured end-of-life intervention that creates a legacy document. Expressive writing usually asks a participant to write privately about thoughts and feelings over a small number of sessions. Narrative exposure therapy and written exposure treatment are manualized trauma-focused interventions with explicit exposure procedures and PTSD targets.

These categories can overlap in ordinary language while remaining clinically distinct. A patient in cognitive therapy may revise a failure story after a behavioral experiment; a psychodynamic therapy may alter how recurring relationships are understood; a couple intervention may help partners tell the same conflict with less hostile certainty. Such work involves narrative processes without becoming narrative therapy. Conversely, calling an intervention 'story-based' says little about its active task. The relevant questions are who chooses the topic, whether detail is required, how emotion is regulated, what the listener does, what is recorded or shared, and which outcome justifies the burden.

The distinction also protects against a common category error: a more coherent account is not necessarily a more accurate, adaptive, or ethical one. Coherence can be achieved by omitting contradiction, assigning premature blame, or adopting a culturally preferred redemption plot. Fragmentation

Haverkampf, C. J. (2024). Working with Stories in Psychotherapy: Narrative Identity, Meaning-Making, and Therapeutic Change. J Psychiatry Psychotherapy Communication, 2024 Mar 31;13(1):12-21

can reflect trauma, developmental limits, intoxication, ordinary memory processes, fear of consequences, or simply an experience that has not acquired words. The clinician can help the patient examine the effects of an account without grading its literary quality. The aim is a usable understanding that remains open to correction.

IV. NARRATIVE IDENTITY, MEMORY, AND POSSIBLE FUTURES

Life stories organize continuity while remaining selective and revisable. McAdams described narrative identity as a psychosocial construction through which individuals give life a degree of unity and purpose (McAdams, 2001). Later empirical work suggests that narrative identity is not one dimension: motivational and affective themes, autobiographical reasoning, and structural features are related but separable (McLean et al., 2020). This matters clinically because a patient may tell a detailed, orderly account that leaves little agency, or an uneven account that nevertheless permits a realistic next step. No single score for coherence captures what therapy needs to know.

Agency has attracted particular interest. In a longitudinal psychotherapy study, within-person increases in narrative agency preceded improvements in mental health, whereas coherence did not show the same longitudinal pattern (Adler, 2012). Under routine clinical conditions, narrative meaning-making was also associated with sudden gains, although observational sequencing cannot exclude other processes that changed at the same time (Adler et al., 2013). These findings support attention to how patients position themselves in accounts, but they do not justify prescribing heroic authorship. Agency can mean choosing help, recognizing a limit, naming dependence, or refusing an unsafe demand rather than acting alone.

Autobiographical specificity provides another clinically relevant dimension. An updated meta-analysis found that overgeneral and specific autobiographical memory predicted aspects of the course of depression, with effects that should be understood as probabilistic rather than diagnostic (Hallford et al., 2021). A patient who retrieves only global summaries such as 'I always fail' has fewer concrete episodes available for comparison. Gently locating a particular time, setting, action, and response may reveal variation that global memory conceals. Yet specificity should not be forced when detailed recall is destabilizing, unnecessary, or unavailable. The purpose is to improve discrimination and choice, not to extract a complete record.

Stories also project possible futures. Depression may narrow the future to repetition; anxiety may organize it around catastrophe; a chronic illness may divide life into a lost before and an uncertain after. Therapy can ask what the dominant account predicts and what evidence would make another future more believable. A possible future becomes clinically meaningful when linked to a tolerable action, a relationship, or a condition that can be observed. Hope is then neither reassurance nor a mandatory positive ending. It is a provisional expansion of what the patient can imagine and test.

V. STORIES AS RELATIONAL AND CULTURAL ACTS

A story is told to someone, even when the immediate audience is the self. Anticipated disbelief can shorten an account; anticipated judgment can move responsibility toward the speaker; an attentive listener can make uncertainty easier to tolerate. Narrative medicine makes this relational function explicit by linking attentive reception, representation, and affiliation in clinical care (Charon, 2001). Psychotherapy adds a sustained opportunity to notice how telling changes in the presence of another person. The therapist is not a neutral container: interruptions, summaries, silence, emotional tone, and the questions chosen all influence which version becomes available.

The therapeutic alliance is therefore relevant without becoming a complete explanation of change. Meta-analysis across adult psychotherapies shows a consistent alliance-outcome association, but early improvement, patient characteristics, therapist skill, and alliance may influence one another (Flückiger et al., 2018). For narrative work, the practical inference is that a patient needs sufficient agreement about purpose and sufficient relational safety to correct the therapist's reading. A polished reflection that cannot be challenged may feel more like appropriation than understanding. Useful listening includes asking what was missed, distinguishing the patient's words from the clinician's inference, and revising the summary when it does not fit. An attachment-informed account likewise treats distance, trust, and repair as hypotheses to be tested in a particular relationship, not as a fixed identity assigned from a story (Haverkampf, 2012).

Stories also borrow from cultural repertoires about independence, family loyalty, gender, illness, productivity, trauma, recovery, and redemption. Narrative identity is formed in dialogue with these social meanings rather than in isolation (Hammack, 2008). A clinician may otherwise celebrate autonomy where interdependence is valued, read endurance as passivity, or frame reconciliation as progress despite ongoing coercion. Cultural humility is not the substitution of one authorized story for another. It involves asking which communities and histories give an account meaning, what social consequences attach to alternative tellings, and who has the power to define the problem publicly.

Communication with oneself is relational in a quieter sense. A patient may address the self as prosecutor, frightened child, practical witness, or compassionate companion. Writing or

Haverkampf, C. J. (2024). Working with Stories in Psychotherapy: Narrative Identity, Meaning-Making, and Therapeutic Change. J Psychiatry Psychotherapy Communication, 2024 Mar 31;13(1):12-21

speaking from another position can reveal assumptions and choices, but it should not be used to split experience into a 'good' author and a disowned problem. The clinically useful shift is often from verdict to inquiry: what happened, what did I need, what did I do to protect myself, what did that protection cost, and what response is possible now? Such questions preserve accountability while reducing the totalizing force of shame.

VI. ASSESSMENT: MAPPING A DOMINANT ACCOUNT WITHOUT MAKING IT A VERDICT

Narrative assessment begins with the difficulty for which the patient is seeking help and the consequences of the current account. The clinician clarifies symptoms, duration, impairment, risk, medical and psychiatric differentials, developmental and trauma history, relationships, culture, material conditions, previous treatment, and sources of support. A story of personal weakness may obscure sleep deprivation, pain, discrimination, caregiving burden, or coercive control. A contextual explanation may in turn leave an avoidance or rumination cycle unexamined. The task is to hold personal meaning and observable conditions together rather than allowing either to absorb the other.

A practical map separates selection, organization, positioning, and audience. Selection asks which episodes enter the account and which are absent. Organization examines sequence and causal links. Positioning considers the roles, agency, responsibility, and voice assigned to self and others. Audience asks who can hear the account, whose response is anticipated, and what disclosure may cost. A future horizon can then be added: what does this account predict, and which alternatives are currently imaginable? Table 1 turns these dimensions into questions without implying that every session must cover every cell.

Assessment should compare episodes rather than accepting global summaries as settled fact. 'No one listens' may contain repeated invalidation, one particularly painful rupture, a current relationship pattern, and a moment when a request was heard. Clarifying those differences is not an argument against the patient. It tests the scope of the conclusion and may identify an exception or a safer audience. Likewise, 'I caused the conflict' requires separation of action, intention, responsibility, and the other person's conduct. Narrative inquiry becomes clinically unsafe when it uses curiosity to dilute credible danger or relocate responsibility for abuse.

The clinician should ask how the account functions now. Does it organize care, preserve dignity, warn of risk, justify withdrawal, maintain connection, invite punishment, or prevent an unbearable uncertainty? The same story can protect and constrain. A patient who says 'I am the dependable one' may gain purpose while losing permission to ask for help. Naming both effects avoids prematurely removing a narrative that has served survival. It also produces a clearer treatment question: what part of dependability should be retained, and what new position would permit reciprocity?

Because assessment is itself an encounter, permission and transparency are essential. The therapist can explain why detail is being requested, offer choices about pacing, and make clear that a patient may decline. Summaries should remain provisional and include what is unknown. If accounts bear on legal, safeguarding, disability, or employment decisions, therapeutic exploration must be separated from factual determination. The clinician records what was reported and what was observed without converting interpretation into verified history.

Table 1. Story dimensions and clinical questions

Story dimension	Clinical question	Possible therapeutic function
Selection	Which events enter the account, and which exceptions or contexts are absent?	Broaden evidence without denying the dominant experience
Sequence	What is treated as the beginning, turning point, or inevitable next step?	Identify transitions and places where action remains possible
Causality	Which links are observed, inferred, or still uncertain?	Separate explanation from verdict and generate rival accounts
Positioning	Who has agency, responsibility, voice, or permission to need help?	Recover choice while preserving realistic constraint and accountability
Audience	Who can hear this safely, and how does the anticipated response shape telling?	Strengthen connection, correction, and ownership
Future horizon	What future does the account predict, and what small alternative can be tested?	Translate possibility into a boundary, request, experiment, or valued action

VII. NARRATIVE PRACTICES: EXTERNALIZING, EXCEPTIONS, AND RE-AUTHORING

Narrative therapy developed a distinctive conversational practice rather than a generic encouragement to tell stories. Externalizing language separates the patient from a problem sufficiently to examine its operations: not 'you are anxious' but 'how does anxiety recruit checking, silence, or avoidance?' The move is useful when it reduces shame and creates room for choice. It becomes artificial when imposed as preferred vocabulary or used to deny that emotions and actions also belong to the patient. The therapist offers language and then follows whether it fits.

Problem-saturated accounts acquire monopoly by selecting confirming events and treating their causal interpretation as settled. Narrative questions look for unique outcomes or

Haverkampf, C. J. (2024). Working with Stories in Psychotherapy: Narrative Identity, Meaning-Making, and Therapeutic Change. J Psychiatry Psychotherapy Communication, 2024 Mar 31;13(1):12-21

innovative moments: occasions when the problem was less influential, contradicted, or met differently. Process research has identified such moments in successful narrative therapy and examined how they develop across treatment (Matos et al., 2009). An exception is not yet an alternative life story. It gains weight when the patient specifies what made it possible, what value or intention it expressed, who noticed, and what later action could extend it.

Re-authoring therefore works through elaboration and enactment rather than positive substitution. If a patient who describes herself as incapable once asked a friend for help, the therapist might explore what allowed the request, what it says about her judgment, how the friend responded, and whether another bounded request is possible. This inquiry does not erase times when help was unavailable. It develops a more differentiated account in which vulnerability and agency coexist. The revised story is credible because it can accommodate disconfirming experience, not because it eliminates difficulty.

External witnesses, therapeutic letters, documents, and carefully chosen audiences may consolidate preferred meanings, but they also change privacy and power. Before any account is written, quoted, sent, or shared, the patient should understand its purpose, destination, storage, confidentiality, and possibilities for withdrawal. A partner or family member should not be recruited simply to validate the therapist's preferred story. Witnessing is helpful when the audience is safe, the patient controls the terms, and the response recognizes rather than appropriates the account.

The therapist also watches for narrative success becoming a new demand. A patient may feel pressure to produce an exception, forgive, find growth, or demonstrate a coherent preferred identity. Narrative therapy is most faithful to collaboration when refusal and ambivalence remain legitimate. Sometimes the clinically important re-authoring is modest: 'I do not yet know what this means, but I can decide whom to tell and what I need today.' That sentence may create more agency than an elegant account of redemption.

VIII. NARRATIVE PROCESSES ACROSS PSYCHOTHERAPY SCHOOLS

Many therapies alter stories without making narrative their declared theory. Cognitive therapy examines appraisals, core beliefs, and predictions; behavioral experiments can change the evidence from which an account is built. Psychodynamic psychotherapy links present affect and relationship patterns with earlier expectations while testing interpretations in the therapeutic relationship. Interpersonal and couple therapies revise accounts of intention and response through communication and repair. Humanistic work may help a patient articulate experience that has been organized around external conditions of worth. These approaches differ in method, but each may change selection, causal linkage, positioning, or audience.

This overlap is clinically useful only if it does not erase mechanism. A therapist who identifies a narrative shift after exposure should not conclude that exposure worked because a new story was told; expectancy violation, emotional processing, attention, and behavioral approach may also be involved. Conversely, symptom improvement may allow a patient to narrate experience with greater agency. An exploratory study in cognitive-behavioral therapy for depression found that narrative changes predicted symptom decrease, but such temporal associations cannot isolate narrative change as the active ingredient (Gonçalves et al., 2017). The result supports measurement and hypothesis testing, not ownership of change by one theory.

A cross-school narrative formulation can remain modest. The clinician asks what account currently organizes the problem, what behavior or relationship sustains it, and what observation could revise it. A patient who expects every disagreement to end in abandonment might examine that prediction through a direct request, a repaired therapy rupture, or a graded conversation with a safe partner. The new information becomes narratively important because it changes both the anticipated sequence and the patient's position within it. The intervention is judged by the quality of the test and the life that follows, not by whether it sounds recognizably narrative.

Different schools also offer different safeguards against narrative overreach. Behavioral observation can challenge an interpretation that has become self-sealing; psychodynamic attention to enactment can reveal how the therapist has joined a familiar role; systemic inquiry can identify power and circular interaction; trauma-focused protocols specify dose and monitoring. Integrative work is strongest when these disciplines correct one another. It is weakest when 'meaning' becomes a label applied after improvement or when a compelling account is allowed to outrun evidence.

IX. OUTCOME AND PROCESS EVIDENCE FOR NARRATIVE THERAPY

The outcome literature for narrative therapy is promising but comparatively small. An open study of adults with major depressive disorder reported improvement in depressive symptoms and interpersonal outcomes, but without a randomized comparator it could not separate treatment effects from expectancy, time, selection, or other influences (Vromans & Schweitzer, 2011). In a controlled trial for moderate depression, both narrative therapy and cognitive-behavioral therapy were followed by improvement; some depression-score differences favored CBT, whereas a broader outcome measure did not show a group difference (Lopes, Gonçalves, Machado, et al., 2014). A naturalistic follow-up of

Haverkampf, C. J. (2024). Working with Stories in Psychotherapy: Narrative Identity, Meaning-Making, and Therapeutic Change. J Psychiatry Psychotherapy Communication, 2024 Mar 31;13(1):12-21

the same cohort found continued gains but did not control the course of depression or subsequent treatment (Lopes, Gonçalves, Fassnacht, et al., 2014). These comparisons cannot show that the therapies work through the same process.

Process research offers a more detailed but still bounded account. Innovative moments identify departures from a dominant problem narrative, and successful cases tend to show development from initial exceptions toward more elaborated accounts of change (Matos et al., 2009). These patterns are clinically intelligible: an exception that is linked to intention, identity, relationship, and action should be more usable than an isolated contradiction. Yet coding a change process after the fact can be influenced by outcome knowledge, and temporal order does not exclude common causes such as alliance, hope, or early symptom relief. Process markers are hypotheses about change, not certificates of mechanism.

The evidence therefore supports neither dismissal nor broad superiority claims. Narrative therapy can be offered as a coherent collaborative treatment where the patient's problem and preferences fit its methods, provided progress is monitored in symptoms, function, relationships, and risk. Evidence is thinner for deciding which patients benefit most, how therapist competence affects outcome, and whether effects generalize across diagnoses, cultures, and service settings. A systematic review of narrative identity in personality disorder reports group-level differences across motivational-affective themes, autobiographical reasoning, and structural features, but these findings do not define an individual narrative deficit (Lind et al., 2020). A narrative formulation should guide inquiry without becoming a diagnosis in disguise.

X. LIFE REVIEW, DIGNITY THERAPY, AND ILLNESS NARRATIVES

Life review is a structured examination of experiences across the lifespan, often including turning points, conflicts, achievements, losses, and unresolved themes. Its task is broader than pleasant reminiscence and need not produce a single harmonious conclusion. Meta-analysis of reminiscence interventions found average benefits across psychosocial outcomes, with heterogeneity in populations, formats, and comparison conditions (Pinquart & Forstmeier, 2012). In a pragmatic randomized trial, life-review therapy reduced depressive symptoms in older adults with moderate symptomatology, but the result does not establish that every form of remembering or every patient will benefit (Korte et al., 2012). Selection, dose, social contact, and therapist skill remain plausible contributors.

Dignity therapy is more specific. Developed for patients nearing the end of life, it uses a structured interview about roles, achievements, hopes, and messages, then produces an edited generativity document for chosen recipients. In a randomized trial, the prespecified distress outcomes did not differ between groups; participants nevertheless reported advantages on several secondary appraisals of helpfulness, dignity, and family experience (Chochinov et al., 2011). The intervention should therefore be presented as an option with a particular purpose, not as an obligation to summarize a life, reconcile relationships, or leave a positive legacy. Fatigue, cognition, prognosis, privacy, family conflict, and the patient's wish not to create a document all affect suitability.

Illness narratives arise in ordinary care as patients explain bodily change, disrupted roles, uncertain prognosis, and encounters with services. Attentive clinical communication can restore personhood where a chart has reduced experience to findings and procedures (Charon, 2001). It can also reveal practical barriers, differing explanatory models, and the relational consequences of illness. The clinician should not ask a patient to make illness meaningful before adequate information, symptom control, and medical care are available. Sometimes the most honest narrative task is to tolerate an unfinished account while clarifying what is known, what remains uncertain, and which decision must be made next.

XI. EXPRESSIVE WRITING AND STRUCTURED TRAUMA-FOCUSED NARRATIVE METHODS

Expressive writing involves brief, repeated private writing about thoughts and feelings related to stress. It is inexpensive and under the writer's control, but average effects are small and variable. One broad meta-analysis found a small overall benefit with substantial moderation; another found no significant pooled benefit for somatic or psychological health (Frattaroli, 2006; Mogk et al., 2006). A 2022 meta-analysis of 20 randomized trials found a modest pooled symptom advantage for journaling with high heterogeneity (Sohal et al., 2022). The converging caution supports monitored, optional use rather than a universal or stand-alone prescription. A patient may change topic, stop, keep the text private, or choose another method.

Narrative exposure therapy is a manualized PTSD treatment developed for patients with multiple traumatic experiences. It constructs a chronological lifeline and uses repeated, detailed exposure to traumatic memories within a broader autobiographical context. Systematic reviews report benefit relative to non-trauma-focused comparators and evidence of maintained effects, while study settings, populations, comparators, and risk of bias vary (Grech & Grech, 2020; Siehl et al., 2021). Written exposure treatment is a different brief protocol in which patients complete structured written trauma accounts across sessions. A randomized noninferiority trial found written exposure treatment was not inferior to cognitive processing therapy on PTSD outcome within the prespecified margin and had fewer dropouts, but one trial does not make the methods interchangeable (Sloan et al., 2018).

Haverkampf, C. J. (2024). Working with Stories in Psychotherapy: Narrative Identity, Meaning-Making, and Therapeutic Change. J Psychiatry Psychotherapy Communication, 2024 Mar 31;13(1):12-21

The clinical distinction lies in task and containment. Expressive writing may be self-directed and need not pursue exposure; narrative exposure and written exposure deliberately engage trauma memories within protocols that specify rationale, dose, monitoring, and therapist response. None should be described as simply 'telling the story.' Detailed work requires informed choice, assessment of current danger and acute instability, a plan for distress during and after sessions, and coordination of comorbidity or practical needs. The aim of exposure-based work is not a perfectly coherent record or proof of what occurred. It is reduction of PTSD-related impairment through the treatment's proposed learning processes.

Table 2. Distinct narrative intervention families

Intervention family	Primary task	Evidence signal	Principal limitation
Narrative therapy	Externalize problems, elaborate exceptions, and re-author preferred accounts	Small depression trials and process research support promise	Limited disorder breadth, sample size, and mechanism evidence
Life review	Structured reflection across the lifespan	Meta-analytic and pragmatic-trial support for some late-life outcomes	Heterogeneous formats, populations, and comparators
Dignity therapy	End-of-life interview and optional legacy document	Prespecified distress outcomes were null; some secondary patient appraisals were favorable	Secondary appraisals do not establish antidepressant or general distress efficacy
Expressive writing	Brief private writing about thoughts and feelings	One meta-analysis found a small average benefit; another found no significant pooled health benefit	Not a substitute for assessment or trauma treatment
Narrative exposure therapy	Chronological lifeline with repeated trauma-memory exposure	Systematic reviews support PTSD benefit and maintenance	Setting, population, comparator, and bias vary
Written exposure treatment	Session-based structured written trauma accounts	Noninferiority trial supports a brief PTSD option	Protocol-specific evidence should not be generalized to writing alone

XII. TRAUMA, AUTOBIOGRAPHICAL MEMORY, AND THE LIMITS OF COHERENCE

Trauma can disturb attention, encoding, retrieval, bodily regulation, trust, and the sense that events belong to a continuous past. Accounts may be vivid in places, absent in others, repetitive, emotionally detached, or altered as cues and meanings change. These features can be clinically important, but they are not reliable credibility tests. Research on autobiographical memory shows that suggestion can alter autobiographical belief and sometimes recollective experience, with substantial variation across procedures and individuals (Brewin & Andrews, 2017). The responsible conclusion is not that trauma memories are generally false or generally accurate; it is that therapeutic confidence, narrative detail, and emotional conviction cannot establish factual truth.

Meaning-making requires the same caution. An integrative review distinguishes attempts to make meaning from the attainment of meaning and shows that repeated efforts can accompany poorer adjustment when a discrepancy remains unresolved (Park, 2010). A therapist who repeatedly asks what a trauma 'taught' the patient may inadvertently intensify rumination or impose redemption. Patients may find meaning, reject the question, hold several meanings, or decide that an event was senseless. Clinical progress does not require forgiveness, gratitude, post-traumatic growth, or a unified moral conclusion.

Non-leading communication protects both care and epistemic humility. The clinician asks open questions needed for treatment, reflects uncertainty, and avoids filling gaps or rehearsing a preferred sequence. When safeguarding or legal processes are active, psychotherapy should not become an informal forensic interview. Records distinguish the patient's report, the clinician's observation, and any therapeutic hypothesis. Symptom relief, increased coherence, delayed disclosure, changing detail, or a calm presentation should not be presented as corroboration or disconfirmation of an event.

Coherence is best treated as one possible resource among several. A patient may benefit from a clearer timeline, from recognizing that two episodes were different, or from locating a memory in the past rather than the present. Another may need less detail and more grounding, sleep, safety, or social support. The test is whether the work reduces disabling intrusion or avoidance, improves orientation and functioning, and remains tolerable and chosen. A narrative that ends with uncertainty can still be clinically sound if it restores ownership and action.

XIII. PARTNERS, FAMILIES, CULTURE, AND PUBLIC RECOVERY STORIES

Partners and families often become the first audience for a changed account. Where relationships are safe, the therapist can help a patient make a specific disclosure or request, and help the listener respond with acknowledgment before explanation or advice. A partner may learn to ask, 'Do you want listening, practical help, or a different conversation?' The patient may learn to state uncertainty without surrendering the need for a boundary. These exchanges make narrative change interpersonal: a new position becomes more credible when another person can recognize it without taking authorship away.

Involvement is not automatically therapeutic. A partner or relative may retaliate, dispute, publicize, or use disclosed information as leverage. Joint work therefore requires consent, separate attention to safety, clarity about confidentiality, and

Haverkampf, C. J. (2024). Working with Stories in Psychotherapy: Narrative Identity, Meaning-Making, and Therapeutic Change. J Psychiatry Psychotherapy Communication, 2024 Mar 31;13(1):12-21

an explicit right to withhold detail. Communication training cannot neutralize coercive control. When involvement is unsafe, therapy may instead strengthen private authorship, selective disclosure, advocacy, and connection with a safer audience. Cultural and community contexts also shape whether speaking, silence, collective identity, spirituality, or family duty carries dignity or risk; these meanings should be elicited rather than assumed (Hammack, 2008).

Recorded and public recovery stories introduce a different audience. A systematic review found that receiving recovery narratives can produce hope, connection, validation, or understanding, while also provoking distress, comparison, or disconnection depending on content and context (Rennick-Egglestone et al., 2019). A later review identified ethical and practical risks when lived-experience narratives are recorded, selected, circulated, or reused in health and community settings (Yeo et al., 2022). Consent at creation does not answer every later-use question. Patients should know who controls editing, quotation, attribution, storage, withdrawal, and future audiences.

The clinical implication is that audience is part of the intervention. A responsive listener can help an exception become socially real; an unsafe or commercial audience can remove control. Clinicians should therefore monitor not only what story changes, but where it travels and what response follows. The best audience is not necessarily the largest or closest. It is one that the patient chooses, that can receive the account without coercion, and that supports the action the patient wants to take next.

XIV. MONITORING CHANGE AND RECOGNIZING FAILURE MODES

Language alone does not show whether narrative work is helping. The clinician can track target symptoms, risk, functioning, relationship quality, avoidance or rumination, and the patient's sense of authorship. A revised account that sounds hopeful in session but leaves sleep, work, self-care, danger, or isolation unchanged needs further examination. Conversely, a patient may function better before having a coherent explanation. Measures and concrete examples should inform one another: a symptom scale identifies trend, while a recent conversation, boundary, or completed task shows what changed in life.

Process monitoring asks whether the work is increasing specificity and choice or merely producing more narrative. Warning signs include escalating arousal after writing, repetitive retelling without new discrimination, pressure to agree with the therapist's interpretation, dependence on an approving audience, or avoidance disguised as endless meaning-making. A patient who cannot stop revising a document may need a limit and a different task. A patient who feels worse after disclosure may need safety planning, repair, or a decision not to tell that audience again. Table 3 pairs common risks with responses that preserve agency.

Failure can occur at several levels. The selected method may not fit the active problem; the dose may exceed capacity; the relationship may not permit correction; symptoms may reflect an unrecognized medical or psychiatric condition; or environmental danger may make reflective work secondary. Review points should ask what the treatment predicted, what actually happened, and which rival explanation now fits better. Lack of benefit is information about the formulation and intervention, not evidence that the patient has resisted a necessary story.

Table 3. Narrative-work risks and safer responses

Risk signal	Why it matters	Safer response
Flooding or destabilization	Detail exceeds current capacity and may worsen function or risk	Pause, ground, assess acute needs, reduce dose, or change method
Rumination	Repetition adds distress without specificity, choice, or action	Shift to present function, a bounded question, or behavioral task
Suggestive certainty	Therapist language can shape memory and overstate factual inference	Use open questions and separate report, observation, and hypothesis
Imposed redemption	Growth, forgiveness, or positivity becomes a condition of progress	Permit anger, grief, ambiguity, and an unfinished account
Unsafe disclosure	A listener may retaliate, coerce, disbelieve, or publicize	Assess audience and consequences; support selective or no disclosure
Loss of public-story control	Recording and reuse can outlast initial consent	Clarify editing, storage, attribution, withdrawal, and future audiences

XV. A PRACTICAL CLINICAL SEQUENCE AND SAFETY BOUNDARIES

A practical sequence begins by agreeing on purpose. Therapist and patient identify the problem to be addressed, the hoped-for change, and whether story-focused work is acceptable. The clinician then checks immediate safety and differential needs: suicidality, self-harm, psychosis, mania, severe dissociation, intoxication or withdrawal, abuse or coercion, acute medical concerns, and the patient's capacity to regulate after the session. Urgent assessment, stabilization, safeguarding, or medical care takes priority when indicated. Detailed trauma narration is not a prerequisite for compassionate care.

The pair next map one bounded account through selection, organization, positioning, and audience. They identify what the story predicts, how it affects emotion and action, what it protects, and what it costs. The therapist asks permission before seeking detail, explains the reason for questions, and

Haverkampf, C. J. (2024). Working with Stories in Psychotherapy: Narrative Identity, Meaning-Making, and Therapeutic Change. J Psychiatry Psychotherapy Communication, 2024 Mar 31;13(1):12-21

summarizes tentatively. Alternatives are generated as rival accounts, not corrections delivered from authority. An exception is examined for context, intention, response, and repeatability. If no exception is available, therapy can begin with conditions that would make one possible rather than insisting that the patient has overlooked a strength.

A preferred account is then translated into a proportionate test. The patient might make a specific request, set a boundary, resume a valued activity, correct the therapist, write privately for ten minutes, or choose a safe person with whom to share one part of the account. Prediction and outcome are recorded in the patient's language. The review asks what occurred, what remains uncertain, whether the action expanded agency or connection, and whether distress or risk increased. This cycle prevents re-authoring from becoming an attractive description detached from daily life.

Communication continues after the exercise. The therapist checks how the patient experienced the questions and whether any formulation felt leading, minimizing, or appropriative. Rupture repair is clinically relevant narrative work because it permits the patient to revise what the therapist has said and experience disagreement surviving. Decisions about notes, letters, recordings, legacy documents, or public narratives require separate consent and explicit discussion of access, confidentiality, legal limits, quotation, sharing, storage, and withdrawal. Ownership should not be inferred from participation.

Treatment is reconsidered when the patient deteriorates, feels unable to decline, becomes more ruminative or dissociated, encounters retaliation, or gains no functional benefit. The response may be slower pacing, a different audience, shorter or less detailed work, condition-specific treatment, practical intervention, consultation, or referral. No narrative technique overrides credible danger or necessary medical and psychiatric care. The governing principle is simple: the method serves the patient's safety and chosen life; the patient does not serve the method's preferred story of change.

XVI. CONCLUSION

Stories organize identity, suffering, relationships, and possible action, but their therapeutic value does not lie in storytelling alone. Personal narrative identity, narrative therapy, life review, dignity therapy, expressive writing, narrative exposure therapy, and written exposure treatment name different constructs and tasks. Their evidence must be interpreted separately. Across them, a useful clinical synthesis is that selection, organization, positioning, and audience provide four levers for inquiry, while agency, specificity, connection, and workable choice provide more defensible outcomes than positivity or coherence by themselves.

The listener is part of the intervention. Careful questions, transparent purpose, validation, correction, and relational safety can help a patient say what was previously unsayable or see variation where a problem account had become total. The same influence creates responsibility: therapy must not force disclosure, prescribe redemption, manufacture certainty, or treat narrative form as forensic evidence. Patients retain authority over what is told, withheld, recorded, and shared.

The strongest narrative change is visible beyond the consulting room. It permits a safer boundary, clearer communication, renewed relationship, tolerable experiment, or valued action while remaining open to revision. A story need not explain everything to be useful. It needs to help the patient understand enough, choose more freely, and meet the next part of life with a position that can be tested rather than a verdict that must be obeyed.

XVII. CONFLICTS OF INTEREST AND DISCLOSURES

Conflicts of interest—The author developed and writes about Communication-Focused Therapy (CFT). Where CFT is discussed, it is presented as a formulation perspective and not as a substitute for established assessment, evidence-based treatment, or independent replication. No other conflict of interest was reported.

Funding—No specific funding was reported for this article.

Author contributions—Christian Jonathan Haverkampf is the sole named author and is responsible for the conception, literature review, manuscript preparation, and approval of the final draft.

Patient material—No identifiable patient material is presented. Any brief examples are generic composites created to illustrate clinical reasoning and are not case reports.

XVIII. REFERENCES

Adler, J. M. (2012). Living into the story: Agency and coherence in a longitudinal study of narrative identity development and mental health over the course of psychotherapy. Journal of Personality and Social Psychology, 102(2), 367–389. https://doi.org/10.1037/a0025289

Adler, J. M., Harmeling, L. H., & Walder-Biesanz, I. (2013). Narrative meaning making is associated with sudden gains in psychotherapy clients' mental health under routine clinical conditions. Journal of Consulting and Clinical Psychology, 81(5), 839–845. https://doi.org/10.1037/a0033774

Brewin, C. R., & Andrews, B. (2017). Creating memories for false autobiographical events in childhood: A systematic review. Applied Cognitive Psychology, 31(1), 2–23. https://doi.org/10.1002/acp.3220

Charon, R. (2001). Narrative medicine: A model for empathy, reflection, profession, and trust. JAMA, 286(15), 1897–1902. https://doi.org/10.1001/jama.286.15.1897

Chochinov, H. M., Kristjanson, L. J., Breitbart, W., McClement, S., Hack, T. F., Hassard, T., & Harlos, M. (2011). Effect of dignity

Haverkampf, C. J. (2024). Working with Stories in Psychotherapy: Narrative Identity, Meaning-Making, and Therapeutic Change. J Psychiatry Psychotherapy Communication, 2024 Mar 31;13(1):12-21

therapy on distress and end-of-life experience in terminally ill patients: A randomised controlled trial. The Lancet Oncology, 12(8), 753–762. https://doi.org/10.1016/S1470-2045(11)70153-X

Flückiger, C., Del Re, A. C., Wampold, B. E., & Horvath, A. O. (2018). The alliance in adult psychotherapy: A meta-analytic synthesis. Psychotherapy, 55(4), 316–340. https://doi.org/10.1037/pst0000172

Frattaroli, J. (2006). Experimental disclosure and its moderators: A meta-analysis. Psychological Bulletin, 132(6), 823–865. https://doi.org/10.1037/0033-2909.132.6.823

Gonçalves, M. M., Silva, J. R., Mendes, I., Rosa, C., Ribeiro, A. P., Batista, J., Sousa, I., & Fernandes, C. F. (2017). Narrative changes predict a decrease in symptoms in CBT for depression: An exploratory study. Clinical Psychology & Psychotherapy, 24(4), 835–845. https://doi.org/10.1002/cpp.2048

Grech, P., & Grech, R. (2020). A comparison of narrative exposure therapy and non-trauma-focused treatment in post-traumatic stress disorder: A systematic review and meta-analysis. Issues in Mental Health Nursing, 41(2), 91–101. https://doi.org/10.1080/01612840.2019.1650853

Hallford, D. J., Rusanov, D., Yeow, J. J. E., & Barry, T. J. (2021). Overgeneral and specific autobiographical memory predict the course of depression: An updated meta-analysis. Psychological Medicine, 51(6), 909–926. https://doi.org/10.1017/S0033291721001343

Hammack, P. L. (2008). Narrative and the cultural psychology of identity. Personality and Social Psychology Review, 12(3), 222–247. https://doi.org/10.1177/1088868308316892

Haverkampf, C. J. (2012). Adult attachment in psychotherapy: Security, distance, and the work of relationship. J Psychiatry Psychotherapy Communication, 1(4), 91–99.

Korte, J., Bohlmeijer, E. T., Cappeliez, P., Smit, F., & Westerhof, G. J. (2012). Life review therapy for older adults with moderate depressive symptomatology: A pragmatic randomized controlled trial. Psychological Medicine, 42(6), 1163–1173. https://doi.org/10.1017/S0033291711002042

Lind, M., Adler, J. M., & Clark, L. A. (2020). Narrative identity and personality disorder: An empirical and conceptual review. Current Psychiatry Reports, 22(12), Article 67. https://doi.org/10.1007/s11920-020-01187-8

Lopes, R. T., Gonçalves, M. M., Fassnacht, D. B., Machado, P. P. P., & Sousa, I. (2014). Long-term effects of psychotherapy on moderate depression: A comparative study of narrative therapy and cognitive-behavioral therapy. Journal of Affective Disorders, 167, 64–73. https://doi.org/10.1016/j.jad.2014.05.042

Lopes, R. T., Gonçalves, M. M., Machado, P. P. P., Sinai, D., Bento, T., & Salgado, J. (2014). Narrative therapy vs. cognitive-behavioral therapy for moderate depression: Empirical evidence from a controlled clinical trial. Psychotherapy Research, 24(6), 662–674. https://doi.org/10.1080/10503307.2013.874052

Matos, M., Santos, A., Gonçalves, M., & Martins, C. (2009). Innovative moments and change in narrative therapy. Psychotherapy Research, 19(1), 68–80. https://doi.org/10.1080/10503300802430657

McAdams, D. P. (2001). The psychology of life stories. Review of General Psychology, 5(2), 100–122. https://doi.org/10.1037/1089-2680.5.2.100

McLean, K. C., Syed, M., Pasupathi, M., Adler, J. M., Dunlop, W. L., Drustrup, D., Fivush, R., Graci, M. E., Lilgendahl, J. P., Lodi-Smith, J., McAdams, D. P., & McCoy, T. P. (2020). The empirical structure of narrative identity: The initial Big Three. Journal of Personality and Social Psychology, 119(4), 920–944. https://doi.org/10.1037/pspp0000247

Mogk, C., Otte, S., Reinhold-Hurley, B., & Kröner-Herwig, B. (2006). Health effects of expressive writing on stressful or traumatic experiences: A meta-analysis. GMS Psycho-Social-Medicine, 3, Doc06. https://pmc.ncbi.nlm.nih.gov/articles/PMC2736499/

Park, C. L. (2010). Making sense of the meaning literature: An integrative review of meaning making and its effects on adjustment to stressful life events. Psychological Bulletin, 136(2), 257–301. https://doi.org/10.1037/a0018301

Pinquart, M., & Forstmeier, S. (2012). Effects of reminiscence interventions on psychosocial outcomes: A meta-analysis. Aging & Mental Health, 16(5), 541–558. https://doi.org/10.1080/13607863.2011.651434

Rennick-Egglestone, S., Morgan, K., Llewellyn-Beardsley, J., Ramsay, A., McGranahan, R., Gillard, S., Hui, A., Ng, F., Schneider, J., Booth, S., Pinfold, V., Davidson, L., Franklin, D., Bradstreet, S., Arbour, S., & Slade, M. (2019). Mental health recovery narratives and their impact on recipients: Systematic review and narrative synthesis. The Canadian Journal of Psychiatry, 64(10), 669–679. https://doi.org/10.1177/0706743719846108

Siehl, S., Robjant, K., & Crombach, A. (2021). Systematic review and meta-analyses of the long-term efficacy of narrative exposure therapy for adults, children and perpetrators. Psychotherapy Research, 31(6), 695–710. https://doi.org/10.1080/10503307.2020.1847345

Sloan, D. M., Marx, B. P., Lee, D. J., & Resick, P. A. (2018). A brief exposure-based treatment vs cognitive processing therapy for posttraumatic stress disorder: A randomized noninferiority clinical trial. JAMA Psychiatry, 75(3), 233–239. https://doi.org/10.1001/jamapsychiatry.2017.4249

Sohal, M., Singh, P., Dhillon, B. S., & Gill, H. S. (2022). Efficacy of journaling in the management of mental illness: A systematic review and meta-analysis. Family Medicine and Community Health, 10(1), e001154. https://doi.org/10.1136/fmch-2021-001154

Vromans, L. P., & Schweitzer, R. D. (2011). Narrative therapy for adults with major depressive disorder: Improved symptom and interpersonal outcomes. Psychotherapy Research, 21(1), 4–15. https://doi.org/10.1080/10503301003591792

White, M., & Epston, D. (1990). Narrative means to therapeutic ends. W. W. Norton. https://www.loc.gov/item/89048776/

Yeo, C., Rennick-Egglestone, S., Armstrong, V., Borg, M., Franklin, D., Klevan, T., Llewellyn-Beardsley, J., Newby, C., Ng, F., Thorpe, N., Voronka, J., & Slade, M. (2022). Uses and misuses of recorded mental health lived experience narratives in healthcare and community settings: Systematic review. Schizophrenia Bulletin, 48(1), 134–144. https://doi.org/10.1093/schbul/sbab097