MASARYK UNIVERSITY

Faculty of Social Studies

NARRATIVE SENSITIVITY:

Towards an Integration of Psychology and Psychotherapy in Medicine

MUDr. David Skorunka, Ph.D.

Brno 2021

To Marie and František, who sparked off my passion for all sorts of stories…

I declare that this thesis has been composed solely by myself and is based only on my own research, on a bibliographical review and my clinical work. It has not been submitted for any other degree or professional qualification. Only short parts of this work have already been included either in my doctoral thesis or in articles published elsewhere. These parts are appropriately marked, when indicated. The data presented in the research part of the thesis was obtained in an experiment, which I designed and carried out by me. Although another collaborating researcher and an auditor participated in the data analysis, I played the main role in the research process and the interpretation of the findings is entirely my own. Any contributions from colleagues in the collaboration are explicitly referenced in the text. All resources used in the thesis are referenced appropriately throughout the text as well.

In Hradec Králové, 1st December 2021 David Skorunka

CONTENT

FOREWORD

Before embarking on a path which includes both a review of theoretical knowledge and presenting the results of one’s research, it is important to reflect on the initial motivations for choosing a topic and/or adopting a particular perspective. This holds true particularly if the chosen topic involves disciplines that draw on the social construction of knowledge and question the illusion of certainty regarding scientific truth. Writing about the concept of narrative while forgetting one's own subjectivity and personal autobiography would be a striking antithesis to a general narrative framework. A thesis about narrative key in medicine would not be complete without including subjectivity and context. Due to ongoing self-reflection within personal and professional development, it is quite easy for me to recall the significant moments (arguably key events in my life) which might have initially drawn me to the field of medicine and later sensitised me to its shortcomings. My experiences during my undergraduate medical study, filtered through my own personal lens, encouraged me to reach beyond biomedicine for different kinds of knowledge. Perhaps that is when the interest in psychotherapy and psychosomatic medicine first began—in order to integrate relevant psychology and psychotherapy knowledge into medicine and embrace the bio-psycho-social complexity of prevention, health, disease, and clinical treatment. Let us paraphrase a quote from the first book of a highly acclaimed Harry Potter series: “Curious indeed how these things happen. The topic chooses the author, remember.” What follows are three recalls of different encounters with medicine, from early childhood to young adulthood, which might have contributed, the former probably unconsciously and the latter with conscious reflection, to my decision to study medicine and be critical of narrow biomedical models.

Image 1.

Dark corridor, strange smell, silence. Scary posters on the wall. Pain and fear of greater pain. Tension, sense of threat, uncertainty.

The child's first encounter with medicine, particularly in the early stages of development, may leave only traces of sensations and perceptions. One cannot be sure whether they are an exact match to the real experience at the time or how the current recall is shaped by later experiences and other factors at the moment of the recall. On top of that, making a link between such an experience, common for childhood, with an eventual pursuit of a medical career is obviously a sheer speculation. However, this image may offer an idea of what it is like for a pre-schooler to visit a healthcare facility.

Image 2.

> *Strange feelings, constant fatigue. First a medical examination at the paediatrician outpatient office, then other examinations and a subsequent consultation at the paediatric department. Sitting alone in the hall, waiting for my parents, who were having a conversation with the paediatrician in the office. Seeing my mother come back with wet eyes, looking sad. Uncertainty and confusion. A few days into the fortnight stay at the paediatric department for observation, experiencing the first ward round. A group of doctors and nurses coming into the room, talking only among themselves, speaking in a "foreign" language and telling me nothing.*

The second image brings us to the time when I was entering my teens. The recall is more complex, being more of a story rather than a mixture of sensations. Other characters participate in the plot, as well. The protagonist is now able to also notice the feelings of others. Many aspects are still missing from the recall—my mother's emotions, for instance, as well as the potential gravity of the situation. Soon after this event, I started high school. I was already reading a lot back then. I can remember three fiction novels from within the hospital environment, which, at the time, I found utterly gripping. In *The Final Diagnosis*, Arthur Hailey depicted some of the challenges of professional career development, the dilemmas in clinical medicine, and the patients' tragic predicaments and the impact they had on their loved ones. In *Unwanted*, Christiaan Barnard, the notable South-African cardiac surgeon who performed the world's first human-to-human heart transplant, offered his life experience in a novel co-written with Siegfried Stander, a professional writer. The thrill and exclusivity of transplant surgery, which was not so frequent at that time, along with the social circumstances that shaped the personal dilemmas faced by the characters in their professional and personal lives are likely what drew me in. In *Doctors*, Erich Segal vividly depicted the hardship of medical study and the challenges which young doctors faced in the early stages of their careers when balancing their personal and professional lives. These fictional stories did not discourage me from my plans, and I took a summer job as a care assistant at the county hospital. Work experience at the internal department was a stark contrast to those fictional accounts, but it was an exciting experience for a 17th year old high school student, nonetheless. So, I registered for the entrance exams in my last year of high school and then enrolled at the Faculty of Medicine.

Image 3.

> *The second half of my undergraduate medical study, my 4th year. A growing sense of confidence from effectively adapting to the challenges of medical study. At the same time, an unexpected sense of disillusionment was creeping in. At one of the surgery classes at the Department of Surgery, the teacher asked our group of 7 medical students to conduct an interview with a patient and carry out the basic physical examination. A 76-year-old man who was diagnosed with and treated for cancer was waiting for us. Despite the diagnosis and prognosis, he came across as lively and completely reconciled with his destiny, while looking back at his life and sharing a few stories with us. Being affected by this interpersonal experience, we eagerly shared it with the teacher afterwards. His response surprised us. He expressed rather sceptical and possibly disparaging comments about our interest in the patient's subjective experience, including his reflection in the face of imminent death. I can still remember the teacher's words: "Such talks are useless! You are too young to think about life and death issues."*

This recall presents a more elaborate narrative. The experience comes from young adulthood and is the one which often resurfaces during my professional and personal development as well as during my conversations with medical students. This experience, and possibly all those recalled here, might have sensitised me to the blind spots of biomedicine and driven me towards psychology, psychotherapy, and psychosomatics. There were more, similar experiences during my undergraduate training and internships but this one was the first and therefore most prominent. There were also a few fellow students who felt disillusioned by such experiences during our undergraduate study. Sharing those experiences sparked interest in fields outside of medicine and resulted in some fruitful, lifelong friendships.

Obviously, there have been more factors and motivations, more or less unconscious, which triggered my interest in psychotherapy and psychosomatics. I have come to understand some of them during psychotherapy training and even later during personal therapy. It took a few more years after graduation before I came across articles and textbooks, which helped me understand my disillusionment with biomedicine stemming from some experience during my undergraduate study. The new resources opened new worlds and brought about new learning opportunities. I started training in family therapy, accomplished other training programs, including internships abroad and then embarked on a path of integrating psychotherapy in my medical specialisation. Many clinicians and scholars, whom I met both at home and abroad, introduced me to other perspectives and thus enriched my knowledge as well as my modes of clinical practice. Among them, I would like to mention Harlene Anderson, Patricia Crittenden, Ivo Čermák, Rudi Dallos, Šárka Gjuričová, Vladislav Chvála, Jiří Kubička, John McLeod, Eija-Liisa Rautiainen, Jaakko Seikkula, Ludmila Trapková, Arlene Vetere, Zbyněk Vybíral, and Michael White. Each of them uniquely contributed to both my personal and professional development either through their writing or personal interactions and friendships. I would like to thank them all.

1. THEORETICAL PART I.

1.1. Introduction

Storytelling is a ubiquitous phenomenon in human evolution and the development of civilisations. A great deal of historical, philosophical, and anthropological studies provides sound evidence that storytelling plays a key role in both individual and cultural development. At different stages of human evolution, stories and narratives were embedded in important traditions, rituals, and religious systems. The means for creating, sharing, and consuming stories have evolved from oral traditions and cave painting, through written word, to images distributed through various media. On one hand, the overproduction of stories in popular culture and the development of sophisticated technology including social media and virtual reality make an impression of narrative inflation. On the other hand, feedback from people struggling with various forms of distress consistently shows that storytelling still serves as an antidote to suffering, helplessness, demoralisation, and isolation. Although it was rather neglected by some scientific fields nearly until the end of the 20th century, “story” and “narrative” have now become frequently used terms in many disciplines.

Among their many functions, stories and narratives served as explanatory frameworks, a moral compass, guidelines for managing and coping with life challenges, inspiration for solving various dilemmas, a means of processing traumatic experiences, and incentives for rites of passage. Some of the so-called grand narratives provide answers to many “Why?” questions, explaining the aspects of the world and life that people did not understand. At the same time, the so-called grand narratives had a constitutive power over peoples´ lives. Grand narratives served as templates for people to structure and direct their lives in a particular way. They strengthened social cohesion and also ignited conflicts. Storytelling and sharing of personal narratives have been a crucial way of both experience and knowledge exchange in various forms of communal and social worlds. It is only recently that the forms of such exchange and even consumption have seen any dramatic change. Today there is much discussion about the powerful narrative industry that has emerged over the last 70 years and the wide range of new and sometimes problematic narratives it has generated that shape our ways of making sense of various aspects of human life, such as health, illness, family, sexuality, and the meaning of life. Drawing on McLeod's (1997) review of narrative forms in different periods of human social development, we can be concerned about newer forms which have emerged recently, and which can be anticipated soon (see Tab.1)

Table 1. *Storytelling in different periods of time (McLeod, 1997, p.24; additions Skorunka, 2016*)*

Traditional society	**Modern society**	**Postmodern society**	***Near future? ****
Oral culture Participatory, communal storytelling	Literary, print culture	TV, cinema, internet computer, smartphone, Emerging possibilities of interaction with electronic media	*Brain-IT interface* *Artificial intelligence* *Virtual experience*
Share storytelling in the community	Passive, individualised story-reading	Passive consuming of stories-visual images Prevailing communication with Social media	*Virtual, interactive reality* *Blurred boundaries between private and communal*
A collective religious and moral framework	Secularised everyday life	Global everyday reality and interconnection	*Fragmented society and/or new interconnections*
Relatively limited range of stories and narratives	Expanded range of stories available, reflecting the increased individual´s possibilities	Seemingly limitless narrative choice	*Indoctrination with new narratives* *Manipulation* *New norms*
Heroic themes Circular story structure, musicality and poetry	Romantic themes - ordinary man as a hero Linear, logical structure	Relativisation and questioning the previous themes Experimentation and deconstruction of traditional structures	*New themes or revival of old ones* *New identities*
Personal/family problem stories understood in moral-religious terms and shared in community arena	Personal/family problem conceptualised in scientific terms and told in confidence to one other person	Public disclosure of problem stories (testimony, survivors speak out, shows)	*Exposure and control of privacy* *Wide range of conceptualisation of problems*
Narrative unity sought at community level	Narrative unity sought at individual level	Questioning of possibility of narrative unity	*Narrative multiplicity* *New identities*

This thesis is primarily focused on exploring the potential of the narrative concept in medicine. It consists of a Foreword, Introduction, Theoretical Part I. and II., Research Part and the Final Word. Because the so-called narrative turn first started in the humanities and social sciences including psychology, the first theoretical part will give a brief overview of the shift in those disciplines. We will also review recent knowledge from developmental psychology and interpersonal neurobiology regarding narrative, health, illness, and therapy. In the second section of the theoretical part, we focus on the use of metaphor of a story and narrative in contemporary psychotherapy. We will explore the ways in which those metaphors were embraced in both theory and the clinical practice of well-established psychotherapeutic modalities. Referring to McLeod (2004a, 2006), we will distinguish two manifestations of narrative metaphor in psychotherapy: a) narrative-informed psychotherapy embedded in psychological knowledge with emphasis on an individual Self; b) narrative-informed psychotherapy and narrative therapy embedded in postmodern philosophy and the theory of social construction with emphasis on the relationship between an individual and culture. Using examples from clinical practice, we will demonstrate how different psychotherapeutic modalities work with the metaphor of story and narrative.

Why do we first deal with narrative in psychotherapy, if the primary focus of the thesis is on exploring the potential of narrative in medicine? There are two reasons for giving a detailed overview of narrative and psychotherapy before moving on to the narrative turn in medicine. First, the evolution of psychotherapy was heavily influenced by medicine during the 20th century. On one hand, the biomedical model shaped the psychotherapeutic theory of pathology and research of both the psychotherapy process and its outcome (Wampold & Imel, 2015). On the other hand, an appeal to integrate relevant psychology and psychotherapy into medicine has been included in the calls for a bio-psycho-social model and the development of psychosomatic medicine (Asen et al., 2004; McDaniel, Doherty & Hepworth; 2014; Skorunka, 2020). As will be explained in the text, we consider narrative to be an integrative concept both within the diverse field of psychotherapy and beyond, with potential to bridge the world of psychology/psychotherapy and medicine. In the second section of the theoretical part, we first give a detailed overview of narrative medicine development in the context of a critical reflection of biomedicine, solid arguments for retaining humanistic principles in clinical medicine, and the application of bio-psycho-social model not only in theory and research, but particularly in clinical practice. Regarding the application of narrative ideas in medicine, we will discuss the notion of narrative competence coined by Charon (2001 a, b). We will introduce our concept of narrative sensitivity, which we derived from both Charon's writing, our clinical experience, and interdisciplinary consultations about the skills necessary in psychosomatic medicine based on the bio-psycho-social model. Apart from a review of relevant research, we will also complement the research findings and support our arguments with examples from clinical practice.

In the research part, we will first review the research on narrative medicine programs including training in narrative and related reflective skills. We will also explain the situation in the Czech Republic, which is strikingly different from the development of narrative medicine in some other countries, to provide the necessary local context for our research. Then we will describe our mixed-method study on narrative sensitivity in medical students. We will describe in detail the design, methodology, data collection, data analysis, and results. Finally, we will discuss and interpret the results and draw some conclusions. The Final Words section will shortly summarize the main arguments based on both theory, research and practice.

As we have already mentioned, there will be examples from the author's clinical practice. Because they do not allow any generalizations, case studies were placed low in the hierarchy of scientific evidence in both medical and psychotherapy research (Fonagy & Roth, 2005). Despite this, case studies have long been a traditional way of sharing clinical experience as well as a means for conveying various aspects of the psychotherapy process in training. On top of that, case study research has become a well-established way of studying psychotherapy among qualitative research methods including those based on the concept of narrative (McLeod, 2010). We are fully aware that these examples are not rigorous case studies that include all voices and aspects of both the therapy process and its outcome. Instead, the examples are clinical vignettes narrated with the aim of emphasizing how a particular psychotherapeutic approach embraces the concept of narrative. The examples are also selected with the intention of capturing the complexity of the presented problem, including the interconnection between mind, body, and relationships, where indicated. In presenting the clinical vignettes, we have no ambition to indicate any causal relationships to the “etiopathogenesis” of the presented problem and the therapy outcome. By including the examples from the author's clinical practice, we try to strike a balance between paradigmatic knowing (theory, research) and the narrative one in Bruner's sense (1987, 2004). These vignettes are presented in a manner that preserves the ethical principles of anonymity and confidentiality.

1.2. The Concept of Narrative in the Humanities and Social Sciences

Since the 1980's, there has been a significant increase in the use of terms such as “narrative”, “narrations”, and “narrate” in citations, titles of journal articles, and the foci of research projects (Hevern, 2003). Representatives of a wide range of academic and clinical disciplines seemed to rediscover the concept of narrative and set off this so-called narrative turn. Since then and in the following decade after 2000, both story and narrative became basic metaphors for the exploration, study, and research of various psychological and social aspects of human life. When illuminating the historical background of narrative ideas, Čermák (2003) suggested that the emergence of narrative psychology coincided with similar thoughts and diverse movements in various fields, such as philosophy (Ricoeur, 1984), epistemology (Bruner, 1986), psychology (Sarbin, 1986; Baerger & McAdams, 1991, Gergen, 1999), anthropology (Geertz,1973; van Gennep, 1997; Kleinman, 1988), literary theory, and linguistics (Marková, 2007; Seikkula &Arnkill, 2006). “*The emergence of narrative psychology results from a long and difficult development of thinking about a human being… Narrative psychology did not come out of the blue as an unforeseen concept or a new discovery without context. It emerges because of rather differentiated movements of thought particularly in literary theory, philosophy, and linguistics*” (Čermák, 2003, p. 1).

Story and narrative have been acknowledged as essential organizing structures in human perception, cognition, the development of Self and or identity, and interpersonal processes (Bruner, 1987, 2004; Baerger & McAdams, 1999; Chrz & Čermák, 2015; Polkinghorne, 2004; Sarbin, 1986; Spence, 1984). The benefit of storytelling for both mental and physical health, whether in expressing the narratives through various means or sharing with others, has been observed by clinicians and evidenced by researchers. Based on the basic need to disclose an experience, particularly a distressing one, expressing the emotionally salient stories affect both the mind (e.g., processing emotions, strengthening personal agency) and body (e.g., decrease in blood pressure and muscle tension, a positive impact on the immune system, etc.; Kiecolt-Glaser et al., 2002; Kiecolt-Glaser et al., 2011; Morgan et al., 2008; Pennebaker & Seagal, 1999; Pennebaker & Niederhoffer, 2002; Smyth et al. 1999, 2001). Given the research from various disciplines, it is understandable that the narrative concept became a useful framework for understanding various aspects of psychotherapy and the family therapy process, which include witnessing, social support, regulating emotions, story re-construction, development of new identities, etc. (Dallos & Johnstone, 2013; Freedman & Combs, 1996; McLeod, 1997; Parry & Doan, 1994; White & Epston, 1990).

It is evident that story and narrative are inescapable constants of our lives—as human beings, we live our lives through stories. We relate accounts of our day to our loved ones when we return home from work, exchange family and personal narratives in annual holiday letters and at reunions and tell bedtime stories to our children. Likewise, we assimilate the stories of our place and time—and other places and times—through immersion in the countless narratives offered to us on television, in films, on stage, or in print. When troubled, we sometimes sort through stories to our current struggles and childhood conflicts with those we trust, including helping professionals. Even dreams and spontaneous fantasies often take on a storied form as if the human brain were destined or evolutionarily designed to create stories. So pervasive is the human tendency to integrate experience through the (co)-construction of stories that we as a species might appropriately be named *Homo narrans* rather than *Homo sapiens* (Neimeyer & Tschudi, p. 167; Neimeyer & Levitt, 2001; Herman et al., 2007). This conclusion, first hypothesized and then researched by psychologists and representatives of other disciplines, is now evidenced from interdisciplinary fields, such as interpersonal neurobiology (Siegel, 2020).

Regarding the process of building our knowledge (epistemological discussions), Bruner (1987) distinguished paradigmatic and narrative knowing. Paradigmatic knowing is rooted in scientific modes of thought. It aims to describe/discover the world with the help of theoretical systems, concepts, and abstract knowledge. The narrative of knowing, on the other hand, is derived from stories that people recount and share about their experience. Those stories are represented by collective resources, such as myths, legends, etc. and also by personal accounts of unique individual experience. For Bruner (1987), both the narrative and paradigmatic modes of building up our knowledge are essential and, arguably, complementary ways to make sense of the world and ourselves. In our process of knowing we should seek a balance between the two. However, the paradigmatic mode seems privileged in sciences including psychology and psychotherapy whereas narrative knowing is still perceived as less important, irrelevant, or even illegitimate. For instance, in medicine, the objective data which comes from physical, laboratory, or various imaging methods are considered of utmost importance for making the diagnosis, the prerequisite for the right treatment according to the clinical guidelines. Until recently, the subjective experience of illness, including the impact of the disease upon the person, his/her family, and their quality of life was largely overlooked, downplayed and/or deemed as irrelevant for clinical assessment and for the physician's approach.

Why has the notion of narrative become so popular? According to Tantam (2007), the increased popularity of the concept of narrative reflected the epistemological crisis of both contemporary culture and science. Narrative is all that remained after the belief in objectivity and progress became seriously eroded by a combination of tragic events during the 20th century, the reflection of postmodern philosophy, the theory of social construction, etc. On top of that, there is a growing danger of dehumanisation in contemporary science, including medicine, due to unprecedented and rapid biotechnological advancement, reliance on meta-analysis data, and the belief in decontextualized objectivity. In this development of human civilization, a recognition and even rediscovery of subjectivity, respect to uniqueness of each individual human story. As McLeod (2007) noted: "*Enormous success of engineering, technology and the physical sciences in the 19th and 20th centuries led to a situation in which it became commonplace to view human beings as mechanisms, as objects, machines or organisms that might break down and require fixing. … This attitude, while valuable in some respects, brought with it the danger of dehumanisation"* (McLeod, 2007, p. 2.).

Thus, it is not surprising that many scholars, researchers, and clinicians from psychology and medicine have been advocating for an integrative, bio-psycho-social framework to understand various problems in human life, including health-and illness-related issues. We will discuss this in detail in the next part of the thesis.

1.3. Narrative in Lens of Interpersonal Neurobiology and Attachment Theory

So far, we have discussed the application of a narrative framework in different psychotherapeutic modalities. As most psychotherapies are based on conversations (the so-called talking cure) or a combination of conversations with other approaches (e.g., body work, relaxation techniques, mindfulness, psychedelic assisted psychotherapy, etc.), the role of the client/patients' level of storytelling ability should be discussed as well. We all differ in our ability to story our experience and share it with others, especially in the form of an often emotionally charged narrative. What factors nurture or hinder the development of those crucial skills? The answer to such questions comes from the field of social and developmental psychology and neuroscience. Research on attachment and interpersonal neurobiology over the last two decades has shed more light on early relationship experience and mind processes. As both contemporary attachment theory and interpersonal neurobiology are rather vast fields, we will only shortly summarize the main findings here. Providing a detailed description of all brain circuits and areas involved is beyond the scope of this work, so we will focus mostly on the developmental and mind processes related to narrative.

Interpersonal neurobiology (IPNB) is a framework developed on the basis of findings from a wide range of disciplines from neuroscience, developmental psychology, and infant mental health to psychopathology and psychotherapy. It was created to understand the complexity of the interconnections between body, brain, mind and relationships during development. Siegel (2020) introduces the IPNB framework as one organized around three fundamental principles: 1. A core aspect of the human mind is an embodied and relational self-organizing process that regulates the flow of energy and information within the brain and its body, and in relationships between and among individuals and their connections with the broader natural world. 2. The mind, as an emergent property of the body and relationships, is created within internal neurophysiological processes and external relational experiences. In other words, the mind is a process that emerges from the distributed nervous system extending throughout the entire body, and from the connecting communication patterns that occur within relationships. 3. The structure and function of the developing brain are determined by how experiences, especially within interpersonal relationships, shape the genetically programmed maturation of the nervous system (Siegel, 2020, p. 6-7).

In his recent, highly acclaimed work, Siegel (2020) provides an in-depth synthesis of research evidence that both the structure and function of the developing brain are determined by how experience, especially within close interpersonal relationships, shape the genetically programmed maturation of the nervous system, particularly in the early stages of development. Relationship experiences have an influence on the brain because the circuits for social perception are the same as or tightly linked to those that integrate the important functions controlling the creation of meaning, the regulation of bodily states, the modulation of affect/emotion, the organisation of memory, and the capacity for interpersonal communication. Given the vast evidence from neurobiology and related disciplines, it seems as if the human brain is evolutionarily designed to organize internal and external stimuli into a narrative structure. Furthermore, this neurobiological proneness to storying experience is an essential prerequisite for physical and mental health and for the ability to create social connections between human minds (Cozolino, 2012; Dimaggio & Semerari, 2004; Schore, 2015).

A coordination of several neurobiological processes is needed from the first moments of human development. Siegel (2020) emphasizes both the differentiation of different areas of the brain and the linkage of those areas of the brain with specific functions. A balanced differentiation and linkage are necessary to facilitate integration of experience and narrative organisation that maximizes coherence within the mind. Almost all parts of the brain (e.g., thalamus, limbic system, hippocampus, prefrontal regions of cortex, HPA axis, etc.) with different functions (e.g., perception, emotion, cognition, memory, and stress response) participate in those fundamental processes. Those processes provide a sense of the Self in space and time, regulate perceptual organisation, and intertwine emotional appraisal processes with an array of mental representations. Several authors suggest that the associational areas of the neocortex, such as the prefrontal regions (including the medial prefrontal and orbitofrontal cortex) that link various widely distributed representational processes together, are fundamental to narrative and form dynamic global maps or complex representations in order to establish an experiential integration of the Self across space and time (Coan, 2016; Crittenden & Landini, 2011).

To achieve coherent narratives, the participation of both hemispheres and their different modes of processing information is required. The right brain's perceptually rich, analogical, context-dependent, autonoetic, mentalizing representations create much of the imagery and many of the themes of the narrative process. The logical, linear, "making sense" interpretations of these representations and the communication of narrative details stem from the left hemisphere's interpretive and linguistic processing of representations. Coherent narratives are created through interhemispheric integration that recruits multiple layers of circuits, creating the most complex states of mind as it links various forms of representation throughout the brain and between brains in interpersonal communication (Siegel, 2020). According to an extensive body of research in neuroscience and developmental psychology, relationships with caregivers in the early stages of development shape neurobiological processes which are both genetically pre-programmed and experience dependent (Crittenden, 2015; Siegel, 2020, Schore, 2015, Priddis & Howieson, 2010).

It is current attachment theory, a robust developmental concept, which provides an understanding of the interconnections between the mind, the body, and relational processes. Today, attachment theory can be considered a) a theory on the social regulation of affective (psychobiological) processes; b) a developmental theory on the interconnectedness of complex neurophysiological processes (perception, stimuli/information processing, memory, affect, cognition); c) a theory connecting intrapersonal phenomena (thought, emotions, behaviour) and interpersonal phenomena (interpersonal strategies, communication patterns); d) a theory exploring the mutual influence of the mind, the body, and relationship processes, including epigenetic mechanisms (Cassidy & Shaver; 2016; Siegel, 2020; Waite & Ryan, 2019). Research based on attachment theory provides consistent evidence that experiences with primary caregivers in the first months and years of life shape brain, mind, and body physiology that is related both to basic functions (e.g., affect regulation) and more complex skills during an individual's development (e.g., empathy, narrative and reflective skills; Kobak et al., 2016; Cassidy & Shaver, 2016). In a broader sense, attachment can be understood as a stable progression of a cognitive, affective, and behavioural style that persists into adulthood, creating an interpersonal template that underpins one's ability to relate to others, regulate one's own emotions, manage autonomic arousal in order to cope with challenging/threatening factors and situations, and also to relate to oneself in a balanced way.

In a recent, expanded version of attachment theory, a Dynamic Maturational Model (DMM), Crittenden (2015) offers a thorough developmental framework for understanding how individual's affective, cognitive, and somatic processes organize behaviour and how these processes, traditionally understood as individual-based, are dependent on context and are mutually interconnected with interpersonal experience. In her DMM, Crittenden (2015) expands John Bowlby's ideas about separation and loss to all other kinds of dangers, including emotional, physical, and sexual harm. The standard classification of main attachment patterns was first conceptualized by Ainsworth (1976) and then expanded by her students and followers (e.g., Mary Main, Eric Hesse, Patricia Crittenden; Hesse, 2008; Crittenden, Landini, 2011). Crittenden (2015) suggested a developmentally increasing array of subtler strategies which function as: a) a self-protective strategy as a response to a threat/danger; b) a strategy to fulfil basic needs, such as safety, acceptance, closeness, care, etc.; c) individually unique information processing that gives rise to dispositional representations of Self in context. The individually unique information processing comes from two main sources of stimuli, the sequence of events/stimuli and the sensory intensity of stimuli (both internal and external). Stimuli from those sources are processed and transformed into dispositional representations. In this process, the caregiver's response to and interactions with a child affects the transformation and in many times distortions of representations, which then become inevitable part of self-protective strategy learned in the context of attachment relationships (Crittenden, Dallos, Landini, & Kozlowska, 2015). Put simply: "*Families and family members differ in how clearly, openly, reflexively and coherently they are able to generate talk about their experiences*" (Dallo &, Vetere, 2009).

Adults help the child to regulate their neurophysiological arousals (emotion) and organize inner and relational experiences of the Self across the past, present, and future (Montgomery, 2013; Schore, 2015; Siegel, 2020). Families differ significantly in how they facilitate or hinder their children's abilities to describe their experience, recollect memories, and share their imaginations. Repeated patterns of children's interactions with their caregivers become "remembered" in various modalities of memory and directly shape not just what children recall, but how the representational processes develop. As a result, a sense of self emerges. Behaviour, emotion, perceptions, sensations, and models of others are engrained by experiences that occur before children have autobiographical memory processes available to them. It is through complex memory systems, both implicit and explicit, what we remember, how we remember and how we shape the narratives of our lives. Memory can be understood as the way an individual encodes events and experiences into various representations, while creating a sense of continuity across time, linking past experiences with present perceptions and anticipations of the future (Siegel, 2020). As a result, the generalisations about Self, Self with others and the world are developed through time. As Dallos (1997, 2006) points out, there are two essential dimensions of representations: a) assumptions about the Self—whether one is accepted and/or loveable as he/she is; b) assumptions about others—whether others are a source of danger or care/love, and whether others will be available in times of distress or danger. This could be simplified into a generalisation about the world: is the world a place of opportunities for growth or is it a place of danger. All those assumptions can be seen as narratives and self-narratives which are both a result of past relational experiences and also a template for life in the future.

Not all patterns of interaction between caregivers and a child enable those processes to develop smoothly in a balanced, coordinated way. A pattern coined as secure attachment seems to be crucial for both the development of mind functions and their neurophysiological correlates. Secure attachment can be described in various terms. For instance, a securely attached child finds the caregiver to be consistently available in times of need and distress. A caregiver is capable of being sensitive to the state of mind of the child including his needs at a particular moment and responding appropriately. This complex skill was coined “sensitive responsiveness” by Ainsworth (1976) and later expanded by Crittenden (2015). This term refers to a situation of secure attachment whereby a parent's emotionally sensitive responses to a child's signals (needs, emotional expressions) either amplify the child's positive emotional states (joy, playfulness, imagination) and to modulate negative ones (sadness, anxiety, anger). The downregulation of the so-called negative or, in other words, uncomfortable emotions in distressing, threatening, or potentially harmful situations is particularly important. Because of neuroplasticity within development and the maturation of neural circuits in different parts of brain, including their developing interconnections, the patterns of attachment relationship during infancy and early childhood are associated with the development of important processes of affect regulation, autobiographical memory, social relatedness, and the development of self-reflection and narrative abilities (Siegel, 2012, p. 91).

When a caregiver and/or a parent can align one's own mental state as closely as possible with the child/person/patient's subjective world in each moment, we call that emotional attunement. An open, emotionally balanced, and safe family environment is an important context for that. This leads to an experience frequently described by the patient/client as “*being heard*”, “*being fully understood*” or “*feeling felt*”. In the early stages of development, such experience has a crucial impact on the mind and its neurophysiological correlates (Siegel, 2020). The role of the so-called attachment figure’s state of mind and his/her ability to attune and sensitively respond to is to assist in organizing and functioning of the child/person's own state of mind. This directly shapes the development of specific neural circuits, brain areas, and integrative fibres which are necessary for coordinated activity of the brain connectome and consequently for the full integration of experience.

The sense of a narrative coherence of one's experience and one's whole life—the ability to create rich, coherent, reflective narratives about Self, others, and the world stems from family contexts—is likely to occur under those secure attachment circumstances. At the same time, a reflective ability develops as well, which enables the person to reflect upon his/her own mind states but also those of others. Fonagy et al. (2002) argues that such a "mentalizing capacity" is necessary for understanding one's mind, imagining the other's mind and connecting with others through sharing one's experience in a narrative structure.

This also has implications for psychotherapy and medicine. First, there is sound evidence that the quality of the therapeutic relationship is one of the most reliable predictors for therapy outcomes (Holmes, 2014). Second, some therapists representing various psychotherapeutic modalities who integrate knowledge from attachment theory and neurobiology into their framework argue that, to some degree, the therapist represents an attachment figure for some patients/clients regardless of presented problems or a diagnosis (Wallin, 2015; Slade, 2016). Third, narratives shared with the therapist (or a significant other) can reveal an individual's unique representation of internal and external experience and connection (or dissociation) between various memory systems and sometimes between mind, language, and body. As Siegal (2012) points out, we can never see mental models/representations directly. However, their manifestations in various memory systems and, consequently in narratives, allow us to approach the "shadows" they cast on other systems of mind including our behaviour. This seems to be highly relevant in the treatment of patients with some mental disorders and also with so-called medically unexplained symptoms, whereby family distress, developmental issues, or traumatic experience manifest as tormenting somatic symptoms presented at a physician's office.

The issue of trauma is therefore also relevant here. There is a vast of amount of evidence from various fields, including trauma studies, that a stressful and/or traumatic experience in the early stages of development may have damaging and lasting effects on neural circuitry in some parts of the brain (e.g., amygdala, hippocampus, thalamus, prefrontal cortex). Not only morphological/structural changes but also functional disturbances (e.g., irregularities or dysfunctions in neurotransmitter systems, imbalance of the autonomic nervous system, etc.) may ensue with a consequence of functional, so called medically unexplained symptoms (Skorunka, 2010). The functioning of the hypothalamic-pituitary-adrenocortical axis (HPA) is also affected, along with the autonomic nervous and neuro-immune systems, which may lead to altered physiology, dysregulation, and chronic arousal with various symptomatology (Montgomery, 2013; Siegel, 2021; Waite & Ryan, 2019).

Attachment disturbances (e.g., inconsistencies, deprivation, neglect, abuse) in the first months and years of a child's development can lead to neurotransmitter abnormalities, overactivity of the HPA axis, and structural changes including alteration of connectivity between parts of the brain (Coan, 2016). No matter how crucial the attachment experiences for the brain (e.g., neural circuits, neurotransmitter systems functioning) and mind (e.g., feelings, thoughts) development are in the first years of an individual’s life, family dynamics including attachment relationships are important in the subsequent stages of development too. Transitional periods (e.g., birth of a child, separation during adolescence, bereavement) in the family life cycle and any individual’s development-related changes are typically accompanied by stressful experiences and demands for adaptation so that problems including mental distress/ill-health are frequent and well-reported by clinicians (Crittenden et al., 2014; Chvála, Trapková & Skorunka, 2012).

There has also been accumulated evidence about how both developmental processes and trauma are encoded in certain brain areas and the autonomous nervous system, creating or setting particular “psycho-biological modes of (dys)functioning” that lead to long-term problems in adulthood. A rapidly expanding body of literature confirms the high prevalence of trauma and abuse (both broadly defined) in many psychiatric nosological categories (personality disorders, eating disorders, depression, anxiety, and psychosis) but also regarding physical illness (Anda et al., 2006; Read, 2013; Read et al., 2008). There is compelling evidence that not only extreme distress such as physical violence, sexual abuse, or severe maltreatment in childhood and adolescence can affect both physical and mental health, but also more subtle variations of traumatisation or attachment disruptions that are described in detail in contemporary attachment research. (Crittenden & Landini, 2011; Dallos &Vetere, 2009).

Depending on their form and timing (period of life and stage of development), traumatic experiences can affect brain regions important to essential processes, such as memory storage, information processing, language, affect regulation, physical arousal response, integration of experience and more complex skills, such as empathy, reflective and narrative skills (Schore, 2015; Reading, 2006; Edwards et al., 2003). To sum up, trauma results in fundamental reorganisation of the way the mind, brain and body manage perception, information processing, stress-related arousal regulation, and responding to experience and events. A traumatic experience (dangerous, threatening) leads to a disconnection between the thalamus, hippocampus, and other deeper structures from prefrontal and frontal areas of the neocortex. The activation of areas and circuits interconnected with the neurophysiological systems responsible for stress response takes over during traumatic experience. The activation of those deeper structures (thalamus, brain stem, limbic system) and stress response related systems is unconscious and without direct control. The cortical consolidation of the experience into explicit memory systems is impaired and subsequent verbalisation is not possible. The storying and full integration of experience is hindered. As a result, the imprints of traumatic experiences are organised not as coherent, logical narratives of the Self, others and life events, but in fragmented psychobiological traces: emotions, images, sounds, physical sensations including pain, etc. Thus, it is a challenge not only for psychotherapy but also for medicine because some of the patients seeking health care for their mental and/or physical symptoms may need complex, integrative therapy, which takes those mind-brain-body-relationships interconnections into account (Skorunka, 2020; Chvála, Trapková & Skorunka, 2012; Kozlowska; 2016).

Although psychotherapy and family therapy have an important role in helping to find words and meanings for what happened (and ways to cope), verbally articulating the traumatic experience is not always possible and sometimes it is not enough. As trauma studies suggest and clinicians working with people with traumatic experience report, the act of telling the story "*does not necessarily nor easily change the automatic physical and hormonal responses of bodies that remain hypervigilant, prepared to be humiliated, threatened or violated at any time"* (van der Kolk, 2015, p.21). The body has got many mechanisms how to manifest any sorts of distress we might experience. Extensive clinical experience with patients who suffer from so called medically unexplained symptoms shows that on such cases only psychotherapeutic approaches, the "talking cures", do not often lead to satisfactory treatment outcome. *"We have discovered that helping victims of trauma find the words to describe what has happened to them is profoundly meaningful, but usually it is not enough. The act of telling the store does not necessarily alter the automatic physical and hormonal responses of bodies that remain hypervigilant, prepared to be assaulted or violated at any time (and any bodily expressions of distress, no matter how conscious it is, my note). For real change to take place, the body needs to learn that the danger has passed and to live in the reality of the present. "*(van der Kolk, 2015, p. 21)

With extensive clinical experience in mind, it is clear that therapeutic relationship providing a "secure base" is the most important factor for dealing with trauma. As Montgomery (2013) suggests, a therapeutic relationship serves multiple functions: "*Some clients 'brains will need to repetitively „borrow" the arousal system management of the clinician in order to manage arousal in nonproblematic ways. This repetitive experience of synchronising appropriate arousal management strategies with the brain of another has the potential to change brain functioning for the better. Some clients will not need to make such basic changes, but rather will need to re-establish a previous level of arousal management that was temporarily disrupted. And, of course, many clients will fall somewhere in between*" (Montgomery, 2013, p. 27).

A combination of treatment including pharmacology is usually necessary to help mind and body regulated the sensitised, inappropriately aroused neurophysiological systems. In some cases, an intervention must include psychoeducational elements or be more cognitive - behavioural, pragmatically everyday-life problem solving. In other cases, however, more experiential,

1.4. NARRATIVE AND PSYCHOTHERAPY; An Overview[1]

The narrative turn resulted in a great variety of applications of the narrative concept in theory, research, and practice in every major psychotherapeutic modality. McLeod (1997) was first to document such development in psychotherapy and others followed with comments and additions (Angus & McLeod, 2004; Čermák, 2003, 2004; Skorunka, 2012; Skorunka, 2010b, c; Skorunka, 2016). In this part, we will give a brief overview of ways in which the narrative key was played in the major psychotherapeutic modalities. This will also be illustrated with clinical vignettes.

1.4.1. Narrative Key in Psychoanalytical and Psychodynamic Psychotherapies[2]

"Even when a so-called presenting problem does not appear initially as an interpersonal one, much of what is later recounted is in the form of relational stories."

Hadas Wiseman, Jacques Barber

The psychoanalytical and psychodynamic approaches are the most influential traditions among psychotherapeutic modalities (McLeod, 2009). In its infancy at the beginning of the 20th century, it originated from Sigmund Freud's ideas (1997) about the human psyche, the development of problems, and therapy methods. It evolved soon after into a very diverse field due to the distinct ways Freud's followers thought as they developed his initial formulations (Fonagy, Target, 2015). Psychoanalysis and psychodynamic approaches shaped the development of other psychotherapeutic modalities in the second half of the 20th century, sometimes just by being a target of criticism or a frame of reference to which the pioneers of other approaches related to and/or defined against. Even in the 21st century, the influence of psychoanalytical and psychodynamic thinking is visible in other psychotherapy approaches. Some of the initial ideas have been revived, perceived in new lights, and/or supported by research evidence thanks to advancements in neuroscience (Schore, 2015).

---

[1] The section Narrative and Psychotherapy is partly based on the unpublished manuscript of the author´s doctoral thesis (Skorunka, 2008). However, the section is written in a different structure and content, with updates and with examples from the author´s clinical practice to demonstrate how the concept of narrative can be embraced within different psychotherapeutic modalities.

[2] The example from clinical practice in Tab. 3. is derived from a detailed case study included in the unpublished manuscript of a doctoral thesis (Skorunka, 2008).

Still relevant today, traditional psychoanalytic assumptions could be summarized in the following way: a) the assumption that a client's difficulties originate from childhood experience (from a developmental and relational perspective); b) the assumption that clients may not be consciously aware of the true motives, impulses, or needs that fuel his or her behaviour (importance of unconscious processes in the mind); c) the assumption that the use of interpretation of a transference relationship between the therapist and the client is the most important "vehicle" of therapeutic change; d) the goal of therapy is to help clients gain more insight into and understanding of the origins of their problems and then foster the development of more adaptive ways of coping with various issues.

Since those traditional assumptions were formulated, both the theory and practice of psychoanalysis and psychodynamic psychotherapies has obviously changed. For instance, the patient's problems used to be viewed as unfinished developmental tasks, unresolved traumatic experiences, etc. Different authors offered their concepts and theories, only to make the field more diverse and sometimes even more difficult to orient within. On the other hand, there was a rapprochement of psychoanalytical and psychodynamic approaches with other psychotherapeutic modalities, such as cognitive-constructionist, emotion-focused, and systemic family therapies in the beginning of the 20th century (Dallos, 2006; Greenberg & Goldman, 2006; Pocock & Flaskas, 2009).

Thus, it is not surprising that such a rich and influential psychotherapy tradition was arguably the first in which the narrative key was played. Čermák (2006) argues that the narrative turn in psychology and psychotherapy could be dated back to Sigmund Freud's ideas. In the psychoanalytical and psychodynamic approach, story and narrative presented in therapeutic offices represent an access to the clients'/patients' subjective worlds, to the foundational layers of their psychological reality, fundamental emotions, more-or-less conscious needs, motivations, and relational patterns. Logically, a psychoanalytical/psychodynamic therapist would foster the patient's narratives and be very attentive to both narrative content and form to make the unconscious more conscious in order to enable exploration, insight, and consequently help the patient to become free from those inner constraints and live a richer and more fulfilling life. Regarding psychosomatic medicine based on the bio-psycho-social model, so-called functional or medically unexplained symptoms are understood as manifestations of unconscious attachment needs, conflicts, dilemmas, components of automatic self-defensive and relationship strategies, or substitutes for unlived yet important parts of one's identity (Crittenden, 2015; Poněšický, 2012). Apart from Freud's time and the next generations of psychoanalysts, such as Franz Alexander (in Honzák, 2017), who presumed a direct relationship between specific personalities, unconscious conflicts, and physical symptoms, contemporary psychoanalytic thinkers and clinicians emphasize the uniqueness of the patient's narrative including their situations and symptomatology and advocate for an individualised therapy approach, emphasis on therapeutic relationship without the traditional stance of an expert, and awareness of attachment history (Poněšický, 2021; Pocock, 1997; 2006).

Few influential psychoanalytic thinkers adopted a narrative framework to enrich various traditional psychoanalytic ideas and/or offered a different view. Spence (1984) suggested that traditional psychoanalytic “tools”, such as free association and dream analysis are not reliable means of verifying whether the event/experiences described by the patient really happened in his/her childhood. In his view, a therapist should help clients reach the “narrative truth”, the story which makes sense, includes all key events, and corresponds with both their subjective representation but also with verifiable historical facts. For Schafer (1994), the client's narrative is not just an access to “deeper” structures, motivations, or desires. It is primarily information about a client's life, her view of herself, others, and the world. It conveys her understanding of her situation, her problems, and her position in social relationships. According to Schafer (1994), the therapist must aim at “transformative dialogue”, in which reflection, destabilisation, and deconstruction of rigid, habitual self-narratives is possible. Only then does the development of a new identity (e.g., a new story of self and self with others) become possible during the therapy process, with assistance from the therapist.

Identity formation is central to the work of McAdams (2000), who integrated the psychodynamic approach with narrative framework. For McAdams (2000), identity is an internalized and constantly evolving narrative of the self which an individual starts to construct in late adolescence and young adulthood. Because a human being's life is so rich and full of various information, it becomes necessary to select the most important—those related to his/her identity. Regarding life story, McAdams (1988) distinguishes between 4 categories: 1) Key events; 2) Values and set of beliefs; 3) Goals and prospects; 4) Imagoes. Key events are related to the past, as well as prospects and goals for the future. According to McAdams (1988), values, set of beliefs, and imagoes (simplified and idealised self-images) connect the categories to the whole story. Although McAdams (2000) assumes that the metaphor of a life story offers the possibility of re-storying, seeking and finding a new storyline, changes in values and set of beliefs, Čermák (2003), on the other hand, makes a point that McAdams’ integrating concept of narrative metaphor does not ensure that we can understand a person just from a single storyline.

One of the most influential frameworks within the psychoanalytical and psychodynamic approaches to narrative and psychotherapy is the method of the *Core Conflictual Relationship Theme* (CCRT). In this method, Luborsky et al. (1992, 1994, 1998) offered a way to understand and work with patients’ narratives in psychotherapy. Luborsky called the narratives told by the patient about others and his/her relationship with them Relationship Episodes (REs). REs usually contain typical features of a story (beginning, plot/conflict, end). REs are composed of three basic components: a) wishes/needs/intentions; b) response from others (experienced, anticipated, or fantasized response from others; c) response of Self; anticipated or consequential response of the self in the form of thoughts, emotions, behaviours, or symptoms (Wiseman & Barber, 2004). Many representatives of the CCRT framework assumed that RE recurring themes capture the central relationship patterns or schemas that underlie a person's characteristic way of relating to other people. It is also assumed that these relational schemas/patterns are the result of emotionally charged interactions with parental figures in the early stages of individual development. Being based on developmentally dependent, mostly unconscious representations of Self, others, and relationships, they are carried onward into subsequent relationships. They affect information processing regarding social interaction, as well as relating to Self and others (Holmes, 2014; Crittenden, 2015). According to Luborsky & Crits-Christoph (1998) and Wiseman & Barber (2004) identifying the CCRT through listening to a patient's narratives and through re-enactment in a therapeutic relationship during sessions may make it possible to work with transference phenomena. As a result, this work can help gain insight, promote reflection, and foster development of different patterns of relating to others. Through self-understanding of the habitual CCRT pattern (my note: and through corrective emotional experience with the therapist patients are able to gain novel, more satisfactory ways of interacting with others. This eventually leads to symptom alleviation (Wiseman & Barber, 2004).

1.4.2. Narrative Key in Cognitive and Constructivist Therapies

"All purposive human behaviour depends greatly on the views or premises people hold, which govern their interpretations of situations, events, and relationships."

John Weakland

The beginning of cognitive and constructivist psychotherapies dates back to 1950, when early figures such as Aaron Beck, Albert Ellis, and George Kelly started to introduce new ideas regarding the "etiopathogenesis" of various problems that people presented in the therapist's office. The most notable was the idea that psychological problems resulted from rigid cognitive "beliefs or constructs which people held about themselves, others, and the world. Some of the representatives of that psychotherapy movement tied cognitive ideas with behavioural approaches. "Homework" assignments were added to the psychotherapy process to enable clients to extend and consolidate the experiences (a form of learning) that take place in the therapy session, remind them of ideas and metaphors that emerged during the conversations, to strengthen alternative schemas, and foster new actions. Suggestions of take-home experiments, carefully designed expositions to feared situations, letters, and documents were some of the interventions used decades before they were modified by narrative therapists within social constructionist's framework.

Cognitive behavioural therapy later became one of the most established psychotherapy approaches and for some even the most effective one. One reason for such claims was growing Some influential figures in the psychotherapeutic community argued that this was due to compatibility between the format of cognitive behavioural therapy, the biomedical model, and the trend towards the empirically supported treatments including the manualized psychotherapy programs (Lambert, 2013; Wampold, 2001; Wampold & Imel, 2015). Later generations of cognitive and constructivist therapists focused more on research in cognitive psychology and neuroscience. They started to assume that people represent the world through complex schemas or so-called scripts. These were understood as dynamic representations of possible actions that a person can take in relation to objects and other people. As those dynamic representations manifest themselves in the stories people told in the psychotherapists' office, it is no surprise that cognitive/constructivist therapists embraced story and narrative as useful metaphors for understanding the development of problems, the therapy process, and change.

Cognitive/constructivist psychotherapists regard stories as a means of gaining access to and facilitating change in fundamental underlying schemas and scripts. Referring to George Kelly's personal construct model, Dallos (2006) summarizes the constructivist stance as "*a framework in which individuals and families are considered to be sort of self-contained organisms that constructs* *private meanings about the world they encounter''* (Dallos, 2006; p. 31). In Kelly's model, the personal constructs are individually private, unique models that help the person make sense of reality. Those models operate outside of conscious awareness and may become less viable or even rigid over time. For Efran & Clarfield (1993), the aim of therapy is to help a person reflect on those rigid models and dominant preconceptions through which he/she perceives Self, others, and the world, and develop different ones. Because the therapist has an advantage of being a person outside of the client's life, he is more able to help the client to see things differently and act accordingly.

Constructivist theory or philosophy deals with the elementary question of how we construct our knowledge of ourselves, others, and the world. From the constructivist perspective, we do not come to know the world directly but through so-called cognitive schemas, constructs, or theoretical concepts. The interaction between seemingly objective reality, which exists independently, and the active process of the person's knowing is therefore emphasized. The radical version of constructivism was introduced by philosophers and theorists (H. von Foerster, E. von Glassersfeld) and by biologists and cognitive scientists (H. Maturana, F. Varela) whose ideas enriched different psychotherapeutic fields (McLeod, 1997; Dallos, Draper, 2015; von Schlippe & Schweitzer, 2001). Biologists Maturana and Varela put forth the idea that all living systems are autopoietic systems, which means that they organize or even create themselves (Maturana & Varela, 2016; Maturana & Poerksen, 2004). The process of self-organization is determined by their structure, so it is impossible, as Maturana (2004) argued, to affect them unilaterally in terms of a simple linear causality. Such ideas struck a chord particularly in the family and systemic community (Dallos & Draper, 2015). von Schlippe & Schweitzer (2001) argued that because any observer's ideas regarding relationships are based on a preferred construct and/or certain assumptions, it is impossible to make absolutely objective assessments or conclusions. These should be brought forth, questioned, or confronted by sophisticated interviewing techniques.

Radical constructivism was criticized from various positions for its overemphasis on language, cognitive processes, abandoning responsibility during therapeutic process, and downplaying or even emotions as psycho-biological phenomena (Flaskas, 2006). Despite that, constructivists' ideas shed light on important aspects of the process of knowing, including the process of psychotherapy. Drawing on George Kelly's personal construct theory, Dallos (1997) pointed out that our assumptions and set of beliefs are the main building blocks of our personal interpretation or knowing the world. Those assumptions and sets of beliefs are constantly tested through the various everyday interactions and experiences we have with others and the world. Arguably, those assumptions and set of beliefs are both the pillars of our narratives (built up from our experience) and the factors that shape the content and form of narratives we develop about ourselves, others, and the world.

Several representatives of cognitive/constructivist psychotherapy considered narrative to be a helpful metaphor in understanding human psychology and the psychotherapy process. For instance, Goncalves (1995) proposed a five-stage constructivist model of narrative change: 1) Recalling narratives: the process of recalling the details of various important life events; 2) Objectifying narratives: the process of recalling all sensations, facts, sometimes with the help of documents, artefacts, etc.; 3) Subjectifying narratives: connecting awareness of an emotional experience with the story/events; 4) Metaphorizing narratives; supporting the client's in adopting various metaphorical associations regarding the important stories and discussing them; 5) Projecting narratives: the clients ponder on alternative metaphors with the help of art and/or literary resources. The new metaphors are discussed and elaborated on during subsequent conversations and become new building blocks in everyday life. The main aim is to help the client become more aware of ways to perceive, think about and experience life and construct meaning from it. This model is an attempt to integrate cognitive, narrative, and experiential elements during the process of individual psychotherapy.

Later, Goncalves et al. (2004) offered their cognitive narrative therapy approach, based on the fact that human beings have a unique ability to use language to construct and share personal experience as narratives. They advocate for the assumption of other scholars and therapists from different traditions that problems (including psychopathology) are not the result of an underlying internal mechanism (biological or psychoanalytical), but a product of the patient's narrative constructions (Angus, Levitt & Hardtke, 1999; Neimeyer & Levitt, 2001; White & Epston, 1990). According to those authors, psychopathology can be understood as a result of a narrative construction that, for some reason, does not fully or flexibly capture/correspond with the complex experiential reality of the patient. In their narrative process model, Angus, Levitt & Hardtke (1999) distinguished three stages of narrative processing: external, internal, and reflexive. Apart from offering another theoretical framework, they also developed a coding system to identify and evaluate empirically key components of the model. They expanded their model with a narrative assessment interview to evaluate self-change in psychotherapy (Angus & Hardtke, 2004).

An integrative framework offered by Botella et al. (2004) offered another integrative framework called the relational-constructivist approach. This model links individual-linguistic and relational perspectives and is based on ten main assumptions of the constructivist narrative conceptualization: 1. Being human entails construing meaning from experience; 2. Any meaning is interpretative and linguistic achievements; 3) Language and interpretations are relational achievements; 4) Relationships are conversational; 5) Conversations are constitutive of subject positions (selves); 6. Subjects' positions are expressed as voices; 7. Voices expressed along a time dimension constitute narratives; 8. Identity is both the product and the process of self-narrative construction; 9. Psychological problems are embedded in the process of constructing narratives of identity; 10. Psychotherapy can be equated to a collaborative dialogue addressed to transform the client's narratives of identity. Not only did Botella et al.’s (2004) relational-constructivist approach connect constructivist assumptions with a narrative framework, it also overlapped with other essential topics in psychotherapy, such as mutual influence between individual and relational process, the collaborative-dialogical nature of psychotherapy interactions, and formation or reconstruction of identity as one of the main goals of psychotherapy.

1.4.3. Narrative Key in Experiential/Emotion-Focused Psychotherapies

"In the first stage, the therapist listens and lets the story and its emotional significance emerge."

Leslie Greenberg, Lynn Angus

Structuring disconnected and/or distressing experiences and challenging events into a particular form, narrative offers a space for processing emotion, self-reflection, self-construction, and help in making meaning of such experiences (Bruner, 2004). As Sarbin (1986) emphasized, all stories are organized around emotional themes and, at the same time, all emotions are shaped by stories. Experiential and emotion-focused therapies developed from the humanistic and experiential roots of both individual (e.g., C.R. Rogers, F. Perls) and family therapy approaches (e.g., V. Satir, C. Whitaker, S. Minuchin). In the beginning, the central tenets of narrative-informed psychotherapy were not explicitly included in experiential therapies (Johnson, Greenberg, 1988). Representatives of emotion-focused therapies expanded those approaches by emphasizing the role of emotion in the creation of meaning, identity, and relationships (Greenberg & Pascual-Leone, 2001; Greenberg, Angus, 2004; Greenberg & Goldman, 2008).

As Greenberg (2002) noted, a central task for an experiential psychotherapist is the facilitation of a client's emotional processing so that primary emotional responses can be accessed, articulated, and meaningfully understood. An experiential psychotherapist strives at s active facilitation of client's disclosure of emotionally salient personal experience for the purpose of differentiation of differentiation between emotions and meaning making. In addition, the disclosure of such a story seems to be the means by which clients show the therapist who they are and who they would prefer to be. It is also the key prerequisite for building up shared understanding and trust, the foundation for therapeutic alliance. Emotion-focused therapy (EFT) is an integrative psychotherapy approach. It is derived from the person-centred approach, gestalt therapy, psychodynamic and cognitive approaches, and early systemic approaches (Greenberg & Goldman, 2008). Arguably, this development in psychotherapy was also fostered by a shift in focus from cognitive to affective processes in neuroscience (Damasio, 2000). While gestalt therapy enriched the field of psychotherapy with interventions designed to evoke feelings, thoughts, and habitual patterns of behaviour (preferred interactional patterns), the client-centred approach emphasized an accepting, emphatic stance towards people as well as authentic attunement to their emotionally charged experience shared in form of a story in therapy.

EFT fosters clients' emotional processing, promotes personal agency, and aims at a sense of coherence and well-being in their lives (Greenberg & Angus, 2004). EFT's primary therapy goal is to increase emotional awareness of clients either in individual or couples' therapy. It is designed to help transform so-called maladaptive emotions into more adaptive ones that fuel more adaptive behaviour and result in more satisfactory lives and relationships. On top of that, by helping to differentiate, transform, and flexibly regulate people's emotions, it aims to explore and make sense of their stories in order to achieve more satisfying intrapersonal and interpersonal outcomes (Greenberg & Angus, 2011). To achieve such ambitious goals, the representatives of EFT enhanced emotion-focused approaches with narrative perspective. According to Greenberg and Angus (2011), integrating the emotion-focused approach and narrative perspective resulted in the understanding that: a) narrative expression is a manifestation of unique subjective experience and the basis for the construction of a sense of Self; b) stories bring meaning to emotions and significantly expand the ways in which EFT can effectively facilitate emotional change; c) re-storying salient personal experiences and the meanings they entail is also an important change and new views of Self including new life possibilities emerge during the process (Greenberg & Angus, 2011, p. 11).

On the basis of their clinical experience and various research sources, Greenberg & Angus (2004) succinctly summarized the mutual relationship between emotion and narrative. The client's disclosure of an emotionally charged personal narrative is fundamental to the process of change in therapy. Emotional shift is related to and perhaps necessary for a positive outcome in any psychotherapy. The emotional processing as well as reflecting over such processing is considered important for successful outcomes in psychotherapy in general (Elliot, Greenberg & Lietaer, 2004; Cooper, 2013). Emotional Expression is a key marker of the personal significance of autobiographical memory narrative. The meaning of an emotion is fully understood when organized within a sequential narrative framework that identifies what is felt, about whom, and in relation to what need or issue. Thus, it appears that in psychotherapy, as generally in life, all significant emotions are embedded in important stories and all significant stories revolve around important emotional themes. It is also widely recognized that not just the story people tell but its bodily expression reveals information about the state of Self in a given context. The EFT involves an interpersonal, dialectic process, which relies on an acknowledgment of biology, relationship, emotion, and cognition (Greenberg & Angus, 2004, p. 20). The interconnection between emotion, cognitive processes, body, and relationships is strongly evidenced in current neurosciences and psychosomatic research (Siegel, 2020; Schore, 2015, Waite & Ryan, 2019). Thus, it should be addressed in both psychotherapy and medicine. Angus et al. (2004) emphasize that emotional processes including empathy together with client reflexivity contribute significantly to the outcomes of experiential psychotherapy. The recent integration of narrative framework into experiential psychotherapy addressed issues, such as the importance of a client's unique narrative expression, particularly the narrative disclosure of emotionally charged, autobiographical memories, for the facilitation of personal meaning-making (Angus et al., 2004).

In their narrative process model, Angus et al. (2004) view narrative expression as arising from a dialectical interplay of autobiographical memory, emotion, and reflexive meaning-making processes. "*The Narrative Process Model goes well along a dialectical-constructivist view of experiential therapeutic change. Core assumptions underlying this model include: a) client agency; human reflexivity and meaning-making; c) the importance of emotion schemes and emotional processing for facilitation of second order or identity change; d) the constructive nature of the client-therapist dialogue. ... The emotional tone of the narrative—anger, sadness, joy, or fear, appears to be one of the primary ways in which personal memories and narratives are linked to one another. Accordingly, implicit emotional themes and the personal memories they contain become the lens through which we classify, tell a story about, and make meaning of our new interpersonal experiences with others and the world*." (Angus, et al., 2004, p. 88).

1.4.4. Narrative Key in Existential Psychotherapies

“It is essential for any person to find something that is worth living and fighting and even dying for.”

Emmy van Deurzen

Existential psychotherapy developed alongside other humanistic approaches, such as Rogers's person-centred therapy, gestalt therapy, etc. (McLeod, 2013). Existential psychotherapy is based on a broad philosophical tradition within which questions about various aspects of human life have been asked for centuries. It particularly draws on the ideas of existential philosophers, such as Martin Heidegger, Soren Kirkegaard, Jean Paul-Sartre. So-called existential issues were explored and integrated into practice by many renowned European and American psychotherapists, including Viktor Frankl, Rollo May, Irvin Yalom, Emmy van Deurzen, Ernesto Spinelli, and Mick Cooper.

According to van Deurzen (2002), the most basic assumption of existential psychotherapy is that it is possible to make sense of life and that making sense of life is itself something good and meaningful. Human problems are perceived as parts of difficulties and dilemmas of the human condition. Van Deurzen (2002) gives a succinct overview of how the process of existential psychotherapy can be seen: a) as an exploration of what can make our lives meaningful; b) a process of helping people explore the givens of their particular existence, including its inherent possibilities as well as accepting its limitations; c) a thorough consideration of realities, limitations, options, choices, responsibilities, and consequences; d) a process of reflecting on one's goals, intentions, and general attitude towards living; e) helping people understand their situation and find a meaningful way forward; f) encouraging people to become increasingly self-reflective about their interaction with the world and with others; g) helping people recognize their talents and exploring ways of further developing them; h) assisting people in their coming to terms with inevitable limitations and life characteristics (polarities, paradoxes, finality) (Van Deurzen (2002, p. 32).

Although the term narrative is seldom found in the texts of renowned existential psychotherapists, narrative themes are somewhat implicitly present in existential ideas or are closely tied to them. Existential thoughts regarding meaning, dilemmas, values, freedom, authentic living, and responsibility can be easily connected to narrative framework with concepts of temporality, interactions with the world and others, reauthoring one's life, personal agency, preferred identities, and the like. Van Deurzen & Adams (2011) explicitly state that existential psychotherapy is a process of storytelling. The client tells a story of what is important to them and how they came to be the person they are now. Their stories often have gaps of either time (periods of life that seem to have been forgotten or not fully appreciated) or meaning (of a challenging or traumatic experience).

"The therapist tells stories based on her understanding of the client's world and these are inevitably informed by her life experience, personal values, her existential interest, and professional background. The therapist needs to understand that different clients and cultural groups have different narrative styles, different ways of telling stories, and it is up to us therapists to remember this and not to try to define the right way of telling a story… What the therapist and client do is to re-story the client's experience so that new possibilities can be entertained, and alternative meanings can be owned. It is about being able to make and to break narrative. It involves discovering that life is in flux, historical, and dynamic, so that one story may be a good way of understanding events now, but not in a year's time. It involves trusting another person, the therapist, enough so that alternatives can be entertained without fear that the therapist will impose their own story on the client and constrain their emerging autonomy." (van Deurzen & Adams, 2011, p.124). Similar thoughts, perhaps expressed in different words, can be found in the seminal work of White & Epston (1990), the most well-known representatives of the narrative therapy movement.

The fact that the narrative framework of psychotherapy and counselling goes well with principles/assumptions of existential psychotherapies is evident from Tantam's (2007) thoughtful reflection on the importance of personal values in the psychotherapy process. Metaphorically speaking, personal values could be seen as guiding lights in one's life. They determine our identities, provide directions in our lives, a recognition of what is right or wrong, as well as what is worth living for. One of the most important tasks for a psychotherapist is therefore to help the client identify his/her own values and how they were challenged by the client's crisis/difficulties (Tantam, 2002). Respecting the client's values and addressing his/her concerns that she has about her situation are other important tasks at the beginning of any psychotherapy as well. Most people strive to live a so-called authentic life, which means being themselves, actualizing their unique potential, and fulfilling their needs in balance with others. When they experience distress, face challenges, and/or deal with dilemmas, they need to tell their story to someone who listens. The experience of sharing the story, of being listened to and respected, can lift some of the burden resulting from that troubling experience. Those qualities also fuel the development of therapeutic alliance—a crucial prerequisite if the client and the therapist are to co-construct a coherent and meaningful narrative that includes reauthoring one's life and strengthening personal agency.

An impressive addition to the theory and practice of existential psychotherapy is the autobiography of one of its most respected representatives, Irvin Yalom. In his memoir *Becoming Myself*, Yalom (2017) engagingly weaves the recall of his personal and professional journey together with existential issues, such as freedom, choices and limitations, the search for meaning, experience of existential loneliness, and the finality of life. Looking back over his life through its trajectory from cradle to possibly final review, Yalom also shows his proneness for psychotherapy integration, which he developed during the later stages of his professional life. Apart from the strong existential flavour in his writing, he emphasizes the importance of emotions, relationships, and the influence of transgenerational heritage for both personal and professional identity. He also makes a point to mention the times when he began to take an interest in the humanities, especially philosophy: *“The more philosophy I read, the more I realized how many profound ideas psychiatry ignored… More and more I grasped that many of the issues my patients struggled with—aging, loss, death, major life choices, such as what profession to pursue or whom to marry, were often more cogently addressed by novelists and philosophers than by members of my own field*.” (Yalom, 2017, 176-178).

When Yalom (2017) decided to work with patients in terminal stages of an oncological disease in the 1970's, he soon found out how the issues of death, dying, loss, coming to terms with the inevitable, and bereavement were largely avoided and neglected by the medical community at that time. Although it has changed in the last decades, these issues can still be of peripheral importance during both undergraduate and postgraduate medical education.

1.4.5. Narrative Key in Systemic Family Therapy[3]

“Family can be a source of both support and distress.”

Rudi Dallos, Arlene Vetere

As a new psychotherapy modality, family therapy started to develop in the 1950´in the United States and later on in some European countries such as the Great Britain, Italy, and Germany. Amid the after-effects of the second world war, emergence of new scientific fields including interdisciplinary exchange of ideas, and social change, the birth of family and systemic therapy signified a paradigmatic shift in therapists ‘moving away from an intrapsychic view to an interpersonal/interactional view of understanding problems and symptoms in the context of human relationships. The pioneers of family therapy movement, such as Donald Jackson, Jay Haley, Virginia Satir, Nathan Ackerman, Salvador Minuchin, and Murray Bowen independently or in a mutual collaboration formulated the first systemic principles about the family dynamics and development of problems. On top of that, they took a major leap in meeting families with various problems in therapy. set the foundations of systemic thinking and started meeting the families in therapy. They drew on a rather wide range of ideas, for instance Sullivan´s interpersonal theory, Bateson´s ecosystemic thinking and thoughts on communication, von Bertalanffy´s theory of systems, and Wiener´s cybernetics (Dallos & Draper, 2015; Gehart, 2017). Two projects symbolized such development during the 1950´: a) The Bateson Research Project focused on communication patterns in families with a member diagnosed with schizophrenia; b) the foundation of Mental Research Institute, one of the first institutions, in which conjoint family therapy sessions were carried out at that time.

During the 1960´- 1980´, family therapy evolved in a rather diverse field with many concepts and family therapy models. (e.g., strategic therapy, structural therapy, Milan systemic school etc.). The history, main assumptions and ideas, characteristics of different phases in family therapy development, and specifics of various family therapy models are described in detail in many resources (Dallos & Draper, 2015; Carr, 2012; Gehart, 2017; Skorunka, 2010). In his *Three Column Formulation Model*, Carr (2009) sorted out the existing family therapy models in three categories according to the central focus of the therapeutic concern, which guided the therapist´s hypotheses and interventions during therapy. The first category of family therapy models is focused on problem – maintaining behaviour patterns in the family. The second category is focused on problematic and

---

[3] The example from clinical practice in Tab. 8. is derived from a detailed case study included in the unpublished manuscript of doctoral thesis (Skorunka, 2008).

constraining beliefs and narratives, that subserve repetitive problematic interaction patterns. The third category is focused on historical, contextual, and constitutional factors that predispose family members to adopt particular belief systems and engage them in particular problematic interaction patterns (Carr, 2012).

Dallos & Stedmon (2013) summarized the core systemic assumptions/principles/concepts that are tied with the original ideas but also reflect the following development and current state-of the-art: a) an enduring concept is that problems apparently located in one individual can instead be seen as a product of the interactional dynamics in the family. Thus "symptoms" are perceived as problems in interaction and communication between people/family members rather than residing within individuals; b) the cause and effect have a circular relationship whereby problems are maintained through vicious cycles of unhelpful feedback; c) for understanding the "etiopathogenesis" of the problem and planning the intervention, the understanding triadic relationships, whereby conflictual processes between two people may recruit, or "triangulate" a third person is necessary; d) the recognition of importance of trans-generational processes for contextualising current difficulties (e.g., exploration how parents´ ideas about caregiving connect with their early childhood experiences of being parented); e) awareness that families like other social systems may experience distress including various symptoms at points, where significant and fundamental changes need to be made (e.g., the onset of problems in families can be seen as connected to the emotionally destabilising aspects of family transitions, especially during family life cycle transitions points such as birth of a child etc.); f) focus on the centrality of language and the joint construction of understanding between family members, and the therapist (Dallos & Stedmon, 2013, p. 67-69.)

In the late 1980´s, several renowned therapists as well as newcomers to the field, started to question some of the original systemic assumptions and family therapy models (Luepnitz, 2002; Andersen, 1992, 1993; Anderson & Goolishian, 1993). Instead of the first systemic and cybernetic metaphors, the new generations of family therapy took the inspiration from linguistics, constructivism, theory of social construction, narrative psychology etc. It triggered the shift from an expert stance and directive approach, typical for some family therapy models, to a not - knowing stance, reflective practices, dialogical perspective, and collaborative practices (Anderson & Goolishian, 1993; Anderson, 1997; Friedman, 1995; Seikkula & Arnkill, 2006). Some family therapists and thinkers expanded the systems theory to another level. Not only family but awareness of other systems is highly relevant for our prevention of, reflection on and intervention with individuals and families, who face various challenges in their lives. A term systemic therapy was proposed and later favoured by some, because it did not, arguably, imply that family is to be blamed for the problems /symptoms. von Sydow et al. (2010) defined systemic therapy as "*a form of psychotherapy that* *conceives behaviour and especially mental symptoms within the context of the social systems people live in, focusing on interpersonal relations and interactions, social constructions of realities, and the recursive causality between symptoms and interactions. Partners/family members and other important persons are included directly or virtually in the therapy through systems-oriented questions about their behaviour and perceptions.* " (von Sydow et al. 2010, p. 459)

Since the beginning of the new millennium, the already stablished field of family and systemic therapy entered the new phase of development, which was characterized by to trends: a) a growing body of research on both outcome and process of therapy; b) integration both within the diverse field of family therapy and beyond. Along with the general psychotherapy research development, there has been an expansion of studies focused on effectiveness of family/systemic therapy to foster establishing family therapy as an empirically supported treatment (Sexton, Alexander & Leigh Mease, 2004; von Sydow et al., 2010; Sexton, et al., 2013; Stratton et al., 2020). At the same time, a great deal of studies was carried out to explore various aspects of family therapy process, for instance the therapeutic alliance with the family (Friedlander, 2006), the family therapist´s both cognitive and affective processes during the therapy (Rober, 2011) and/or assessment of family functioning with regard to therapeutic change (Carr & Stratton, 2017).

Having an experience with both clinical and conceptual limits of existing family therapy models, some therapists and scholars made an effort to develop conceptual frameworks as well as multiple interventions to tackle complex family problems (i.e., various manifestations of distress in families; combination of behaviour, physical and mental problems etc.), socio-cultural differences, and also a pressure for a manualised treatment program for some clinical populations. The aims were to create an overarching theoretical framework that would provide a guide for selection of concepts and interventions from a range of less complex theories for clinical practice. Such a framework could allow a greater flexibility for a therapist particularly for work with "complex cases ". Several integrative concepts were developed to meet such goal for clinical work with both couples and families (Breunlin, Schwartz & MacKune-Karrer, 1997; Gurman, 2005; Greenberg & Goldman, 2008; Pinsof et al., 2017).

The trend of integration in family and systemic therapy reached far beyond those modalities. Since the first decade of the 20th century until now, we could witness a rapprochement between psychotherapeutic fields, whose representatives were distant or even hostile to each other in the past (Dallos & Draper, 2015). For instance, gestalt therapy met with systemic thinking, psychoanalytical therapies befriended with family therapies, narrative framework was integrated to clinical work with children, adolescents, and their families (Evans & Gilbert; 2005; Pocock & Flaskas, 2009; Gilbert & Orlans; 2011; Dowling & Vetere, 2005; Dallos, 2006). In contrast to the past phases of development, in which the founders of different concepts and family therapy models seemed to compete with one another, the current situation is characterized by an emphasis on integrative, collaborative, and ethical principles (Rivett & Street, 2010).

Within such integrative trends, an application of the narrative framework to family and systemic therapy occurred in various ways. Some family therapists adopted the narrative framework together with constructivist and social constructionist stance, while other used it as a bridge to current psychoanalytical therapies and developmental psychology (Dallos, 2019; von Schlippe & Schweitzer, 2001; Pocock & Flaskas, 2009; Johnson & Whiffen, 2003). The concept of narrative enabled to connect interpersonal, intrapersonal and socio/cultural processes, which are manifested in the family dynamics therapy and which should be taken in consideration during family/systemic therapy: "*We live in a storied world. Our reality can be seen as composed of stories in which we are embroiled. When we are born, we emerge into a plot thick with anticipation of our arrival. We are raised in families that have their own intricate narratives, and we become a part of these well before our birth…Family stories speak about our place and role in the family and the hopes and expectations placed on us. They label, explain, and organize our experiences as we grow. They shape our emerging personalities even before we learn to talk*." (Osatuke, Glick, Gray et al., 2004, p. 194).

One of the most interesting and inspiring examples of integrative trend in family therapy, which includes the narrative framework, is the model of attachment narrative therapy (Dallos, 2006; Dallos & Vetere (2009; 2014). In this model, the authors integrate systemic theory and therapy, narrative theory and therapy approaches, and current attachment theory. In Dallos & Vetere´s (2009) view each of these concepts is both useful and limited so only an integration provides a "complex-enough" framework for clinical work with families. The integration of attachment theory is particularly relevant because the recent development in both neuroscience and developmental psychology enriched the psychotherapy and family therapy and enabled to see the past concepts in the new light. For instance, family therapists need to be aware that different attachment experiences lead to different development of narrative abilities or styles. Understanding how and why family members have come to develop different narrative styles may help the therapists better attune to their emotional states of mind, attachment needs, and choose the appropriate therapeutic intervention (Dallos & Vetere, 2009). With this in mind, therapy is then focused on fostering the family members narrating their experience and developing the skills for open, consistent and coherent communication about their relationships.

The guiding framework for formulation and therapy based on Dallos Vetere´s (2009) attachment narrative therapy model consists of: a) creating a secure base; b) exploring attachment and narratives within a systemic framework; considering alternatives; c) consolidating change and maintaining the therapeutic base. Alongside with this model, they also proposed the theory of change based on narrative perspective in family therapy (see Tab. 8.).

Tab. 7. Theory of Change Based on Narrative Perspective in Family Therapy

(adapted from Dallos, Vetere, 2009, p. 14-16)

- Change occurs through helping people and their families to shift from narratives that view problems as residing essentially within individuals to narratives that view them also as relational problems.
- Change is facilitated when people feel emotionally secure and safe so that their abilities to think, reflect, and attempt to new ways of acting and relating are enabled.
- Change occurs through shifts in how family members think, feel and act towards each other (including oneself). Shifts in only one of these areas is often not sufficient for substantial change to occur and to be maintained.
- Change occurs through the development of open communication in families and other important relationships, namely, when it becomes emotionally sager to talk about feelings, ideas, actions and intentions that had previously been difficult to acknowledge or discuss.
- Change occurs through a revision of the ways that we have learnt to deal with a wide variety of feelings, distress, threats, anxiety and loss through our early childhood experiences.
- Change occurs through a reflection on and utilisation of patterns of behaviour from our attachment scripts (early childhood experiences) to cope with difficult feelings and relationship issues.
- Change occurs by working alongside people to help them to be able to develop their skills in constructing open, coherent, integrated and reflective narratives that effectively communicate their wishes, feelings, and intentions in their intimate relationships.

Either in the attachment narrative therapy model or in other narrative-informed family therapies, the narrative framework is thought to allow different, co-existing stories to be shared, different voices to be heard, multiple perspective to be explored including the contradictions and discrepancies (Dowling & Vetere, 2005). The narrative approach in working with families is considered by Fredman (2002) as "*a co-creation of preferred stories with people that have a good enough fit with their lived experience and are meaningful and coherent for themselves and those in significant relationships with them*". The stories are obviously co-constructed and shared by individuals, but the scripts, plots and attachment narratives connect our personal story with the stories of others, mostly in a rather emotionally charged way. Exploration of differences among the story lines, both open and concealed, both past and prospective, may foster understanding among family members, alleviate distress and strengthen individual family members ´well-being (Dowling, Vetere, 2005). The conjoint search for a story, which would bring family members together in challenging times (e.g., life cycle transitions, distressing events, diseases), is far from being easy. However, it might be one of the most important goal for family therapy.

1.4.6. Narrative Therapies Based on Theory of Social Construction

„I see my role as to get the access to the stories and identities in people´s life that are seemingly invisible and that can make their life richer contrary to dominant, problem-saturated stories."

Michael White

In previous sections of the thesis, we have discussed how the concept of narrative have been integrated into well-established psychotherapeutic modalities. The utilisation of the concept of narrative arguably enabled both a deeper understanding of and a different perspective on a variety of psychotherapeutic assumptions and ideas about therapeutic process. It is clear, that the concept of narrative manifested in slightly distinct ways in those psychotherapeutic modalities accordingly to the theoretical as well as clinical differences among them.

Apart from that, there has been an increasingly popular movement described as "*narrative therapy*" since the end of the 1980´triggered by White and Epston (1990) publication "*Narrative Means to Therapeutic Ends*". In their book, the authors drew on diverse resources: a) epistemological ideas of Gregory Bateson; b) an anthropological perspective of Clifford Geertz; c) a comparative ethnography of Arnold van Gennep; d) a philosophical reflection of Michel Foucault; e) narrative psychology of Jerome Bruner; d) social constructionist´s ideas by Kenneth Gergen. The next two decades were characterised by a growing popularity of narrative ideas in psychotherapy, family therapy, mental health, and social work (Freedman & Coombs, 1996; Parry & Doan, 1994; Marner, 2000; Payne, 2006; Dowling & Vetere, 2006). The ideas of postmodern philosophy and theory of social construction seemed to be particularly appealing for some of the representatives of the narrative therapies' movement. These ideas could be shortly reviewed as: a) our realities or what we consider as realities are socially constructed; b) the realities are constructed through language and dominant cultural discourses; c) the realities are organized and maintained through various narratives; d) there are no essential truths out there waiting to be discovered (Freedman & Coombs, 1996).

McLeod (2004a, b) argues that this movement can be characterised as the formation of a post-psychological approach to therapy, because narrative therapy does not focus primarily on an individual cognitive structures, schemas and/or emotional drives, needs, and processes. Instead, the post-psychological approach represented by narrative therapists, who were inspired by theory of social construction, pays more attention to narratives within relationships, community, and culture. There has been a shift from focusing on how an individual constructs a model of reality from his/her own unique individual experience to focusing on how people interact with each other to construct and maintain what is held true, normal, real, and meaningful in their society in a particular time (Gergen, 1999). This shift in focus including the preference of metaphors regarding therapy expressed Freedman & Coombs (1996) in the following paragraph: "*Our experience of the process that we call therapy has shifted as we have taken on the narrative and social constructionist metaphors. We no longer organize our experiential worlds in terms of "information" and "pattern". Instead, we think in terms of "stories". Rather than "systems" we think about "culture" or "society". Instead of seeing ourselves as mechanics who are working to fix a broken machine or ecologists who are trying to understand and influence complex ecosystems, we experience ourselves as interested people – perhaps with an anthropological or biographical or journalistic bent – who are skilled at asking questions to bring forth the knowledge and experience that is carried in the stories of the people we work with. We think of ourselves as members of a subculture in collaborative social interaction with other people to construct new realities. We now work to help people notice the influence of restrictive cultural stories in their lives and to expand and enrich their own life narratives.*" (Freedman & Coombs, 1996, p. 18.)

Narrative therapists emphasized the role of a shared stock of cultural narratives, which embody moral values and assumptions about what it means to be human within that particular cultural setting (McLeod, 2004a). Thus, the shared stock of culture affects the way people organize their lives, their understanding of themselves including various human phenomena (e.g., family relationships, sexuality, mental health etc.). The stories that people tell about themselves in their everyday lives are drawn from or embedded in such a shared stock of cultural narratives and therefore may be both inspiring or oppressive regarding their identity and preferred lives (White & Epston, 1990; Parry & Doan, 1996; Freedman & Coombs, 1996; Payne, 2006). The goal of narrative therapy is to explore and sometimes even question these cultural narratives and their oppressive influence on people view of themselves and of their life possibilities. On top of that, it also can also help in finding and expanding those elements of their identities and seemingly "hidden initiatives". Not only might these contradict the problem – saturated story but they may also become the foundations for new identity, enhanced personal agency, and consequently the alternative story. Polkinghorn (2004) summarizes it in the following way: *„A repertoire of life stories is provided by the culture in which a person lives. These stories are often internalized and employed by people to make sense of their lives. However, these culturally provided stories are regularly constrictive and blaming. Narrative therapy works to assist clients to revise these internalized culture stories into ones that are more inclusive and appreciative of clients´ personal power and responsibility. It assists clients in gaining some power of self-creation by deconstructing the plots imposed in them by the social system. "*(Polkinghorn, 2004, p. 53.)

Among the central tenets of narrative therapies was also Harré´s idea of “positioning (Harré & Van Langenhove, 1991; Van Langenhove & Harré, 1994). The idea means that if we live in a culture with a stock of multiple discourses, then our identity or subjectivity (our unique experiencing of Self and the world) is influenced and therefore could be understood in terms of how we position ourselves (or are positioned by significant or influential others) in relation to these discourses or dominant discourses (e.g., what a family means; normative expectations regarding family; what mental health means; work commitments etc.).This idea has also implications for psychotherapy. First, an important part of any psychotherapy should be a reflection on the stock of social/cultural discourses and dominant narratives and how they shape the person´s subjectivity, his/her understanding of the problem and coping strategies. Second, the therapy process could be understood as an incessant co-constructing of individual subjectivity, understanding and tackling the problem through interaction between the client/family and the therapist.

Since the seminal work of White & Epston (1990) was published, narrative therapists with experience from different institutions, work contexts, and continents developed a great variety of linguistic strategies and interviewing techniques. The novel techniques were developed to bring forth the influential discourses and narratives to help people in “re-authoring” their lives and expand their personal agency. The have been described in detail in other texts (Payne, 2006; Skorunka, 2008; Skorunka, 2010; White & Epston, 1990). For a short summary, please see Tab.7.

Tab. 9. Process of Narrative Therapy

(adapted from Marner, 2000; Morgan, 2000; Payne, 2006; Vromans, 2005; White & Epston, 1990)

1. Description of the problem/symptom/concern (*problem-saturated description*).
2. Identifying, defining, and/or naming the problem.
3. An externalizing conversation of the problem as an entity separate from the person (*externalisation of the problem*).
4. Conversation about the problem´s influence on the person/family´s life (*relative influence questioning, exploring the identity of the problem*).
5. Inviting the person/family to take a position towards a problem.
6. Identifying the exceptions in the problem´s influence on the person/family´s life (*identifying the unique outcomes*).
7. Use of therapeutic documents (e.g., invitation letter, report of the consultation, certification of new status/identity).
8. Considering social and political issues that may shape the construction of the person/family´s realities.
9. Drawing on memories of significant people who have been lost or with whom the connection has been lost (*re-membering*).
10. Encouraging the person to identify and engage the people who might assist in telling, re-telling and revising the stories (*outsider witnesses*).
11. Enrichment and reinforcement of new self-story/identity through boost sessions or engaging significant others.
12. Celebration of a new identity - a consultancy status regarding the problem.

Narrative therapists started to use various forms of literary means (documents) during therapy process. The aimed at several goals: a) to help change the client´s/family positioning to the externalized problem; b) to strengthen their determination to challenge the problem; b) to foster the family cohesion and collaboration when facing the problem; d) to engage the client´s/family´s social network; e) to provide the scaffolding in the re-authoring one´s life and development of a new identity (Marner, 2000; Morgan, 2000; Dowling & Vetere; 2005; White, 2007).

Despite the popularity of narrative therapies, some psychotherapists and family therapists criticised the narrative approach for overemphasis on language and neglecting other issues. Minuchin (1998) found disappointing that some narrative therapists seemed to depart from conjoint family therapy sessions. He argued that observation and enactment of various scenarios as well as interactions among family members during the consultations was invaluable component of therapeutic collaboration. Flaskas (2006) and Pocock (2009) assumed that some experiences, particularly those from early stages of development including attachment, go beyond language and our abilities to simply revise the old and construct the new stories. Dowling & Vetere (2005) warned against zealous overuse of externalising conversation without prior exploration of the situation in the family and other systems.

In a similar vein, Skorunka (2010, 2016) reminded of bodily manifestation of distress and experience of a chronic physical disease. In such experiences, he argued, the cognitive dimension, the focus on language and conversations may not be sufficient enough. A combination of therapeutic approaches including work with the body, and sometimes even pharmacotherapy, is necessary in therapy with individuals and families, who struggle with physical symptoms. Together with Pocock (1997) and Pocock & Flaskas (2009), he also emphasized the phenomena such as a human connection, caring attitude, and therapeutic alliance, which are essential common factors for any psychotherapy to be effective. Let´s give voice to Flaskas (2006) who expressed with passion her critical stance towards postmodernist ideas and theory of social construction: "*Many of the families I have worked with in therapy have been living in chronic poverty; many have been on the receiving end of systemic racism across generations; many have histories of a very real tragedy; and many have had destructive experiences with health, welfare, and justice systems as well as seriously abusive experiences within family relationships. I have to say that I have often been struck more forcefully by the concrete realities of social existences than the limitless possibilities of construction in language*." (Flaskas, 2006, p. 57).

Regardless the critical arguments, narrative therapies based on postmodern philosophy and theory of social construction remain as inspiring resources for meta-positions, ideas and therapeutic techniques that enrich psychotherapy and family therapy. There has been no doubt, that post-psychological perspective in general, and narrative therapies in particular, questioned the pathologizing concepts, enabled critical reflection and inspired therapists in their attempts at and empowering people and families in their everyday struggles with various challenges. On top of that, those approaches emerged as a needed balance to concepts, which saw a human being as a bounded, autonomous individual. Regarding the consequences of globalisation, the threat of climate change, and recent global pandemic experience, we have seen how insufficient and potentially limiting such concepts are. For tackling such complex issues successfully, we need to acknowledge the interconnections between individuals, families, communities, and different parts for the world.

1.4.7. Narrative as an Integrative Concept in Psychotherapy

We have already mentioned how creating and sharing stories played a central role in both human evolution and the development of human cultures around the world. Storytelling is now recognized as an important variable in individual human development as well as in social interactions between both human beings and cultures. Given the reviewed ideas from various psychotherapeutic modalities and research findings from neurosciences, we can perceive narrative as an integrative concept. The narrative concept connects the intrapersonal (individual mind) and interpersonal (social) dimensions of human life (Angus & McLeod, 2004). It also helps to link processes of the mind and body—two dimensions that most scientific disciplines have long considered, and consequently studied, as separate (Honzák, 2019). The recent development of new, integrative disciplines such as interpersonal neurobiology shows that the concept of narrative bridges the humanities and social sciences with natural sciences (Siegel, 2020).

Since the end of the 20th century, there has been a growing trend towards integration in the field of psychotherapy (Castonguay, 2011; Prochaska & Norcross, 1999). This trend is a result of psychotherapy research as well as the activities of several representatives of the well-established psychotherapeutic modalities who made an effort to encourage integration both within and beyond particular psychotherapeutic approaches (Dallos & Draper, 2015; Evans & Gilbert, 2005; Pinsof, 2017; Gilbert & Orlans, 2011). Some of the proposed integrative models did not explicitly include the concept of narrative, while others considered narrative to be one of the key integrative ingredients (Dallos & Vetere; 2009). Regarding psychotherapy, Angus and McLeod (2004) argue that narrative is a ubiquitous phenomenon of both psychotherapy theory and practice, no matter whether representatives of different psychotherapeutic approaches use the narrative concept explicitly. Angus & McLeod (2004) see the main contribution of the concept of narrative to psychotherapy in its transformation of psychotherapy into a field, which is shaped not only by psychology and medicine but also other, potentially relevant, disciplines, such as philosophy, anthropology, linguistics, neuroscience, etc. Not only does the client's narrative capture his/her subjective experience, including the presented problem or difficulties, but also the important dimensions of human life, such as temporality, life events, relationships, dilemmas, meaning, socio-cultural context, and finality (McLeod, 2004 a, b).

Tab. 11. Narrative as an Integrative Concept

(adapted from Angus & McLeod, 2004, p. 367-374; additions from Skorunka, 2016)

- Narrative expression is a fundamental self-making practice.
- The concept of narrative encompasses a number of different storytelling structures.
- Narration is in itself a basic therapeutic process and is ubiquitous in every psychotherapeutic modality.
- Emotion is a marker of subjective significance in the client´s stories and the therapist´s response.
- Therapeutic alliance emerges from the storytelling activity of both the client and the therapist.
- Effective therapeutic work involves sensitivity to narrative multiplicity including attunement to the emotional "flavour" of different narratives.
- Effective therapeutic work involves a narrative integration of various aspects of client´s experience (both intrapersonal and interpersonal).
- Narrative coherence is an indicator of a client´s well-being and a good outcome of psychotherapy.
- The concept of narrative interconnects an individual subjectivity and dominant narratives/discourses of a particular society/culture.

It is interesting that one of the most respected representatives of narrative turn in psychotherapy theory and research and advocates of narrative, McLeod (2004 a, b) eventually became more sceptical of the integrative potential of narrative. According to McLeod (personal communication), researchers and clinicians understand the concept of narrative differently and interpret it with different meanings, primarily due to the varying theoretical positions and applications of narrative metaphor within a particular psychotherapeutic modality. As a result, both students and seasoned psychotherapists can be confused about the usefulness of narrative metaphor in clinical practice and see it as a solely theoretical or research related subject.

With considerable working experience in the intersection of medicine and psychotherapy, the author of this thesis considers the concept of narrative as a fitting bridge between a biomedical focus, with its emphasis on biological and the so-called objective aspects of health and illness, and the arena of psychology/psychotherapy, with its main focus on subjectivity, relational, social, and cultural context. Medicine in general and its evidence-based framework in particular had a great impact on the evolution of psychotherapy during the 20th century. It has been reflected and criticised by several authors (McLeod, 2007; Wampold, 2001; Wampold & Imel, 2015). The concept of narrative, together with current research in health psychology and contemporary neuroscience, proves to be a useful framework which balances the reductionist approach in biomedicine and supports the call for a consistent bio-psycho-social approach (Pennebaker & Seagal, 1999; Kiecolt-Glaser et al., 2011, Larner, 2018; Skorunka, 2020, Waite & Ryan, 2019).

Even in medicine it is worth mentioning Frank & Frank's (1999) notion of demoralisation, which they introduced in their discussion about healing factors in psychology and psychotherapy. Any disease usually brings about various forms of suffering. However, it is not just the disease itself but a combination of feelings such as hopelessness, helplessness, and demoralisation, all of which distress the person and prompt him/her to seek treatment, care, and guidance. In narrative terms, a disease is a disruption of the person's life story (Neimayer & Levitt, 2001). Thus, it should not surprise healthcare professionals that ill people as well as their families need emotional support, information, and guidance during times of illness. The concept of narrative as well as other relevant psychology and psychotherapy knowledge might provide valuable inspiration in medicine, especially by adding important perspectives for a complex understanding of health/illness experience. On top of that, such knowledge might be indispensable for training competencies which healthcare professionals, including physicians, need for communicating with the patients and their families. In the next theoretical part, we will focus on the narrative turn in medicine, including discussions about narrative competence and relevant research. We will also introduce the concept of narrative sensitivity.

2. THEORETICAL PART II.: NARRATIVE MEDICINE

2.1. The Bio-Psycho-Social Model

The biomedical model has been criticized in the past from various positions for many shortcomings, such as the mind-body split, neglecting patients' subjectivity, dehumanisation, fragmentation of healthcare, and downplaying the role of psychological and social factors in health and illness (Asen et al., 2001; Engel, 1977; Illich, 1976; Rapley, Moncrieff & Dillon, 2011). In his rather provocative paper in the journal *Science,* already an established and renowned scientific periodical at that time, Engel (1977) challenged the medical community by suggesting that a biomedical model has its limits in efforts to fully understand the complexity of health, illness, and treatment. He argued that academic and clinical medicine should look beyond pathophysiological processes towards psychological and social factors, such as mind processes, family dynamics, community, as well as socioeconomic and cultural variables.

Being a trained psychoanalyst and also inspired by the general systems theory, Engel coined the term “bio-psycho-social model”, in which the interplay between interdependent systems such as biological, psychological, family, and larger social systems would be acknowledged. The suggested model was derived from general systems theory, but also on the clinical observation that any medical condition may affect (and could be affected by) multiple levels in the system’s hierarchy and that every treatment reverberates across multiple systems, even if it is targeted at just one level (von Bertalanffy, 1968; von Schlippe & Schweitzer; 2001). On the basis of his personal experience with chronic disease, Engel pointed to the idea of isomorphism—that there are similar systemic processes occurring across different levels in the system of hierarchy, for instance the psychological and physiological. The idea of isomorphism was popular among some family therapists, psychoanalysts, and representatives of psychosomatic medicine in the 1950–1970's (McDaniel, Doherty, Hepworth, 2014). It was originally derived from mathematics and today is part of theoretical and research studies attempting to explain human consciousness (Horáček & Drtinová, 2021).

Engel's ideas corresponded with developments in other fields and systemic thinking at that time among biologists (Maturana & Poerksen, 2004), anthropologists (Bateson, 1972), epistemologists (Kuhn. 1997), systemic theorists (Luhmann, 2006), and family/systemic therapists (Bowen & Kerr; 1988; Bloch, 2002; Trapková & Chvála, 2004). What first seemed to be a blend of theorizing, clinical observations, and searching for new perspectives to improve treatments eventually developed into more rigorous scientific inquiry. Since Engel's bold suggestions, scientific knowledge about the interconnection between mind and body processes and between individual health and family attachments in the early stages of development has expanded enormously.

There are many studies about the interplay of bio-psycho-social variables. For instance, the impact of conflict in couple relationships on the immune system have been well documented (Kiecolt-Glaser et al., 2002, 2005; 2011). The interconnection between the experience of social rejection and the activation of neural circuits involved in the regulation and perception of pain has also been evidenced (Coan, Kasleb & Jackson, 2013; Coan & Schaefer, 2007). The seminal epidemiological study on adverse childhood experiences and subsequent mental and physical health was followed with further supportive findings (Anda, Felliti, & Bremner, 2006; Gilbert, Breiding & Merrick, 2015). Even though there is still much to be discovered about the detailed mechanisms of the connections across various system levels, reviews of the most recent findings in neuroscience and developmental psychology leave no doubt that the assumptions of clinicians and scholars in the second half of the 20th century were pointing in the right direction (Siegel, 2020; Schore, 2015; Teicher et al., 2016; Waite & Ryan, 2019).

However, the research progress in traditional and new interdisciplinary fields is slow to be incorporated into medicine. Clinical medicine and the organisation of healthcare still predominantly rely on knowledge from life sciences and a biomechanical perspective on the human organism (Komárek, 2005). This reliance is understandable, given the enormous success of engineering, technology, and the physical sciences in the 19th and 20th centuries. On the other hand, this success led to "*humans being viewed as mechanisms, objects, or machines that might break down and require fixing, which brought with it the danger of dehumanisation"* (McLeod, 2007, p.2). In recent decades, biotechnological advancement has become even faster and more impressive. Imaging technologies, new methods in molecular biology and genetics, and progress in organ transplants are only a few examples of the advancements that have enabled improved diagnostic and treatment possibilities. Nevertheless, such development also brought about new clinical challenges, ethical dilemmas, and also highlighted the shortcomings of a narrow biomedical model. Instead of becoming outdated, Engel's ideas were adopted by new generations of clinicians and scholars who pursued the application of the bio-psycho-social model in medicine and launched new approaches in the decades that followed.

2.2. Emergence of Narrative Medicine

As a response to the drawbacks of the narrow biomedical model, several approaches emerged at the end of the 1980's and the beginning of the new millennium, namely patient-centred care, family systems medicine, and narrative medicine. These approaches share an emphasis on an individual approach to patients and acknowledging their subjectivity, recognition of the role of family in disease and disability, and communication skills in medicine, including the importance of therapeutic alliance between healthcare professionals, patients and their families. The representatives of those approaches called, more or less explicitly, for the integration of knowledge from psychological disciplines and psychotherapy research into medicine.

The emergence of narrative medicine followed the narrative turn in the humanities and social sciences other disciplines including psychology and psychotherapy. The metaphors of story and narrative became the cornerstones of the framework for understanding those aspects of illness experience, medical treatment, and healthcare, concepts that had been largely ignored or marginalized in the biomedical model. Kleinman (1988) could be considered one of the first representatives of emerging narrative medicine. He introduced the distinction between disease (the medical definition of pathology based on clinical examination, including objective findings) and illness, which refers to the subjective experience of a patient (experience of symptoms, emotional response, explanatory models, etc.) In their series of articles published in the *British Medical Journal*, Greenhalgh and Hurwitz (1999a) reviewed the main ideas of the newly developed narrative medicine and their potential implications for both academic and clinical medicine. Charon (2001a, b; 2008) developed a rich description of various theoretical underpinnings of narrative medicine, ideas regarding clinical practice, and suggestions for the development of narrative skills in physicians.

The first representatives of narrative medicine found inspiration in anthropology, narrative psychology, art, literary theory, and also narrative-informed psychotherapy. They embraced the idea that *"the need to tell one's story is an important impulse for people in distress and that telling one's story to a receptive audience lifts some of the burden of the distressing experience/events and also sets up the foundation of the therapeutic alliance"* (Tantam, 2007, p.81). Such ideas seem to be more and more relevant in medicine today. There has been a significant increase in non-communicable diseases in well-developed countries. Given the social and economic consequences, cardiovascular, oncological, metabolic, and mental disorders pose a major challenge to public health. Those diseases tend to be mostly long-term (chronic), and so the patients suffering from them require long-term treatment and regular collaboration with healthcare professionals. Given the often-distressing experience and those diseases' impact on the patient's quality of life, it is not surprising that patients and their families need guidance and supportive therapeutic alliance with the physicians and/or other professionals (Rolland, 2018; MacCormack et al., 2001).

Perhaps in anticipation of misunderstanding, Cenci (2016) interestingly offers a definition of narrative medicine by first stating what it is not: “*Not all storytelling is narrative medicine… it is not alternative medicine which heals through stories, it is not psychological or psychiatric competency that uses storytelling as therapy, it is not a collection of patients' stories in a book, it is not online blog therapy, it is not qualitative research, it is not the kind doctor who listens to what you have to say.*” (Cenci, 2016, p. 23). He then continues with a definition provided by Italian guidelines: “*The term narrative medicine refers to a clinical assistance methodology based on a specific communicative competence. Narrative is the fundamental tool to acquire, understand, and integrate the different points of view of those involved in an illness and in the treatment process. The goal is to develop a shared personalised treatment plan (care story). Narrative Based Medicine (NBM) is integrated with Evidence-Based Medicine (EBM) and, by considering the various perspectives, makes clinical assistance decisions more complete, personalised, effective and appropriate*.” (Cenci, 2016, p. 23).

In their influential series of papers in the *British Medical Journal*, Greenhalgh and Hurwitz (1999a, b) proposed that the processes of becoming ill, being ill, getting better (or getting worse), and coping (or failing to cope) with illness can all be viewed as enacted narratives within the wider stories of people’s lives. The metaphors of story and narrative offer a method for addressing existential qualities, such as hurt, despair, loss, hope, grief, and moral pain that frequently accompany, and may even constitute, people’s illnesses. As Charon & Wyer (2008) restates, the essence of health, pain, suffering, and the inevitable reality of death should not be reduced to their “bare bones”—to narrowly conceptualised biological phenomena that neglect their complexity. In other words, narrative provides a framework for various aspects of the patient's illness experience, including emotions, meaning, and context. In a similar vein, Charon (2001a, b; 2004, 2008) advocates for the potential of the narrative framework to deal with issues inevitably linked to illness experience and the patient's interaction with healthcare. Finding inspiration in philosophy, literary theory, creative art, and narrative psychology, she became one of the leading figures who captured the attention of academic and clinical medicine to narrative framework.

In her writings, Charon explores the divisions between the experiences of the doctor and the patient, challenges typical healthcare practices, and makes suggestions regarding medical education, including narrative skills training. Charon critically reflects on the inherent shortcomings of the biomedical model, which can still be experienced by patients and their families in healthcare institutions (see Tab. 12.).

Tab. 12. Family Experience in the Hospital

(Respekt, 30(50), 2019)

The nurse at the ward speaks to us in a tone that isn't sensitive to our feelings." "*No, you cannot see him, it is impossible."* She seems surprised by my brother's question of how our father died. She does not understand. Then she recalls that our father was restless and pulled out the intravenous tubes, and that his last words were something like *"I am giving up."* I remember all those harsh comments from the care assistant, who swore that my dad ate nothing, when actually he could not eat on his own. I also remember the remarks from the nurses that he should have asked, and also the assistants' complaints that they had to lift someone up again. The worst thing, after all, is not the pain related to the disease but the fact that they treat you like a burden, with contempt. And the worst thing for the family is when nobody talks to you at all.

Despite impressive progress in biotechnology, doctors are often criticized by patients and their families "*for their limited capacity to recognize the plights of their patients, to extend empathy to those who suffer, and to join honestly and courageously with patients in their struggles toward recovery, accompany with chronic illness, or in facing death*" (Charon, 2008, p. 3). The flip side of biotechnological advancement and the division of medicine into many sub-specialisations is the impersonal and fragmented care provided by detached professionals, who are "*so focused on scientific knowledge and biological processes that they seem to be divided from ordinary human experiences, such as pain, disability, suffering, and dying*" (Charon, 2008, p. 6). Patients complain that doctors do not listen to them, do not take their personal accounts of illness seriously, or seem indifferent to their suffering including the burden which the disease poses for them and their loved ones. Instead of being provided with hope, reassurance, guidance, and compassion, patients find themselves "*being treated like an object that is frequently referred from one specialist to another, from one procedure to another, often without explanations ore appropriate attunement to their emotions and concerns*" (Charon, 2008, p. 3). For this reason, many patients feel abandoned and distressed in the most challenging moments of their lives—times when they need support more than ever. In psychiatry and psychotherapy clinics, we often hear the patients' stories of the humiliation, misunderstanding, and abandonment they experienced in healthcare institutions (see Tab. 13.).

Tab. 13. An Individual Patient´s Experience with Health Care System

“It has been 4 or 5 years, I am not sure, it has been really a long time. Actually, I don’t know why it took so long. Maybe, it’s because I guess doctors do not collaborate at all, you know, the neurologist does not speak to the cardiologist and so on. … I was referred to so many examinations but there was no medical team consultation, you know, where they would discuss it all together. And no one was willing to tell me why or what was going on, because it was beyond their medical specialty. They always used to say: “Well, it is really unusual, hmm, but it is not this disease.” It seems to me that unless you are in their category, doctors are not really interested, I don’t know. So it was taking such a long time and they kept repeating “We will see you again in 6 months.” Why the hell didn’t they organize a team consultation? Everyone wrote his report but no team consultation whatsoever. They sent me to the neurologist, because they thought it could be epilepsy, but it wasn’t. Then they tried to find out if it was Parkinson´s disease, but it wasn’t that either. Then multiple sclerosis, because of the onset of some symptoms. Then other tests and afterwards they seemed to be desperate because they couldn’t find anything. And finally, they referred me to psychiatry because they assumed it was psychological or something…”

It has been reported in clinical settings, evidenced by research, and repeatedly emphasized by representatives of narrative and psychosomatic medicine that patients long for doctors who try to comprehend what they are going through, who show genuine interest in their distressing experience, and who also accompany them through their journey with their diseases (Skorunka, 2020; Charon, 2008). According to Launer (2018), the mission of narrative medicine has been to restore humanity, imagination, and moral engagement to the medical world. Narrative turn in medicine revitalizes context and places the patient's and the doctor's subjectivity at the centre of clinical judgement, clinical practice, and the mindset of healthcare professionals.

Charon (2008) speaks about four major divides that contribute to the conflicts between the doctor and the patient: a) relation to mortality; b) contexts of illness; c) beliefs about disease causality; d) emotions. The divides come from different experiential gaps between the doctor (the caregiver) and the patient (the sick person who needs care). These experiential gaps are frequent sources of mutual misunderstanding and the patient's frustration and sense of abandonment. As a result, the therapeutic collaboration between doctor and patient during the treatment may be disrupted. In some cases, it may even result in the patient’s complete disengagement from the healthcare system (McGowan et al., 2007; Griffith & Griffith 1995). Such experiences may accompany any disease or health condition, though they are more frequently reported by patients with so-called medically unexplained symptoms (MUS)—those which could not be explained by an underlying pathology after thorough and often repeated diagnostic examination (Polakovská, Řiháček, 2021; Skorunka, 2010). Whereas the narrow nature of the biomedical model may not be sufficient for treatment, those patients may benefit from psychosomatic medicine based on bio-psycho-social model, which integrates psychotherapy, family therapy, and physiotherapeutic approaches into the treatment (Chvála, Skorunka, 2017; Chvála, Trapková, Skorunka, 2012; McDaniel, Doherty, Hepworth, 2014, Kozlowska, 2016).

Let us take a closer look at the divides described by Charon (2008). Doctors and patients differ fundamentally in their way of understanding and dealing with mortality. Doctors learn to detach themselves from the issue of death (and arguably from their patients) early on, typically as medical students during their first lessons in the anatomy lab. Doctors may look upon death as a phenomenon that is not related to them personally or as a technical problem to deal with. Patients and their families see death as both unthinkable and inevitable, something that terminates their lives and all the aspirations, hopes, and needs that come with it. For patients, the threat of death is an intense personal experience. Regarding the context of illness, doctors tend to understand disease only as a biological phenomenon requiring biochemical or surgical intervention, while patients tend to see illness within the frame and scope of their entire life trajectory (see Tab. 14.). For patients, future plans, fulfilment of their potential, and quality of life matter more than understanding the immunological variables, molecular processes, etc. related to their disease. What doctors conceptualise and describe in medical terms (disease) and what patients experience and must face (illness) are entirely different, though mutually related, aspects of health/illness conditions (Kleinman, 1988).

Tab. 14. An Example from the Author´s Clinical Practice: Different Worlds ‘Narratives

Patient: “My mother died last year. I took care of her the last few months. Because my husband was so busy, so it was all on my shoulders, you know. We’ve got two kids and my father-in-law lives with us too, so there’s no chance for me to get any rest. Sometimes I feel like… I can’t even take a deep breath. … Two months ago, I started to have these strange feelings like I had a stone on my chest, my heart started pounding suddenly, and that scared me a lot. I have been feeling so exhausted the last half a year, not enjoying anything in particular, just doing what was necessary.”

Physician: “All right, how long have you been feeling depressed? Have you had any recent trouble sleeping? And what about those strange feelings, it sounds like you experienced anxiety, how often does that happen?”

As for the causality, healthcare professionals and patients may have deeply conflicting ideas about the causes of symptoms and diseases. At the same time, they fundamentally differ in their ways of thinking about the actions that should be taken regarding prevention and treatment. Such differences are even more prominent today, when a vast amount of knowledge is available online in the form of research findings, personal narratives, and alternative explanations. As a result, physicians struggle to communicate with patients more often than in the past, when such information was less accessible. Perhaps the most striking divide is related to dealing with emotions. All emotions are an inevitable part of a subjective experience, including illness. However, emotions were largely ignored in biomedicine until the dawn of neuroscience (Damasio, 1994; Honzák, 2017). Thanks to cutting-edge research in new interdisciplinary fields, such as, for instance, interpersonal neurobiology and the like, emotions are now considered important and complex psycho-biological phenomena which play both a role in an individual's development and the aetiopathogenesis of many diseases (Montgomery, 2013, Schore, 2015). Without acknowledging emotions in health and illness research, and appropriately attending to emotional experience, prevention and effective care can be thwarted and the rift between patient and physician will persist.

Charon (2008) also makes a distinction between the four main interactional situations in medicine that includes the narrative organization of experience and the overlap between an individual story and social context: a) doctor-patient relationship; b) doctor's relationship to herself/himself; c) doctor's relationships with colleagues; e) doctor's relationships with society. Medical practice unfolds and the healthcare system is provided through a series of those complex narrative situations. Other important interactional situations involving narrative organization do exist in medicine and healthcare as well. For instance, interactions between physicians and the patients' families, between patients and their family members, and among patients themselves. It is well known that family can be both a source of distress and support (Dallos & Vetere, 2009). The influence of family system development on health and illness of family members has long been theorized about in family/systemic therapy (Minuchin, 1974; Bowen & Kerr, 1988; Boszormenyi-Nagy, Grunebaum, & Ulrich, 1991; Chvála, Trapková & Skorunka, 2012) and most recently evidenced in research in various disciplines, such as health psychology, developmental psychology, trauma studies, and interpersonal biology (Bick & Nelson, 2016; McCarthy-Jones et al., 2018; Waite & Ryan, 2019). The disease, which one or more family members suffer from, affect both the family functioning and quality of life. The family dynamics and quality of relationships affect the family member´s process of being ill, his/her s coping with the disease, and therapeutic collaboration with healthcare professionals (Rolland, 2018; Russell Crane & Marshall, 2005). Though they may affect the patient's compliance with treatment and adherence to medication, interactions between the patient and his/her family may go unnoticed by physicians (Skorunka, 2018). There are various approaches designed to engage the patient's family in the treatment and foster “healing” narrative interactions (Asen et al., 2004; Crittenden, et al., 2014; McDaniel, Doherty & Hepworth, 2014).

In most medical specialties the doctor-patient relationship is still the cornerstone of clinical practice. The patient's talking about his/her illness experiences is always a complicated act of narrating, which includes not only words, but also non-verbal variables, all of which convey valuable information about the patient's emotional experience. Arguably, the doctor should be able to focus not only on biological variables (disease) including the patient's symptoms, but also on affective and cognitive components of the patient's subjective experience related to the symptoms (illness). According to Charon (2008), doctors need to be able to follow the narrative thread of the patient’s story to imagine his/her situation and recognize the multiple and often contradictory meanings of the words used and the events described, and somehow enter the world of the patient and be moved by his/her narrative. Thus, to perform such clinical narrative tasks, the physician should be able to: a) establish a therapeutic alliance; b) generate and proceed through a differential diagnosis; c) interpret physical findings and laboratory reports correctly; d) experience and convey empathy for the patient's experience. Only then can the patient be fully engaged in obtaining effective care (Spiro et al., 1993; Skorunka, 2020, Skorunka, 2011).

If the physician cannot perform these narrative tasks, the patient may fail to tell the whole story, express all important concerns, ask the most frightening questions, and might not feel heard. As a result, the physician's final diagnostic workup might be unfocused and therefore more expensive than necessary—the correct diagnosis might be missed, the therapeutic alliance might not be built up properly, the treatment might falter due to noncompliance. As a result, the patient might seek another examination and/or consultation elsewhere. The illness experience and its consequences push the patient to consider various aspects of his/her past and present life. Typical questions include: a) “*Why me*”? b) *What did I/we do wrong*? “; c) *What can I/we do to recove*r? d) "*What will become of me*?” Many patients expect their doctors to answer those questions. Being trained solely in a biomedical model, many physicians may struggle to answer these questions, avoid them completely, or downplay their legitimacy. Thus, some patients might feel misunderstood, rejected, and abandoned and seek help from healers using complementary and alternative treatment.

The issue of the doctor's relationship to herself/himself is vastly neglected in mainstream medical education in the Czech Republic. In the past, the ideal doctor was presented as detached from their own emotions and the emotions of the patient. In psychotherapy, the Self of the therapist is considered among the variables that significantly affect psychotherapy outcome (citation). In medicine, on the other hand, such a variable was not considered important to treatment outcome until only recently. Even today, medical students may be advised by their teachers to avoid being empathic with their patients and focus solely on objective findings, scientific knowledge, etc. Such ideals fit well with the so-called paternalistic model of doctor-patient interaction and the inherently narrow biomedical model (Beisecker & Beisecker, 1993). Given recent shifts toward collaborative practices, more symmetrical doctor-patient relationships, and individualized treatment/care, such a model has begun to fall out of fashion. It could be argued that courses focused on helping medical students and junior doctors “know themselves” should be part of medical training. For instance, understanding and regulating one's own emotions, the ability to reflect over the clinical interactions with the patients, narrative competence, etc. are crucial prerequisites in developing therapeutic collaboration with patients with a great variety of health conditions. Reflective practitioners can identify and interpret their own emotional responses to patients, can make sense of their own life journeys, and are therefore able to provide what is called for when facing sick and dying patients. Indeed, it may be that the physician's most potent therapeutic instrument is a self that is attuned to the patient through engagement, positioned on the side of the patient through compassion, and available to the patient through reflection. (Charon, 2001a, b; Skorunka, 2020).

How are the doctor's relationships with his/her colleagues related to narrative-informed medicine? Being a doctor means belonging to a community with particular values, rituals, traditions, commitments, and narratives. Sharing narratives about health, illness, disease, prevention, and treatment affect the individual doctor’s way of organizing his/her experience which may go well beyond professional life in a healthcare institution. The symbols and rituals strengthen the membership in the medical community and contribute to identification with a profession which shares some values and narratives. Membership in the medical community is also characterized with a certain exclusivity which manifests itself in traditions and rituals but also in the public's attitude towards doctors (Křížová, 2006; Komárek, 2005). Clinical situations are frequently bound with uncertainty, pressure, and distress. Collaboration, peer support, and a sense of commitment might serve as valuable remedies against those medical job-related challenges.

However, the strength of the bonds among physicians has eroded in the last decades because of the trends of managed healthcare and so-called defensive medicine. Managed healthcare has become the standard organisation of healthcare in some countries to maximize resources and achieve cost-effectiveness. The principle of informed consent within medical ethics was designed to protect vulnerable patients in distressing conditions. Both the emphasis on economic aspects and an increase in bureaucratic procedures forced physicians and healthcare institutions to develop “defensive” mechanisms to prevent lawsuits on behalf of the patient. As if “safety first” sometimes referred to physicians and institutions themselves and not the patients, whose voices may still be easily marginalized. Sharing those powerful “narratives” within the medical community may also lead to so-called professional blindness, such as the inability to put oneself in the patient’s/family’s shoes or pseudo solidarity when something goes wrong. It further deepens the fragmentation of contemporary medicine, with deleterious consequences for patients and their families. What is more, physicians seem isolated from one another and from their colleagues in nursing, social work, and other health professions, divided from their ideals, and disconnected from their broad professional goals in the face of narrow, competitive drives toward individual distinction or reward.

The last category of interactions related to narrative, according to Charon (2008), is the doctor's relationships with society. In other words, it is the awareness of interconnectedness between the development of a profession (medicine) and the development of society. Such interconnectedness is manifested as a) social and political development affecting the conceptualization of various health-related conditions (for instance, removing homosexuality as a disease from the system of classification of mental disorders; inclusion of category of posttraumatic stress disorder in the classification of mental disorders); b) advancement in other disciplines affecting our understanding of biological/medical phenomena (for instance, metaphors from computer technologies used in current neuroscience); c) advances in medical sciences affecting social processes (for instance, the process called medicalization). On top of that, the doctor is not only a specialist but also a representative of a powerful professional community.

As Křížová (2006) remarked, the healthcare system and the profession of medicine manifest themselves for us, the patients, but the doctor is also affected and even limited by those systems more than the patients can imagine. We cannot study the medical profession and the doctor's role separately from trying to understand *“the interconnectedness with the organization of the healthcare system and without reflecting on the development of modern and late modern societies”* (Křížová, 2006, p. 10). There has been some critical commentary on the social context of medicine, particularly the economy-first models and the influence of the pharmaceutical industry on the biased building-up of scientific knowledge and corruption practices. As a result, reversals in public trust with accusations of overbilling for services, withholding information from patients on the potential risks of research, and deriving financial benefit from professional knowledge (Moynihan, 2002; Moncrieff, 2004; Rapley, Moncriff & Dillon, 2011). As Snyder (2020) emphasized, a marketplace-driven healthcare system widens social inequality and fails to provide healthcare to those who need it. Medicine's—if not individual physicians'—trustworthiness has been called into question, which we witnessed recently in the tragic wake of the pandemic (Skorunka, 2020).

Charon's (2001) division of interactional and narrative-informed situations in medicine corresponds and overlaps with Kalitzkus & Matthiessen's (2009) distinction of four categories of stories, which are related to medicine, health, illness, and treatment: a) patients’ stories; b) stories about doctor-patient collaboration; c) physicians' stories; d) grand narratives. Some stories fit into more than just one category. There is a wide range of stories, both in terms of content and form. Stories in each category are narrated in different ways, either as fiction, true stories or as professional accounts. They are written as novels or short stories by either the physicians (Sacks, 1985) or the patients (Jamieson, 1996). They are a part of textbooks, presentations at scientific conferences, etc. These days they are more frequently adapted for a movie (e.g., 50/50, 2011; Still Alice, 2014; The Father, 2020), quality TV series (e.g., I know this much is true, 2020), or documentary series (e.g., Lenox Hill, 2020).

The patient's stories are organized around the unique experience with a particular health condition, the diagnosis of a disease. They may include the subjective experience with symptoms, the impact on the person and his/her family life, emotional responses, coping strategies, the experience with physicians and the healthcare system, etc. There are also electronic databases, such as DIPEX (*The Databases of Individual Patient Experience*), which record experiences with various diseases and their treatment (DIPEX International, 2021; DIPEX CZ, 2021). The category of the physicians' narratives is also rather diverse. There is a recollection of professional experience integrated into fictional stories with a more-or-less dramatic and/or humorous tone (e.g., Cronin, 1993; Haley, 1991). Other writers recall their medical education with a critical attitude (e.g., Gordon, 2009; Shem, 2010). Some physicians’ narratives are intertwined with the patients' illness narratives and are adapted for the TV or cinema (eg. Doctor, 1991; The Knick, 2014; Lenox Hill, 2020). For instance, the recent documentary series Lenox Hill was highly acclaimed as a realistic depiction of the medical profession from the perspective of several hospital specialists who introduce the audience to everyday clinical dilemmas, challenges, their emotions, and balancing professional life with the personal one.

The third category are stories about physician-patient therapeutic encounters, either from the physician's or the patient's perspective. Those stories, either in writing (e.g., Greenberg, 1998) or cinema (e.g., Awakening, 1990), seem to capture the key factor in the physician/therapist-patient therapeutic collaboration, the therapeutic relationship. In those stories, the therapeutic relationship between a patient and a physician/therapist is depicted as the main vehicle of the story of healing. The last category, the grand narratives, include influential stories, sometimes even myths, about major discoveries in medicine and milestones in biotechnological progress, including the biographies of great researchers, clinicians, or thinkers. Some stories in this category represent criticism from some scholars and clinicians who deconstruct the myth of the superiority of biomedicine (Rapley, Moncrief & Dillon, 2011), while others offer more philosophical or sociological perspectives in this regard (Illich, 1976; Foucault, 1994; Le Fanu, 2000). A specific and recent example that also falls at least partially into this category is a narration of a patient's experience embedded in a blend of historical and philosophical writing about issues, such as human rights, values, the healthcare system, and society (Snyder, 2020).

Tab. 15. Narrative and Medicine; Summary

(Greenhalgh & Hurwitz, 1999; Launer, 1999; Elwyn & Gwyn, 1991; Jones & Hudson, 1999; Charon, Hermann & Devlin. 2016; Skorunka, 2010)

1. The onset of a disease, the process of being ill, the treatment, and the coping strategies in such a potentially stressful situation can be understand as plots in a wider life story of the individual.

2. Narrative perspective enables the inclusion of the subjective experience of the individual in the overall picture of the disease and the process of being ill.

3. Narrative perspective enables a more sensitive approach to existential issues related to the disease such as loss, sadness, hope, hopelessness, meaning, and death, etc.

4. In the narrative perspective, the collaboration between the physician and the patient includes a co-construction of a story that is meaningful for the patient and that includes hope for recovery or reconciliation with the unavoidable.

5. The interactional aspect of physician-patient communication is an important part of narrative perspective. Thus, discourse analysis and related methods can be used to improve the interaction, including the physician’s understanding of the patient’s needs.

6. Narrative perspective includes an ethical dimension in recognizing the co-existence of various viewpoints regarding clinical situations which may pose ethical dilemmas for the patient, his/her family, and the healthcare professionals.

7. The ethical dimension reminds us that illness narratives have several potential interpretations, but it is the patient who should be the main “author” of his/her own life story, if possible.

2.3. Narrative Competence

With regard to medical education and ongoing discussions about the shortcomings of a narrow biomedical model, Charon (2001, 2004, 2008) introduced the term narrative competence, which she defined as a "*set of skills required to recognize, interpret, and be moved by the stories one hears or reads. This competence requires a combination of textual skills (identifying a story's structure, adopting its multiple perspectives, recognizing metaphors and allusions), creative skills (imagining many interpretations, building curiosity, inventing multiple endings), and affective skills (tolerating uncertainty as a story unfolds, entering the story's mood)*" (Charon, 2004, p. 862). Charon assumes that a physician practicing medicine with narrative competence can quickly and accurately hear and interpret what a patient is trying to say. "*The doctor who has narrative competence uses the same time of a clinical interaction efficiently, wringing all possible medical knowledge from what a patient conveys about the experience of illness and how he or she conveys it.*" (Charon, 2004, p. 862). This may have a profound effect on the patient's experience of and satisfaction with the encounter with the doctor. The following is feedback which a patient gave at the end of a consultation: *"I soon had a sense that you caught it, I mean I felt that you understood what I was concerned about and that you care to help me with it. It was like, after 15-20 minutes or so, I had such a feeling. I already had a few consultations with two other therapists in the past and this was different."* It is obvious that factors other than the physician/therapist's narrative competence could have contributed to the patient's experience. In my own experience and qualitative research, patients (and their families) really value the so-called narrative flavour of consultations in which the physician/therapist makes an effort to come close to the patient's experience and to his/her unique narrative including the major concerns they have about their health conditions and their impact on their lives (Skorunka, 2008). As Charon (2004) puts it, "*the doctor with narrative skills habitually confirms the patient's worth in the process of attending seriously to what he or she tells. Such a doctor will demonstrate concern for a patient while concentrating on what the patient says and, as a result, can achieve the genuine intersubjective contact required for an effective therapeutic alliance*." (Charon, 2004, p. 863).

It has been evidenced in psychotherapy research that therapeutic alliance and the Self of the caregiver/therapist are among the most important variables regarding psychotherapy outcome (Wampold & Imel, 2015; Cooper, 2013). However, these findings have been slow to integrate into academic and clinical medicine in some countries, particularly those where psychotherapy and psychosomatics development was delayed due to past political situations. Of course, psychotherapy differs from medicine, in which medication and instrumental/surgery procedures are the main treatment interventions. Nevertheless, the common factors deemed important in psychotherapy regarding its outcome (e.g., the Self of the therapist, empathy, therapeutic alliance) also play a role in therapeutic collaboration between the physician and the patient. As both patients and clinicians report, the therapeutic alliance seems to be necessary in order to engage patients and their families in effective care (Skorunka, 2020).

Regarding narrative competence, Charon (2008) and Charon et al. (20016) speak about three important elements: attention, representation, and affiliation. Attention is a complex, difficult, and demanding task to achieve when in contact with patients and their families. Charon characterizes it as a focused attention that requires the physician to actively mute all distraction, both external (e.g., setting, other events in the department, distraction from other healthcare professionals) and internal (e.g., personal issues), to concentrate fully on the patient's presence (Charon, 2008, 131-151). To make it even more challenging, patients are often unable to tell the story in logical, coherent, organized language. Instead, the message comes to physicians through both verbal and non-verbal means, such as the patient's words, silences, tone of voice, gestures, facial expressions, bodily postures, etc. Therefore, to perceive such complexity and understand the message in a clinical context, one must be fully attentive. It is the patient's story, together with physical examination and so-called objective findings (e.g., lab measurements), which the doctor must interpret in his/her clinical judgement. The information from all of these sources (patient's speech, non-verbal behaviour, lab findings, etc.) may even be contradictory. Thus, it is the doctor's task to help the patient organize his/her experience in a coherent way with a clear, comprehensible meaning. What's more, the interaction and the need for focused attention is even more complex and necessary, when the physician meets the family.

The second important element of narrative competence, according to Charon (2008), is a representation. The doctor's complex representation in clinical practice comprises a) the patient's experience; b) one's own clinical experience and medical knowledge; c) the overall impression of the interaction with the patient, including one's own emotions. The complexity of such representations requires a utilization of as many resources as possible in clinical situations. In addition to the symptoms, biomedical data, and scientific knowledge, hunches based on past clinical experience, subjective experience, psychological and social variables, and metaphors also matter. The third element of narrative competence is affiliation. Charon (2008) describes affiliation as a myriad of various interpersonal encounters which the doctor has with patients, colleagues, students, the medical community, professional organisations, etc. The individual partnership with the patient and alliances with his/her family is emphasized. Collaborative practices with colleagues, learning experience with students and senior colleagues, etc. are vital sources of life-long learning, peer support, and professional identity.

Empathy and reflection are considered to be important elements of general narrative skills (Charon, 2001, 2008). These qualities may be seen as antidotes to the typical practices embedded in the rigid application of the narrow biomedical model, such as detachment, ignoring the unique individual experience, fragmentation of healthcare, overlooking the social and cultural dimension of care and so forth. Patients and their families are often frustrated with such drawbacks that, in our view, could be remedied in part by the rigorous development of narrative and related skills. Charon (2001, 2004, 2008, 2016) concludes that by developing narrative competence, healthcare professionals can become more attentive to patients, more attuned to their experience, more reflective in their own practice, and more accurate in interpreting the stories patients tell about their illness experience. Thus, the training of general narrative skills should be included in both undergraduate and postgraduate medical education to achieve the following: a) development of clinical imagination; b) deepening of empathy; c) increased awareness of ethical dimensions of clinical situations; e) extended capacity for attention and attunement; f) development of more complex mental representation of the patient's subjective experience and his/her world.

2.4. The Challenge of Traditional Medical Education

Reflecting the shortcomings of a narrow biomedical model and the consequent lack of narrative skills among physicians should not lead to a simple blaming of physicians. After all, the physicians can only deliver what they are trained to do. The system of medical education either provides or fails to provide the learning context in which medical students–future doctors—acquire both the knowledge and skills necessary in clinical work, including how to communicate with their patients. In most Czech Faculties of Medicine, traditional medical education still revolves around the biomedical model. Medical students typically begin their undergraduate study with lessons in Latin and in the anatomy lab. For their first experience in the anatomy lab, they are confronted with a corpse—a human body. They are expected to memorize a vast number of details about all the body parts. This is arguably the beginning of their detachment from and objectification of the human body. There are no courses focused on prompted self-knowledge, reflection, or experiential work in general, which would balance this emphasis on cognitive processes (memorizing data) and un-reflected detachment.

Later, the students learn to understand detailed mechanisms of pathological and pathophysiological processes. By their third year, they have progressed to clinical subjects, where they focus on the manifestations of different diseases, diagnostic and treatment options, and clinical judgment. The biological phenomena are considered the most important, while the subjectivity of the patients and their families are often marginalized by the lecturers. During this time, the medical students adopt the biomedical model as the only framework for understanding the complexity of health and illness. It is even more reinforced during internships in the last year of study and after graduation. To make matters worse, training in many departments and hospitals is still based on a so-called see-if-they-swim ethos. In healthcare institutions, there is a typical atmosphere of hierarchy, competitiveness, pressure, and high expectations. Such an atmosphere and lack of appropriate mentorship lower the threshold for feelings of inadequacy, humiliation, shame, fear of failure, and self-doubt, all of which might undermine the development of the sound confidence necessary to deal with clinical challenges. As a result, some young physicians may perceive the patients as “the most feared” creature/species (Shem, 2010; Luhrman, 2000). Perhaps the see-if-they-swim ethos in postgraduate training should be superseded by mentorship based on the Vygotsky´s notion of zone of proximal development, which has been applied in training at other so-called helping professions, such as psychology and psychotherapy (Dallos & Vetere, 2009).

The trends such as managed healthcare and defensive medicine, which evolved as a response to the danger of the patients' complaints and potential litigations, increase the pressures and call for balancing support in the changing medical world. Those trends and their consequences have been criticized from different positions. As Charon (2008) recalls: “*The personal mentorship and role modelling that was once the hallmark of medical education have been eroded by time and money pressures. The competitive, and deficit, environment of most teaching hospitals leaves little room for the dutiful raising of young professionals or the nurturing of those in full career. Instead of committing themselves to the professional development of their members, professional medical organisations more often indulge in legislative lobbying or market positioning. Turf battles threaten to undermine respectful alliances with nurses, physician assistants, social workers, psychologists and psychotherapists, leaving many healthcare professionals feeling isolated, distrusted, and struggling against one another instead of working together on behalf of the patient. The threat of malpractice litigation leaves doctors feeling they must practice a rigid, suspicious medicine.”* (Charon, 2008, p.7)

The above-mentioned experiences from undergraduate medical education and residency are still rather frequently recalled by interns and physicians during supervision and/or counselling consultations. What those experiences have in common is a sense of failure, humiliation, exhaustion, and a loss of ideals of care and an estrangement from patients. It is no surprise that those experiences serve as inspiration for popular fiction (Shem, 2010; Kay, 2019) or explored in research (Luhrman, 2000; Grendar, et al., 2018; Rich et al., 2016). As Irvin & Spencer (2016) note, the harsh nature of medical education is something akin to military indoctrination, during which *“the junior clinician experiences a dissociation that runs parallel to the patient's: One must learn to separate from oneself—to disregard the needs of one's own body and spirit. To successfully withstand the crucible of medical training”* (Irvin & Spencer, 2017, p. 69). In contrast to typical practices in medical education, some research suggests that more supportive approaches by healthcare organisations and educators would be better not only in developing various skills but also for the medical trainee's well-being (Ansell, Read & Bryce, 2020).

2.5. Narrative and Evidence-Based Medicine

The question is whether narrative medicine can fit in the current framework of evidence-based medicine. It could be argued that narrative ideas and/or narrative medicine do not rest on the same irrefutable scientific data that biomedical knowledge does. Such potential criticism could be responded to with solid arguments. First, the evidence-based approach stems from basic assumptions, which are openly reflected far less frequently in medicine than in other fields. They are the assumptions of so-called naturalism, which have been explored in detail, for instance, by Slife (2004). Second, such critique might result from a misunderstanding of the evidence-based framework, which was originally postulated by Sackett et al. (1996). Let's first discuss the assumptions of naturalisms.

All knowledge systems including modern biomedicine have implicit and often unexamined points of view that are “behind” our examination and explanation (Jaspers, 1954). Even the scientific method, which is at the core of contemporary evidence-based doctrine, is not free of basic assumptions that could bias/distort the process of exploration and its findings (Feyrabend, 1975; Kuhn, 1997; Popper, 1959). Without thorough reflection upon those assumptions or implicit point of views, the process of building our knowledge could be limited or obstructed. At the background of the life sciences that fuelled progress in medicine and later influenced the development of other disciplines lies the philosophy of naturalism. According to Slife (2004), this philosophy essentially postulates that natural laws and/or principles ultimately govern the events of nature, our bodies, behaviours, and minds.

Naturalism rests on five key assumptions: a) objectivism; b) materialism; c) hedonism; d) atomism; e) universalism (Slife, 2004). Objectivism considers the objective world “out there”, which presumably exists outside of our minds, as the subject matter of traditional science (including medical research). This world exists and can be discovered without the biases of our subjectivity and values. Until recently, subjectivity, in other words the mental world of emotions, opinions, biases, and values, has been of no interest to traditional natural sciences. The second assumption, materialism, considers matter to be the only thing worth exploring (Slife, 2004). In medicine, there has been increasing emphasis on the biology, biochemistry, and/or mechanics of disorders and treatment (pharmacology and surgery). Non-material variables, such as relationships, complex emotions, quality of life, and their influence on health and disease, were completely excluded from scientific exploration in medicine until very recently because it was not easy to directly observe and measure them.

The third assumption, hedonism, is related to our perspective of life, human nature, the meaning of suffering, and therapy goals and outcomes. Hedonism suggests that human beings and other living species primarily seek pleasure and try to avoid suffering. Broader ideas of “pleasure”, well-being, happiness, and self-benefit are considered the main goals of life. Regarding medicine, the assumption of hedonism is at the background of ongoing discussions about a life worth living, for instance in older age, in terminal stages of serious disease, and euthanasia. Atomism is the notion that the natural world is composed of basic particles (e.g., atoms, molecules, cells), with specific properties, qualities, and functions that are contained in themselves. One of the goals of naturalism is to discover the basic mechanisms that govern the interactions and functioning of those basic particles (Slife, 2004). The assumption of atomism lies behind the focus on an individual in medical treatment, the notion of the autonomy of the patient, the idea of patient-centred care, and individualised genomics. Whatever the case, these approaches are based on the notion of specific characteristics contained within the individual. The assumption of atomism is also implicit in the scientific effort to isolate selected physiological or pathophysiological variables and target them either in diagnostic or treatment procedures. The final assumption, universalism**,** implies that there are some fundamental and natural phenomena which do not change and are universal across both time and space (and across other contexts, such as instance epistemological, social, etc.). Universalism is implicit in the emphasis on standardised diagnoses, guidelines, manualized treatment and in the formal principles of research, such as uniform procedures, reliability, and generalizability (Slife, 2004).

In epistemology, the humanities and social sciences, the philosophy of naturalism has been critically reflected within various thought movements, such as postmodern thinking, the theory of social constructionism, and so forth. However, medicine seemed to be rather resistant to such epistemological inquiry. There is no doubt that the above-mentioned assumptions brought about unprecedented biotechnological advancement. On top of that, the luxury of plurality of perspectives, which is usual in other fields, is less possible, at least in clinical medicine, where action typically must be taken quickly to avoid fatal consequences. On the other hand, any influential “central” philosophy of any discipline should be open to questioning because it ultimately forecloses other potentially useful conceptual and clinical options. Without thorough reflection upon those assumptions or implicit point of views, the process of further developing our knowledge could become limited, obstructed, constrained (Slife, 2004).

Regarding evidence-based medicine, Greenhalgh (1999) underlines a common misunderstanding that clinical observation and examination is objective and therefore is, similarly to scientific measurement, reproducible. “*Conventional medical training teaches students to view medicine as a science and the doctor as an impartial investigator who builds differential diagnoses as if they were scientific theories and who excludes competing possibilities in a manner akin to the falsification of hypotheses. This approach is based on the somewhat tenuous assumption that diagnostic decision making follows an identical protocol to scientific inquiry—in other words, that the discovery of “facts” about a patient’s illness is equivalent to the discovery of new scientific truths about the universe.* “(Greenhalgh, 1999, p. 323) However, differential diagnostics (an equivalent of hypothesizing and case formulation in psychology and psychotherapy; Johnstone, Dallos, 2013), is not taking place under the same circumstances as scientific inquiry in an experimental research setting. Physicians do not examine the patients and assess their symptoms in an objective way. They interpret them within classification systems of nosological categories, based on current knowledge, and also on the basis of their own clinical experience and specific features of the patient's individual story. Maybe it is better to acknowledge the inevitability of bias and subjectivity rather than deny it or pretend it does not exist during clinical practice. Only then is it possible to reflect upon it with an open mind and the ability to flexibly modify clinical judgment.

Perhaps we shall stress here that in clinical medicine (as well as research) it is impossible to completely escape from the tension between the known/knowable and the unknown/unknowable or inexplicable. There is a tension between “*the complex narrative that a patient brings into the consulting room and a doctor's understanding of what is really going on, as formulated in a diagnosis or an idea about pathology*” (Launer, 1999, p. 117). Another tension which clinical professionals face daily is between the universal and the unique, which corresponds with Bruner 's (1987) epistemological distinction between paradigmatic and narrative knowing. Whereas universal, generalizable, and, in Bruner’s sense, paradigmatic knowledge has traditionally been favoured in medicine, the unique aspects of clinical situations such as subjectivity, individual context, and the like were overlooked only until very recently (See Tab. 16.).

Tab. 16. Narrative and Evidence-Based Medicine; Key Points
(Greenhalgh, 1999, p.323-325)

1. The "truths" established by the empirical observation of populations in randomized trials and cohort studies cannot be mechanistically applied to individual patients (whose behaviour is irremediably contextual and idiosyncratic) or episodes of illness.

2. Even "evidence based" clinicians uphold the importance of clinical expertise and judgment.

3. Clinical method is an interpretive act which draws on narrative skills to integrate the overlapping stories told by patients, clinicians, and test results.

4. The art of selecting the most appropriate medical maxim for a particular clinical decision is acquired largely through the accumulation of "case expertise" (the stories or "illness scripts" of patients and clinical anecdotes).

5. The dissonance we experience when trying to apply research findings to the clinical encounter often occurs when we abandon the narrative-interpretive paradigm and try to get by on "evidence" alone.

It is one of many challenges and ethical commitments physicians deal with, when they navigate their action between the clinical guidelines based on research evidence and the unique experience of the patient and his/her context of being ill. The dangers lie at both extremes and can be metaphorically likened to Ulysses' journey through the strait between Scylla and Charybdis. Narrative could be perceived as a remedy to such dangers. It could be perceived as a bridge from aggregated data from meta-analysis, multicentric studies, and randomized controlled trials, to a respect for the uniqueness within the patient/family-centred approach, which is based on the art of applying scientific knowledge in the treatment of an individual patient. In this perspective, evidence-based medicine and narrative-informed medicine could be perceived as two complementary principles or perspectives which embrace both so-called objective data embedded in the evidence-based framework and the unique subjectivity of the patient (and the physicians themselves) (Kalitzkus & Matthiessen, 2009).

Even if the narrative turn in medicine is not accepted, the narrative dimension of both academic and clinical medicine is ubiquitous. Scientific explanations, the conceptualisation of biological phenomena, descriptions of etiopathogenetic processes, medical records, representations of patients and their disease, and interpretation of findings, all of these have narrative structure. (Good & Good, 2000). According to Misak (2010), narratives and personal experience are irreplaceable and legitimate components of evidence-based medicine. Even the experimental design of research, such as randomized controlled trials, include subjectivity (e.g., a decision making about an experimental situation, the control of confounding variables, the patients´ expectations regarding the experimental treatment).

Launer (1999) emphasizes common narrative aspects in general medical practice: a) the familiar role of taking a traditional medical history, assessment, differential diagnosis; b) listening to the narrative the patient needs to share and to be listened to, including the need for assistance in giving coherence and meaning to their experience; c) commenting and questioning the patient's narrative in a way that explores new meaning, which provide new insights, and generally make a difference to the patient. The goal is not to "*reject medical activity in the name of interpretive purity but to acknowledge the partnership between patient and doctor in exploring, creating, and testing the efficacy (or usefulness) of a new story*" (Launer, 1999, p. 119).

To sum up, storytelling is a ubiquitous component of doctor-patient interaction. It could be used as a major resource for clinical judgement. It could be seen as an engine of the doctor-patient co-construction of therapeutic collaboration—even a vehicle of change. Not in a sense of neglecting, obscuring, or denying biological processes, but in a sense of processing the experience partly embedded in disordered body functioning. Storytelling is the patient's way of sharing his/her health condition, related experience, and context. In this way, narrative is not information about general knowledge about disease and treatment, but an invaluable source of information about an individual patient (Misak, 2010).

2.6. Narrative and Medical Ethics

Narrative medicine has now generated a tremendous variety of activities, including the study of literary texts and personal narratives of illness, as well as encouraging reflective writing by medical students (Kalitzkus & Matthiessen, 2009; Jones & Tansey, 2015). A similar movement is now emerging in social work that relies on narrative as its base but does not focus exclusively on ideas from narrative therapy (Riessman & Quinney, 2005; Roscoe, Carson & Madoc Jones, 2011; Gibson, 2012). Narrative ideas flavoured with postmodern and social constructionist thinking have made most health and social care professionals aware that few service users these days believe that what practitioners say or do is entirely objective or politically neutral (Launer, 2018). Professionals are coming to accept that they do not have a monopoly on describing people's experiences, or on telling them what to do about it. Experience with a disease and even reality in healthcare institutions, including our experiences with healthcare professionals, have (or should) become contestable and open to reflection and negotiation (Foster, 2006; Skorunka, 2011).

This thinking has also influenced the development of a field known as narrative ethics (Charon & Montello, 2002; McCarthy, 2003; Wilks, 2005). Only recently did ethics become a point of utmost interest in medicine, primarily as a result of rapid and dynamic biotechnological advancement that in turn brought about many unexpected ethical dilemmas that healthcare professionals, including physicians, would need to on a regular basis at work. As Sokol (2021) emphasized, while life sciences tend to reduce reality in order to construct definite models which allow prediction and control, when it comes to human affairs and relationships, if we want to understand and not to control, we must accept that reality is more complex than our assumptions. Therefore, we need more than one perspective. Not only does medical ethics invite multiple perspectives and give voice to the most vulnerable, it also provides some principles and sets the limits for specific research and clinical situations. In his writings about the ethics of responsibility, Lipovetsky (2011) mentions the incessant search for a balanced degree between an individual's rights and common interest as well as between an individual's freedom and community benefit. The key role of ethics in such a search, according to Lipovetsky (2011), is to reject any extremes while avoiding any compromise regarding an individual’s dignity and rights.

The practice of bioethics has adopted narrative theory and methods to reach beyond a rule-based enterprise embedded in the legal system, towards an individualized and meaning-based practice. In contrast to the abstract principles of traditional ethics, narrative ethics emphasises the importance of storytelling and listening, and the role of professionals in ethically conducting conversations during treatment. According to this view, every juncture in a professional conversation is an opportunity to offer choices, so that clients can mould their own encounters with less direction or control by the professional.

Irvine & Charon (2017) clearly explain the need for ethics in medicine and the junction between narrative and bioethical concepts in the context of power asymmetry in medical situations: “*Typically, the professional is assumed to know more—and to know with certainty, about the illness situation of the patient than does the patient. The patient's lived experience of having the disease does not automatically count for much in healthcare's proceedings. The power is all on one side. When disagreements between them arise, the power asymmetry privileges the stance of the professional. If a patient consents to medical treatment, the treatment proceeds. If a patient refuses medical treatment, the patient is charged with incompetence”* (Irvine & Charon, 2017, p. 114-115) Narrative ethics, a field closely related to so-called helping professions that include medicine, emerged as a response to the power asymmetry and to complex multidimensional situations in both research and clinical practice. It offers principles for ethical conversation based on the concept of narrative, with an emphasis on collaborative stance and critical reflection of the expert approach, and opening space for choices for people in need of help (Charon & Montello, 2002; McCarthy, 2003;

Wilks, 2005). In practical terms, representatives of narrative-informed medical ethics emphasize attentive listening to the stories told by patients and their families, giving voice to those most vulnerable and therefore most easily silenced during encounters with healthcare professionals (Irvine & Charon, 2017).

2.7. Narrative Medicine and Realistic Expectations

No matter how inspiring and innovative narrative ideas may be for healthcare professionals, they may also become a rigid ideology, especially if they are adopted too eagerly without considering the wider context. Launer (2018), one of the main contributors to the discussion about the concept of narrative medicine and healthcare, warns against zealous enthusiasm in using narrative "techniques" in the face of disease and disability. "*Disease, disability, deprivation and death are not "just stories." Although they may be open to different interpretations by different individuals and cultures, they each rest on a bedrock of incontestable reality… Knowledge applied uncritically can lead to abuses of power but pursuing narratives without a sense of realism can be literally fatal. Narrative ideas can help people question their own convictions, but no one should play linguistic games with people's lives. … Knowledge applied uncritically can lead to abuses of power but pursuing narratives without a sense of realism can be literally fatal. Narrative ideas can help people question their own convictions, but no one should play linguistic games with people's lives.* (Launer, 2018, p. 11).

A realistic stance has already been called for in psychotherapy and family therapy. The dynamic historical development of those fields unfortunately also includes several examples of simplifications and the overzealous application of new ideas in the clinical practice of mental health. (McLeod, 2009; Dallos & Draper, 2015). Regarding the popularity of narrative approaches within the postmodern and social constructionist movement, Flaskas (2002) points out that some experiences, particularly those related to early trauma, may lie in the zone of the body, well beyond our conscious and worded stories. On top of that, she argues that in any therapy, we should not only focus on capacities but also acknowledge the limits to the realness of our experience: "*We do not have limitless possibilities in storying our lives, we come to exist in very particular landscapes of events, people, ideas and histories. In the same way we do not have limitless stories about our lives, we do not have limitless possibilities in our experience of our Selves*." (Flaskas, 2002, p. 93) The physical dimensions of our lives, particularly when we are ill, remind us about the universal aspects of our human destiny. No matter how sophisticated the technology or conversational prowess we are endowed with, we cannot control and overpower everything, because we are, after all, part of and dependent on Nature, whose mysteries we still endeavour to fully understand. As an appeal for humbleness as well as a request for realistic expectation, McDaniel, Doherty & Hepworth (2014) share their experience from a medical family therapy training for young doctors: "*We recalled a case with a frustrated medicine resident in which therapy helped a young woman with a serious Crohn's disease handle her disease more constructively and develop a better relationship with her family. Ultimately, the patient did get along better with her family, and she did take better care of herself, but she died anyway. The therapist remembered his dismay when her mother called him to give him the news. He felt like a failure until the mother told him that the last months of her daughter's life were the most peaceful, she'd spent in many years, thanks to therapy, and that she and her husband were grateful that their frayed relationship with their daughter had healed before she died. The therapist was relieved to hear that yet couldn't stop thinking about the old lines: the surgery succeeded, but the patient died.*" (McDaniel, Doherty & Hepworth, 2014, p. 18).

It is clear that there are more variables than those related to the physician, patient, family, and the disease, which might enable the application of narrative ideas during the treatment and its outcome. Integrating narrative skill into everyday clinical practice does not depend only on the physicians themselves. The institutional and socio-political context of healthcare also plays a critical role in integrating narrative ideas in medicine. There are so many challenges that may easily compromise a healthcare professional's determination to provide the best treatment and care for their patients, including their ability to open space for their narratives. Most professionals are forced to work under tremendous pressure of time and workload, responsibility and uncertainty. The pandemic underlined the weaknesses in the medical institutions and the organization of healthcare of many countries, including lack of qualified staff, limited funding of some areas, and inadequate or absent social support for healthcare professionals. It is not surprising that a common first response among professionals when first encountering narrative-based practice for the first time is often: "*In an ideal world we would use it, but it isn't possible given the kind of pressure we work under nowadays*." (Launer, 2018, p.11) There are many constraints: a) limited consultation times; b) performance targets; c) standardised guidelines; d) the presence of computers and electronic record-keeping; e) changing workforce patterns; f) wider problems of changing demographics among clients; g) shrinking budgets resulting in disparities in healthcare, and many more. Even undergraduate medical students are aware of these systemic (socio-political and economical) factors and point them out during the feedback they provide when talking about the need for a bio-psycho-social perspective during their undergraduate studies. Thus, it is clear that profound changes at the microlevel of everyday doctor-patient interactions must be made within a systemic transformation on the macro-level of institutions and healthcare systems (Skorunka, 2020).

2.8. Narrative Medicine Programs in Medical Education

Given the above-mentioned thoughts, it is no surprise that many clinicians and scholars have been looking for ways to include the training of narrative and related skills into mainstream medical education. Some medical schools developed courses based on interdisciplinary, process-based approaches in order to examine various aspects of the experience of illness, disability, therapeutic collaboration, and meaning of suffering through a narrative lens.

The study of the humanities such as literature, creative writing, history, philosophy, arts, and anthropology has emerged in medical training as a means of conveying skill in interpretive, relational, and reflective areas that are otherwise hard to teach (Arntfield et al., 2013). Medical schools, residency training programs, and professional organizations have developed curricula, educational strategies, and workshops using narrative writing to foster reflection and personal awareness among students and physicians (Brady et al. 2002; Branch, 2010; Branch et al. 2001; DasGupta & Charon 2004; DasGupta et al., 2006; Gaver, Borkan & Weingarten 2005; Misra-Herbert et al., 2021). Teachers of literature, novelists, storytellers, and the patients who have written about their experience of disease have become collaborators at medical institutions in teaching both students and healthcare professionals the skills needed to listen to narratives of illness, to understand what they mean in a patient's unique life story, and to grasp the plights of patients in all their complexity. Narrative-based courses in a medical school setting include close reading, writing, creative reflection, and group discussion as a pedagogic strategy. Narrative writing by students and physicians has become a staple in many medical schools to strengthen reflection, self-awareness, and the adoption of patients' perspectives (Charon, et al., 2016).

The benefits of the narrative medicine courses were threefold: to reveal patients’ perspectives, to facilitate self-reflection, and as a means of providing emotional support among students and colleagues (Holmgren et al. 2011, p. 261). In other words, the results should later be apparent in medical professionals’ awareness of themselves, in their ability to reflect meaningfully upon their emotions and actions, in their relationships with their colleagues, and in their interactions with their patients. In addition, supporters of narrative medicine have argued that such teaching methods do not merely aim to stimulate a more symmetrical and empathetic doctor-patient interaction. There was an underlying idea that training in self-reflective practices enriched with an exposure to the arts (e.g., film, music, paintings, literature) will enhance self-knowledge as well as relationships with both patients, one’s colleagues, and the public (Charon 2001; 2008; Marchalik, 2017; Yu, 2017).

It has been recognized that the capacity for self-reflection, awareness and interpretation of emotional responses, and the development of insight and wisdom to enact what is required in the care of the suffering are all central to narrative skills. The relief of suffering, the central task of the health professional, demands an ability to partly identify, through empathic connection, with human suffering. Awareness of self, awareness of the other, and awareness of the relational space between the two are key objectives for contemplative approaches to cultivating empathy (Machalik, 2017). Thus, training in narrative skills in medical education has frequently been closely tied with reflective practices or based on narrative writing. These teaching methods are thought to strengthen narrative skills by helping practitioners understand patients' experience of illness and what they themselves undergo in caring for patients**.** Such endeavours aim to facilitate clinical practice informed by mindfulness, self-awareness, self-knowledge, and reflective and empathic competence.

Reflective capacity, defined as the critical analysis of knowledge and experience in order to achieve deeper meaning and understanding, guides future behaviour and is deemed an essential characteristic of professionally competent clinical practice. Reflection, a metacognitive process, is a strategy to develop an understanding of self, the other, and the situation (Karnieli-Miller, 2020) Training of reflective ability is based on: a) describing and trying to expand one's understanding of events through identifying different perspectives and experiences; b) fostering awareness and exploration of emotions and feelings; c) engaging in critical analysis of the event and the dilemmas/challenges within it to enhance the meaning-making; d) developing various scenarios to prepare for future behaviour (Karnieli-Miller et al., 2021; Karnieli-Miller, 2020). Reflective capacity fostered through reflective writing during medical education is posited to help develop critical thinking skills and an empathic stance, informs clinical reasoning, and is an essential component of professionally competent practice (Sandars, 2009). As we have already mentioned, the pioneers of the narrative turn in medicine considered empathy and reflection to be important elements of general narrative skills (Charon, 2001, 2008; Greenhalgh, 1999; Launer, 1999).

Despite the fact that narrative medicine courses and narrative/reflective writing teaching methods were adopted in several medical schools in some countries (particularly in North America), there is still no definitive conclusion regarding the utility of the methods, or the changes experienced as a result of the training (Milota et al., 2019; Arntfield, et al., 2013). According to some studies, narrative medicine methods have demonstrated improvements in team cohesion and the perception of others' perspectives while decreasing burn-out and compassion fatigue (DasGupta, et al., 2006; Sands, Stanley, Charon, 2008). Yet it is still unclear whether the long-term impact of such interventions is felt by patients, or whether such interventions positively impact patient care. If one of the cornerstone goals of narrative medicine is indeed to approach a patient's story with humility, openness, and empathy, the transfer of these goals from the classroom setting to the clinical encounter deserves further study and valorisation (Yu, 2017). In other words, more research into the gap between the ideal and real practice of narrative medicine is needed to determine if, how, and to what extent the skills of interpretation and reflection taught in the narrative medicine classroom are implemented by students after graduation when they engage with patients in their everyday practice.

As indicated by Shapiro et al. (2009) and Friedman (2002), the educational initiatives rooted in the humanities (the inclusion of the humanities and social sciences in medical schools in general) are struggling to succeed due to significant resistance posed by some academic authorities and sometimes even by medical students. This is particularly true for institutions of medical education in those countries, in which the humanities and social sciences have difficulty to catch up because of past political situations which thwarted the development of those disciplines, including international exchange. In such countries, a move towards narrative medicine and so-called “humanisation” of medicine is still to come. For instance, in the Czech Republic, there is currently no narrative medicine course in any of the Faculties of Medicine's curriculums. Contemporary psychosomatic medicine, medical psychology, and psychotherapy/family therapy integration in medicine are sluggishly being established in a thorough and systematic way in both undergraduate and postgraduate medical study despite the students' and physicians’ growing interest in these disciplines and their integration into clinical medicine (Stackeova, 2018).

3. RESEARCH PART

Narrative Sensitivity in Medical Students: A Mixed-Method Exploration

3.1. Research Background

Until very recently, there has been little research on training medical students in narrative skills and narrative medicine courses in medical education. In the first decade of the new millennium, only few studies were conducted to support application of narrative ideas in medical education to enhance students ‘reflective and narrative skills. Later, many studies emerged to develop explore innovative teaching methods based on reflective and narrative skills and to assess the outcome of various narrative medicine programs, which were developed at some universities.

For instance, Dasgupta and Charon (2004) conducted an exploratory study, which followed a 6-week seminar for undergraduate medical students focused on reading the patient´s stories and training of reflective writing. The research showed that most of the participants (11 out of 16) reported that their ability to understand patients, empathize with them and take care of them improved due to the training. In a comparative study, Shapiro et al. (2006) explored the differences between two groups of medical students who attended two courses with different designs. One was focused on writing from the patient´s point of view, whereas the other was focused on clinical thinking, interpreting the examination findings, and the physician’s decision-making regarding diagnosis and treatment. The students in the group focused on writing from the patient´s point of view was more able to feel empathy towards patients and their emotions, expressed their emotions more freely and assessed the clinical situation in a more complex manner. The students from the other group tended to blame the patients for their situations. Several studies were focused on developing a narrative perspective through reflective writing and expressive art among medical students and physicians (Kalitzkus & Matthiessen, 2009; Younie, 2009). Wald & Rise (2010) discussed the challenges of fostering the students ‘reflective capacity during medical education. Stanley & Hurst (2011) suggested that reflective writing allows health care professionals to develop a representation of their own emotions and of the patients’ suffering during palliative care.

Levine, Kern & Wright (2008) designed a year-long qualitative study to determine the impact of prompted narrative writing on participants’ attitudes and behaviours. The study was carried out in the context of residency training. The authors point out that residency training is a stressful period during which physicians-in-training are faced with complex and powerful situations. However, little is known about the reflective practices of residency physicians, the factors that promote and/or inhibit reflection, and the best methods for encouraging reflective practice. Thus, the purpose of this study was to determine the impact of prompted narrative writing on reflection. Narrative writing has been used to promote reflection and increased self- awareness among physicians. The thirty-two interns at 9 internal medicine residency programs wrote narratives every 8 weeks and at the study completions they wrote a final narrative describing what impact the study had on them. The responses were reviewed, analysed, and organized into domains. The authors found that prompted narrative writing was almost uniformly successful in promoting the interns´ reflection. Writing about their experiences routinely throughout the year on a regular basis reminded them to stop and think about how they were feeling and acting during the year. Interns described how writing narratives led to a greater understanding of themselves, an examination of their core values and priorities, and motivation to improve (Levine, Kern & Wright, 2008). The authors concluded that prompted narrative writing was almost uniformly successful in promoting reflection. Writing about ones' reflections on powerful events encourages exploration of one's emotions and reactions related to that particular experiences.

Wald et al. (2010) described a narrative medicine curriculum innovation at Warren Alpert Medical School of Brown University). The students' reflective writing (field notes) with individualized feedback from an interdisciplinary faculty team (in pre-clinical years) has been implemented in a Doctoring course to cultivate reflective capacity, empathy, and humanism. Interactive reflective writing (student writer/faculty feedback provider dyad). The authors proposed that such innovative course can additionally support students with rites of passage at critical educational junctures, such as the loss of the first patient. To assess such possible outcome, this purpose, they devised a tool to guide faculty in crafting quality feedback, i.e., the Brown Educational Guide to Analysis of Narrative (BEGAN) which includes identifying students' salient quotes, utilizing reflection-inviting questions and close reading, highlighting derived lessons/key concepts, extracting clinical patterns, and providing concrete recommendations as relevant. In their paper, the authors conclude, that a faculty response using BEGAN to a student's narrative, can support the processing/integrating such emotionally powerful and meaningful event as the loss of their first patient. The provision of quality feedback to students' reflective writing – supported by BEGAN – can facilitate the transformation of student to professional through reflection within medical education.

Reis et al (2009) designed a study to develop a method to further enhance the educational benefit of medical students' reflective writing. As a result of the study, the Brown Educational Guide to Analysis of Narrative (BEGAN) framework was created as a guide for crafting feedback to students' reflective writing. The BEGAN framework was then integrated into the faculty and student manuals for the Doctoring Course in 2008–2009. The authors of the study argue that reflective capacity, defined as critical analysis of knowledge and experience to achieve deeper meaning and understanding, guides future behaviour, and is deemed an essential characteristic of professionally competent clinical practice. In the same vein, the strengthening of narrative competence help clinicians to understand their patients ‘experience of illness and what they themselves undergo in the process of both treatment and care for their patients (Brady et al., 2002). Therefore, the BEGAN framework and similar guides are necessary steps to develop research and training programs for enhancement of reflective and narrative competence in the emerging medical professional (Reis et al., 2009).

A case study approach was adopted by Pikren Valenti & Mehl-Madrona (2010), who demonstrated, how a case study can be used in a narrative approach-based course, to help students avoids stereotypical images of some psychiatric patients as hopeless and “burned-out”. As the authors remind, in contemporary psychiatric settings, patients with diagnosis of a serious mental disorder are sometimes presented as hopeless, recalcitrant, and devoid of social grace. In their research they present the result of the interaction of a faculty and a student to change a “burned-out” patient into an interesting person through elicitation of his narrative. The authors concluded that narrative approaches may help reconstruct as a richly complex human being, foster better therapeutic relationship between patients and staff, and humanize medicine in general. As an antidote to maintaining stereotypical view of people with serious mental disorder, the narrative perspective provided the students to create richer descriptions of patients and the ability to empathize with them.

In the last decade, there has been a growing body of research focused on assessment of narrative medicine courses including training of narrative and reflective skills among medical students and physicians. The scope of aims, designs, and methods used in such research is rather diverse. Some of the studies were designed to assess the outcome of narrative medicine training. Others were focused on reflective and narrative skill training in both undergraduate and postgraduate medical programs. Research focused on general communication skill including fostering empathy among medical students sometimes overlap with exploration and/or enhancement of narrative or reflective skills. Most of the studies are based on either qualitative or mixed-method approach, while some of the studies are based on case studies. In the next part, we will give an overview of several studies that are closely related to our research project.

Liben et al. (2012) assessed the impact and outcome of faculty development workshop on narrative medicine within the trend of narrative ideas becoming increasingly popular in undergraduate medical curricula. In the research, two groups of clinical teachers were studied; one group had already attended a half-day narrative medicine workshop (N = 10) while the other had not yet attended (N = 9). Both groups were interviewed about their uses of narrative in teaching and practice. Additionally, the understanding of a set of narrative skills was assessed by first viewing a video of a narrative-based teaching session followed by completion of an 18-item assessment tool.

Both groups reported that they used narrative in both their teaching and clinical practice. Those who had attended the workshop articulated a more nuanced understanding of narrative terms compared to those who had not yet attended. The study is one of the first to describe measurable impacts of a faculty development workshop on narrative medicine at that time.

Arntfield et al. (2013) sought to explore the perceived influence of narrative medicine training on clinical skill development of fourth-year undergraduate medical students. With use of grounded theory, three methods of data collection were used to query twelve medical students participating in a one-month narrative medicine elective regarding the process of training and the influence on clinical skills. The data was analysed through thematic analysis and data triangulation. The study showed that student perceived a development and improvement of specific communication skills: enhanced capacity to collaborate, empathize, and be patient-centred; personal and professional development through reflection. The authors concluded that these skills are integral medical practice, difficult to teach and that further research must explore the impact of such training on actual clinical performance.

Branch & Frankel (2016) conducted a study to identify and define “highly humanistic” formation narratives. They wanted to understand how these events described, together with a reflective learning process, the professional development of physicians in a longitudinal faculty development program. They selected twenty highly humanistic appreciative inquiry narratives from a total of 124 written narratives at the beginning and end of an eighteen-month program at eight medical schools. As appreciative inquiry narratives were derived from a storytelling, in which the faculty writers provided their account of the best care they provided. As a result, the authors found that some of the narratives described deeply meaningful humanistic interactions in which the writers built respectful and compassionate relationships with patients and others. The writers’ most cherished professional values, including altruism, compassion, respect, integrity and caring seemed to be strengthened and validated during the program. The authors conclude that emphasis on humanistic values in the faculty development may sensitized and motivate faculty members to meet their patients ‘emotional needs and improve care (Branch & Frankel, 2016).

Caverly et al. (2018) developed a narrative reflection program in which they encouraged medical trainees to reflect on and write up clinical narratives about instances of avoidable medical overuse. In their qualitative evaluation they conducted semi-structured interviews to explore how participating in the project influenced the thinking, attitudes, and behaviours of participating the trainees, the internal medicine residents. From their analysis, the following themes emerged: 1) learning through reflection (with three sub-themes: empathy for the patient perspective, a critical approach to one’s own clinical practice, and awareness of the problem of overuse); 2) empowerment to discuss instances of overuse and act before it occurs; and 3) perceptions of enhanced evidence-based practice and shared decision-making. Authors concluded their study with a finding that trainees, who volunteered to complete a reflective writing exercise, perceived improved ability to avoid overuse and improved self-efficacy to change clinical behaviours compromising the optimal patient care.

Stojan, Sun & Kumagai (2019) conducted a study to find out whether a narrative educational program involving patient stories have any impact on physicians' attitudes towards the patients and care. They also wondered, the influence of such programs on physician attitudes persists beyond medical school. The authors of the study took advantage of The Family Centred Experience (FCE), a required learning activity that was implemented in the University of Michigan Medical school during the first and second years of the pre-clinical curriculum from 2003-2016. In the FCE, pairs of medical students were matched with individuals and families in the community who lived with chronic illness for a series of scheduled home visits over two years. The home visits were devoted to ongoing conversations between the students and volunteers about their experiences in living with chronic illness and focused on different themes. The students were engaged in reflective dialogs about the volunteers' stories. Interviews were conducted with former students at the end of or after post-graduate training. All had completed the FCE between 4 and 10 years before the study. Thematic analysis was informed by a constructivist Grounded Theory approach. As a result, the FCE made graduates aware of the patients' perspectives and impacted their clinical practice in specific ways, such as developing collaborative partnerships, conducting family meetings, and breaking bad news. The course had influenced career choices and interest in teaching. Finally, the FCE enhanced appreciation of the human dimensions of medicine, which graduates had drawn upon in subsequent years. On the basis of the study´s finding, Stojan, Sun & Kumagai (2019) made a bold proposal. An educational program early in health professions training that is founded on narrative interactions with individuals with chronic illness and learners may influence the ways in which physicians-in-training come to see themselves and their profession. This influence may persist in memory beyond the years of medical school and for some, beyond the years of clinical training and may exist often at a tacit level, which subsequently comes to awareness through reflection and dialog. The authors suggest that that the opportunity to meet and interact with patients and their families in their homes, to listen with respect and openness to their stories of illness and its care, to participate in the creation of educational spaces in which fellow students and clinicians engage in reflection and dialog about the human dimensions of medicine in a safe and creative manner (Stojan, Sun & Kumagai (2019).

Rieffenstahl et al. (2020) explored what and how medical students learn from patients with chronic conditions in the context of communication skills training. In this research, semi-structured interviews and focus groups with 32 medical students, who attended a mandatory communication course “Patient-Cantered Information Delivery “, were conducted. Interviews were recorded, transcribed, analysed inductively and organized into four main narrative themes. The results showed that such training, which included learning from patients, provided medical students with opportunities to “*see the world through the patients’ eyes, understand the diversity of patients’ needs, and recognize the importance of matching patients’ and doctors’ perspectives*” (Rieffenstahl et al., 2020, p. 3-4). According to the authors, such unique experience enabled the students to engage with their own emotions and capacity for empathy. However, the authors also emphasized that to benefit from such training, the students need guidance to balance professional and personal aspects in the encounter with the patients.

In one of the most recent research, Karnieli-Miller et al. (2021) aimed at assessment of association between medical students’ reflective ability demonstrated in written narratives, and communication skills demonstrated later in simulated patient - breaking bad news interactions. They analysed 66 medical students’ reflective ability, using ‘REFLECT’ rubric and four newly developed parameters: Noticing Explanations provided to patients, Noticing Emotions, Remoteness/ Connectedness in their writing, and mentioning Self-Emotions. They also used two different questionnaires to measure students ‘communication skills. The results of the study showed significant positive correlations between students’ reflective ability, measured by REFLECT and three of the new parameters, and global communication skill scores. Reflective ability of Noticing Explanations in writing was associated with ability to tailoring information to patients’ needs and address emotions. The authors concluded that high reflective ability may improve communication skills. Specifically, ability to notice explanations to patients may enhance later capability to tailor information to patients and address emotions empathically. They also suggest that to improve physician – patient communication, the medical educators have to invest in the development of medical students ‘reflective capacity by engaging them in narrative exercises.

To provide an overview of the field of narrative medicine, Milota et al. (2019) recently published a narrative review of 36 articles that were focused on providing evidence of effect of various narrative medicine teaching models. They used the Best Evidence in Medical Education (BEME) Global Scale and Kirkpatrick Scale for strength and importance of evidence to categorize reported assessment strategies and to evaluate the effectiveness of their narrative medicine programs. The authors found that narrative medicine is an effective pedagogic tool with a clear and replicable structure and methodology. They also determined that a positive impact could be measured when pertaining to participation and modification of attitudes, knowledge, and skills. However, unequivocal evidence of the effect of narrative medicine on students’ behaviour or ongoing interaction with colleagues and patients is still lacking. What is more, it is remains unclear whether the long-term impact of narrative medicine classroom interventions are felt by patients, or whether such interventions positively impact patient care. In contrast to the abovementioned research on narrative medicine and narrative skills training, there is no such course or training program at any medical faculties in the Czech Republic. Obviously, there has been no research on narrative medicine conducted. Frankly, we can admit that the medical education is well behind the medical faculties in other countries, in which the narrative ideas were integrated to various level of education of health care professionals including physicians.

Thus, we thought of a research that would be a first step in mapping the Czech medical education territory untouched with narrative ideas so far. We introduced the concept of narrative sensitivity, which we derived both from Charon´s (2008) notion of narrative competence and ongoing discussion about application of bio-psycho-model in clinical medicine. We propose that it is useful to define the concept of narrative sensitivity (NS) as a first level of the complex set of narrative competence. In some European countries including the Czech Republic, the bio-psycho-social model of health and illness is considered as a basis of the field of psychosomatic medicine. Regarding the application of such model in clinical medicine and discussion about necessary skills for such application, we conceptualize NS as: a) the physician´s sensitivity to/awareness of the patient´s subjective experience; b) the physician´s awareness of the interplay of bio-psycho-social factors in the patient´s disease; c) the awareness of the disease's impact on the patient´s life. We suggest that NS is an important prerequisite for the physicians well-attuned communication with their patients including appropriate level of empathy and reflection. during treatment. Judging from our clinical experience and from many writings, which we reviewed in the part of narrative medicine, patients with various health conditions long for well-attuned communication, empathy, and care.

Not only narrative ideas can be useful to foster such skills in both medical students and physicians. Scholars and clinicians argued, that integrating other ideas and findings from psychology and psychotherapy to medicine is necessary (Skorunka, 2020; McDaniel, Doherty, Hepworth, 2014; Asen et al. 2004). Many studies, which support such arguments, can be found today. We mention just Mac Cormack´s et al. (2001), in which explored the question, whether the cancer patients might benefit from psychotherapy and what elements of their psychotherapy they find most helpful. The researchers interviewed cancer patients diagnosed with metastatic disease who had been offered two different forms of individual psychotherapy. These interviews were then transcribed and analysed using grounded theory. The findings showed that the participants valued most the spending time with someone who listened and care. Central to participants' experiences was the opportunity both therapies gave them to enter a relationship in which they could safely share their thoughts and feelings with someone who seemed genuinely interested in understanding their cancer experience and 'truly cared'. This relational experience, being with someone who was willing to listen, who expressed genuine care, provided unique conversational space to explore and discuss both thoughts and feelings related to their serious disease experience. The study shows, what the proponents of narrative medicine have been suggesting for a long time.

In the context of undergraduate medical education in the Czech Republic, we wanted to know out, if any aspects of narrative sensitivity, as we conceptualized, could be found in undergraduate medical students. We also wondered, if and how narrative sensitivity develops during undergraduate study. To answer those questions, we designed an exploratory, inductive mixed-method study, which we will describe in the next section.

3.2. Methods

3.2.1. Aims:

The study aimed to 1. Identify and elaborate the facets of NS in undergraduate medical students and 2. Tentatively assess the change in NS during undergraduate medical study.

3.2.2. Participants

The sample consisted of *N* = 50 Czech medical students (66% males) in the second term of the second year of their undergraduate medical studies at Faculty of Medicine, Charles University in Hradec Králové, Czech Republic. In this phase of their study, the students had only theoretical, pre-clinical courses (i.e., anatomy, histology, biophysics, biology, and physiology). We followed the same group of students three years later, in their second term of the fifth year of their undergraduate studies. The number of the participants three years later was lower (*N* = 42, 67% males) because of absences or transfers to another university.

3.2.3. Analysts

D. S. was a board-certified psychiatrist and a psychotherapist with an academic background, trained also in systemic/family therapy. He served as a lecturer for the participants. T. K. was an undergraduate student in psychology with no clinical experience. T. Ř. was a psychologist researcher and a Gestalt therapist.

3.2.4. Data collection

The participants in both years were exposed to a photograph of a patient with clear signs of a disease on the screen. The photograph depicted a man lying on a hospital bed with an open pyjamas jacket and schemes drawn on his abdomen indicating a target either for a diagnostic or therapeutic intervention. The photograph was carefully selected from a free, publicly available sample of photographs of several anonymous patients. We deliberately chose a black-and-white photograph made in a plain documentary style without any artistic manipulation with the composition and/or the light to avoid any interference with the participants associations.

Prior to the photograph being shown, the students were handed a sheet of paper (A4) with the following introduction: ‘When you see this photo, what comes to your mind? Please put all your ideas and impressions down on the sheet of paper’. The instruction was chosen to be as open as possible so as not to induce any preconceptions. No cues were provided regarding the concept of NS. Furthermore, voluntariness, anonymity, and confidentiality of the participants’ responses were emphasized. The students had up to 30 minutes to respond to the instruction. The procedure was repeated with the same group of undergraduate students three years later.

We chose to carry out the study in the second and fifth years because of the aims and feasibility. In the second term of the second year, most students are already adapted to the new challenges of medical studies. Until the third year, they had only theoretical subjects and no clinical courses. From the fourth year on, the students had only clinical courses at different departments at the University hospital. Arguably, such experience starts shaping their ideas about physician-patient communication in various clinical situations. During the final (sixth) year, all students had their rotations at different clinical departments in hospitals around the country to prepare for their State final exams, so it was not possible to reach them for the second phase of the study.

3.2.5. Ethical aspects of the research design

The participation at the research and collection of data were confidential. The participants were ensured about that prior to their participation at the research. This was important for the participants protection and for the data´s credibility. The confidentiality enabled the participants to be as honest about their ideas and emotions as possible during their reflective writing. The collected data were shared only among the researchers and the independent auditor. No third party had access to the data. No personal data of the participants that could lead to their identification were included in the examples of text units presented in this work or related publications. The students participated voluntarily at the research. They were informed about the voluntariness prior to their participation so that they had the chance to decide whether they would or would not participate. However, it was not possible to explore and check the data through personal follow-ups with the participants because of the confidentiality. This was one of the disadvantages.

Prior to the reflective writing, the participants were given only basic information about the research design and simple instructions. They were not informed about the aims and scope of the research in detail so that their reflective process was not biased. They were only explained in general terms that the research was focused on communication skills in clinical practice. An email contact was provided to the participants in case they would be interested about findings, when the research was completed.

3.2.6. Data analysis

The data were analysed using thematic analysis according to Braun and Clarke (2006) with elements of Hill´s (2005) consensual qualitative research (CQR).

Thematic analysis is a method for identifying, analysing, and reporting patterns (themes) within data (Braun & Clarke, 2006, p 79). In many cases, it includes interpretations of some aspects of the research topic. Thematic analysis is a qualitative analytic method within psychology and beyond. It is an accessible and theoretical flexible approach to analysing qualitative data. Braun & Clarke (2006) describe the advantages of the method in detail (see Tab. 17.).

Tab. 17. Advantages of Thematic Analysis, (Braun & Clarke, 2006, p. 97)

- Flexibility.
- Relatively easy and quick method to learn and do.
- Accessible to researchers with little or no experience of qualitative research.
- Results are generally accessible to educated general public.
- Useful method for working within participatory research paradigm, with participants as collaborators.
- Can usefully summarize key features of a large body of data, and/or offer a ‘thick description’ of the data set.
- Can highlight similarities and differences across the data set.
- Can generate unanticipated insights.
- Allows for social as well as psychological interpretations of data.
- Can be useful for producing qualitative analyses suited to informing policy development.

Among qualitative methods, thematic analysis has an advantage of theoretical flexibility. It does not require the detailed theoretical and technological knowledge of other approaches such as, for instance, grounded theory. In contrast to other methods, thematic analysis is not vetted to any pre-existing single theoretical framework and therefore can be used within different theoretical framework. It could be an “essentialist” or a “realist” method, which reports experiences, meanings and reality of participants. It can be a” constructionist” method, which examines the ways, in which events, realities, meanings, and experiences are the effects of a range of discourses operating within society. It can also be something “in between”, something like a “contextualist” method, which acknowledges the ways individuals make meanings of their experience and, in turn, the ways the broader social context impinges on those meanings. Braun & Clarke (2006) openly admit that the active role (influenced by professional experience and background) of the researcher always plays role in identifying patterns/themes. For all the above-mentioned reasons, the method is widely used because It offers a more accessible form of analysis, particularly for researchers, who are also busy scholars and/or practitioners.

We also incorporated the essential components of CQR according to Hill et al. (2005), such as a) open-ended question which enabled consistent data collection across in individuals as well as a more in-depth examination of individual experiences; b) two researchers with different clinical and training experiences for data analysis to foster multiple perspectives; c) consensus to arrive at judgments about the meaning of the data; d) at least one auditor to check the work of the primary team of researchers; e) domains, core is, and cross analyses in the data. We carried out the research with CQR epistemology-based (constructivist and post-positivistic) acknowledgment, that our biases as researchers influence our understanding and analysis of the data, and so we endeavour to be as transparent as possible to disclose these biases and report how they may have influenced the data analysis. To achieve such goal, we strived to be objective, summarizing the participants’ words (texts) and remaining close to the data rather than making major leaps of interpretation.

We also looked for themes across participants and hope to generalize, at least to some degree, to the specific population (medical students in general). We strived to uncover meaning through words and text. When making effort to attain consensus during the process of data analysis, we worked hard to discuss all disagreements and feelings among the two researchers and the auditor. We kept in minds Hill et al.´ (1997) emphasis to distinguish and be transparent about both expectations (“*beliefs that researchers have formed based on reading the literature and thinking about and developing research questions*,” p. 538) and biases (“*personal issues that make it difficult for researchers to respond objectively to the data,*” p. 539) so that the findings of the research could be understood in context. Transparency about both expectations and biases is mainly expressed in the theoretical section about narrative medicine and the discussion about research findings.

In the process of data analysis, two researchers including the author of this thesis first familiarized themselves independently with the data by repeatedly reading texts and generating tentative codes related to the concept of NS. In the subsequent phases, they searched for themes and refined them together (see Tab. 18.). In this process, T. Ř. served as an auditor who provided independent reflections and suggestions at different phases of the analysis, which were then discussed by all three analysts (see Fig. 1). First, the data from the second year was analysed. When analysing data from the fifth year, we used the existing codes and themes wherever possible, with the openness to introduce new codes and themes where necessary. During the process of analysis, the data coding was performed manually.

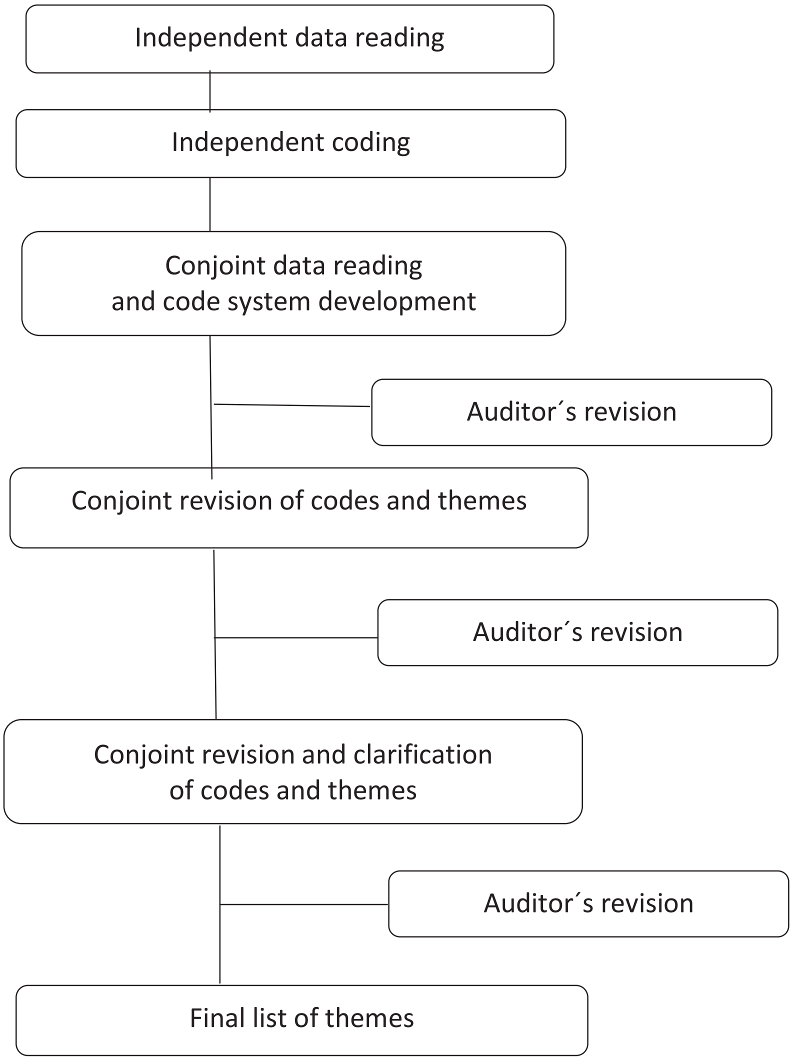
Tab. 18. Example of Coding process

Data extract	**R1 (Researcher 1)**	**R2 (Researcher 2)**	**Final Theme**
It seems to me, that he feels hopeless, but slowly coming to terms with the destiny.	Reflection about the person´s emotions – hopelessness but perhaps also reconciliation.	Reflection about the person´s emotions and thoughts.	Reflection about the person´s subjective experience
Maybe the person was devastated by a challenging life event and might have tried to commit a suicide.	Thinking about the causes of the person´s life situation.	Hypothesizing about the person´s life situation, behaviour, perhaps coping…	Reflection about the person´s life story (narrative sensitivity)

Each of the analysts brought a different perspective based on their distinct professional and personal experience. According to the Hill´s (2005) principles of consensual qualitative research, all disagreements were discussed thoroughly until we found an interpretation we could agree upon. We followed the suggestion Braun & Clarke (2006) that the keyness of a theme is not necessarily dependent on quantifiable measures but rather on whether it captures something important in relation to the main research question. See Figure 1 for the delineation of the analytic process.

Consequently, we counted the theme frequencies (i.e., the number of students in whose response a theme was identified) for each theme in each year separately and assessed the change in frequencies between the second and fifth years (See Tab.18.). To prevent unwarranted generalizations, we conducted Fisher's exact test to determine the statistical significance of the change using R software version 3.6.3 (R Core Team, 2020).

Figure 18. *Phases of the analysis*



3.3. Results

3.3.1. Division of themes

We identified nine themes in the data from the second year that we found relevant regarding NS. No new themes emerged in the data from the fifth year. The list of themes and their frequencies is presented in Table 1. We divided the themes into those that defined NS positively and those that defined NS negatively. We identified three themes as irrelevant to the concept of NS. These included clinical reflections about the patient´s health condition, reflection about the health care system, and therapeutic suggestions.

3.3.2. Themes defining narrative sensitivity positively

Reflection on the patient´s life story

We considered this theme to be the essence of NS. The excerpts showed some typical attributes of a narrative such as the presence of a plot, the imagination of the patient´s subjectivity, temporality, and context. The following excerpt also presents disease as a narrative disruption:

> *The picture evokes some anxiety and images of hopelessness regarding what happens to human beings when they fall ill. The man on the picture was, for sure, absolutely healthy and energetic and then the disease turned his life upside down. Now he is ill, perhaps he lost his strength to fight, his resigned look seems to tell that. He might even look forward to being dead so that his suffering will be over. (second year).*

Expression of one´s own emotions

Some students expressed their own emotional reactions. Some were positive, such as interest, care, curiosity, and compassion, others negative, including fear, despair, sadness, and hopelessness, as in *'The picture makes me feel a little bit anxious with a sense of hopelessness, when you imagine what it may look like when you fall ill…'* (second year).

Reflection on the patient´s subjective experience

These excerpts captured the patient´s subjective experience related to illness, its symptoms, and the treatment. Sometimes the participants used direct speech, assumingly with the intention to emphasize the feelings and experience: "*Disappointed, sad, accusing look, searching a bit of hope. He is saying: 'Should I really give up?'*" (fifth year). This can be interpreted as empathizing with the patient, ‘putting oneself in his shoes’. Occasionally, the excerpts overlapped with *Expression of one´s own emotions*, when the students tried to imagine what it was like for the patient, hypothesized about the patient´s emotions, and sometimes even imagined how they would feel in such a situation themselves:

> *The patient appears spacey, not because of medication, but because he is exhausted. The lips look as if they wanted to say something, maybe wanting to express anger towards the physician or wanting to ask a question if what the physician told him was really true. (…) The hand is lying loosely and almost without any life, any feeling, as if he does not believe it belongs to him. Perhaps he is indifferent, as if ‘I do not care what happens to me, do, whatever you want’. (second year).*
>
> *Perhaps he feels ashamed, because he is naked in front of the group of doctors and dorses during the ward round*. (second year).

Awareness of other perspectives

In this category, the students’ responses showed a degree of uncertainty regarding the disease, the patient´s subjective experience, or life circumstances. This was expressed not only by the content of the text units but sometimes even by using qualifiers such as ‘perhaps’, ‘maybe’, and ‘what if’. We considered the awareness of other perspectives and alternative explanations to be an essential component of NS.

Reflection on the patient´s coping

In most text units belonging to this theme, the students hypothesized about the patient´s resignation, hopelessness, and lack of strength due to a disease. Sometimes they used the metaphor of a war or battle: *‘He looks resigned as if he already stopped fighting and gave up the battle with the disease. His eyes might be saying this: So, could you cut me off, will you?’ (fifth year)*. Occasionally, they hypothesized about the patient´s attitude towards physicians or the treatment.

Existential reflection

The participants shared their thoughts about existential aspects of the human life. Their responses were related to phenomena such as the gravity of a disease, pain, loneliness, suffering, and death: *‘(…) death, the end of life. I can see a patient in the terminal stage of a disease, who is reconciled with* *death*' (fifth year). In our view, this theme can serve as a bridge to the patient's subjective experience.

Reflection on the patient´s relational context

In this theme, the participants expressed their thoughts about the patient´s family and close ones. Some participants wondered if the patient had the social support he might need: *'He looks lonely, which makes me think whether he has got a family or friends, someone, who could look after him.'* (second year). In our view, the relational context of a patient´s life story is an important dimension of NS.

3.3.3. Themes defining narrative sensitivity negatively

Description of the patient´s appearance

These descriptions were often rather simple and focused on physical features. Sometimes, they were expressed with a moral judgement and/or revealed the students´ stereotypical thinking about the patient. In few cases, the participants focused on description of the photography itself rather than the patient. Supposedly this could be understood as an avoidance of more reflective approach. These descriptions, sometimes combined with a dispassionate clinical assessment, can be interpreted as examples of detachment and dehumanization, which stand in striking contrast to NS.

> *There is a patient with scars in the abdominal region. In the thoracic area, there is a plaster covering the wound from the central catheter. The patient seems to be a male around 50, looking feminine, possibly because of hormonal treatment. I reckon he is treated for prostate cancer in a generalizable state. On the other hand, the multiple scars in the abdominal region do not fit with this clinical picture. However, they may not be scars but signs for targeting the radio-oncological treatment. (fifth year).*

> *The general impression is distorted by the fact that a black and white filter was used (actually it could be primarily a black and white photography). So it is impossible to assess the health condition and aetiology without any additional information. (fifth year).*

Downplaying the subject

Only few excerpts were difficult to comprehend, such as the following: '*Kojak, pregnant woman, Hawaii, 8bit hand, mafia, what do you want? Just lying here and you disturb…*' (second year). We hypothesized that in those texts the participants might have either expressed disinterest in the study or even attempted to avoid participating by not being serious. A lack of a sincere concern for the patient is in contradiction with NS.

3.3.4. Themes considered irrelevant regarding narrative sensitivity

Reflections about the patient´s health condition

The text units categorised in this theme were among the most common in the participants´ reflective writing. They referred to description of possible health problems of the person and possible causes of those problems. Some participants used only a general statement made in common language about the person suffering from a serious disease. Other participants used medical jargon including a diagnostic term for the description of the patient´s health condition. These text units were more frequent in the 5th year. The participants ‘hypotheses about the health condition causes ranged from a car accident, oncological disorder to the side effects of medical treatment (i.e. radiotherapy, surgery).

> *The man stays in the hospital apparently after a medical procedure. Perhaps a radiotherapy (bald head). I wonder what those bruises on the belly are…* (second year).
> *When I look at the photo, I can see a man, who must have undergone a complicated surgery, possibly because of a serious disease. Judging from the scars on the belly, he probably had a chemo so it could be cancer…” (fifth year).*

Therapeutic suggestions

This theme includes the participants ‘thoughts about possible therapeutic, and sometimes even psychosocial, intervention. Generally speaking, the text units categorised under this theme were expressions of the participants ‘willingness to help. Occasionally, the participants expressed their own desire to help the patient and rarely they broadened such ideas towards a general expectation about the doctor´s role. In most cases, however, the participants imagined, that another person should help the patient, for instance another family member, psychiatrist, or another professional. This was more prominent in the participants´ text units in the fifth year.

> *In my opinion, he really need help from his family…or perhaps from a psychiatrist…something like a friendly support…* (second year).
> *The most important thing is that we, the future doctors, should always satisfy the patient. (second year).*

Reflection about the health care system

In the text units categorised under this theme sometimes the participants commented on typical practices in a health care institution and overall health care system. Some of those comments were critical of either the nurses´ or the doctors´ way of interacting with the patient. Others were thoughtful reflection about the usual way the health institution function. These text units frequently overlapped with other themes such as Reflection about the patient´s subjective experience. Although we considered that this theme irrelevant of the concept of narrative sensitivity, the physician´s ability to reflect not only about his/her own way of interacting with patients but also about the typical institutional practices are important components of personal and professional development.

> *I personally dislike the messed bed linen… it seems to me like the nurses´ disinterest in the patient´s comfort.* (second year)
> *Maybe he feels embarrassed…being undressed in front of the doctor, who does not come alone to the room but with the group of other professionals during the ward round.* (second year)

Given the examples of themes, which we considered as irrelevant regarding the concept of narrative sensitivity, one could argue, that they actually fit well within general narrative framework. However, the do not meet the tentative definition of narrative sensitivity based on a bio-psycho-social model, which we described in previous part. On the contrary, the abovementioned examples, particularly those in categories as Reflections about the patient´s health condition and *Therapeutic suggestions,* show the narrow biomedical perspective with its emphasis on symptoms of a disease and biomedical treatment, when broader bio-psycho-social dimension of health/illness and experiential dimension is lacking.

3.3.5. Refining narrative sensitivity and layers of themes

As we have mentioned in the beginning of the research part, our conceptualisation of narrative sensitivity consists of a) the physician´s sensitivity to the patient´s subjective experience; b) the physician´s awareness of the interplay of bio-psycho-social factors in the patient´s disease; c) awareness of the impact the disease has on the patient´s life. However, other dimensions emerged during thematic analysis of collected data (see Tab. 19.).

Tab. 19. Example of Text Units and Coded Themes

The picture makes me feeling a little bit anxious with a sense of hopelessnes, when you imagine what it is like when you fall ill…	Expression of one´s own Emotions
The man on the picture was, for sure, absolutely healthy and energetic and then the disease turned his life upside down. Now he is ill, perhaps he lost his strength to fight, his resigned look seems to tell that. He might even look forward to being dead so that his suffering will be over.	The Essence of Narrative Sensitivity?
Human health is pretty uncertain thing, if we do not feel healthy, we have nothing ´cause health is absolute necessity for everything.“	Existential reflection

In our view, themes such as *Expression of One´s Own Emotions* and *Existential Reflection* are another important dimension related to our concept of narrative sensitivity. They capture the experiential dimension of doctor – patient interactions and universal existential aspects of life related to health, illness, suffering and death, respectively. The physician’s ability to reflect upon his/her own emotions during interaction with the patient is important part of making rapport with the patient and developing a therapeutic collaboration. Awareness of existential issues might be important for empathic interactions with patients and consequently for building up therapeutic alliance. Thus, aiming at refinement of the concept of narrative sensitivity we suggest including those dimensions to the concept.

On top of that, the complexity of narrative sensitivity is also manifested by layers which could be distinguished in each of the category/theme in the process of thematic analysis (see Tab. 20.). The multi-layered quality of themes could be understood not only by complexity of narrative framework in medicine in general and the concept of narrative sensitivity in particular. It also portrays the richness of experiential dimension of health, illness, and interaction between health care professionals and patients, when reflected.

Tab. 20. Example of Layers within a Theme: Expression of One´s Own Emotion

---

a) Simple description of one´s own emotions evoked by photography

b) Description of one´s own emotions with indication of relating to the person on the photography *(overlap between one´s own subjective experience and supposed subjective experience of the person on the photography)*

  - expression of compassion (empathic quality)

  - expression of „negative “experience (rejection, fear, hostility)

  - expression of interest, curiosity, and desire to help

In Tabs. 21-23. we provide the list of layers of the themes defining narrative sensitivity positively, negatively, and irrelevant regarding the concept. It is clear, that there are more subtle nuances in each category derived from the thematic analysis of the data. The layers show the richness of the participants´ experience expressed in writing in a response to the photograph.

Tab. 21. Layers of the Themes Defining Narrative Sensitivity Positively

---

1. **Reflection on the person´s life story**
   Temporality regarding the person´s life story (past, present, future). Arguably the essence of narrative sensitivity

   1.1. What preceded and/or contributed to the person´s illness? (bio-psycho-social perspective)
   1.2. What is the impact of the person´s condition/disease/treatment on his life now?
   1.3. What is the impact of the person´s condition/disease/treatment on his life in the future?

2. **Reflection on the person´s subjective experience**

   2.1. Simple description of the person´s experience
   2.2. Thoughts about the person´s needs
   2.3. Description of the person´s experience with use of a metaphor or a typical idiom
   2.4. Description of the person´s experience emphasized with direct speech
   2.5. Description of the person´s experience with tentative empathy and expression of one´s own experience (intersubjectivity)
   2.6. Description of the person´s experience overlapping with other themes

3. **Expression of one´s own emotion**

   3.1. Simple description of one´s own emotion
   3.2. Description of one´s own emotion with indication of relating to the person (intersubjectivity)
      3.2.1. Expression of compassion (empathising quality)
      3.2.2. Expression of so-called negative emotion (aversion, fear, sense of threat, conflict)
      3.2.3. Expression of interest and desire to help

4. **Awareness of other perspectives**

   4.1. Admitting one´s own uncertainty regarding the person´s situation/health condition/experience
   4.2. Mentioning a possibility of other perspectives without specifying them
   4.3. Indication of other specific possibilities (health condition, situation, diagnosis, experience, causal factors etc.)
   4.4. Indication of a possibility of other perspectives in a linguistic form (“Perhaps…”; “On the other hand…”)

5. **Reflection on the person´s coping**

   5.1. Reflections about the person´s coping with the disease and the treatment
   5.2. Reflections about the person´s stance towards the treatment and physicians as a demonstration of struggling with the challenges of the disease and the treatment

6. **Existential reflection**

   6.1. General ideas about existential aspects of human life (suffering, temporality, end of life, quality of life, meaning of life)
   6.2. Connecting the general ideas about existential aspects with the person on the photography

7. **Reflection on the person´s relational context**

   7.1. Reflections about the existence or absence of the person´s support from other people

Tab. 22. Layers of the Themes Defining Narrative Sensitivity Negatively

1. **Description of the person´s appearance**

    1.1. Simple description of the person´s appearance
    1.2. Description of the person´s appearance with hypothesizing about the person´s emotions
    1.3. Description of the person´s appearance with hypothesizing about the person´s life situation
    1.4. Description of the person´s appearance with stereotypes regarding patients
    1.5. Description of the person´s appearance with moral judgment

2. **Downplaying the subject** (interpreted not only from the content but also the form)

    2.1. Considerably expressive and lengthy form of writing and seemingly irrelevant to the photography
    2.2. Rather brief and incomprehensible writing

    (Note: The writings were coded for this theme not only for their content but also for the form, which seemed rather unusual compared to other writings. Although we could not prove that given the design of the study, we hypothesized the students avoided answering the instruction seriously and rather downplayed the subject. It could also be a way of not participating at the research)

Tab. 23. Layers of the Themes Irrelevant of Narrative Sensitivity

1. **Reflection on the person´s health condition**

    1.1. General statement about the person´s health without using medical terminology
    1.2. General statement about the person´s health without using medical terminology
    1.3. Thoughts about the person´s life event (disease, injury, medical procedure)

2. **Therapeutic suggestions**

    2.1. Thinking about a possible therapeutic intervention or help either from a close person or professional

3. **Reflection on the health care system**

    3.1. Reflections about the person´s interactions with physicians
    3.2. Reflections about the person´s interactions with other health care professionals
    3.3. General reflections about care in a health care institution

3.3.6. Theme Frequencies and change

The most frequent theme in both years was *Reflection on the person´s subjective experience*, a theme closely related to the concept of NS. There was a clear trend towards a decrease in themes positively defining NS and an increase in those negatively defining NS between the second and the fifth year. However, only the decrease in *Awareness of other perspectives* and the increase in *Description of the person´s appearance* reached statistical significance due to the small sample size. Furthermore, we noticed a marked difference in the form of reflective writing as well. In the fifth year, the students used medical jargon more often, the text units were generally shorter and more structured, resembling a formal health record rather than a fluent narrative.

Tab. 24. *Themes and their frequencies*

Theme	Frequency (%)		Difference
	second year (*N* = 50)	fifth year (*N* = 42)	*p*
Reflection on the person´s subjective experience	36 (72%)	34 (81%)	.339
Reflection on the person´s health condition	28 (56%)	35 (83%)	.007**
Expression of one´s own emotions	23 (46%)	12 (29%)	.131
Awareness of other perspectives	19 (38%)	6 (14%)	.018*
Reflection on the person´s coping	16 (32%)	10 (24%)	.487
Existential reflection	6 (12%)	6 (14%)	.766
Reflection on the person´s relational context	6 (12%)	4 (10%)	.750
Reflection on the health care system	3 (6%)	5 (12%)	.462
Description of the person´s appearance	15 (30%)	21 (50%)	.057(*)
Therapeutic suggestions	8 (16%)	11 (26%)	.303
Downplaying the subject	4 (8%)	4 (10%)	1.00
Reflection on the person´s life story	16 (32%)	13 (31%)	1.00

Note: The frequency represents the number of students in whom a theme was identified. The differences between the second and fifth years were tested using Fisher’s exact test. ** $p < .01$, * $p < .05$, and (*) $p < .10$.

3.4. Discussion

Because undergraduate medical study in our country is characterized by little emphasis on physician – patient communication skills including narrative sensitivity and neglecting of bio-psycho-social perspective in medicine, we designed a study to explore the concept of NS among undergraduate medical students. We identified nine themes that captured various aspects of the NS in students' responses to a photograph of a patient. Both the content and form of participants´ text units varied in each year´s sample. Whereas some participants showed a marked propensity for mentalization of one´s own and the patient´s subjective experience and empathizing with the patient, others were focused more on the so-called objective aspects of being ill. Some participants seemed to be well aware of the interpersonal situation of the patient, existential issues, and context of being treated in a hospital, while others were interested only in biological aspects of a disease and medical treatment.

In terms of the form of writing, the text units from the second year were mostly lengthy, imaginative, and rich in narrative. The text units from the fifth year tended to be rather brief, structured, as if resembling a formal health record rather than a fluent narrative. The participants in the fifth-year sample used medical jargon including diagnosis and technical terms. At the same time, the subjectivity of the patient was often missing, the participants' stance towards the patient on the photograph could be characterized as a professional detachment. Regarding the frequency of themes essentially related to NS, we were quite surprised by how often the participants' text units included various facets of NS, particularly in the second year. However, the changes in the frequency of themes between the second and fifth years of the undergraduate study was notable. We observed an increased frequency of themes negative or irrelevant to NS and a decreased frequency of themes positive to NS. However, the exploratory nature of this study and the small sample size did not allow us to make any generalizations.

The changes between the second and fifth years of the undergraduate study could be interpreted in the context of the Faculty´s medical curriculum. Students have only clinical subjects from the fourth year of their undergraduate study on and, arguably, start to focus more on objective measures of a disease and keep a distance from the patients. We call this a manifestation of emerging clinical mentality, which stems from observing various clinical situations and social learning from their teachers´ interactions with patients in university hospital departments. These findings correspond with those of Lim et al. (2013) who reported a decline in expressed empathy in medical students during undergraduate study and attributed it to higher perceived responsibility, a focus on diagnostic skills, and a lack of empathic role models during clinical training. Coulehan (2005) argues that any effort of passing on the ethical and humanistic principles to medical students during their studies is in vain, since later in the clinical setting they implicitly adopt the communication patterns based on objectivity, emotional distance, and a focus on disease. Such training outcomes have consequences later during clinical practice. As Rakel et al. (2011), for instance, showed in their study, the patients´ perception of the physicians ‘empathy during the physician – patient interactions might even interfere with the severity and duration of a disease. Thus, the findings expose the drawbacks of undergraduate medical study based solely on the biomedical model. If medical students lose their ability to reflect on their own and the patient´s subjective experience during undergraduate years, they may have difficulty in communicating with their patients in the beginning of their career. As a result, they might struggle to develop a trustful, collaborative relationship with their patients and to cope appropriately with emotionally challenging situations in clinical practice.

Because medical studies are usually one-sidedly focused on memorizing large amounts of theoretical knowledge and learning a range of diagnostic and treatment procedures, the time necessary for adopting important communication skills may be missing. McLeod (2007) argues that the increasing use of biotechnology raises the danger of further dehumanization of patients and neglecting their needs for understanding, support, and care. A rapid biotechnological advancement combined with the narrow biomedical model contributes to what Charon (2008) coins as profound divisions between doctors´ and patient´s position and experience with regard to illness beliefs, subjectivity, context, and mortality. In our view, NS encompasses all those issues and could serve as a bridge across those divisions.

Consequently, the main implication of our research is a proposal for a shift in medical education towards a balance between theoretical knowledge and instrumental skills, on the one hand, and communication skills, including NS, on the other. Such a balance is necessary if we expect future physicians to practice medicine based on the bio-psycho-social model, which integrates psychological and psychotherapeutic knowledge into medical care. An inspiration might come from the concept of embedded counselling and the contextual model of psychotherapy. In embedded counselling, McLeod & McLeod (2011) advocate for the integration of some psychological and psychotherapeutic principles into medicine and other helping professions. In the contextual model of psychotherapy, Wampold & Imel (2015) emphasize the role of a therapeutic relationship and healing context as crucial factors in treatment. In our view, narrative skills including NS are an important part of these inspirational sources and should be integrated in the undergraduate medical education. Proponents of the bio-psycho-social model in medicine, for instance Chvála, Trapková & Skorunka, 2012), McDaniel, Doherty & Hepworth (2014), and Skorunka (2019), argue that such principles and factors are important elements of integrated treatment for patients particularly, but not exclusively, with chronic disorders, mental disorders, and medically unexplained symptoms.

The exploratory study has several limitations. First, each analyst brought her/his own preconceptions and biases. We strived to reflect on these through an open discussion with help of an auditor. Second, it could be argued that some participants might have preferred positive ideas regarding the patient on the photograph and deferred the negative ones because of their expectations of socially accepted expressions. However, the frequency of the expressed negative attitudes towards the patient on the photograph indicates that the participants were not afraid to express ideas charged with negative emotions or moral judgement. Third, some text units had ambiguous meaning that made them difficult to categorize. The design of the study did not allow us to ask the participants for clarifications or further elaboration. Fourth, the data in this study were not based on real communication situations, therefore, we might have missed some important aspects of the NS that did not manifest in the written self-reflections. Fifth, a different picture might have generated different responses and, possibly, different themes. Sixth, a small sample size and the explorative design of the study prevented us from rigorously testing the change over time. Seventh, the absence of a control group did not allow us to control for the effect of maturation. Eighth, given the small sample size, the dropout of eight students could have biased the statistical testing. The use of a paired test and the exclusion of these eight students would be preferable. However, the data were collected anonymously and, therefore, could not be paired.

Despite the limitations, the study findings could inspire transformation of undergraduate medical training especially in medical faculties, in which the curriculum is still based on biomedical model lacking the emphasis on the future physicians´ communication skills and bio-psycho-social complexity. Further research is needed to understand how to best train future physicians in NS as a part of communication skills development during undergraduate and postgraduate level of medical education.

3.5. Conclusion

We found that various aspects of narrative sensitivity could be clearly identified in medical students’ written responses to a photograph of a patient. We also documented a trend for a decline in narrative sensitivity between the second and fifth years of the undergraduate medical training, although our method did not allow us to make rigorous conclusions about these changes. Despite the limitations, the research supports the calls for integrating relevant psychological and psychotherapeutic knowledge into medicine to embrace the bio-psycho-social complexity of health, illness, and treatment. It goes well along with Baessler et al. (2019) call for interactive, communication-oriented teaching methods during undergraduate medical study and with McDaniel, Doherty, Hepworth (2014) arguments for integrative, bio-psycho-social model in medicine. Thus, the research might serve as an inspiration for changes in medical curriculum in terms of emphasis on bio-psycho-social perspective and future physicians ´communication skills including narrative sensitivity training. The goal of such training is to help medical students – future physicians develop representations of patients´ illness narratives so that they can establish effective therapeutic alliance with their patients.

FINAL WORDS

In the theoretical part on narrative and psychotherapy we suggested that narrative is an integrative concept, which weaves together different assumptions and perspectives of different psychotherapeutic modalities. The narrative concept´s integrative potential holds true for medicine as well. It bridges the uniqueness of the patients 'and their families experience with the experts´ ”stories” organized around scientific knowledge. It bridges the patients 'need for sharing their experience in stories and the professionals 'need for structuring those stories together with the so-called objective date in science-based discourse. By bridging those distinctive worlds, in Bruner´s (1986) terminology the narrative knowledge and logico-scientific knowledge, the narrative concept invites for reflective stance, balancing power, and sharing the responsibility between the patient and the health care professional. It corresponds with the arguments why some topics from the humanities including the narrative training should be included in medical education: "*Studying the humanities…(helps us)…become more aware, more insightful, more reflective, and – ultimately – more influential in shaping the trajectory of healthcare…It is about providing an outlet for both emotional engagement and self-reflection in a culture that typically denies both, looks outward rather than inward, and too often ignores not only the personal costs but the personal rewards of medical work.*" (Huyler, 2013, p. 919)

The narrative stance, or in our conceptualisation the narrative sensitivity, involves attentiveness to language and interactions, ethical commitment regarding the tensions of clinical practice and patients 'benefits, and awareness of bio-psycho-social interplay of health and illness. Representatives of narrative medicine recently offered several principles regarding application of narrative ideas in medicine and healthcare. For instance, Launer (2018) speaks about a framework of "*conversations inviting change*", which might help health care professionals to embark on narrative - informed approach in clinical practice. The "conversations inviting change" are based on seven concepts such as a) narrative – based conversations; b) curiosity; c) contexts; c) complexity; d) challenge; e) caution; f) care. Although we will not describe those concepts in detail here, they clearly overlap with ideas discussed thoroughly in the text and fit well with already mentioned bio-psycho-social model. In the same vein, when summarizing clinical contribution of narrative framework to medicine, Charon et al. (2016) emphasize individual interview/relationship techniques, clinician and healthcare team development, and evolvement of novel narrative practices. These principles do not have to be complicated or time consuming. It starts with simple changes in doctor-patient interactions: *"…Hands in lap, listening, without writing, typing, scanning the computer monitor…The rolling of the office chair away from the computer monitor toward the patient as he or she sits in the other office chair is itself a meaningful physical action. Attentive listening is the core of the practice, far more important than exactly what words are used. It is here in the reception of the patient´s response that the narrative aspects of the healthcare encounter occur and that all the skills of narrative medicine are put into practice"* (Charon, 2016, p. 293).

To sum up, let´s remind again the Launer's (2018) statement that disease and disability are not just stories. It should be emphasized, that such human conditions are not solely biological phenomena either. For patients and their families, disease and disability are distressing experiences, which interferes with their lives and sometimes end their lives prematurely. Given the vast and ongoing development of medical knowledge, it is expected that physicians must acquire huge amount of information within life-long education during their career. However, the patients and their families do not need only an expert, who have impressive theoretical knowledge, who can sort out scientific puzzles, who can effectively deal with intriguing clinical problems, and who are skilled to solve instrumental/mechanical problems. They also need human connection, understanding, empathic attunement, support, and guidance as antidotes against phenomena, which are part of a disease experience such as narrative disruption, loss, pain, suffering, and death.

Although more advanced psychological support or even various psychotherapy approaches might be needed in some cases, in our view, it is within physicians 'responsibility to provide at least basic level of these elements within regular interactions with their patients and their families during the treatment. Arguably, the biomedical model is not sufficient for helping the physicians develop skills, which enable them to meet their patient's interpersonal needs. Thus, relevant psychology and psychotherapy knowledge including narrative sensitivity and even selected topics from the humanities should be integrated in both undergraduate and postgraduate medical education.

REFERENCES

Anda, R., Felliti, V., Bremner, D., et al. (2006). The enduring effects of abuse and related adverse experiences in childhood. European Archives of Psychiatry and Clinical Neuroscience, 256 (3), 174-186.

Ainsworth, M. D. S., Blehar, M. C., Waters, E., & Wall, S. (1978). Patterns of attachment: A psychological study of the Strange Situation. Lawrence Erlbaum.

Andersen, T. (1993). Reflections on Reflecting with Families. In S. McNamee & K.J. Gergen (Eds.), Therapy as Social Construction (pp. 54-69). Sage.

Andersen, T. (1995). Reflecting processes; acts of informing and forming: You can borrow my eyes but you must not take them away from me! In S. Friedman (Ed.) *The reflecting team in action; collaborative practice in family therapy (pp. 11-37)*. Guilford.

Anderson, H., & Goolishian, H. (1993). The client is the expert; A not-knowing approach to therapy. In S. McNamee, & K. Gergen (Eds.) Therapy as social construction (pp. 25-39). Sage.

Anderson, H. (1997). Conversation, language and possibilities; A postmodern approach to therapy. Basic Books.

Anderson, H., & Gehart, D. (Eds.). (2006). Collaborative therapy; relationships and conversations that make a difference. Routledge.

Angus, E.L., Levitt, H., & Hardtke, K. (1999) The narrative processes coding system: research applications and implications for psychotherapy practice. Journal of Clinical Psychology, 55(10), 1255-70.

Angus, E.L., & Hardtke, K. (2004). The narrative assessment interview: assessing self-change in psychotherapy. In L. Angus, J. McLeod (Eds.), *The Handbook of narrative and psychotherapy (247-262)*. Sage.

Angus, E. L., McLeod, J. (Eds.). (2004). *The handbook of narrative and psychotherapy*. Sage.

Ansell, S., Read, J., & Bryce, M. (2020). Challenges to well-being for general practice trainee doctors: a qualitative study of their experiences and coping strategies. Postgraduate Medical Journal, 96 1136), 325-330.

Arntfield S.L., Slesar K., Dickson J., & Charon, R. (2013). Narrative medicine as a means of training medical students toward residency competencies. Patient Education Counselling, 91(3), 280–286.

Asen, E., Tomson, D., Young, V., & Tomson, T. (2004). Ten minutes for the family; Systemic interventions in primary care. Routledge.

Bateson, G. (1972). Steps to an ecology of mind. Chicago: University Chicago Press.

Baile, W., F. (2000). SPIKES-A six step protocol for delivering bad news: application to the patient with cancer. Oncologist, 5(4), 302–311.

Baerger, D.R., & McAdams, D.P. (1999). Life story coherence and its relation to psychological well-being. Narrative Inquiry, 9 (1), 69-96.

Baessler, F., Zafara, A., Schweizerb, S., Ciprianidis, A., et al. (2019). Are we preparing future doctors to deal with emotionally challenging situations? Analysis of a medical curriculum. Patient Education Counselling, 103(7), 1304-1313.

Beisecker, A. E., & Beisecker, T. D. (1993). Using metaphors to characterize doctor-patient relationships: Paternalism versus consumerism. *Health Communication, 5*(1), 41–58.

Bertalanffy, L. (1968). *General System theory: Foundations, Development, Applications*. (Revised edition 1976). George Braziller.

Bick, J., & Nelson, A. Ch. (2016). Early adverse experiences and the developing brain. *Neuropsychopharmacology,* 41(1), 177-196.

Block, D. A. (2002). Dr. Biomedicine and Dr. Psychosocial: The dual optic II: Why referral (mostly) does not work. *Families, Systems, & Health, 20*(4), 338–340

Botella, L., Herrero, O., Pacheco, M., & Corbella, S. (2004). Working with narrative in psychotherapy; a relational constructivistic approach. In L. Angus, J. McLeod (Eds.), The Handbook of narrative and psychotherapy (pp. 119-136). Sage.

Bowen, M., & Kerr, M. (1988). *Family evaluation*. W.W. Norton & Company.

Boszormenyi-Nagy, I., Grunebaum, J., & Ulrich, D. (1991). Contextual Therapy. In A. S. Gurman & D. P. Kniskern (Eds.), The *Handbook of Family Therapy, Vol. II* (pp. 200–238). Brunner/Mazel.

Brady, D.W., Corbie-Smith, G., & Branch W.T. (2002). ‘‘What’s important to you?’’ The use of narratives to promote self-reflection and to understand the experiences of medical residents. Annals of Internal Medicine, 137(3), 220–223.

Branch, W.T., & Frankel, R. (2016). Not all stories of professional identity formation are equal: An analysis of formation narratives of highly humanistic physicians. Patient Education and Counselling, 99(8), 1394-1399.

Branch, W.T. (2010). The road to professionalism: reflective practice and reflective learning. Patient Education and Counselling, 80(3), 327–332.

Branch, W. T., Jr., Kern, D., Haidet, P., Weissmann, P., Gracey, C. F., Mitchell, G., et al. (2001). The patient–physician relationship. Teaching the human dimensions of care in clinical settings. Journal of the American Medical Association, 286(9), 1067–1074.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. Journal of Qualitative Research in Psychology, 3(2), 77-101.

Breunlin, D., Schwartz, R., & Mac Kune Karrer, B. (1997). Metaframeworks: Transcending the models of family therapy. Jossey Bass.

Bruner, J. (1987). Actual minds, possible worlds. Harvard University Press.

Bruner, J. (2004). The Narrative creation of self. In L. Angus, J. McLeod (Eds.), The Handbook of narrative and psychotherapy (pp. 3-14). Sage.

Carr, A. (2012). Family therapy; concepts, process, and practice (3rd edition). John Wiley & Sons.

Carr, A. & Stratton, P. (2017). SCORE Family Assessment Questionnaire: A decade of progress. Family Process, 56(2), 285-301.

Castonguay, L. (2015). Research on psychotherapy integration: Building on the past, looking to the future. Psychotherapy Research, 25(3), 1-18.

Cassidy, J., & Shaver, P. (Eds.) (2016). *The handbook of attachment*. Guiford Press.

Carrhart-Harris, R. L., Leech, R., Hellyer, P.J. et al. (2014). The entropic brain: A theory of conscious states informed by neuroimaging research with psychedelic drugs. *Frontiers in Human Neuroscience,* 8(20), 1-22.

Caverly, T., Matlock, D., Thompson, J., & Combs, B. (2018). Qualitative evaluation of a narrative reflection program to help medical trainees recognize and avoid overuse: “Am I doing what’s right for the patient?” Patient Education and Counselling, 101(3), 475-480.

Cenci, C. (2016). Narrative medicine and the personalisation of treatment for elderly patients European Journal of Internal Medicine, 32, 22–25.

Charon, R. (2001a). Narrative medicine; A model for empathy, reflection, profession, and trust, JAMA, 286(15), 1897-1902.

Charon R. (2001b) Narrative medicine: form, function, and ethics. *Annals of Internal Medicine*, 134(1),83-87.

Charon, R. (2004). Narrative and medicine, New England Journal of Medicine, 350(9), 862-4.

Charon, R. (2008). Narrative Medicine, Honouring the Stories of Illness. Oxford University Press.

Charon, R., & Wyer, P. (2008). The art of medicine. The *Lancet*, *371(9609)*, 296–297.

Charon, R., Hermann, N., & Devlin, M.J. (2016). Close reading and creative writing in clinical education: teaching attention, representation, and affiliation. Academic Medicine, 91(3), 345–350.

Charon, R., DasGupta, S., Hermann, N. Irvine, C. et al. (Eds.). (2017). The principles and practice of narrative medicine. Oxford University Press.

Charon R., & Montello M. (Eds.). (2002). Stories matter; The role of narrative in medical ethics. Routledge**.**

Chvála, V., & Skorunka, D. (2017). Biopsychosociální model nabízí větší porozumění. Psychiatrie pro praxi, 18(1), 42-46.

Chvála, V., Trapková, L., & Skorunka, D. (2012). Social uterus; Developmental concept in family therapy for psychosomatic disorders. Contemporary Family Therapy, 34(2), 293-312.

Chrz, V., & Čermák, I. (2015). Narativní komplexita. Československá psychologie, 59 (1), 1-16.

Coan, J. (2016). Toward neuroscience of attachment. In J. Cassidy, & P. Shaver (Eds.), *The handbook of attachment* (3rd ed., pp. 242-269). Guilford Press.

Coan, J., & Schaefer, H. (2007). Lending a hand; Social regulation of the neural response to threat. *Psychological Science*, 17(12), 1032-1039.

Coan, J., Kasleb, S., Jackson, A. et al. (2013). Mutuality and the social regulation of neural threat responding. *Attachment & Human Development*, 15(3) 303–315.

Cooper, M. (2013). Essential research findings in counselling and psychotherapy; The facts are friendly (1st ed.). Sage.

Coulehan, J. (2005). Viewpoint: today’s professionalism: engaging the mind but not the heart. Academic Medicine, 80(10), 892–898.

Cozolino, L. (2012). *The neuroscience of human relationships: Attachment and the developing social Brain* (2nd ed.). W.W. Norton & Company.

Crittenden, P., Dallos, R., Landini, A., & Kozlowska, K. (Eds.). (2014). Attachment and family therapy. Open University Press.

Crittenden, P. (2015). Attachment, representation, and treatment (2nd ed.). Routledge.

Crittenden, P. & Landini, A. (2011). *Assessing adult attachment. A dynamic-maturational approach to discourse analysis*. W.W. Norton & Company.

Cronin, A.J. (1993). Příhody z černého kufříku. Knižní klub.

Čermák, I. (2003). Psychologie v narativní tónině se vynořila v souvislostech. *Československá Psychologie*, *47(6)*, 513–532.

Čermák, I. (2004). Narativní terapie: mnohohlasý chór. In M. Miovský, I. Čermák, V. Řehan (Eds.), Kvalitativní přístup a metody ve vědách o člověku III., 33-48. Univerzita Palackého v Olomouci.

Dallos, R., & Vetere, A. (2009). *Systemic therapy and attachment narratives*. Routledge.

Dallos, R. (1997). Interacting stories; narratives, family Beliefs and therapy (1st ed.). Karnac Books.

Dallos, R. (2006). Attachment narrative therapy; integrating narrative, systemic and attachment therapies. Open University Press.

Dallos, R., & Draper, R. (2015). An Introduction to Family Therapy. Systemic Theory and Practice (4th ed.). Open University Press.

Dallos, R., & Stedmon, J. (2013). Systemic formulation: mapping the family dance. In R. Dallos, & L. Johnstone (Eds.), Formulation in Psychology and Psychotherapy (pp. 67-95). Routledge.

Dallos, R., & Johnstone, L. (Eds.) (2013). Formulation in psychology and psychotherapy. Routledge.

Dallos, R., & Vetere, A. (2014). Systemic therapy and attachment narratives: Attachment narrative therapy. *Clinical Child Psychology and Psychiatry, 19*(4), 494–502.

Damasio, A. (2000). Descartesův only: Emoce, rozum a lidský mozek. Mladá Fronta.

Dasgupta, S., & Charon, R. (2004). Personal illness narratives: Using reflective writing to teach empathy. Academic Medicine, 79(4), 351–356.

DasGupta, S., Meyer, D., Calero-Breckheimer. A., Costley, A., & Guillen, S. (2006). Teaching cultural competency through narrative medicine: intersections of classroom and community. Teaching and Learning Medicine, 18(1), 14–7.

Dimaggio, G., Semerari, A. (2004). Disorganised narratives; The psychological condition and iIts treatment. In L. Angus, & J. McLeod (Eds.), The handbook of narrative and psychotherapy (pp. 263-282). Sage.

DIPEX International; https://dipexinternational.org/, retrieved 20.7.2021

DIPEX Czech Republic; https://dipexinternational.org/czech-republic/ https://hovoryozdravi.cz/, retrieved 20.7.2021

Dowling, E., & Vetere, A. (2005). Narrative therapies with children and their families. A practitioner´s guide to concepts and approaches. Routledge.

Efran, J. S. (1994). Mystery, abstraction, and narrative psychology. *Journal of Constructivist Psychology, 7*(4), 219-227.

Efran, J.S. (1993). Context: The fulcrum of cognitivist psychotherapy. Journal of Cognitive Psychotherapy, 7(3), 173-182.

Elliott, R., Greenberg, L.S. & Lietaer, G. (2004). Research on experiential psychotherapies. In M.J. Lambert (Ed.), Bergin and Garfield's handbook of psychotherapy and behavior change, (5th ed., pp. 493-539) John Wiley & Sons.

Elwyn, G., & Gwyn, R. (1991). Stories we hear and stori-es we tell: analysing talk in clinical practice. British Medical Journal, 318: 186–188.

Engel, G. L. (1977). The need for a new medical model: A challenge for biomedicine. *Science*, *196*(4286), 129–136.

Evans, K. & Gilbert, M. (2005). An introduction to integrative psychotherapy. Palgrave.

Fayrabend, K. P. (2011). Rozprava proti metodě. Aurora:

Flaskas, C. (2002). Family therapy beyond postmodernism; Practice challenges theory. Routledge.

Fonagy, P. & Roth, A. (2004). What works for whom? A critical review of psychotherapy research. Guilford Press.

Fonagy, P., Gergely, G., Jurist, E., & Target, M. (2002). *Affect regulation, mentalization, and the development of the self*. Karnac Books.

Fonagy, P., & Target, M. (2005). Psychoanalytické teore; perspektivy z pohledu vývojové psychopatologie. Portál.

Foster, J. (2006). Journeys through mental Illness; Clients' experiences and understanding of mental distress. Palgrave.

Foucault, M. (1994) Dějiny šílenství. Praha: Lidové noviny.

Fredman, G. (2002). Co-ordinating cultural and religious stories with stories of identity. Clinical Psychology, 17, 29-32.

Freedman, J., & Coombs, G. (1996). Narrative therapy; Social construction of preferred realities. WW. Norton & Company.

Frank, J.D., & Frank, J.B (1993). Persuasion and healing: A comparative study of psychotherapy. Johns Hopkins University Press.

Frankl, V. (2006): Vůle ke smyslu; vybrané přednášky o logoterapii. Cesta, Brno.

Friedman, S. (Ed.). (1995). *The reflecting team in action; Collaborative practice in family therapy*. Guilford Press.

Friedman, L. (2002). The precarious position of the medical humanities in the medical school curriculum. Academic Medicine, 77(4), 320–2.

Freud, S. (1997). Nová řada přednášek k úvodu do psychoanalýzy. Psychoanalytické nakladatelství J. Kocourek.

Geertz, C. (1973). The interpretation of cultures. Basic Books.

Gehart, D. (2017). Mastering Competencies in Family Therapy; A Practical Approach to Theories and Clinical Case Documentation (2nd ed.). Brooks/Cole.

Gergen, J. K. (1999). An invitation to social construction (1st ed.). Sage.

Gibson, M. (2012). Narrative practice and social work education: using a narrative approach in social work practice education to develop struggling social work students. Practice, 24(1), 53–65.

Gilbert, L., Breiding, M.J. Merrick, T.M. et al. (2015). Childhood Adversity and Adult Chronic Disease. *American Journal of Preventive Medicine,* 2015. 48(3), 345–349.

Gilbert, M., & Orlans, V. (2010). Integrative therapy; 100 key points and techniques. Routledge.

Goncalves, F.O. (1994). From epistemological truth to existential meaning in cognitive narrative psychotherapy. *Journal of Constructivist Psychology, 7(2)*, 107-118.

Goncalves, F.O., Henriques, M., R., & Machado, P.P. (2004): Nurturing nature; Cognitive narrative strategies. In L. Angus, J. McLeod (Eds.), *The Handbook of narrative and psychotherapy (pp. 119-136)*. Sage.

Good, B. J., & Good M.J.D. (2000). Fiction and Historicity in Doctors´Stories: Social and Narrative

Dimensions of Learning Medicine. In Ch. Mattingly & L. Garro (Eds.), Narrative and the cultural construction of illness and healing (pp. 50-69). California University Press.

Gurman, A. S. (2005). Brief Integrative Marital Therapy: An Interpersonal-Intrapsychic Approach. In J. L. Lebow (Ed.), *Handbook of clinical family therapy* (pp. 353–383). John Wiley & Sons..

Greenberg, J. (1998). Neslibovala jsem ti procházku růžovým sadem.Triton.

Greenberg, L. S., & Pascual-Leone, J. (2001). A dialectical constructivist view of the creation of personal meaning. *Journal of Constructivist Psychology, 14*(3), 165–186.

Greenberg, L. & Angus, L. (2004). The Contributions of Emotion Processes to Narrative Change in Psychotherapy: A Dialectical Constructivist Approach. In L. Angus, J. McLeod (Eds.), *The handbook of narrative and psychotherapy (pp. 331-349)*. Sage.

Greenberg, L. & Goldman, R. (2008). Emotion-focused couples therapy. American Psychology Asociation.

Greenberg, L., & Angus, L. (2011). Working with narrative in emotion-focused therapy. American Psychological Association.

Greenhalgh, T., & Hurwitz, B. (1999). Narrative based nedicine; Why study narrative? British Medical Journal, 318(7175), 48-50.

Greenhalgh, T. (1999). Narrative Based Medicine in Evidence Based Medicine World. British Medical Journal, 318(7179), 323-325.

Grendar, J., Beran, T., & Oddone-Paolucci, E. (2018). Experiences of pressure to conform in postgraduate medical education. BMC Medical Education, 18(4).

Griffith, M. E., & Griffith, J. L. (1995). When patients somatize and clinicians stigmatize; Opening dialogue between clinicians and medically marginalized. In S. Friedman (Ed.), *The reflecting team in action; Collaborative practice in family therapy* (pp. 11-37). Guilford Press.

Griffiths, R.R., Johnson, M.W., Carducci, M. A. et al. (2016). Psilocybin produces substantial and sustained decreases in depression and anxiety in patients with life-threatening cancer: A randomized double-blind trial. *Journal of Psychopharmocology*, 30(12), 1181-1197.

Gordon, R. (2009). Doktor v domě. Mladá fronta.

Haley, A. (1991). Konečná diagnóza. Svoboda.

Herman, D., Jahn, M., & Ryan M.L. (Eds.). (2007). *Routledge Encyclopedia of Narrative Therapy*. Routledge.

Hesse, E. (2008). The Adult – Attachment Interview: Protocol, methods of analysis, and empirical studies. In J. Cassidy, & P. Shaver (Eds.), The handbook of attachment (2nd ed., pp. 552-598). Guilford Press.

Hevern, W.V. (2003). Narrative Psychology; Internet and Resource Guide, http://web.lemoyne.edu/~hevern/narpsych/narpsych.htmlwww. Vyhledáno 16.7.2007

Hill, C. E., Thompson, B. J., & Williams, E. N. (1997). A guide to conducting consensual qualitative research. *The Counseling Psychologist, 25(4),* 517–572.

Hill, C.E., Know, S., Thompson, B.J., Nutt Williams, E., Hess, S.A., & Ladany, N. (2005). Consensual Qualitative Research; An Update. Journal of Counselling Psychology, 52(2), 196-205.

Holmgren, L., Fuks, A., Boudreau, D., Sparks, T., & Kreiswirth, M. (2011). Terminology and praxis: clarifying the scope of narrative in medicine. Literature and Medicine, 29(2), 264-73.

Holmes, J. (2014). John Bowlby and Attachment Therapy (2nd ed.) Routledge.

Honzák, R. (2017). Psychosomatická prvouka. Vyšehrad.

Horáček, J., Drtinová, D. (2021). Vědomí a realita. Vyšehrad.

Hunter, K. M, Charon, R., & Coulehan, J.L. (1995). The study of literature in medical education. *Academic Medicine*; 70(9), 787-794

Huyler, F. (2013). The Woman in the Mirror. Academic Medicine, 88(7), 918-920.

Illich, I. (2012). Limity medicíny; Nemesis – zaprodané zdraví. Emitos.

Irvine, C., & Charon, R. (2017). Deliver Us from Certainty: Training for Narrative Ethics. In R. Charon, S. DasGupta, N. Hermann et al. (Eds.), The Principles and Practice of Narrative Medicine (pp. 110-136). Oxford University Press.

Irvine, C., & Spencer, D. (2017) Dualism and its Discontents I.: Philosophy, Literature, and Medicine. In In R. Charon, S. DasGupta, N. Hermann et al. (Eds.), The Principles and Practice of Narrative Medicine (pp. 63-86). Oxford University Press.

Jamieson, K. R. (1996). An Unquiet Mind. Vintage Books.

Jaspers, K. (1954). Way to Wisdom; An Introduction to Philosophy. Yale University Press.

Jones Hudson, A. (1999). Narrative in medical ethics. British Medical Journal, 318(7178), 253–256.

Jones, E.M., & Tansey, E. M. (Eds.). (2015). The Development of Narrative Practices in Medicine. Queen Mary University of London.

Johnson, S., & Greenberg, L. S. (1985). Emotionally focused couples therapy; An outcome Study. Journal of Marital and Family Therapy, 11(3), 313-317.

Johnson, S., & Whiffen, V. (2006). Attachment Processes in Couple and Family Therapy. Guilford Press.

Kalitzkus, V., & Matthiessen, P.F. (2009). Narrative-based medicine: Potential, pitfalls, and practice. The Permanente Journal, 13(1), 80–6.

Karnieli-Miller, O., Michael, K., Gothelf, A. B., Palombo, M., & Meitar, D. (2021). The associations between reflective ability and communication skills among medical students. Patient Education and Counselling, 104(1), 92-98.

Karnieli-Miller, O. (2020). Reflective practice in the teaching of communication skills. Patient Education and Counselling, 103(10), 2166-2172.

Kay, A. (2018). This is Going to Hurt; Secret Diaries of a Junior Doctor. Picador.

Kiecolt-Glaser, K.J., McGuire, L., Robles, T., & Glaser, R. (2002). Psychoneuroimunology and Psychosomatic Medicine; Back to the Future. *Psychosomatic Medicine, 64(1)*, 15-28.

Kiecolt-Glaser, J., Loving, TJ., Stowell, J.R., Malarkey, W.B., Lemshow, S., Dickinson, S.L., & Glaser, R. (2005). Hostile marital interactions, proinflammatory cytokine production, and wound healing. Archives of General Psychiatry, 62(12), 1377-84.

Kiecolt-Glaser, K.J., Guin, J.P., Weng, N., Malarkey, W.B., Beversdors, D.Q. & Glaser, R. (2011). Childhood adversity heightens the impact of later-life caregiving stress on telomere length and inflammation. Psychosomatic Research, 73(1):16-22

Kleinman A. (1988). The illness narratives: Suffering, healing and the human condition. Basic Books.

Kobak, R., Zajac, K., & Madsen, S. (2016). Attachment Disruptions, Reparative Processes, and Psychopathology: Theoretical and Clinical Implications. In J. Cassidy, & P. Shaver (Eds.), *The handbook of attachment* (3rd ed., pp. 25-39). Guilford Press

Komárek, S. (2005). Spasení těla; Moc, nemoc a psychosomatika. Mladá Fronta.

Kozlowska, K. (2016). The Body Comes to Family Therapy: Utilising Research to Formulate Treatment Interventions with Somatising Children and their Families. *Australian and New Zealand Journal of Family Therapy,* 37(1), 6-29.

Křížová, E. (2006). Proměny lékařské profese z pohledu sociologie. Slon.

Kuhn, T. (1997). Struktura vědeckých revolucí. Oikoymenh.

Lambert, M. (Ed.). (2013). Bergin and Garfield´s handbook of psychotherapy and behavioral change. John Wiley & Sons.

Launer, J. (1999). A narrative approach to mental health in general practice. *British Medical Journal*, 318(7176), 117– 119.

Launer, J. (2018). Narrative-based practice in health and social care; conversations inviting change (2nd ed.). Routledge.

Lieblich, A., McAdams, P.D., & Josselson, R. (Eds.). (2004). Healing plots; The narrative basis of psychotherapy. American Psychological Association.

Le Fanu, J. (2000). Rise and fall of modern medicine. Basic Books.

Levine, R.B., Kern, D. E., & Wright, S.M. (2008). The impact of prompted narrative writing during internship on reflective practice: a qualitative study. Advances in Health Science Education, 13(5), 723-733.

Liben, S., Chin, K., J. Boudreau, D., Boillat, M. & Steinert, Y. (2012). Assessing a faculty development workshop in narrative medicine. Medical Teacher, 34(12), 813-819.

Lim, B., T., Moriarty, H., Huthwaite, M., Gray, L., Pullon, S., & Gallagher, P. (2013). How well do medical students rate and communicate clinical empathy? Medical Teacher, 35(2), 946–951.

Lipovetsky, G. (2011). Soumrak povinnosti. Prostor.

Luborsky, L., Barber, J.P., & Diguer, L. (1992). The meaning of narratives told during psychotherapy: the furits of a new observational unit. Psychotherapy Research, 2(4), 277-290.

Luborsky, L., Popp, C., Luborsky, E., & Mark, D. (1994). The core conflictual relationship theme. Psychotherapy Research, 4(3-4), 172-183.

Luborsky, L., & Crits-Christoph, P. (1998). Understanding transference; the core conflictual relationship theme method (2nd ed.). American Psychological Association.

Luepnitz, D. (2002). The family interpreted; Psychoanalysis, feminism, and family therapy. Basic Books.

Luhrman, T.M. (2000). Off two minds. An antropologist looks at American psychiatry. Vintage Books.

Lynch, G.A. (1992). Words and Silence: Counselling and Psychotherapy after Wittgenstein. Counselling 8(2), 126-128.

Marchalik, D. (2017). The return to literature-making doctors matter in the new era of medicine. Academic Medicine, 92(12), 1665–1667.

Marner, T. (2000). Letter to Children in Family Therapy. Jessica Kingsley Publisher.

Marková, I. (2007). Dialogičnost a sociální reprezentace. Academia.

Maturana, H. & Poerksen, B. (2004). From Being to Doing; The Origins of the Biology of Cognition. Carl Auer.

Maturana, H. & Varela, F. (2016). Strom poznání; Biologické základy lidského rozumu. Portál.

McAdams, D.P. (1988). Power, intimacy and the life story; Personological inquiries into identity. Guilford Press.

McAdams, D.P. (2000). The person; an integrated introduction to personality psychology (3rd ed.), Harcourt College Publishers.

McCarthy, J. (2003). Principlism or narrative ethics: must we choose between them? Journal of Medical Ethics: Medical Humanities, 29(2), 65–71.

McCarthy-Jones, S. Oestrich, L.K.L., Lyall, A.E. et al. (2018). Childhood adversity associated with white matter alteration in the corpus callosum, corona radianta and uncinate fasciculus of psychiatrically healthy adults. Brain Imaging Behavior, 2(2), 449-458,

MacCormack, T., Simonian, J., Lim, J., Remond, L., Roets, D., Dunn, S., & Butow, P. (2001). „Someone who cares.“ A Qualitative INvestigation of Cancer Patients Experiences of Psychotherapy. Psycho-Oncology, 10(1), 52-65.

McDaniel S, Doherty W, & Hepworth J. (2014). Medical family therapy and integrated care (2nd ed.), American Psychological Association.

McGowan, L., Luker, K., Creed, F., & Chew-Graham, C. A. (2007). How do you explain a pain that can´t be seen? The narratives of women with chronic pelvic pain and their disengagement with the diagnostic cycle. British Journal of Health Psychology, 12(2): 261-274.

McLeod, J. (1997). *Narrative and Psychotherapy*. Sage.

McLeod, J. (2004a). The significance of narrative and storytelling in postpsychological counseling and psychotherapy. In A. Lieblich, D.P.McAdams, & R. Josselson (Eds.) Healing plots; The narrative basis of psychotherapy (pp. 11-27). American Psychological Association.

McLeod, J. (2004b). Social Construction, Narrative, and Psychotherapy. In L. Angus, & J. McLeod (Eds.), The handbook of narrative and psychotherapy (pp. 351-366). Sage.

McLeod, J. (2006). Narrative thinking and the emergence of post-psychological therapies. Narrative Inquiry, 16(1), 201–210.

McLeod, J. (2007). Counselling Skill. Open University Press.

McLeod, J. (2010). Case Study Research in Counselling and Psychotherapy. Sage.

McLeod, J., & McLeod, J. (2011). Counselling Skills; A Practical Guide for Counsellors and Helping Professionals (2nd ed.), Open University Press.

McLeod, J. (2010). An Introduction to Counselling (4th ed.), Open University Press.

McNamee, S., & Gergen, K.J. (1992). Therapy as social construction. Sage.

Milota, M., G. J. M. W., van Thiel, G. J.M. W. & van Delden, J. J. (2019). Narrative medicine as a medical education tool: A systematic review, Medical Teacher, 41(7), 802-810.

Minuchin, S. (1998). Where is the family in narrative family therapy? Journal of Marital and Family Therapy, 24(4), 397-403.

Minuchin, S. (1974). Families and Family Therapy. Harvard University Press.

Misak, C. J. (2010). Narrative evidence and evidence-based medicine. *Journal of Evaluation in Clinical Practice*, *16*(2), 392–397.

Misra-Hebert, A.D., Isaacson, J.H., Kohn, M., Hull, A.L., Hojat, M., Papp, K.K., & Calabrese, L. (2012). Improving empathy of physicians through guided reflective writing. International Journal of Medical Education, 3, 71–77.

Montgomery, A. (2013). Neurobiology essentials for clinicians. W.W.Norton & Company.

Morgan, A. (2000). What is narrative therapy? An easy-to-read introduction. Dulwich Centre Publications.

Morgan, L. (2020). MDMA-assisted psychotherapy for people diagnosed with treatment-resistant PTSD: what it is and what it isn’t. Annals of General Psychiatry, 19(11), 1-7.

Morgan, N.P, Graves, K.D., Poggi, E.A., & Cheson, B.D. (2008). Implementing an expressive writing study in a cancer clinic. Oncologist, 13(2), 196-204.

Moyinihan, R. (2002). Selling sickness; the pharmaceutical industry and disease mongering. British

Medical Journal, 324(7342), 886-891.

Moncrieff, J. (2004). Is psychiatry for sale? Influence of the pharmaceutical industry on academic and practical psychiatry. Maudsley.

Newton, B.W., Barber, L., Clardy, J., Cleveland, E., & O'Sullivan, P. (2008). Is there hardening of the heart during medical school? Academic Medicine, 83(3), 244-249.

Neimeyer, R.A. & Tschudi, F. (2003). Community and Coherence: Narrative contributions to the Psychology of conflict and loss. In G.D. Fireman, T.E. McVay, O.J. Flanagan (Eds.) Narrative and Consciousness: Literature, Psychology and the Brain (pp. 166 – 194), Oxford University Press.

Neimeyer, R.A. & Levitt, H. (2011). Coping and coherence. In D. Snyder (Ed.) Stress and coping (pp. 47-67), Oxford University Press.

Parry, A., & Doan, E.R. (1994). *Story re-visions; Narrative therapy in the postmodern world*. Guilford Press.

Payne, M. (2006). *Narrative therapy; an introduction for counsellors (2nd ed.). Sage.*

Pennebaker, J.W. & Niederhoffer, K.G. (2002). Sharing one´s story; On the benefits of writing or talking about emotional experience. In G. Snyder, & J.S. Polez (Eds.), The h*andbook of positive psychology*. Oxford University Press.

Pennebaker, J.W. & Seagal, J.D. (1999). Forming a story; Health benefits of narrative. Journal of Clinical Psychology, 55, 1243-1254.

Pinsof**,** W. M., Breunlin, D., Russell, W. P., Lebow, J. L., Rampage, C., & Chambers, A. L. (2017). Integrative systemic therapy: Metaframeworks for problem solving with individuals, couples, and families. American Psychological Association.

Pikren Valenti, M. & Mehl-Madrona, L. (2010). Humanizing patients through narrative approaches: The case of Murphy, the "motor-mouth". The Permanente Journal, 14(2), 47-50.

Pocock, D. (1997). Feeling understood in family therapy. *Journal of Family Therapy, 19(3)*, 283-302.

Pocock, D., & Flaskas, C. (2006) Family therapy beyond postmodernism; Practice challenges theory. Routledge

Polakovská, L., & Řiháček, T. (2021). What is it like to live with medically unexplained physical symptoms? A qualitative meta-summary. Psychology & Health, 19, https://doi.org/10.1080/08870446.2021.1901900

Polkinghorne, D.E. (1988). *Narrative knowing and the human sciences*. State University of New York Press.

Popper K. (1959). Conjectures and refutations: the growth of scientific knowledge. New York: Routledge and Kegan Paul.

Poněšický, J. (2012). Úvod do moderní psychoanalýzy. Triton.

Poněšický, J. (2021). Proces změny v dynamické psychoterapii a psychoanalýze. Kosmas.

Priddis, L.E., & Howieson, N.D. (2010). Narrative as a window to the inner world of young children: attachment representations, affect, and memory. Journal of Early Childhood Research, 8(2),161-174

Prochaska, O.J., Norcross, C.J. (1999). *Psychoterapeutické systémy; Průřez teoriemi*. Grada.

Osatuke, K., Glick, M. J., Gray, M. A., Reynolds, D. J., Jr., Humphreys, C. L., Salvi, L. M., & Stiles, W. B. (2004). Assimilation and narrative: Stories as meaning bridges. In L. Angus, & J. McLeod (Eds.), *The Handbook of narrative and psychotherapy (pp. 193-210)*. Sage.

Rakel, D., Barett, B., Zhang, Z. et al. (2011). Perception of empathy in the therapeutic encounter: effects on the common cold. Patient Education Counselling, 85(3), 390-397.

Rapley, M., Moncrieff, J. & Dillon, J. (Eds.). (2011). De-medicalizing misery; psychiatry, psychology, and the human condition. Palgrave.

R Core Team (2020). R: A language and environment for statistical computing. R Foundation for Statistical Computing, Vienna, Austria. Retrieved from https://www.R-project.org/.

Redfield Jamieson, K. (1996) An Unquiet Mind. Vintage Books.

Reis, S.R., Wald, H. S., Monroe, A.D., & Borkan, J.F. (2009). Begin the BEGAN (The Brown Educational Guide to the Analysis of Narrative) – A framework for enhancing educational impact of faculty feedback to students' reflective writing. *Patient Education and Counselling,* 80(2), 253 -259.

Ricoeur, P. (1984). Time and Narrative: Volume 1. University of Chicago Press.

Rich, A, Viney, R., Needleman, S., Griffin, A., & Wolf, K. (2016). 'You can't be a person and a doctor': the work–life balance of doctors in training—a qualitative study. BMJ Open, 6(12), e013897.

Rieffestahl, A.M., Risør, T., Mogensen, H. O., Reventlow, S., & Mette Morcke, A. (2020). Ignitions of empathy. Medical students feel touched and shaken by interacting with patients with chronic conditions in communication skills training. Patient Education and Counselling, 104(7), 1668-1673.

Rivett, M., & Street, E. (2010). Family therapy; 100 key points and techniques. Routledge.

Rolland, J. (2018). *Helping couples and families navigate illness and disability; An integrated approach*. Guilford Press.

Roscoe, K.D., Carson, A.M. & Madoc-Jones, L. (2011). Narrative social work: conversations between theory and practice. Journal of Social Work Practice, 25(1), 47–61.

Riessman, C.K. & Quinney, L. (2005). Narrative in social work: a critical review. Qualitative Social Work, 4(4), 319–412.

Rucker, J. H. (2015). Psychedelic drugs should be legally reclassified so that researchers can investigate their therapeutic potential. *British Medical Journal*, 350:h2902.

Russell Crane, D. & Marshall, S.E. (Eds.). (2005). Handbook of families and health; Interdisciplinary perspectives. Sage.

Sacks, O. (1985) The man who mistook his wife for a hat. Touchstone.

Sackett, D.L., Rosenberg, W.M.C, Gray, J.A.M, Haynes, R.B, & Richardson, W.S. (1986). Evidence based medicine: what it is and what it isn't. British Medical Journal, 312(7023): 71–72.

Sandars, J. (2009). The use of reflection in medical education: AMEE Guide No. 44. Medical Teacher, 31(8), 685–695.

Sands, S.A., Stanley, P., & Charon, R. (2008). Pediatric narrative oncology interprofessional training to promote empathy, build teams, and prevent burnout. Journal of Supportive Oncology, 6(7), 307–12.

Savidge, C.J., Slade, P., Stewart, P., & Li, T.C. (1998). Women´s perspectives on their expeirences of chronic pelvic pain and medical care. Journal of Health Psychology, 3(1), 103-116.

Sarbin, T. R. (1986). The narrative as root metaphor for psychology. In: T.R. Sarbin (Ed.), Narrative psychology: The storied nature of human conduct (pp.3-21), Praeger.

Seikkula, J. & Arnkill, T.E. (2006). Dialogical meetings in social networks. Karnac Books.

Sexton, T.L., Alexander, J.F., & Leigh Mease, A. (2004). Levels of evidence for the models and Mechanisms of therapeutic change in family and couple Therapy (pp. 590-676). In M. Lambert (Ed.), Bergin and Garfield´s handbook of psychotherapy and behavior change (5th ed.), John Wiley & Sons.

Sexton, T.L., Datchi, C., Evans, L., LaFollette, J., & Wright, L. (2013). The effectiveness of couple and family-based clinical interventions, 587-639. In M. Lambert (Ed.), Bergin and Garfield´s handbook of psychotherapy and behavior change (6th ed., pp. 587-639). John Wiley & Sons.

Shapiro, J., Coulehan, J., Wear, D., Montello, M. (2009). Medical humanities and their discontents: definitions, critiques, and implications. Academic Medicine, 84(2), 192–198.

Shapiro, J., Rucker, L., Boker, J., & Lie, D. (2006). Point-of-view writing: A method for increasing medical students' empathy, identification and expression of emotion, and insight. Education and Health, 19(11),96–105.

Shem, S. (2010). The house of god. Berkley.

Schafer, R. (1994): Re-telling a life. Basic Books.

Schore, A. (2012). The science of the art of psychotherapy. W.W. Norton &.

Schore, A. (2015). Affect regulation and the origin of the Self. Routledge.

Siegel, D. (2012). *The Developing Mind (2nded.).* Guilford Press.

Siegel, D. (2020). *The Developing Mind (3nded.).* Guilford Press.

Slife, B.D. (2004). Theoretical challenges to therapy practice and research: The constraint of naturalism. In M. Lambert (Ed.), Bergin and Garfield´s handbook of psychotherapy and behavior change (5th ed., pp. 44-84), John Wiley & Sons.

Skorunka, D. (2009). Životní příběhy jako základ psychosomatické medicíny. *Psychosom*, 2009, 7(1), 24-44.

Skorunka, D. (2010a). Narativita a psychoterapie. In Z. Vybíral, & J. Roubal, J. (Eds.), Současná psychoterapie (pp. 561-583). Portál.

Skorunka, D. (2010b): Rodinná terapie. In Z. Vybíral, & J. Roubal, J. (Eds.), Současná psychoterapie (pp. 235-269). Portál.

Skorunka, D. (2011a): Duševní nemoc; subjektivní perspektivy a faktory, které je formují. In J. Mareš, & E. Vachková (Eds.), Pacientovo pojetí nemoci III. (pp. 53-74). MSD.

Skorunka, D. (2011b). Psychoterapeutický přístup v medicíně. *Praktický lékař* 91(12):718-722.

Skorunka, D. (2012). Narativní perspektiva v medicíně. *Praktický Lékař*, *92*(7), 383–389.

Skorunka, D. (2016a). Narativní tónina v psychoterapii; od psychologické k post-psychologické perspectivě. *Československá psychologie, 60(5)*, 482–499.

Skorunka, D. (2018). Pacient má rodinu! Individualizovaná péče v systemickém pojetí. Praktický lékař, 98(1), 18-25.

Skorunka, D. (2019). Mental health; Arguments for integrative bio-psycho-social model. Psychiatria – Psychoterapie - Psychosomatika, 26(4), 10-18.

Skorunka, D. (2020). Lékaři v médiích aneb stojí výroky kolegů za pozornost, souhlas či polemiku? Netradiční úvaha o psychosomatické medicíně. In D. Stackeová (Ed.) *Psychosomatická medicína – nástroje psychosomatické léčby (pp. 60-91).* Palestra.

Skorunka, D., Keřkovská, T., & Řiháček, T. (2021). *Narrative sensitivity in medical students: A mixed-method exploration*. Manuscript submitted for review.

Slade, A. (2016). Attachment and adult psychotherapy: theory, research, and practice. In J. Cassidy, & P. Shaver (Eds.), *The handbook of attachment* (3rd ed., pp. 759-779). Guilford Press.

Smyth, J.M. Stone, A.A., Hurewitz, A., & Kaell, A. (1999). Effects of writing about stressful experiences on symptom reduction in patiens with astma or rheumatoid arthritis; A randomized trial. *JAMA, 281(14),* 1304-1309.

Smyth, J.M., True, N., & Souto, J. (2001). Effects of writing about traumatic experience:the necessity for narrative structuring. *Journal of Social and Clinical Psychology* 20(2), 161-172.

Snyder, T. (2020). Our malady; lessons in liberty and solidarity. The Bodley Head.

Sokol, J. (2021). Odvaha ke svobodě. Vyšehrad.

Spence, D. (1984). Narrative truth and historical truth. W.W. Norton & Company.

Spiro, H.M., McGrea Curnen, M.G., Peschel, E., & St. James, D. (1993). Empathy and the Practice of Medicine: Beyond Pills and the Scalpel. Yale University Press.

Stackeová, D. (2018). Zpráva o současném stavu výuky psychosomatiky na vysokých školách v ČR. Psychosom, 16(4), 244-247.

Stanley, P. & Hurst, M. (2011). Narrative palliative care: a method for building empathy. Journal of Social Work in End-Life and Palliative Care, 7(1), 39–55.

Stojan, J.N., Sun, E. Y., & Kumagai, A. K. (2019). Persistent influence of a narrative educational program on physician attitudes regarding patient care. Medical Teacher, 41(1), 53-60.

Stratton, P., Carr, A. & Schepisi, L. (2020). The SCORE in Europe: Measuring effectiveness, assisting therapy. In M. Ochs, M. Borcsa, & J. Schweitzer (Eds.), Linking systemic research and practice – Innovations in paradigms, strategies and methods (pp. 367-384). (European Family Therapy Association Series, Volume 4). Springer International.

Tantam, D. (2007). Psychotherapy and counselling in practice: A narrative framework. Cambridge University Press.

Teicher, M. H., Samson, J. A., Anderson, C. M., & Ohashi, K. (2016). The effects of childhood maltreatment on brain structure, function and connectivity. Nature Reviews Neuroscience, 17 (10), 652–666.

Trapková, L. & Chvála, V. (2017). Rodinná terapie psychosomatických poruch. (2. vydání). Portál.

Van Deurzen, E. (2001). Existential counselling and psychotherapy in Practice. Sage.

Van Deurzen, E. & Adams, M. (2010). Skills in existential counselling and psychotherapy in practice. Sage.

Van der Kolk, B. (2015). *The body keeps the score: brain, mind, and body in the healing of trauma*. Penguin Books.

Van Gennep, A. (1997). Přechodové rituály. Lidové noviny.

Von Schlippe, A. & Schweitzer, J. (2001). *Systemická terapie a poradenství*. Cesta.

Von Sydow, K., Schweitzer, J. & Retzlaff, R. (2010). The Efficacy of Systemic Therapy With Adult Patients: A Meta-Content Analysis of 38 Randomized Controlled Trials. Family Process, 49(4), 457-85.

Vromans, P.L. (2005). A Narrative approach to therapy: Guiding principles and practice. Unpublished manuscript. Queensland University of Technology.

Waite, R. & Ryan, R.A. (2019). Adverse childhood experiences: What every students and health professionals should know. Routledge

Wampold, B. (2001). The great psychotherapy debate (1st ed.). Routledge.

Wampold, B., Imel, Z. (2015). The great psychotherapy debate (2nd ed.). Routledge.

Wallin, D. (2015). Attachment in Psychotherapy. Routledge.

Wald, H.S. & Reis, S.P. (2010). Beyond the margins: reflective writing and development of reflective capacity in medical education. Journal of General Internal Medicine, 25(7), 746–9.

Wald, H.S., Reis, S. P., Monroe, A.D. & Borkan, J.M. (2010). 'The Loss of My Elderly Patient:' Interactive reflective writing to support medical students' rites of passage. Medical Teacher, 32(4), 178-184.

Wilks, T. (2005). Social work and narrative ethics. British Journal of Social Work, 35(8), 1249–1264.

Wiseman, H. & Barber, J. (2004). The core conflictual relationship theme. Approach to relational narratives: Interpersonal themes in the context of intergenerational communication of trauma. In A. Lieblich, D. P. McAdams, R. Josselsson (Eds.) Healing Plots; The Narrative Basis of Psychotherapy (pp. 151-170). American Psychological Association.

White, M. (2007). Maps of narrative practice. W. W. Norton & Company.

White, M., & Epston, D. (1990). Narrative means to therapeutic ends. W. W. Norton & Company.

Woods, A. (2011). The limits of narrative: provocations for the medical humanities. Medical Humanities, 37(2), 73–78.

Yalom, I. (2017). Becoming myself; A psychiatrist´s memoir. Basic Books.

Yu, M. (2017). When I say ... narrative competence. Medical Education, 51(12), 1203–1205.