

A narrative-based approach

Introducing narrative thinking

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In this regular column I aim to explore the new and expanding field of narrative-based psychology and psychiatry.^{1,2} This article offers a basic introduction to the field.

The word 'narrative' itself simply means a story – not in the sense of something childish or untrue, but referring to our fundamental need as human beings to make sense of the world through telling stories to each other about our experiences.³

The drive toward narrative thinking comes from many different influences, but especially from the social sciences.^{4,5} Nowadays, sociologists and anthropologists have largely moved away from trying to describe the solid 'facts' of people's lives and have focused instead on how people reach agreed descriptions of reality within their cultures or their communities. They have paid increasingly close attention to the words or types of discourse that people use in trying to describe their own experiences. They have tried to make sense of these words in the speakers' own terms rather than in the listeners' terms. To put it another way, most social scientists have probably moved away from the idea that exploring reality is like peeling away the layers of an onion, looking for the 'inner meaning' or 'underlying truth' concealed at the centre. Instead, they have started to think of reality in different terms – more like a tapestry of language that is continually being woven and re-woven.

As well as helping to make sense of the different discourses that people use in their everyday lives, narrative ideas have also been used as a way of understanding human belief systems such as medicine, psychiatry or psychoanalysis. Indeed, many commentators now refer to medicine and biomedical science as types of 'grand narrative', sanctioned more by power and popularity than necessarily by intrinsic worth.⁶ In other words, each can be seen as a kind of discourse that is held together by a shared commitment to persuading others of the efficacy or truthfulness of its story. According to this view, psychiatry and medicine can best be understood as an agreed set of 'professional stories' that we try to fit to the personal narratives that people bring us.⁷

Alongside this shift in academic thinking there has been a shift in public attitudes to professional knowledge and authority, which mirrors the 'narrative turn' in the academic world. For example, there has been a greater readiness in society at large to hear a range of different voices, including voices that dissent from 'dominant discourses' such as medicine, psychiatry and other conventional discourses.⁸ These alternative voices have been represented by such movements as feminism, multiculturalism, gay and lesbian rights movements, complementary medicine, disability rights movements, and patients' groups. The people who belong to such movements or sympathise with them have alternative stories to tell. They are no longer prepared to have these ignored or disqualified by more 'official' voices.

In the last ten years many mental health professionals have inevitably come under the influence of such ideas, both from the academic world and through wider social change. Many clinicians are now moving away from 'normative' ways of understanding people to 'narrative' ones.⁹ Rather than believing they should tell people what is wrong with them and what to do about it, they have become more concerned with hearing and validating people's stories about themselves, and offering conventional diagnoses and recommendations – if at all – in a much more tentative or negotiable way, not as 'truths' or 'solutions'.¹⁰

The advantages of taking a narrative approach to mental health are clear.¹¹ This is especially true in primary care, which in so many ways sits at the crossroads between 'biological' and 'biographical' ways of understanding the world. For example, a narrative approach can free doctors, nurses and other professionals from misguided or paternalistic attempts to 'sell' official or inflexible views of how the mind works and might be altered. It can lead them to become more observant and analytical of their own world views and therefore more open to changing themselves. It can extend the practitioner's ability to listen to stories that draw on radically different personal or cultural perceptions and assumptions, and help them to work with these rather than imposing their own presuppositions.

Perhaps most usefully, it can liberate them from attempts to be 'Dr Fixit' with answers to every question and solutions to every problem. Instead, it can encourage them to take a more dispassionate and facilitative stance in helping patients construct new stories for themselves.¹²

At the same time, narrative thinking has its limits. Unlike academic researchers, mental health professionals including general practitioners have to deal with dangers and risks to self and to others. We work within concrete institutional, social and political structures that rightly hold us to account for our technical and ethical standards. If we are to take narrative ideas seriously, we will each need to hold these in creative tension with a sense of reality about 'the bottom line': suffering, deprivation, and death. Probably no practitioner nowadays can entirely ignore the power of narrative ideas, but equally no-one can work entirely within a narrative framework, turning a blind eye to such facts of life as evidence and natural science. We will need to make choices about how to position ourselves on the scale between the narrative and normative views of the world. Probably for most of us, this position will change from day to day, and indeed from circumstance to circumstance, and from moment to moment.

In subsequent articles I shall be addressing the subject of how to make practical use of narrative ideas in consultations and in encounters with colleagues, and how to negotiate some of the grey areas that so often appear in primary care between stories and science.

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