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A narrative stance in consultation

Taking a narrative stance in the consultation

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In the previous issue of *Primary Care Mental Health* I gave a brief account of what it means to take a narrative-based approach to psychology and psychiatry.[1] In this article I want to look at ways of putting a narrative-based approach into practice in the primary care consultation.

Being a narrative practitioner is in some ways more like being an ethnographer than a pure clinician. Just like social scientists, narrative practitioners try to explore and develop the patients' own understanding of their stories, rather than measuring these up against any pre-ordained or conventional version of what is and is not normal. Their chief priority is to establish how patients assign meaning to their own experiences, and how they construct their realities.[2] The personal beliefs of the patient and family will often play a crucial part in these constructions, but so will other contexts such as gender, religion and culture.[3] By contrast, diagnostic categories or professional belief systems are not seen as overriding.[4]

The simpler elements of narrative practice will already be familiar to most people who work in primary care. In fact, they may use them intuitively a lot of the time without necessarily thinking of them in narrative terms. Consider, for example, these two possible openings to a fairly typical consultation with a GP:

Version A:

Patient: I've come about the spots on my face.
Doctor A: How long have they been there?
Patient: I've had them since I was a teenager. But they've really broken out badly in the last few months.
Doctor A: Have you tried anything for them?
Patient: I've bought a few things at the chemist, but nothing seems to work.
Doctor A: Well, let's have a look then ...

Version B:

Patient: I've come about the spots on my face.
Doctor B: How long have they been there?
Patient: I've had them since I was a teenager. But they've really broken out badly in the last few months.
Doctor B: Do you have any idea why?
Patient: I'm not sure. Could it be stress?
Doctor B: Why do you ask?
Patient: Well I lost my job about six months ago, and then my boyfriend left me in the summer and I've been pretty low generally and ... (starts to cry).

One way of looking at these contrasting responses is simply to see the first consultation as more 'doctor centred' and the second as more 'patient centred' but this may be an inadequate description of what is going on.[5] After all, Doctor A could reasonably claim to be addressing the patient's explicit agenda by looking at her spots. Indeed, one cannot be certain that the patient came in initially with the hope or wish of talking about anything else. Nevertheless, it is clear that by keeping to a 'normative' consulting stance that gives primacy to diagnosis and treatment, the doctor is actually avoiding any attempt whatsoever at narrative expansion. As a result, he ends up by providing the patient with a relatively impoverished oppor-tunity in terms of the possible exploration of her story.

From a narrative point of view, Doctor B (by contrast) is clearly able to defer his concern about diagnosis and treatment, in order to stimulate a fuller and more comprehensive story. As a result, both the doctor and the patient are rewarded with a far more revealing human encounter, and one that most practitioners would recognise as containing more potential for helping the patient with a range of interconnected physical and emotional difficulties. His preference for eliciting an extended narrative does not rule out the possibility of offering the patient a formal diagnosis of her skin condition later on if he wants to, or from giving her exactly the same prescription for her spots that Doctor A might have done. What makes the difference here is not so much being 'patient centred' as 'story centred'.

As Doctor B's behaviour shows, putting a narrative stance into practice involves a kind of friendly but focused investigation into what is actually being said. The practitioner stays close to the words and phrases that patients are using, but actively questions them in order to generate more complex descriptions of what is happening. He then encourages them to follow whatever seems to be fuller in meaning or most helpful. This goes beyond 'just listening', and certainly far beyond encouraging repetitive, ruminative, or stereotypical accounts of patients' problems. Instead, there is a constant move towards producing and amplifying alternative accounts of reality that seem more likely than others to promote change. Incidentally, this kind of approach differs from traditional person-centred counselling, since one is actively using questions to seek out possibilities for change in the narrative.[6] It is also different from many psychotherapeutic approaches, since it can be used even in very brief consultations and does not necessarily depend on interpretations or a theory of the unconscious mind.[7]

Practitioners who pursue a narrative-based approach in their everyday work, either by intuition or through training in interview techniques, may be promoting the emotional growth and mental health of their patients. A range of psychological research shows that there seems to be a close and reciprocal connection between the quality of people's attachments to significant figures in their lives, from childhood onwards, and their capacity to articulate coherent, authentic and flexible accounts of their experiences.[8] So whenever practitioners invite patients to move on from trite, superficial or fragmented stories about their problems and instead to express more subtle and emotionally mature ones, they may be helping them not only to speak about themselves in a different way but also to relate to others differently.

In the next article in this series I shall be looking at some specific questioning techniques that can help practitioners to call forth richer and more productive narratives from their patients.

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