

A narrative-based approach

The narrative consultation in action

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In the fourth article in this series, I want to give an account of a consultation conducted on narrative-based principles. Ideally, this should take the form of a transcript. However, these can be lengthy and hard to read, and may breach confidentiality. The most satisfactory way of describing such a consultation is probably by giving a 'fictive' account. Such an account combines recollections of several different patients for didactic purposes.¹ In the fictive account that follows, I give a description of a consultation, interspersed with a commentary. One cautionary note is necessary: this is a description of only one way of using narrative ideas, as practised by one general practitioner (GP) working with a particular kind of patient, in a particular context. Nothing here should be understood as definitive, and there are other ways of applying narrative ideas in practice.²

The patient is a middle-aged man who comes with a diagnosis of schizophrenia. I see him monthly in the surgery and have done so for years. About four times a year he sees a community psychiatric nurse. Twice a year he also sees a psychiatrist who reviews his oral medication and writes me a short letter saying whether or not the dose is to remain the same. I regard my own consultations with the patient as an opportunity for some regular if brief human contact, which may be important as he is isolated socially. The consultations also function as a safety net in case he ever needs some more formal kind of protection.

Commentary: I am careful to say that my patient 'comes with a diagnosis of schizophrenia'. As a narrative practitioner I regard this description, like all diagnoses, as itself part of a narrative: the 'grand narrative' of psychiatry.³ I try to stay aware of this official narrative, but I also try not to be dominated by it. In particular, I try not to pre-judge his utterances or behaviour by testing them against any particular description about who or what he is, unless I believe that he is putting himself or me at risk. In ten years this has never happened.

The patient comes in and sits down in silence for a few minutes as usual. He grimaces, then stands up and paces around the room for a while, then sits again. After a while, I ask him: 'How are things?' He suddenly makes eye contact with me, hostile for a moment, and then shakes his head solemnly to indicate that things are not all right.

Commentary: What on earth is 'narrative' about this encounter? The answer is: nothing, as yet. Practitioners with many different approaches might behave exactly as I have done. However, in my own mind I am already trying to do two particular things. One is to suspend any judgement about the normality or abnormality of how he is acting; I accept that, for him, this silence and bodily communication is a normal mode of making contact. I am also trying to create a space for him to start his own verbal narrative whenever and however he wishes.

He starts to tell me about the women who have been visiting his house at night. They knock on the door, and when he does not answer they climb up on the roof. I ask for more detail. I invite him to speculate about who they are and why they have come. He gives me a vivid description of their appearance, and tells me that they have been sent by neighbours who want to get rid of him because they think he is weird.

Commentary: I assume these women are imaginary in the conventional sense, but from a narrative point of view I am not hugely bothered. To him they are real: his world has been peopled by such presences for as long as I have known him. When professionals have increased his medication to dispel such presences, the consequences have always been worse. Attempts to persuade him that certain aspects of his stories are 'true' while others are 'untrue' have been equally unproductive. From my own perspective, I am more interested in validating his account by hearing it and by active curiosity.⁴ This approach has much in common

with critical psychiatry or 'postpsychiatry'.⁵ However, it is also based on the belief that sympathetic inquiry into such stories enables people to develop better trust in professionals, and to explore their own solutions to their own predicaments.⁶

Having given me more details about his neighbours and the women they have dispatched in order to torment him, he suddenly looks at me again and says: 'They never should have invaded, should they?' I ask him for clarification. He is speaking about Iraq and the coalition army. We then have several minutes of entirely 'normal' social conversation about his strong belief that Britain and America should not have invaded another country.

Commentary: If I was a conventionally minded psychiatrist or GP, I might celebrate the fact that my 'tolerance' of his earlier psychotic story had allowed him to find an island of 'sanity' from which to function. If I was a psychoanalyst, I might offer an interpretation that his 'delusion' about the women on his roof, together with his 'preoccupation' with the war in Iraq, represented his psychotic experience of being invaded by hostile elements projected from his own psyche. In fact, I choose to regard this part of the conversation exactly as I do the previous one: neither right nor wrong. It is his story, and he may take it where he wishes.

We talk about Iraq a bit longer. We approach the end of the consultation time and I ask him whether we can wind up for today. Once again, he looks directly at me and asks: 'Do you think I should go up on the roof and try and get rid of them?' I reply: 'I wouldn't recommend it'. He smiles slightly,

perhaps recognising that my comment, as always, is entirely non-committal about the 'truth' of his narrative. He says: 'Thank you' and leaves.

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