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A narrative-based approach

Uncertainty and not knowing: making space for multiple stories

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Here is an imaginary case, although it will probably not seem too imaginary for anyone working in primary care or mental health. I want to use the case to illustrate a crucial aspect of taking a narrative-based approach in psychiatry and psychology: namely, the importance of uncertainty, or of not knowing, in listening to the accounts of the symptoms and circumstances that patients bring to us.

A chronically depressed woman always comes to your clinic accompanied by her husband. The husband appears, at every consultation, to be immensely solicitous of her welfare, and he often pressurises you with questions. Is there nothing more that can be done to help her, he will often ask: no further increase in the dose of her antidepressant, no change of medication, no psychological approach that has not already been tried?

One day, the woman arrives at your clinic not with her husband but with her 18-year-old son instead. Her husband, it appears, has now run off with a younger woman. Trying to find out what has been going on, the son has gone through his parents' bank and credit card records. As a result, it has become clear that the affair is not just a recent one. In fact, the father appears to have been leading a double life for some years. Weekends spent away 'on business' actually took place in romantic resorts, with lavish spending on meals, clothes and entertainment. The father was even paying a second mortgage on a house in another part of town, where he has now moved with his girlfriend.

Of course, all is now clear to you. In your mind, the previous narrative (inexplicably afflicted wife and caring husband) has been replaced by a new one (cruel adulterer and betrayed family). The woman's depression is now comprehensible in a different way: perhaps she half guessed what was going on, or perhaps she was simply destabilised by the mixed messages and false emotions her husband was displaying. You can also see his solicitous behaviour in a new light too: as over-compensation, or indeed as mere play-acting.

But pause for a moment, and consider how your description of the case might be altered by discovering one or more of the following new facts in the story:

1 The husband's new girlfriend has multiple sclerosis. It is deteriorating, and he feels he now needs to be with her as a carer.
2 The wife herself had an affair many years ago. Her husband has recently found out that his son was probably not his own after all.
3 One of the parties (choose which one) has become involved in a tax evasion scam, or in a revivalist Christian sect, or in running a play scheme for mentally handicapped children, and so on ...

What I hope this brief exercise in story-telling demonstrates is the universal wish we all have to describe our experience in consistent narratives. Every time a new 'fact' emerges, all the other elements will be rearranged in order to sustain the coherence of the story. Previous versions of the story will now be understood to be incomplete, or incorrect. In all likelihood, they will be totally forgotten.

In this case, all the parties concerned in these events (the husband and wife, the girlfriend and the son) will no doubt wish at any moment to tell a good story that presents their own position favourably and, as far as possible, justifies their own actions. But in addition, the professionals who come into contact with them will also try to make sense of what is going on. Almost inevitably, they will do so – whether in their own minds or in presenting an account to others – in a form that bears a remarkable resemblance to literature. In other words, it will have character, times, places, plot, suspense, motivation, moral positions, and above all coherence.[1]

What determines how we each choose to describe the people and events that we come across? Personal

values and beliefs certainly play an important part. It is not hard to imagine, for example, that a woman general practitioner (GP) or psychiatrist who had herself been betrayed in a relationship might give a quite different account of this case from a male colleague who had a strong belief that most married men with a healthy sexual drive would be tempted to err at some time or another. Such beliefs could serve to hold together a preferred narrative, even when new facts emerge that might otherwise challenge its plausibility. There may be a resistance to holding onto a narrative that contains ambiguities, contradictions, or mysteries.

Beyond such personal influences there are also the 'grand narratives' that determine how we understand events: strong cultural streams which dictate the kinds of stories that we deem to be true at any particular time and within any specific milieu. Thus, it is not hard to imagine a 'hard line' organic psychiatrist telling a narrative of the case in which all the biographical details in this case were rendered of no account by comparison with the forces of genetics and brain biochemistry. Equally, a psychoanalyst might produce a version of the story where current events were eclipsed in favour of the early life histories of those involved.

Going beyond such grand narratives, we enter the wider realm of universal human rules concerning good stories: rules that dictate (among other things) that a story should unfold gradually over time, that people should speak and interact, that events should take place, and that these should all have an effect, and throw up problems and possibly solutions.[2]

Clinically, an understanding of our drive to construct narratives, and an awareness of our own narrative preferences are important because they can act as a useful corrective against excessive certainty or dogmatism. Instead of always favouring particular kind of stories (for example, stories that are based exclusively on biochemistry, biography, biology, gender or moral choice), we can become aware of the potential for multiple readings, and multiple constructions, of any set of circumstances. We can choose instead to suspend ourselves imaginatively in a space where we allow people to generate their own understanding of what is happening to them, in a way that is not dictated by our professional and personal prejudices. This is not to say that we should not have, or even express, views and explanations that arise from specialist knowledge or moral values – so long as we make it clear to ourselves, and our patients, that these are not immutable truths. They are our own stories, no more and no less.

REFERENCES

1 Bruner J (2003) *Making Stories: law, literature, life.* Cambridge: Harvard University Press, 2003.

2 www.press.jhu.edu/books/hopkins_guide_to_literary_theory/narratology.html (accessed 15 August 2005).

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