Narratives and therapy

I enjoyed reading the various Commentary articles on storytelling and narrative medicine in the August 2007 issue of *Canadian Family Physician* (pages 1265-89). The articles illustrated the wonderful integration of disciplines in family medicine—anthropology to spirituality, biological approaches to psychosocial-cultural-spiritual approaches. The use of narrative underlines the importance of teaching behavioural science in medical training.

The authors, however, did not fully elaborate on the origin of narratives and the development of narrative therapy. This is an area I am passionate about, and I hope my sharing will add to their contributions. While Charon said that she and her colleagues brought narrative into the medical discipline in 2000, its origins are much earlier and are rooted in the philosophy of social constructivism. Social constructivism started in the second half of the 20th century, in the postmodern age. The previous modernist worldview claimed that knowledge was objective and fixed and that human beings could learn this knowledge and thus find answers to everything in the world. In the postmodern age, where we find ourselves, people believe that knowledge is not objectively learned but is subjective and socially constructed. Therefore knowledge and the knower are interdependent. To acquire knowledge, the knower will have to understand the interrelationship of context, culture, language, and personal experience. People are able to derive meaning from their subjective experiential world. Their stories or narratives about their experiences, problems, and concerns are ultimately more important than determining whether objective facts support their beliefs.

The early pioneers of narrative medicine include Harry Goolishian and Harlene D. Anderson.[1,2,3] They developed the constructivist theory in the 1970s at the University of Texas Medical Branch. Their primary focus was on understanding the client's worldview and values through his or her use of language. Psychotherapists tried not to impose their own language but rather would adapt to clients' points of view. The client would subsequently feel understood and would be willing to make changes on his or her own. In therapy, the client and therapist worked together and communicated in a common language familiar to the client. Together they created a meaning-generating system. They talked *with* each other instead of *to* each other. The therapist assumed a "not-knowing" stance, willing to be informed by the client of his or her situation.

In the early 1990s, Michael White in Australia and David Epston in New Zealand further developed these concepts and established narrative therapy.[4,5] They adopt an approach that recognizes that each person's life is a story in progress that can be viewed from a variety of perspectives and that can have any number of outcomes. The counselor attempts to understand the problems the client faces from the client's perspective. Change occurs when the counselor and the client, working together, find new and alternative ways of looking at things and explore new possibilities about life and the way the client relates to others.

So how do we apply this in family medicine?

I have been advocating that family doctors should include counseling in their practices.[6] They are in a unique position to help patients change. In medicine there are many ways to help our patients. At one end of the spectrum there is science, objective and precise. Take the case of a patient presenting with an acute abdomen: we know exactly what to do—perform proper investigations, establish the diagnosis, and then, for example, consult the surgeon to have the inflamed appendix removed. At the other end there is art, with psychosocial, cultural, and spiritual dimensions. This is where narrative therapy belongs. It takes time and involves the art of listening and understanding patients in their contexts. Family physicians are trained in both the science and the art of medicine in order to serve their patients well. Therefore, family doctors realize the interrelatedness of the biopsychosocial approach and the roles they need to assume in managing patients and their families. They do not just provide diagnoses, physical healing, and disease eradication. They also journey with patients suffering from chronic diseases, psychiatric illnesses, personal problems, and issues accompanying death, dying, and relationships. These conditions interfere with normal physical, psychological, and social functions. When family physicians fully understand the perspectives and circumstances of patients, they can more effectively help them to process and accept what is happening to their bodies and work with them to find alternative ways of perceiving their situations. Patients can then continue to write their life scripts and stories. Physicians can also explore spiritual meaning with patients and their families. This can bring hope and new perspectives to difficult life situations. When family physicians integrate these things into their practices, they will be able to use both the science and the art of medicine to serve patients and their families in a holistic way. I believe physicians themselves would also benefit in their own life storytelling by adopting this mode of narrative medicine.

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4. White M. *Re-authoring lives: interviews and essays.* Adelaide, Australia: Dulwich Centre Publications; 1995.
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Kudos

I am retired now after 42 years in rural practice, which covered all aspects of medicine including obstetrics, anesthesia, critical care, emergency room coverage, and regular office hours, plus geriatric care at a large nursing home. Now I have time to reflect, thank goodness! I enjoyed the article on narrative medicine by Dr Rita Charon[1] and certainly think that such programs are effective and necessary for any medical student. It's too bad this wasn't covered back in the early 60s when I graduated from Queen's University in Kingston, Ont.

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Well put

I am still stunned. All that I came to realize after practising and teaching family medicine for 26 years, the essence of what I have been struggling to achieve in my career, everything was articulated perfectly by Dr Charon: "The writing renders the … treatment a healing conversation between [doctor and patient]. Until the writing, there are 2 isolated beings … both of whom suffer, and both of whom suffer alone."[1]

I just finished reading the summer story issue of *Canadian Family Physician* (August 2007), and that spark of enthusiasm was all I needed to finally get in touch with Dr Charon. I first encountered the formal term of narrative medicine in an article she wrote for the *New England Journal of Medicine* in February 2004 and again a year later in her article honouring Susan Sontag. Ever since, I have been fantasizing about taking a sabbatical at Columbia, but I felt I would be crippled by my lack of knowledge of the English language; and in those matters of creativity (to state the corollary of what Boileau once said), if one cannot express oneself clearly, one just cannot think. Maybe it would be more realistic to start by attending one of Dr Charon's seminars or intensive training workshops at Columbia University. I would appreciate direction to a specific website that would provide me with the appropriate information.

Purely as a dilettante, I started writing articles on how to better understand the practice of family medicine in light of what art, science, and literature have to convey. Last winter I spent all my weekends wrestling with Chekhov in quantum mechanics. This year I intend to tackle the immense achievement of Albert Camus and particularly his notions of absurdity and revolt. (As an anecdote, did you know that Camus went to Columbia in the spring of 1946 and gave a conference in the MacMillan auditorium? He was then introduced as Albert Camoose!) I want to thank Dr Charon for her contributions to the summer story issue.

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For information on training workshops in narrative medicine at Columbia University in New York, NY, please visit **www.narrativemedicine.org**.

Response

I appreciate the thoughtful correspondence I have received in response to my August 2007 essay entitled "What to do with stories. The sciences of narrative medicine."[1] I find each of the comments rich and provocative, both intellectually and relationally. That is to say, the comments demonstrate the emergence of a fresh discourse marked by multiplicity and intersubjectivity, in which the care of the sick becomes the locus for health care practice, discovery-bound intellectual curiosity, and relation-building among members of an international community.

Dr Poon's comments prompt some clarification on my part. By no means did I mean to imply that I thought I had, single-handedly, brought narrative to medicine! Heavens! Hippocrates, Galen, Thomas Mann, and Freud did that long ago. Certainly the social constructivists had a hand in it, as did the sociolinguists, the phenomenologists, the medical anthropologists—in short, all those scholars and writers and artists who realized that the body is a portal of the self.

The case of narrative therapy interests me a great deal. Here, in the practice of family therapists, is a crystallization of the therapeutic implications of narrative medicine theory. I take—and have written on—narrative therapy as a most instructive and pioneering exemplar of the practical sequelae of thinking along the lines of narrative medicine. I hope in the short future to have a means of dialogue between