
Narrative and severe mental illness: what place do stories have in an evidence-based world?

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“Once the patient’s biography becomes part of the care, the possibility that therapy will dehumanise the patient, stripping him of what is unique to his illness experience becomes much less likely” (Kleinman, 1988).

“The loss of story making and telling has its impact on failure to care for the long term chronic or incurable patient” (Hunter, 1991).

Stories have been in retreat for some years, increasingly viewed as the unreliable remnant of an anecdote-based medicine and the unsupported pronouncements of ‘authorities’. Freud’s (1985) concern that his case histories lacked “the serious stamp of science” has found resounding affirmation in the thrust of evidence-based journals such as *Bandolier*, with its millennial (January 2000) call “facts, just give us the facts”, and in the enthusiasm for “data overthrowing dogma” (Eisenberg, 2000).

The rise of evidence-based medicine (EBM) has been founded on the aspiration to produce “a coherent and comprehensive approach to allow clinicians to base their practice on the best available evidence” (Geddes, 1998).

However, the approach to ‘best evidence’ established by *Bandolier* (*Journal of Evidence-Based Health Care*; www.jr2.ox.ac.uk/Bandolier) and enshrined in the National Service Framework (Department of Health, 1999) has created a hierarchy with meta-analysis of randomised controlled trials at the top and the personal account, ‘anecdote’ or story at the bottom – of temporary and conditional value until it is replaced by higher-quality evidence. Thus, the evidence of testimony or opinion has been identified as dirt on the lens of science, which EBM has been

created to remove, and its methods are such as to eliminate the complexity of individual variation.

The clarity of view and precision of focus offered by EBM have given rise to a counterreaction, based on a reconsideration of the significance of what has been excluded (Evans & Sweeney, 1998). A narrative critique of EBM finds it based on a preference for the general over the specific, objective over subjective, quantitative over qualitative, and it threatens to become a story to end all stories. An extreme view is that “at its most arid, modern medicine lacks a metric for existential qualities such as inner hurt, despair, hope, grief and moral pain which frequently accompany, and often indeed constitute, the illnesses from which people suffer” (Greenhalgh & Hurwitz, 1998) (Box 1).

The renewal of interest in narrative in medicine (Greenhalgh & Hurwitz, 1998), psychiatry and psychotherapy (Roberts & Holmes, 1999) has come from many sources, including post-modern philosophy, developments in psychotherapy, the user movement, academic psychology and the observation that doctors, whatever their theoretical orientation and practical commitments, spend most of their working day telling stories (Hunter, 1991).

Narrative- and evidence-based approaches may initially appear to be in tension, even competition. The view advanced here is that they are necessary and complementary companions. Szatmari (1999) has noted an “enormous gap” between our empirical knowledge base and the information that patients need and want. Brody (1987) observed that “stories are essential as means of how scientific knowledge, in its generality, can be applied to

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Box 1 The journal club

At a recent meeting of our journal club three short papers were presented, two editorials from the journal *Evidence Based Mental Health*, and a short story, 'The Conker Tree', from an anthology, *Narrative Based Medicine* (Greenhalgh & Hurwitz, 1998). The first two pieces led to debate and dispute over the merits and limits of evidence-based medicine (EBM), given its aspiration to present clinicians with 'best evidence' and inform them about 'what works'. The third created a touching silence, reflections on what the story meant for those present and quiet tears from a colleague. The story clearly 'worked', but was neither an informative account of pathology nor a descriptive account of treatment. It was a story of a general practitioner attending her elderly dying patient, an experience that touched the doctor and, in the retelling, touched us too. A mature student, previously a professional, said that his career change had been prompted by a desire to be more connected and in touch with people's lives. We observed that the current presentation of EBM misses this altogether.

individuals in their particularity". Each has the potential to leaven, challenge, sharpen and enrich the other; each highlights the other's blind spots – both are needed.

Post-modernism and the rediscovery of narrative

The ascendant interest in narrative perspectives is inextricably linked with the impact of post-modernism, which is as ubiquitous as it is difficult to define. Post-modern influences are everywhere: from contemporary authors, who look out from their texts to wink knowingly at their readers, to transparent buildings that conceal little and make a virtue of showing their workings. It is a peculiar world in which an unmade bed and soiled underwear can be the bookies' favourite to win a premiere award for contemporary art.

To the post-modern eye truth is not 'out there' waiting to be discovered and measured, leading to rules and regularities, but is something which is constructed by people interacting with their environment; it is always provisional and contingent on context. No messages arrive uncoded, innocent of beliefs or persuasion. Post-modern literary theory has given rise to two perspectives on the creation of accounts or narratives: constructivism and social constructionism. The former emphasises a process arising within an individual, attributing meanings to events and creating a story to contain and explain personal experience: our knowledge of 'reality' is considered to be a story we tell ourselves (Mair, 1988). The latter focuses on social perspectives and how meanings are negotiated with an individual to create a narrative, co-constructed by the individual interacting with those around him

(McNamee & Gergen, 1992). Hence, Kleinman's (1988) view that "the clinical account is perhaps better regarded as the active creation of illness meanings in a dialogue with the subject".

The post-modern perspective, with its deconstruction of 'evidence', may seem intellectually provocative but of no practical use to the clinician, and yet clinical practice is conducted in the tension between modernism, with its positivistic emphasis on rationality, materialism and reductionism, and post-modernist paradigms (Murray, 1997; Laugharne, 1999).

The currently popular outcome measures and standardised risk assessments, plotting individuals on an actuarial scale, are quintessentially modernist in their approach and aspirations. However laudable their purposes, they also serve to illustrate that the individually meaningful may not be the same as the reproducibly measurable. For example, Strauss (1994) has described a young man with a long history of schizophrenia who had participated in successive research interviews over 10 years. When asked which was the worst year of his life he unexpectedly identified a period when the objective ratings of his psychopathology and social functioning were rather favourable but, unknown to the researchers, he was traumatically rejected by his family and although relatively well, felt abandoned. Strauss suggests that the rediscovery of an emphasis on the personal story may provide a means of overcoming the tendency endemic in psychiatry to neglect the personal and subjective aspects of an individual's experience.

What purposes do narratives serve?

MacIntyre (cited in Taylor, 1996: 7) has emphasised that it may be through the hearing and telling of

stories that children learn what a child and what a parent is, who populates the world around them and what the ways of the world are. Stories give cognitive and emotional significance to experience, they are a means of constructing and negotiating a social identity, and give moral weight and existential significance to actions and events. Narrative may be amusing, memorable and absorbing, and is characterised by many qualities upheld by narrative approaches. Although EBM appears to be moving towards an integration with NBM (narrative-based medicine) and, by implication, quantitative with qualitative considerations (see below), they can at present be both contrasted and disputed (Box 2).

Narrative is personal

Chadwick's (1993) first-hand account of a psychotic episode, coming from someone qualified in psychology, may give us unique insight into a psychotic crisis. Styron's (1991) observation that depression "is a word that has slithered through the language like a slug, leaving little trace of its intrinsic malevolence" alerts us to the need to look beyond the numbing and blinding statistics that surround this extraordinarily common experience. For although there are an estimated 83 million episodes in the

Box 2 Contrasting qualities of narrative- and evidence-based approaches (qualitative v. quantitative)

<i>Qualitative</i>	<i>Quantitative</i>
Personally meaningful	Generally measurable
Contextualised	Controlled
Relational	Reproducible
Inductive	Deductive
Evocative	Highly probable
Pluralistic	Standardised
Imaginative	Logical
Lateral	Linear
Amusing	Informational
Private	Public
Intimate	Detached
Humanistic	Scientific
Individualistic	Epidemiological
Constructed	Analytical, dissected
Performative	Observational
Symbolic	Theoretical
Wisdom	Knowledge
Practice	Research

developing world annually (Murray & Lopez, 1997), giving rise to more than 3000 scientific publications each year, Wolpert's (1999) arresting disclosure that *his* experience of depression was worse than watching his wife die of cancer offers access to a vital awareness, derived from personal experience, that is not easily found in that collection of dispassionate studies we call 'the literature'.

Narrative is plural: truth or truths?

For any individual there are many stories that could be told from different perspectives. The story of Ben Silcock entering the lion enclosure at London Zoo was foundational to the revision of community care. It was initially reported as an apparent suicide attempt ('Horror in the Lion's Den', *Daily Express*, 1 January 1993). Such banner headlines gave way to his father's frustrated and anguished account of his son's poor response to patchy and inconsistent treatment for schizophrenia: 'Which community, what care? Both have failed Ben' (*The Sunday Times*, 10 January, 1993). Still later Ben Silcock (1994) offered his own perspective, saying:

"I want to try to shed a little light on the experience of madness from the point of view of the afflicted. So often we get descriptions of madness from psychiatrists who can only express their observation in a clinical way, with little consideration for the patient's soul... maybe we should take a breakdown as a sign that our ways of living need to change."

A narrative stance attributes significance to each account, without seeking to reduce one to the other. For, as Hunter (1991) has emphasised, "the subjective, personal, patient story and the interpretative, scientific, medical story are not translations of each other but independently co-existing narratives".

Consequences of losing a narrative perspective

There is a growing concern that modern medicine misses the experience of illness that patients suffer and that there is a tendency for the patient as a person to be overlooked. We risk compounding our patients' suffering by generating impersonal case histories, which fail to illuminate each individual's experience in the struggle to survive illness. Patients, too, increasingly complain about this 'crisis of

Box 3 Mary's story

Mary believes she is turning into a man. She believes this with great conviction and is tormented by it. Sometimes she feels that ending her life will be the only way of dealing with this horrible predicament. Her husband and sister, with whom she lives, find her inconsolable as they try to point out the impossibility of her belief, but this only adds to the tension and frustration they live with, for she knows it is true. In an agonised way she speaks of being ugly, malformed – a freak, unlovely and unlovable – and wishes she had never been born. She speaks of feeling a burden to her loved ones and that it would be better if she were dead, leaving them free to get on with their lives.

On a few occasions she has also spoken confidentially of her complex suffering, which arose on unexpectedly returning from work to find her husband and sister having sex; of the need to continue working to support both of them (“a year of torment”); of her distress at never having had children; of not feeling a proper woman; and of not knowing what goes on at night, as she has slept in a separate room from her husband for many years.

Knowing something of her personal history appears to shed light on her otherwise ‘mad’ and ‘bizarre’ beliefs, and, regardless of whether this could be used directly in treatment, it gives a sense of meaningfulness and context to her life and illness.

meaning’, and criticise the impersonality of psychiatric approaches that are “mechanistic and dismissive of individuality” (Rogers *et al*, 1993). In acute illness, this may be of little importance, but its significance grows with the severity and chronicity of the illness and the need to engage with the ongoing life of the individual (Box 3).

The continuing tension for every practising clinician is how to integrate approaches that depend on an intimate knowledge of patients’ lives with the realities of working in the national health service. This led Maden (2000) to observe that “one of the few remaining opportunities to assemble a comprehensive and insightful case history is via an enquiry after something has gone very badly wrong”.

Narrative processes in the construction of psychopathology

Some grow up with life-denying meanings and are hostage to toxic stories that adversely define and constrain their identity and self-image. They are caught in a story, and the task is first to understand this and then to find ways of modifying (re-authoring) these myths-people-live-by to promote a more constructive, effective and adaptive context for living (Box 4).

The rather simplistic notion that ‘every symptom tells a story’ necessarily draws on the complexities of the biological, psychological and social factors

that exert their effects over time. One view of psychopathology is that it is the product of what remains healthy in a person seeking to make sense of, and give expression to, what has gone wrong. From a

Box 4 Opalanga (from Estes, 1992: 201)

Estes tells the story of Opalanga, a very tall, slender woman, who as a child, in addition to being mocked for her height, was told that the gap between her front teeth was the sign of a liar. However, as an adult she visited The Gambia and found some of her ancestral people. Among their tribe were many who were very tall and slender, with gaps between their front teeth. This gap, they told her, was called *sakaya yallah* (‘opening of God’) and was a sign of wisdom.

Estes comments on the influence this detoxification and revision had on Opalanga: “(her) stories which began as experiences both oppressive and depressive, end with joy and a strong sense of self. Opalanga understands that her height is her beauty, her smile one of wisdom, and that the voice of God is always close to her lips”. Estes offers this as an example of how easily we become ‘caught in a story’ and that the toxicity of attributions is all the more if they are told to us early and authoritatively.

narrative viewpoint, symptoms can be seen as the efforts of a healthy self to find words and meanings that adequately express an individual's struggle with altered experiences.

Thus, the inception of a psychotic episode has been characterised as a breakdown in gestalt perception, leading to the prodromal pre-delusional mood, with all its anxiety, uncertainty and fragmentation of meaning. The attribution of meaning to this alarming and threatening experience brings relief, and in some patients the further elaboration of these delusional meanings into systems of belief may be accompanied by an enhanced sense of meaning and purpose (Roberts, 1999). The action of creating narrative, by attaching words to experiences so that they can be made sense of, forms part of the wider action of responding appropriately to a situation – narratisation as a necessary defence.

Laing (1964) observed that “the mad things done and said by the schizophrenic will remain essentially a closed book if one does not understand their existential context”. A narrative perspective on the construction of complex psychopathologies may not illuminate why they have occurred, but may shed light on their meaningfulness. A simple example is that of a very withdrawn, inarticulate young man, who took considerable time to reveal that his ‘voices’ threatened to desecrate his daughter’s grave. This admission eventually enabled an understanding of his guilt and grief at the breakdown of his family and the death of his young daughter. A more complex example is that of a woman tormented by demeaning and deriding voices telling her to cut herself, as she was “a lump of meat”. Like Mollica’s (1988) torture victims, it took her a long time to develop sufficient trust and confidence to tell her ‘trauma story’, but telling it gave considerable insight into how she had lost her identity and had become just “a lump of meat”.

A narrative view values content, and in seeking to understand delusions and hallucinations, as opposed to explaining them (Jaspers, 1974), one is engaged in re-contextualising the illness in the life experience of the individual. This in turn may inform the rehabilitation process and give insight into the complexities of recovery, which for some will include the loss of the compensations of delusional beliefs and re-engagement with the implications of having a severe mental illness and what preceded it (Roberts, 1999).

Psychotherapy as storytelling

So far I have emphasised the need for any process of treatment and rehabilitation to be based on a

comprehensive, and continually revised, case history, which may illuminate the meaning of symptoms and the process of psychopathology, giving rise to a formulation that stands at the junction between assessment and treatment. Narrative and storytelling have also found direct application in therapy and as therapy.

Dynamically oriented psychotherapies have always engaged in the stories we are host and hostage to. This is epitomised in Winnicott’s characterisation of psychotherapy as “an extended form of history-taking” (quoted in Holmes, 1993). In any therapeutic encounter the patient comes with a story, however tentative and disjointed, which is then worked on by therapist and patient until a more coherent and satisfying narrative emerges. This provides an explanation of the patient’s difficulties and a means of linking inner and outer experience.

Research derived from attachment theory has demonstrated that how we tell our stories says much about our stance towards the world. The way in which people talk about themselves reveals fundamental relationship patterns. Longitudinal studies have shown that children who are securely attached in infancy are more likely to tell coherent stories when talking about themselves in early adulthood than are insecurely attached children, whose narratives tend either to be overelaborated and confused or sparsely dismissive. An awareness of narrative styles can influence how we listen and guide our interventions in ‘story-making’ or ‘story-breaking’ directions. Patients with self-sufficient, unelaborated, dismissive narratives need to be encouraged to break open their defensive stories and consider other possibilities. Conversely, those who seem unable to find a narrative thread and to be drowning in the chaos of their experience need help to find a shape and pattern that enables them to fit things into place (Holmes, 1999). In therapy, patients learn to build up their storytelling capacity, their “autobiographical competence” (Holmes, 1993).

Narrative in therapy

Cox & Thielgaard (1987) have described the excessive defensiveness and extreme aversion to meaning of forensic patients with severe mental illness. In working with such patients they give ample illustration of the application of metaphor “to touch the depths before it stirs the surface”, thus working with understanding, but without threatening the defences a person may have against the unbearable meanings of their experiences (Box 5).

Others have laid emphasis on using traditional stories in therapeutic work (Bettleheim, 1991; Estes,

1992). This attests to the capacity of ancient stories to engage a contemporary readership, and may bear witness to a growing preference for contextualising our problems-in-living within an accessible narrative, rather than having them encrypted within the esoteric language of experts. Traditional stories are thus seen as repositories of wisdom, offering an exposition of life's problems and a method of approaching and resolving them; a source of identification; an opportunity for catharsis; and a model of understanding and insight, yielding a knowledge of motives, causes and some kind of justification for otherwise unjustifiable and unmanageable turns of fate and fortune (Gersie, 1997) (Box 6).

Narrative therapy

Some think that all talking treatments are based on narrative and storytelling, and do not see 'narrative approaches' as different from any other form of psychotherapy. Others, notably Michael White (1995), have drawn on literary criticism, anthropology and a post-modern approach to the construction of meaning to formulate a narrative therapy.

White sees the therapist as a post-modern deconstructionist, inviting a revision of the tyrannising grip of the 'problem-saturated stories' people live in by searching for events and experiences that contradict the dominant plot. He works with the 'audience' to these stories, frequently the family, to make space for an alternative story to emerge.

Therapy is therefore a process of revising the relationship patients have with the stories they live in, deconstructing those 'truths' that hold them hostage to certain life-denying meanings, that trap them in a story, forcing them to live with a 'spoiled identity', for example by succumbing to schizophrenia (see Greenhalgh & Hurwitz, 1998, for other examples).

The practical outworkings of this approach include an emphasis on sharing professional literature with people, which undermines the mystification of therapeutic knowledge, and a method ('externalising conversations') of trying to create a different atmosphere around an individual's illness so that it is seen as something that is acting upon the person rather than intrinsic to the person: "people are not problems – people have problems" (White, 1995).

This therapeutic approach would appear to be supported by a finding of the Yale Longitudinal Study of Prolonged Psychiatric Disorder (Davidson & Strauss, 1992) that a significant factor in recovery is the process of developing a sense of self separate from the diagnosis, of finding in the midst of persisting psychosis a Me separate from It. This reassertion of personhood has also been a strategy in the Royal College of Psychiatrists' anti-stigma campaign, using the slogan:

the person with schizophrenia
is
a person (with schizophrenia)

... How you say it is how you see it.

Box 5 The use of metaphor in therapy: "Do you know anything about peeler crabs?"

A well-educated, middle-aged woman in long-term treatment was, among other problems, suffering from severe obsessive-compulsive disorder and had become something of a recluse, verging on being a vagrant. Over some months she recovered a sense of connection and relationship, became more in touch with those around her and was cautiously able to express herself. She then seemed to relapse, becoming more anxious, avoidant and obsessive. Patient questioning revealed that she was scared of feeling better and of experiencing a measure of trust in those around her. Small events were affecting her greatly, and she could not make sense of why she was feeling so unstable when many things were improving. She tended to be absorbed with circular obsessive worries, and it was difficult to make contact with her.

In this context she was asked, "Do you know anything about peeler crabs?". Somewhat surprisingly, she did. She described them as a transitional state when a crab is growing and has to shed its shell, "if it did not it would suffer increasing constriction, or pain, or would die – it is defenceless – very vulnerable – may get eaten or used as bait – they need to take great care of themselves". She went on to say that the peeler state is essential in expanding and growing bigger, in maturing, before new defences take shape. (She might have added that it is only in the peeler stage that crabs can mate, and so the softness and vulnerability allow intimacy.) She accepted the metaphor and it enabled her to talk about vulnerability and change, despite her fear of letting her thoughts out and anyone else in.

Box 6 Narrative in therapy: Plato's story of 'The cave'

A group of residents met weekly in a rehabilitation unit to 'talk about anything or ask anything they wanted to'. On one occasion, a resident asked the conductor to repeat a story previously mentioned during an individual session. The therapist offered to do so if the group would agree to respond to it. And so Plato's story of 'The cave' (as remembered by the therapist) was told to a group of people at differing stages of recovery from severe mental illness.

The story is of a man imprisoned deep in a cave, chained by both hands, facing the wall. The changing shadows flickering on the wall were the only awareness he and his companions had of the world, and they took this to be reality. One day, the manacle holding the man's left hand worked free and he was able to turn towards cave entrance, but he found the light bright and frightening. His companions exhorted him not to look, saying that he would go blind, but something urged him to look again and to struggle to free his other hand. His companions called him a fool, said that he would go mad and implored him to remain with them. With faltering steps the man walked towards the entrance, but finding the increasing light blinding, doubted that he was going the right way and considered going back. However, the return journey is now too dark, and he was caught in confusion. As he stood at the threshold of the cave, his eyes grew accustomed to the light and gradually he discerned the world outside and a path from the cave mouth, along which he took his own uncertain steps.

The group had much to say. The resident who requested the story admitted, "I was like that", and spoke of his emergence from closeted homosexuality and compensatory heroin addiction. Another mentioned her fear of going out of the house and of public spaces, and several added experiences of their confusion and the mixture of fear of the present and nostalgia for their past protracted stays in hospital. One person was annoyed and frustrated that she was not told how the man fared and where he went next. The therapist concluded the session by saying he did not know, but that he suspected that if she had asked Plato the same question he would have responded, "that is for you to find out for yourself".

Narrative and outcome: the incurable patient – an iatrogenic tale?

Kleinman's particular insight into the anthropology of psychiatry led him to observe that "Chronicity arises in part by telling dead or static stories, situating the individual in a wasteland, a denervated place, robbed of its fertility and potential" (Kleinman, 1988: 180). It is a sombre consideration that chronicity may partly arise from our accumulated negative expectations (Duncan *et al*, 1997). Possessing and perpetuating this narrative of 'incurability' may serve many protective and defensive purposes for the staff involved and even offer some comfort and orientation to the individual; but in doing so we may "collude with building walls and tearing down bridges" (Kleinman, 1988), exchanging the precarious and uncertain struggle for health with acceptance of meanings that forever constrain the individual's hope and potential.

Narratives of recovery

If recovery from severe mental illness is equated with the complete absence of symptoms and a return to the status quo ante, then it appears to be a myth (Whitwell, 1999). However, a different view is being asserted from within the user movement (Coleman, 1999): that recovery involves the restoration of hope, agency, self-determination and a way of adjusting to living with both the reality of the past and the continuing altered experiences of 'illness'. This very different perspective enables the prospect of recovery to become a realistic goal for every patient, and it is one of the inspirational dynamics of rehabilitation, enabling Clay (1999) to declare, "From the experience of madness I received a wound that changed my life. It enabled me to help others and to know myself".

Is double-blind the only way to see? The resurgence of qualitative research methods

Narrative approaches based on constructivism and social constructionism have offered a critique of the highly subjective means by which quantitative science chooses its object and method of enquiry, and of the risk that the resultant scientific discourse

factualises information through the loss of a narrative context, and so creates an illusion of objectivity (Nash, 1994). In doing so it risks losing the meaning and significance of the very things it so carefully measures in such a reproducible way.

The prevailing view that 'real' and worthwhile research is necessarily based on large samples and elaborate methodologies is far too narrow. Increasing discontent within academic psychology has fuelled a shift towards a post-positivistic, non-experimental, qualitative paradigm with greater 'ecological validity' (Smith *et al.*, 1995). The resurgence of interest in qualitative methods, initially developed in the 1980s, has been linked to a cross-pollination from sociology and anthropology, which have demonstrated the benefits of narrative and ethnographic representation of human experience. In many ways this represents recovery of a phenomenological perspective, a move to address individuality, which is otherwise lost in the gross averaging of statistical manipulations.

Quantitative and qualitative methodologies are different, but offer the possibility of combining (triangulating) meaning and measurement. Quantitative research starts with a hypothesis and aims at either verification or falsification, whereas qualitative research starts with a domain of interest, which it explores in a search for meaningful associations, and concludes with new hypotheses. There is therefore a reciprocal relationship between qualitative and quantitative methodologies in the generation, and evaluation, of hypotheses.

Teaching and learning: forgetting the facts and remembering the story

The conscientious student may be able to remember the meaning of 'thought broadcasting', but the concept becomes more interesting and memorable if the phenomenological description is accompanied by the story of a frightened woman who went to an accident and emergency department to ask for a plaster cast to be put on her head in order to stop her thoughts escaping and being accessible to others.

The acquisition of a continually expanding anthology of memorable, evocative and iconic 'master tales' is a significant contribution to developing clinical maturity (Box 7). The consultant psychiatrist with an extended knowledge of patients' lives is also able to bear witness to the possibility that even the most apparently intractable patients change, and many get better, but over longer periods of time than those experienced by any trainee

or travelling mental health professional. Who else is in a post and can follow the progress of individual patients over 5, 10, 15 years?

Some cautionary notes

Some stories illustrate the limits and cautions surrounding narrative itself. Just as there are no theory-free facts, so there are no innocent meanings. Clearly, stories can dissimulate as well as illuminate. Reservations concerning narrative are held by those steeped in narrative perspectives, just as they are by evidence-based enthusiasts.

There are risks in weaving too close a fabric of meaning and in creating a smoothly flowing and persuasive narrative, such that the process of seeking the truth is overwhelmed and lost in the onwards flow of plot and character.

Maden's (1995) review of *The Falling Shadow* (Blom-Cooper *et al.*, 1995) commented on just this process, of constructing an unwarranted sense of inevitability through the skilful injection of plot and purpose into the report of an official inquiry into a fatal incident. He felt that the compelling metaphor of 'the falling shadow' eclipsed rather than illuminated the search for truth, and saw the gravest error as the construction of a spurious sense of inevitability through phrases such as "the most horrifying aspect of the killing was its unpredictability". In this he is accenting the difference between narratisation and novelisation.

Box 7 A story of manic distraction

During manic episodes a patient's thinking and behaviour are disordered: characteristics include flight of ideas, overactivity and the starting of many simultaneous projects, none of which is finished. A patient was admitted in a manic state and was soon after visited by a friend, who brought the customary offering for hospitalised patients – a basket of fruit. This one contained many offerings, decoratively arranged and beautifully presented. When I visited the patient a couple of hours later the arrangement was a complete mess: he had taken a single bite out of each piece and then moved on to the next, scattering the sampled fruit around his room. When asked about his actions he explained that he liked fruit, but could not decide what to eat.

Gersie (1997), as a mature storyteller, is aware that she *is* telling stories and of the possibility of misapplication. She warns of the trend to attribute our sufferings to particular experiences that may create “shackling narratives which foreclose the future and condemn the past” and contribute to the ascendant culture of victimisation. The clarity and simplicity of understanding that we long for can be an obstacle, if such clarity is forged at the expense of denying appropriate complexity. Thus, we are all prone to accept bogus interpretations as pertinent if they fit our expectations or preferences. Some qualities of certitude are hallmarks of immaturity and insecurity rather than of wisdom.

Illness is both profoundly meaningful and simultaneously meaningless. MacNaughton (1998) supported her assertion that “in treating the patient as a person it is essential that we do not forget to treat the person as a patient” with details of a randomised controlled trial of patient-centred care of people with diabetes in general practice. The trial resulted in greater patient satisfaction, but significantly poorer physical outcome on all objective indices.

Conclusions

Post-modern storytelling can be pitted against pragmatic truth-seeking, but having described the difference and tension between these two approaches, I shall conclude by arguing for their complementarity. Relationships between doctors and patients constantly negotiate intimacy and detachment, subjectivity and objectivity: each of these is needed, and there are risks in overemphasising, or losing, any of them.

Dawkins (1998) begins his exploration of “science, delusion and the appetite for wonder” by reporting that “Keats believed that Newton had destroyed all the poetry of the rainbow by reducing it to the prismatic colours”, but counters this with his own view that “Keats could hardly have been more wrong... science is, or ought to be, the inspiration for great poetry”.

Science and narrative, the quantitative and qualitative, are not competitors but represent a complementary duality, as intimately connected as the two sides of the cerebral cortex. Narrative preserves individuality, distinctiveness and context, whereas quantitative methods and evidence-based guidelines offer a solid foundation for what is reliably and generally correct. Palmer (2000) has argued that it is clinicians who need to bridge the gap, if they are to be able both to appraise evidence and appreciate the meaningful experience of their patients: “It may be uncomfortable to ride the twin horses of rigour and richness, of general scepticism and particular enthusiasm, but the clinician has to try to do so”.

Narrative is endemic to medicine, but has been excluded in the rise of EBM. It remains to be seen whether narrative’s ecumenicalism will be rebuffed or reconciled with EBM’s fundamentalism, but there are signs of convergence. A recent issue of the *Journal of Evidence-Based Health Care* (October, 1999) began by declaring that “This issue of *Bandolier* is mostly about updating stories from previous months and years”, and went on to state that “reviews are also beginning to concentrate more on outcomes that are important to patients and practitioners, rather than just on outcomes that are measurable”.

There is an emerging image of the mature and experienced clinician of the future, who will have the capacity to integrate narrative- and evidence-based perspectives, quantitative and qualitative methods, and have a balanced awareness of the contributions and limitations of both as a sound basis for clinical judgements. However, if this is to be more than a heroic ideal, our initial training and continuing professional development will need to encourage the simultaneous development of both the art and science of our subject, reconciling probabilistic *P*-values with personalistic ‘*P*-values’.

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* These references offer a good starting place.

Multiple choice questions

- The increasing interest in narrative approaches has been linked with:
 - a reaction to evidence-based medicine
 - post-modern philosophy and literature
 - renewed interest in qualitative research methodologies
 - discontent among academic psychologists
 - the reapplication of traditional stories to contemporary problems.
- Narrative therapy:
 - is associated with co-constructionism
 - is particularly suitable at bedtime
 - involves reauthoring problem-saturated lives
 - conceptualises the therapist as a demolitionist
 - is conducted using externalising conversations.
- Narrative approaches are:
 - contextual
 - relational
 - verifiable
 - meaningful
 - measurable.
- Understanding narrative processes enhances:
 - understanding of the elaboration of delusional beliefs
 - appreciation of the complexity of recovery and chronicity
 - interpretation of the contents of delusions and hallucinations
 - understanding of the occurrence of a psychotic disorder
 - explanation of the occurrence of a psychotic disorder.
- The following have significantly contributed to the development of narrative approaches in psychiatry and psychotherapy:
 - Bruno Bettelheim
 - Isambard Kingdom Brunel
 - Clarissa Pinkola Estes
 - Kathrine Montgomery Hunter
 - Arthur Kleinman.

MCQ answers

1	2	3	4	5
a T	a T	a T	a T	a T
b T	b F	b T	b T	b F
c T	c T	c F	c T	c T
d T	d F	d T	d T	d T
e T	e T	e F	e F	e T