

Special Article

Applications of Narrative Theory and Therapy to the Practice of Family Medicine

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This article presents narrative theory and therapy as an approach with significant potential for providing family physicians with additional tools to assist them in dealing with difficult clinician-patient encounters. We first define narrative therapy, then briefly describe its theoretical assumptions in relation to psychosocial concepts already familiar to family physicians. Important aspects of narrative therapy are examined, including the unique role of questioning in the narrative process; understanding and helping patients change their problem-saturated stories; renaming and externalizing the patient problem; and the use of rituals, documents, and audience in recognizing and reinforcing patient change. The article concludes with thoughts about how narrative approaches can contribute to more-healing doctor-patient relationships.

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Narrative therapy is a form of psychotherapy, pioneered in Australia and New Zealand in the 1980s,¹ that emphasizes the importance of story and language in the development and expression of interpersonal and intrapersonal problems.² It uses therapeutic questioning to help clients recognize and reflect on the discrepant but positive elements of their current problem-saturated stories and to empower them to reformulate a more-preferred life direction.

Clinical experiences with family practice residents and their patients have convinced us that narrative approaches have much to offer the specialty of family practice. In particular, patients who we label as noncompliant, difficult, somatizing, self-defeating, depressed, or anxious^{3,4} can benefit from the incorporation of narrative elements into their encounters with physicians.

In this article, we use the case study of a patient who initially was not able to comply with treatment recommendations for diabetes to illustrate basic concepts and techniques of narrative therapy that have application to the practice of family medicine.

Narrative theory stresses above all the importance of language in shaping people's realities. It is important, therefore, to make a contextual point about the language used in this article. Narrative therapists do not like to refer to themselves as therapists, and they rarely call the people who consult with them patients or even clients. This is because therapist-client language contains many assumptions about authority, power, and expertise that narrative therapists wish to question. We suspect that narrative therapists might have similar, even stronger, feelings about the terms *doctor* and *patient*, which are heavily freighted with symbolism and expectation. Nevertheless, for the sake of clarity, this article will continue to refer to doctors and patients as a shorthand for roles deeply ingrained in the social fabric. We hope that readers will begin to ask themselves questions about what these labels convey both negatively and positively about the individuals who assume them.

Theoretical Framework

The basis of narrative therapy is social constructionism⁵ or the idea that the way people experience themselves and their situation is "constructed" through culturally mediated social interactions. Through story and language, cultures send powerful messages to their members about the meaning of important concepts that sustain the culture, including gender, race, class, and,

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of course, health.⁶ For example, the psychiatrist/anthropologist Arthur Kleinman distinguished between disease and illness by defining the latter as “how the sick person and the members of the family and wider social network perceive, live with, and respond to symptoms and disability;”⁷ in other words, what a disease means to the patient and family. Kleinman realized that such meaning is made or constructed on the basis of personal beliefs about health and illness that are strongly influenced by cultural norms and standards. Narrative ideas offer a useful framework to help patients and physicians access this process of meaning construction and, in cases of dysfunctional meaning, work to change it.⁸

The Patient

Mr A was a 51-year-old white male with adult onset diabetes mellitus and secondary complications, seen by a third-year family practice resident, Dr B, in a university-based outpatient clinic. Initially relying on a disease model, the physician tried to manage Mr A through a treatment plan of blood sugar monitoring, medication, diet, and exercise. The patient, however, seemed to ignore the physician’s recommendations. Dr B described the patient as chronically noncompliant and in denial, and Dr B was frustrated by his care. In particular, Dr B complained of being “tired of telling him what to do” with so little result. An initial narrative-based intervention invited Dr B to switch from making directive statements to Mr A to asking him questions—lots of questions.

Questioning: the Basic Tool of Narrative Therapy

Physicians use questions to identify the chief complaint, clarify pertinent symptomatology, elicit the history of present illness, and formulate a differential diagnosis. This type of questioning seeks specific answers and generates information used to corroborate or modify the physician’s conclusions. The format of this questioning tends to privilege the knowledge of the doctor over that of the patient, by inferring that the patient can offer either right or wrong responses, relevant or tangential data.

Narrative questioning has the intent of uncovering meaning and generating experience rather than creating information.⁹ This type of questioning emphasizes patients making their own interpretations of events and formulating their own insights. The result is a process in which patient self-discovery and understanding are central, and the physician’s role is facilitator and ally. Narrative therapists use different kinds of questions to achieve these effects (Table 1). For example, questions are used to invite people to see their stories from different perspectives and to understand how they are influenced by sociocultural factors. Other questions ask patients to envision different, more-hopeful outcomes for themselves, to probe the significance of rare but hopeful events in their lives, and help them recognize

that they are constantly making choices for or against a particular problem-saturated story.

The Problem-saturated Story¹⁰

Narrative therapy involves working with people who are stuck in problem-saturated stories that they tell themselves, and that society has told them, about who they are and what their lives signify. These stories have become “disabling”¹¹ in the sense that the individuals feel they have lost control of their stories and are unable to change their meaning. For example, one day, Mr A told us, “Everybody knows you have to be very compulsive to control diabetes, like Mary Tyler Moore. I’m not that kind of person, so I’m sunk.” This “story” is based on prevalent beliefs within both the culture of medicine and the larger society about “good” and “bad” diabetic patients. It may not be the story the teller wants to tell but is perceived as the only story available.

Renaming the Problem

Technical medical language emphasizes pathological processes and deficits and often makes it difficult for patients to accept more preferred or desirable stories about themselves.¹² Noncompliance, for example, is a term rooted in the medical model of disease that has been criticized as pejorative, coercive, and disempowering.¹³ Narrative therapists encourage the use of patient, rather than medical, descriptions of the problem. When the patient creates a personalized “working label” for his/her problem, he/she gains power and control. For example, rather than view himself as noncompliant, Mr A preferred to talk about his attitude of not caring.

Externalizing the Problem^{1,8-10,14}

A major premise of narrative therapy is that the person is not the problem; the problem is the problem. A narrative approach advocates externalizing the patient’s problem by locating it outside the individual and within the culture. Working as a narrative physician, Dr B began to wonder which aspects of her patient’s world and belief system had encouraged this problem of not caring. Specifically, she asked, “Where did the idea that you have to be like Mary Tyler Moore to control diabetes come from?” Questions such as this help patients realize that what they conceive of as their problem is tightly woven into the social and cultural fabric. In the case of Mr A, we learned that societally supported views about how men should handle illness (being “macho,” “ignoring,” and “not being compulsive” about sickness) influenced his not-caring responses. Through a series of such questions, Mr A (and Dr B) began to think of not caring not as some kind of personality flaw at the core of his being but as a problem that existed outside himself and was created in part by societal expectations and pressures about gender roles.

When faced with seemingly intractable patient problems such as noncompliance, physicians may feel, as did Dr B, that patient and disease are in league against them. Externalizing helps reset this boundary by creating an alliance of doctor and patient on one side versus the problem on the other.¹⁵ If physician and patient can become paired against a challenging but ultimately beatable problem, the patient-physician coalition has a better chance of remaining intact.

A common concern about externalizing is that such an approach will cause patients to take less responsibility for their problems. Paradoxically, narrative therapists insist that just the reverse occurs. When people are freed from self-blame and guilt, they are more likely to take responsibility for the effects the problem has on their lives and more likely to assume a position of resistance and overcoming toward a problem they view as something distinct from themselves. At one point,

Mr A confided with a conspiratorial grin, "This not caring thinks it's smarter 'n me. But I can out-trick it."

Exploring the Effects of the Problem^{1,8,9}

By asking questions not about the cause of the problem but about the influences or effects it has on the patient's life, it is possible for the patient to clearly identify the problem story. For our patient, some of these reverberations of the problem included frequent doctor visits, pain, hospitalizations, and neuropathies, as well as a sense of hopelessness and failure. Sometimes it is helpful to ask patients, "What will happen if the problem were to continue on its present course?" The patient can even provide a name for the plot of the problem story.⁹ As Mr A put it, "Unless I start paying attention to this darn thing, my story will be called 'How to Let Diabetes Kill You.'"

Table 1

Types of Narrative Questions

| <i>Term</i> | <i>Purpose</i> | <i>Example</i> |
|------------------------|--|---|
| DECONSTRUCTIVE | Show how stories are constructed; situate narratives in larger systems | <i>Who told you "real men" don't pay attention to their health?</i> |
| RENAMING | Support patient efficacy by sharing authorship and expertise with patient | <i>What would you call this problem of not paying attention to your diabetes?</i> |
| PERSPECTIVE | Explore other people's views of patient | <i>Does everyone agree that you're not capable of managing diabetes, or does someone have a different idea?</i> |
| OPENING SPACE | Allow hopeful thoughts, actions to surface and be explored; highlight patient efficacy regarding problem | <i>Are there ever times when not caring doesn't control you? Tell me about these.</i> |
| HYPOTHETICAL (MIRACLE) | Stimulate patient's imagination to envision different, more hopeful futures | <i>Suppose a miracle happened and not caring was solved, how would your life be different?</i> |
| PREFERENCE | Check to make sure that exceptional moments are actually preferred to the problem story; establish patient preferences | <i>How did you feel when you got the trucking job? Is this something you really want?</i> |
| STORY DEVELOPMENT | Explore and linger on elements of the preferred story | <i>Tell me more about how you were able to resist that fast food? What exactly happened?</i> |
| REDESCRIPTION | Help patient recognize preferred qualities in themselves and probe implications for identity | <i>What does it say about you as a person that you were able to test your blood sugars daily last week?</i> |
| BIFURCATION | Encourage patient to align him/herself against the problem | <i>Is the event you're describing on the side of not caring or against not caring?</i> |
| STOPPER | Refocus patient when he/she seems to be getting stuck in old story | <i>Which story are you telling now?</i> |
| AUDIENCE | Identify supportive witnesses to the new or developing story | <i>Who in your life would be least surprised that you are able to make this change?</i> |

Many different authors have created questions and question types that assist the main tenets of narrative therapy: deconstruction, externalizing, and restoring. White and Epston's¹ work laid wide-ranging groundwork; Freedman and Combs⁹ also provide extensive examples. This table suggests a few types of questions that were helpful in the case at hand.

It is equally important to explore the effects of the patient on the problem. In other words, in what areas does the patient have influence over the problem? In what ways can the patient still stand up to the problem? Here is an example of a typical patient-effects question asked by Dr B: “Can you tell us about a time when you have been stronger than not caring?” at which point Mr A recalled occasions when he had chosen to follow his diabetic diet. Such questions help make visible the positive ways the patient may be acting or planning on acting in relation to the problem.

Searching for Hopeful Exceptions to the Problem^{1,9,10}

The overarching goal of narrative therapy is to help the patient replace the problem-saturated story by constructing a preferred story.¹⁶ The building blocks for this new story are found in the discovery of hopeful moments, thoughts, or events that do not fit with the problem story. For Mr A, holding a job, beating cocaine, and wanting to see his 2-year-old son grow up were examples of such occurrences that, when discussed with the physician, reflected back to Mr A possibilities of hope and transformation.

Patients are often dismissive of these sometimes small and initially uncharacteristic glimmers. At one point, Mr A told us, “Anybody can have thoughts about wanting to change.” The narrative physician can play an important role by questioning this perception. Instead of ignoring such hopeful moments, Dr B chose to focus intently on them. “Wait a moment! Are you telling me you’ve been thinking about tackling your diabetes? How did you manage to do that? How did that make you feel? How is that in line with what you want from your life?” Lingering over such occurrences, and asking the patient to reflect on their details, helps them grow in importance and power.

Patient Preference⁸

Because it is easy to become impatient about identifying hopeful moments and building a preferred story, narrative physicians should remember two cardinal rules: (1) don’t try to convince the patient to rewrite his/her story and (2) stay behind the patient.¹⁴ A narrative approach does not involve physician persuasion or coercion. Rather, it encourages the patient to find his/her own voice and to make choices about how he/she wants to live. Opposing the patient’s viewpoint simply results in an escalation of defensiveness and resistance.

Narrative therapists also caution that rather than becoming cheerleaders for patient change, their role is to stay behind the patient’s progress, recognize it, emphasize it, but always ensure that it is being pursued and desired by the patient. With Mr A, Dr B learned to switch from praise (“That’s great you’ve started to eat more regular meals.”) to respectful interest in the behavior (“How were you able to come up with a more

organized schedule for eating?”). In this model, reinforcement takes a back seat to understanding how successful change occurs, is in line with Mr A’s values, and supports the image he has of himself.

Ritual⁸⁻¹⁰

Although narrative therapy relies primarily on questioning and listening in the search for preferred meanings, it also uses other techniques that have relevance to a family practice setting. Note-taking stresses the incorporation of exact patient language, a willingness to share these observations with the patient, and encouragement of the patient to take his/her own notes during a session, implying that the patient’s observations are as valid and important as the physician’s.⁸ Letter writing from physician to patient is another powerful technique to summarize key points of a session and, with the advent of e-mail, not excessively time-consuming. Documents, such as certificates, awards, and diplomas specifically created to commemorate significant patient developments, are also meaningful. When Mr A’s blood sugars started regularly hovering around 150, we drew up a “Certificate of Unbelievable Progress,” which we all laughed about but that he proudly showed his son. All these approaches take advantage of the power of ritual¹⁷ in solidifying and memorializing significant life changes.

Generating Support^{1,8-10}

One of the most effective ways of strengthening the new, developing story is by creating a receptive audience who serve as “witnesses.” The doctor is an important member of this potential audience, but it is useful to have patients identify other audience members as well. A key aspect of a successful audience is that it be comprised of people who are supportive of and optimistic about the patient. Members of Mr A’s audience included his girlfriend, his mother, and (symbolically) a deceased aunt and Joe Namath. Mr A was a big football fan.

Summary

The patient’s new story is built by linking together hopeful thoughts and actions over time (past and future) and space into a coherent narrative. Building these links is not easy but can be facilitated by paying careful attention to the details of change, the effects of even small increments of change on the patient and his/her significant others, and specific steps leading up to these hopeful moments. In the construction of the patient’s new story, the physician is less coauthor than light-handed editor.¹⁰ The physician’s goal is not so much “selling” interpretations to the patient¹⁸ as assisting to deconstruct problematic behavior, note contradictory occurrences, and wonder about their significance. The patient puts together the pieces.

In a narrative approach, the emphasis between doctor and patient is on creating space for multiple perspectives to emerge and coexist, developing horizontal collaborative relationships, openness, and optimism.¹⁹ The narrative physician can develop a relationship not just with the patient's disease but with the patient's life in ways that surprise and please. As Dr B stated, "Before I began working with Mr A in a narrative way, I really didn't like him. When we became a team against not caring, I stopped disliking Mr A and started to dislike his problem. Then, as Mr A started to care more about himself, I started to care about him too." Mr A created new possibilities for treatment of his diabetes, but Dr B also created a new story about both her patient and the meaning of noncompliance. In this case, incorporating narrative ideas led to a healing and empowering dynamic among doctor, patient, and the problem of not caring.

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