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Narratives and Healing: Implications for Psychiatry and Psychotherapy

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Abstract

In this paper, I shall examine the significance of narratives in mental healthcare. I begin by discussing the narrative approach in medical anthropology and how narrative and healing relate together. I shall move on to examine narrative and psychotherapy. Finally I shall document work examining the role of narrative in teaching mental health professionals about empathy. I end by discussing the limitations of technological approaches in psychiatry and psychotherapy.

Keywords Psychiatry; Psychotherapy; Medical anthropology; Ethnography

Introduction

While narrative has become increasingly important in the humanities, social sciences and medicine and psychotherapy, it is medical anthropology that has predominantly focused on the role of narrative in healing and how individual narratives reflect overarching cultural themes. Collecting narratives is part of the everyday work of medical Anthropologists. As part of fieldwork they typically spend at least a year living in another community asking people about their families, their religion, their understanding of the Cosmos, politics, social roles and various other aspects of their lives. The ethnographic accounts are then published using narrative as an analytic tool to support arguments.

Launer [1] points out how sociology and ethnography see psychiatry among the medical specialities as peculiarly culture bound and occupying the uncomfortable no man's land between conventional medical science and the search for meaning. Medical anthropology with its emphasis on cultural meaning would seem very appropriate to understand illness experience. Illness narratives describe other people's experiences of acute or chronic illness and have become part of a growth industry. Medical anthropologists have explored narratives for the ways in which they help individuals understand their illness and their therapeutic potential. Illness narratives make sense of the unexpected and give shape to untoward events. They are grounded in cultural understandings in what it means to live, experience and be ill. As Levy [2] notes, illness of any degree shatters our everyday assumptions about the world. While people maintain a belief that the world which they inhabit is the same and experienced in the same way as those around them, illness calls this assumption into question. In cases of life threatening illness time is truncated and the limited quality of time takes on a new perspective. The limited time takes on a new perspective [3].

Telling a story is to present a sequence of events not just serially or chronologically but in the way that shows how things are interconnected while providing listeners or readers with a differing degree of a sense of the beginning, the middle and the end. Ochs and Capps [4] talk about narrative as a 'fundamental genre in that it is universal and emerges early in the community of development of children'. Mattingley [5] in healing dramas and clinical plots asserts that narratives are so compelling because life itself is structured narratively; patients literally have a need for narrative.

In the narrative approach Illness is understood through the elicitation of narratives and their interpretation. As Bruner [6] points out 'our anthropological productions are our stories about their stories; we interpret the people as they are interpreting themselves'. The anthropological use of narratives has been shaped by a number of prominent Anthropologists; Byron Good, Allan Young, Clifford Geertz, Victor Turner, James Clifford, Laurence Kirmayer and Arthur Kleinman. Perhaps it is Kleinman who most poignantly pointed out the significance of medical histories. He notes that each patient brings a story to the medical practitioners, enmeshing the disease in webs of meaning which can only be understood in relation to that particular person's life. In mental health anthropological narratives of depression are not just accounts of symptoms but also strategies through which people become aware of, and make sense of their symptoms [7]. They move from something lived to something interpreted. Contemporary philosophers propose the idea that narratives have an intrinsic relationship to a person's self -understanding [8,9].

Kleinman's [10] 'The illness narratives' is a paradigmatic text in medical anthropology. For him all forms of personal suffering are embedded in a nexus of meaningful relationships that are, in turn, influenced by cultural and political systems. He distinguishes between disease which privileges practitioners' perspectives and biomedical reductionism, from illness which emphasizes the lived experience of monitoring bodily processes. He is critical of clinicians for focusing on disease rather than documenting the experience of illness and argues for in relation to chronic illness 'a sensitive solicitation of the patients and families stories of illness, the assembling of a mini ethnography of the changing context of chronicity' as 'a core task in the work of doctoring'. For him patients draw on cultural and personal models; illness narratives derive from local cultural systems- local forms of knowledge pertaining to the self, suffering, coping and the management of illness (Kleinman, Good) [3,10]. Patients and family members use 'plot lines, core metaphors and rhetorical devices' to create stories. For Kleinman [10] these narratives provide the function and enable sick persons to communicate and symbolically control symptoms. Furthermore narration can engender hope. Mattingly [5]

writes: 'when a story is told, if that storytelling is successful, it creates in the listener a hope that some endings (generally the endings the hero also cares about) will transpire'.

How do narrative and experience relate together? Waitzkin and Mischler [11,12] argue that the narratives do not spring directly from the illness experiences but are coproduced and shaped by great differences in power. Good [3] in Medicine, Rationality and Experience notes that clinicians and that anthropologists and social scientists are more generally becoming increasingly concerned with questions like 'to what extent the stories report or depict events or experiences as they occurred. Does a good history mirror events and experiences or does it select events and organise them culturally? To what extent is social life itself organised in narrative terms. For Good [3] stories not only tell of past events but project them in time 'organising our desires to strategies, telelogically directing them towards imagined ends of forms of experience which in our lives are intended to fulfil'. However, Good [3] cautions illness stories may not provide much resolution since the narrators are still engaged in the striving in the quest for a cure and may be considering several outcomes in a given time. Individuals seek to construct the sense of coherence but also expose interruptions and interjections caused by illness.

Frank [13], focusing on Western cultures, describes three types of illness narratives deriving from written accounts of illness in North America and Europe– the restitution narrative, the chaos narrative and the quest narrative. Individual narratives often contain elements of each of these perspectives. The first focuses on ultimate victory over illness and individual's reintegration into society and return to normalcy of everyday life - 'yesterday I was healthy, today I'm sick but tomorrow I'll be healthy again'. This narrative reflects the modernist societal expectations of healing which reinforces the future oriented linear trajectory. The second claims that chaos is told in the silences that speech cannot penetrate or illuminate and is anti-narrative that highlights interruptions caused by illness- the individual maintains that nothing will ever change and that he/she will never be well. The quest narrative focuses on the temporal enactment of the illness experienced and the individual's transformation over time- the ill person maintains that something will be gained through the experience of illness. Unsurprisingly the restitution narrative is the most popular in Western cultures with those who are not healed feeling guilty.

The healing power of narratives

How do narratives heal? Anthropologists have long pointed out the healing potential of myths. Levi Strauss's [14] classic description of the healing power of narratives in The Effectiveness of Symbols involves a Cuna Shaman who deploys narrative, song and vivid visual imagery to help a pregnant woman through a particularly difficult delivery. The Shaman narrates a heroic story where the god Muu enters the vagina with other spirits to retrieve the foetus. Levi Strauss notes the treatment was purely psychological because the Shaman neither administers a remedy nor touches the woman instead he provides her with a language in terms of which unexpressed psychic states can be immediately expressed and induce the release of physiological processes. He asserts that the song evokes a psychological response which allows his patient to relax, thus making childbirth easier.

For him the myth works on the imagination to produce a psychological and physiological response; 'the song constitutes a psychological manipulation of the sick organ and it is precisely from this manipulation that a cure is expected.' The incoherent and arbitrary pains of the patients's situation are placed into a comprehensible and meaningful framework that enables the patient to deal with them. Thus myth can be viewed as a concrete interpretation or representation for a more abstract concept. 'Once the sick woman understands, however, she does more than resign herself; she gets well'. Levi Strauss further asserts that the woman is healed through psychological-magical means without any physical interventions. For him this result is achieved through a mechanism that is the same as abreaction of Freudian psychoanalysis – the reaction takes place in a parallel manner in the mind and the body but elicited through psychological mechanisms only. Importantly however psychoanalysis emphasizes transference, interpretation and working through; in fact analysis emerged on account of the fact that Freud recognized that abreaction was not enough. While Levi Strauss lacks support for his comparison between shamanism and psychoanalysis, there is no doubt that this healer helps this woman by explaining and confirming what they both believe to be the cause of the problem in a language which is understandable to both of them.

Narrative in psychotherapy

All therapies from psychodynamic to narrative therapy to CBT contain a 'therapeutic narrative' and begin with the therapist listening to the stories clients tell, and then clients are helped to gain a new perspective on their situation and new tools for coping with their problems. Since the contributions of Erikson and Volkan, there has been much attention to context and to therapeutic stories [narratives] in the lives of patients. Each approach deploys structural elements of narrative (metaphor, plot, character, character and point of view) to facilitate the reauthoring of their stories. Holmes [15] points out how metaphor-the juxtaposition of words to create new meaning-is a central part of dynamic psychotherapy.

'A metaphor is a fundamental narrative device: a memorable image that gives meaning to the patient's difficulty, a "third term" which helps a patient to begin to objectify her problems. It links together different aspects of the patient's life, and is open to discussion, modification, or elaboration by both patient and therapist. In a Winnicottian sense it lies "transitionally" between patient and therapist, with a life of its own, and is not wholly the property of either.'

Furthermore Holmes [15] notes that a significant part of the effectiveness of psychotherapy can be attributed to "common" or "non-specific factors" which constitute part of the therapeutic process, whether psychoanalytic or cognitive. Supportive psychotherapy is dependent upon this phenomenon for its usefulness. A basic technique in supportive psychotherapy involves encouraging patients to tell their story, and to "ventilate" their feelings about the events of their life.

Recent work on attachment research suggests that people who are able to "represent" and consequently reflect upon their experience in words, however problematic or painful, are more likely to be able to form secure attachments than those who lack such capacity [16]. Holmes [15], building on Fonagy [16] notes that reflexive function and narrative style generally are linked with early relationship patterns. Longitudinal studies indicate that children who are securely attached in infancy are more likely to demonstrate a coherent and "free-autonomous" narrative style when talking about themselves in early adulthood. This is in contrast to insecurely attached children whose narratives tend either to be overelaborated and confused (linked with

ambivalent attachments) or sparsely dismissive (linked with the avoidant attachment pattern).

Recovery

For narrative psychiatrists the stories people tell about themselves not only describe their lives but shape them as well.1 When old stories fail, new ones are required. This narrative insight fits well with the recovery movement. The central theme of this movement is a shift from the notion that the expert knows best, to one of service user control. The focus of narrative medicine is to emphasize subjectivity and the particular in the consideration of a patient's condition. This approach contrasts with the emphasis on objectifying and universalizing modern medicine. It can be seen, as Holmes [15] suggests, a counter reaction against the hegemony of evidence based medicine which applies the scientific method within a given reality. In his view advocates of narrative assert that with all the huge advances of modern scientific medicine there has been a loss of "meaning" in psychiatric practice and in what has been offered to the patient.

With the advent of the recovery movement in mental health over the last few decades [17], a new way of understanding depression has emerged, which differs from the idea of professionals counting symptoms and diagnosing depression. It moves beyond professional understandings of illness in terms of biology and psychology and the emphasis on psychopharmacology. For instance Styron [18] discusses how clients' narratives of depression often focus on biochemical themes. Indeed mental health clients are frequently taught to recount biological narratives focusing upon disordered brain functioning - 'neurochemical selves' [19] or 'pharmaceutical persons' [20] emphasising pathology and malfunctioning. Furthermore narrative psychiatry teaches that even psychopharmacology is imbued with meanings, medications have chemical and symbolic effects, both of which are responsible for outcome [21].

There is increasing awareness that personally meaningful recovery from serious mental disorder is not necessarily related to the specific treatments that are deployed [22] and that non –specific factors are important for the efficacy of drugs such as antipsychotics [23] and psychotherapy such as CBT [24]. Recovery is often defined as meaning 'building a meaningful and satisfying life, as defined by the person themselves, whether or not there are ongoing or recurring symptoms or problems' [25]. User-driven narrative approaches to depression and recovery do not replace medical approaches like the recognition of the meaning of symptoms, diagnosis, and provision of medical treatments in psychiatry.

Within this model clinicians stop asking; 'where is the pathology' and start asking 'how can I help' and start to open a clinical dialogue in a way that people can re-story their lives. Ridge and Zeibland [26] note that recovery tools may involve alternatives such as complimentary and analytic services and also attention to spirituality and to creativity and community and involvement that goes beyond the usual province of clinical models These authors found that mental health service users did not use a single approach rather they selected a variety of narrative tools such as talking therapy, yoga, complimentary therapies. A key finding was that recovery tools considered effective by patients are closely related to telling a good story about recovering from depression. For them the process of assembling a range of tools for recovery helped create the stories that were effective. Furthermore the most helpful therapies functioned as recovery allies rather than experts. The authors finally argue that we need to take account of the findings of the humanities, social science, medicine and psychotherapy to cultivate narrative psychiatry.

Using stories to teach mental health professionals about human values

The narrative move in psychiatry may be seen as an outgrowth of medical humanities and bioethics. Lewis [27] in Narrative Psychiatry: How stories can shape clinical practice argues that psychiatry pays scant attention to the intrinsic nature of patient's stories. he looks at how patient's stories can be understood using studies of narrative from outside psychiatry using philosophical and fictional writing such as Chekhov's play Ivanov and stresses the importance and uses of narrative material in psychiatric practice. He underscores the fact that narrative work in psychiatry provides an opportunity to put science in perspective to keep empathic meaning connections with patients at the center of psychiatric education, research and practice. For him DSM-3 represents a watershed moment when the field turns its focus to science and biology and now psychiatrists are losing their human skills. He argues that reading short stories with psychiatric trainees can counter this trend towards dehumanization and diminished empathy and cites Chekhov, Joyce, Camus who bring out a richness and depth of psychic life and suffering that could be impossible to reach in other ways.

Furthermore, he asserts, narrative psychiatry 'seeks a deep and empathic understanding of the patient as a person' and 'appreciates that the process of recovery often involves reauthoring and retelling the stories of our lives'. He asserts that while narrative psychiatry is aware of the use of medication and the distinction between disease and illness, most significantly 'narrative psychiatrists are self-reflexively adept at a narrative understanding of the many stories psychiatrists tell as they are at understanding the stories of psychic life that their clients tell' (p. 74). In a similar vein Deen et al. [28] demonstrate that when psychiatric trainees write narratives about their clients the creative practice fosters empathy and helps trainees to be more connected to their patients in developing interviewing skills and engage in more self-reflection. Tucker [29] found that reading short stories with psychiatric trainees can counter 'alienation. dehumanization, and diminished empathy', on account of the fact that writers such as Chekov, Joyce, Camus, and O'Connor bring a richness and depth to psychic life and suffering that cannot be reached in other ways.

Conclusion: Moving beyond the technological paradigm.

The above discussion has focused upon narrative and healing in mental healthcare. While narrative has a central place in psychiatry and psychotherapy this is by no means to deny that evidence based medicine is equally important and the two approaches complement each other. However, in agreement with Bracken et al. [30] I would argue that psychiatry needs to move beyond the current and predominant 'technological' paradigm which asserts that:

- Mental health problems arise from faulty mechanisms or processes of some sort, involving abnormal physiological or psychological events occurring within the individual.
- These mechanisms or processes can be modeled in causal terms. They are not context-dependent.
- Technological interventions are instrumental and can be designed and studied independently of relationships and values.

This technological paradigm ignores cultural beliefs and practices, meanings and relationships. Kirmayer and Gold [31] assert: 'Defining psychiatry as applied neuroscience valorizes the brain but urges on us a discipline that is both mindless and uncultured'. The emerging discipline of cultural neuroscience and recent interest in gene-culture interaction (epigenetics) integrates narrative, culture and neurology [29]. Emerging science shows us that relationships, meaning and narrative matter. Much of the therapeutic potential of psychiatric treatments, both psychological and pharmacological, derive from the non-specific elements of such treatments including meanings and relationships. We need a more nuanced form medical understanding and practice and it is here that client narratives are central.

Note

Lewis [27] has provided an excellent overview of narrative psychiatry and the discussion above derives from him.

References

1. Launer J (1999) A narrative approach to mental health in general practice. British Medical Journal 318: 117-119.
2. Levy JM (2005) "Narrative and Experience: Telling stories of illness". NEXUS 18: 1-26.
3. Good B (1993) Medicine, rationality, and experience: an anthropological perspective. Cambridge University Press, Cambridge.
4. Ochs E, Capps L (1996) "Narrating the self". Annual Review of Anthropology 25: 19-43.
5. Mattingly C (1998) Healing dramas and clinical plots: the narrative structure of experience. Cambridge University Press, UK.
6. Bruner J (1986) Ethnography as Narrative: The Anthropology of Experience. Sage, London.
7. Clark H (2008) Depression and Narrative. State University of New York Press, USA.
8. Bruner J (1990) Acts of meaning. Harvard University Press, Cambridge.
9. MacIntyre A (1980) Epistemological crises, dramatic narrative and the philosophy of science. In: C. Gutting (ed.), Paradigms and revolutions (pp. 54-74). Notre Dame: University of Notre Dame Press.
10. Kleinman A (1988) The illness narratives: suffering, healing, and the human condition. Basic Books, New York.
11. Waitzkin H (1991). The politics of medical encounters: How patients and doctors deal with social problems. Yale University Press, New Haven.
12. Mishler GE (1984) The discourse of medicine: Dialectics of medical interviews. Norwood: Ablex Publishing Corp,
13. Frank A. (1995) The wounded storyteller: body, illness, and ethics. The university of Chicago Press, USA.
14. Levi- Strauss (1967) The Effectiveness of Symbols." In C Lévi-Strauss, Structural Anthropology. Garden City: Doubleday.
15. Holmes J (2000) Narrative in psychiatry and psychotherapy: the evidence?. Med Humanities 26: 92-96.
16. Fonagy P (1999) Psychoanalytic theory from the viewpoint of attachment theory and research. Handbook of attachment, Guilford Press, New York.
17. Anthony W (1993) "Recovery from mental illness: The guiding vision of the mental health service system in the 1990s". Psychosocial Rehabilitation Journal 16:11-23.
18. Styron W (1990) Darkness visible: a memoir of madness. Vintage, New York.
19. Rose N (2003) Neurochemical selves. 46 Society 41: 46-59.
20. Emily Martin (2006) The Pharmaceutical Person. Biosocieties 1: 273-287.
21. Metzl JM, Riba M (2003) "Understanding the Symbolic Values of Psychotropic Medications". Primary Psychiatry 10: 45-48.
22. Davidson L (2003) Living Outside Mental Illness: Qualitative Studies of Recovery in Schizophrenia. New York University Press, USA.
23. Lepping P, Sambhi RS, Whittington R, Lane S, Poole R (2011) Clinical relevance of findings in trials of antipsychotics: systematic review. Br J Psychiatry 198: 341-345.
24. Jacobson NS, Dobson KS, Truax PA, Addis M, Koerner K, et al. (1996) A component analysis of cognitive-behavioural treatment for depression. J Consult Clin Psychol 64: 295–304.
25. Shepherd GJ, Boardman J, Slade M (2008) Making Recovery a Reality. Sainsbury Centre for Mental Health, London.
26. Ridge D, Ziebland S (2006) "The old me could never have done that": how people give meaning to recovery following depression. Qualitative Health Research 16:1038-1053.
27. Lewis B (2011) "Narrative and psychiatry." Current Opinion in Psychiatry 24: 489-494.
28. Deen SR, Mangurian C, Cabaniss DL (2010) Points of contact: using first-person narratives to help foster empathy in psychiatric residents. Acad Psychiatry 34: 438-441.
29. Chiao JY, Hariri AR, Harada T, Mano Y, Sadato N, et al. (2010) Theory and methods in cultural neuroscience. Soc Cogn Affect Neurosci 5: 356-361.
30. Bracken P, Thomas P, Timimi S, Asen E, Behr G et al. (2012) Psychiatry beyond the current paradigm. Br J Psychiatry 201: 430-434.
31. Kirmayer LJ, Gold I (2012) Re-socializing psychiatry: critical neuroscience and the limits of reductionism. Critical Neuroscience: A Handbook of the Social and Cultural Contexts of Neuroscience 307-330.