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Poon, Vincent H.K. "Narratives and Therapy." *Canadian Family Physician* 53, no. 11 (November 2007): 1881-1882.

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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