Dear Reader — a letter about stories, and vice versa

Dear Reader,

My name is Tim Caroe and I work as a GP. In my job, I often meet people who are struggling with things in their lives, and 2 years ago I began to feel dissatisfied with what I was able to bring to their distress, so I started investigating different types of therapy. I was most attracted by narrative therapy, a type of therapy used for many years by family therapists. This led me down a new avenue in my consultations, one which has led to me writing to you today.

In this letter, I'm going to tell you a bit about the theory of narrative, and then how I have used it in my consultations to date. As you read, I'm sure that my letter will stir up ideas of your own and it would be good if you could add these thoughts to my own, because I believe that something new can emerge through the meeting of ideas. That's the kind of thing that I hope happens when I write letters to people I meet in my job, people who are often called 'patients'.

So what is a narrative? It is much more than just a story. It is a created thread that links events in our lives and puts them into a context — it gives them a certain meaning. As such it tells us who we are, and where we are going. One philosopher wrote:

> *'Making sense of my present action … requires a narrative understanding of my life, a sense of what I have become which can only be given in a story … We grasp our lives in a narrative.'*[1]

In this setting, the stories we tell about ourselves create for us the reality that we experience, not the other way round; and stories, by their very nature, are told in language. Language therefore is no longer a passive vehicle for expressing our reality, but formative — it creates our reality. To give a familiar example, making a diagnosis, or giving a set of symptoms a name, can alter the recipient's experienced reality. Saying, 'You are depressed' creates a different set of expectations and experiences than those created by, 'You are feeling low', even though they may be describing the same phenomenon. Hoffman,[2] referring to the old proverb about sticks and stones, says that far from words never hurting, words are powerful, and names can often maim, and sometimes kill.

Being 'depressed' or 'feeling low' may both be 'true'. Both can be representations of an unknowable underlying reality, and as such can be equally valid simultaneously. As Bateson,[3] one of the early thinkers in this area, always liked to say — the map is not the territory. That is, our internal representations of the world can only ever be approximations. Which description someone holds for themselves affects the way that he or she see things now, and the way that they incorporate new things into their evolving narrative. It affects their 'lens' — that part of themself that dictates what they see in the world, what they perceive as real.

So our lens is affected by the narrative that we hold. For example, a person with a pessimistic narrative develops a lens which makes him see a half empty glass. This then confirms his belief that he is always short-changed. Or put into academic language:

> *'Eventually the culturally shaped cognitive and linguistic processes* [lenses] *that guide the self-telling of life narratives achieve a power to structure perceptual experience, to organise memory, to segment and purpose-build the very 'events' of a life. In the end, we become the autobiographical narratives by which we 'tell about' our lives.'*[4]

So far, I've referred to narrative as something purely inside our heads, but it's also important to see it in the social context of relationships. Narrative therapists hold to the ideas of social constructionism — that through social interaction over time, members of a culture construct their own reality. Thus, the story that I tell others about myself affects the stories they tell me back — it affects my relationships. As Taylor puts it, we know ourself in relation to other selves.[1] It is in relationships that we receive the feedback that shapes our narrative, and thus our perception of reality.

So, the narratives that shape our lenses are not created in isolation. Each person's narrative shapes the way they relate, and their relationships in turn shape their narrative. But these individual narratives are also influenced by norms, expectations and beliefs held at many different levels — for example by our family, our community and our over-arching culture.[5] My nuclear family promotes praise and shuns conflict. My community believes that you should keep yourself to yourself and my culture has a belief that there is no other way than democracy. Only getting married, changing my community and going abroad helped me to analyse the way that my lens had been influenced by these 'dominant discourses' — the way my reality had been shaped. A fish does not easily see the water in which it swims. An observer finds it hard to observe the way in which he observes.

What does this mean for my consultations? Well, I believe that the people I see can be helped to recognise their lenses and what these do to their perceptions of themselves and reality. We can look together at their narrative and create space to try out a new lens and to develop a different narrative — one that validates them and can help them resist the subjugation of oppressive community or cultural narratives. This can mean drawing out and strengthening hidden or forgotten narratives, which have been overpowered by their dominant narrative.

Medicine has recognised the power of narrative long before now. Helman's folk model of the consultation is all about narrative — how people put their illness experience into a coherent thread.[6] The narrative approach simply expands this and encourages people who are struggling because of their current narrative to put their life experience into a different, more empowering one.

How can that work practically? The first point is that theory is no good without good relationships. These are fundamental to any exchange of ideas, and narrative therapists believe that change occurs through the interaction between people.[7] The Cambridge–Calgary consultation model[8] also sees relationship building as vital — it is described as an on-going task throughout any consultation. A good rapport creates the opportunity for reflection.[9]

With the importance of relationship in mind, I think about three stages when I see people struggling with things and anxious for change.

In the first stage, I often find it helpful to explore with people how much their personal narrative is influenced by all the powerful narratives that surround them in families and the wider culture.

Families can be highly influential and I will often do genograms with people. These are family trees with a difference — they also include information about what has happened in people's lives and the relationships between family members. Often patterns of loss or break-up become clear and put the present into a context. Questions about what family members believe can help people to reflect on how their narrative has been influenced by their family.

Our culture has strong beliefs about the way things are — 'depression is always bad', 'young people should leave home' and 'real men don't cry'. It can be good to reflect on these socially-mediated cultural beliefs as they are often taken for granted and mistaken for 'truth'. I have had helpful discussions about how people feel society views them, and how these impressions of a societal norm can reinforce their problems. Taking a step back and reflecting begins to help us to see the way in which we are influenced.

The aim of these questions is to create a sense of perspective — to help people to see how their reality has been shaped. In doing so, they begin to feel the possibility of evolving new ways of looking at things.

I often use a technique called 'reframing'[10] which involves offering a different perspective on things. Taking our previous example of the pessimist, it can be applied to his lens 'had you ever thought the glass might be half full rather than half empty?'. More effectively though, it can apply to his narrative 'you say that you are a pessimist. Society often sees that as a bad thing, but had you ever considered that being good at seeing possible bad outcomes allows you to plan and prepare for the worst?'.

This leads on to the second phase — exploring new narratives. I ask questions about times the problem wasn't so bad, or when things were going right. This is not a history of the presenting complaint but of the forgotten strength. For example, we explore the joys and skills needed for paintballing with a lad who otherwise feels he cannot do anything and doesn't have any friends. We explore how someone's skill in disciplining her children doesn't fit with her view of herself as helpless when it comes to her 'out of control' eating. An alternative narrative can be drawn out that can empower people to see things differently. These stories are often initially fragile, and this brings us to the third phase.

People often express a real thoughtfulness after our sessions together, and I then ask them whether our discussion has been helpful and whether they would like some help remembering it. If they agree, then I arrange to write them a letter with the thoughts that we have had. The letter often starts with a reflection on their strength in telling their story, before going on to reflect on the 'problem' in a different light. I then focus on their hidden strengths and begin to offer an alternative narrative, before helping them project that alternative narrative into the future with questions like, 'I wonder what difference it might make if …?' The letter doesn't take long to write as its content comes mostly straight from the meeting and as it is really a continuation of our conversation, it is written in a conversational style.

Letter writing has always been central to narrative therapy[4] and I am only beginning to explore its possible use in primary care. They can have several benefits — they act as an aide memoir and are available for people to read over and over again, reminding themselves of their alternative narrative. In the same way that a new motor skill takes practice to become automatic, so the new narrative needs repetition to become more than just ephemeral. Also, it has been estimated that one letter can be as effective as four or five face-to-face consultations[11] and I hope that they will thus decrease visits for mental health issues that are normally dealt with in primary care.

I agree with John Launer[12] when he refers to general practice as 'ultra-brief, ultra-long' therapy. We see people over a long period of time for small snapshots and a consistent supportive approach can be the impetus for change. If we believe that no approach we can use will change people, then we are right. The locus of change is in the people we meet, but we can create space and signposts. I don't try to make a difference in people's lives, but to offer a difference that helps them to make a difference.

Although this letter itself is almost finished, in a narrative sense, it has only just begun. The last word is the beginning of its life off the page and I hope that as my thoughts and your thoughts meet, something new might evolve. As I often do in letters, let me finish with a few questions.

Are any of these ideas new and interesting for you? How might you follow them up? What might happen if you read a book about narrative therapy? Do you think that people you meet in your job might sense the possibility of something new if they could receive a letter?

I look forward to hearing from you,

Tim Caroe

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