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CLIENT NARRATIVES: A THEORETICAL PERSPECTIVE

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Abstract

The role of subjective client narratives in health care represents a clinical and therapeutic tool, useful in complementing objective, scientific data. Of particular interest to mental health practitioners is the role narratives play as a therapeutic tool to guide clinical practice. This paper lays a foundation for understanding the importance of narrative in the psychotherapeutic process. It provides a brief overview of narrative theory and methods of structural analysis in order to provide a theoretical approach that can be utilized by nurses to address clients' needs.

The role of subjective client narratives in health care has attracted the attention of clinicians and scholars alike. Personal stories of illness, it is argued, are useful in developing health care practices that are more ethical (Nelson, 1992, 1997; Noddings, 1984) and equitable (Charon, 2001). Of particular interest to practitioners, however, is the role narratives play as a therapeutic tool to guide clinical practice. This paper provides a brief overview of narrative theory and methods of structural analysis, in order to suggest a theoretical approach that can be applied by nurses to client narratives in therapeutic health care practice.

NARRATIVE THEORY

Narratives are subjective, personal accounts told to others as stories, and have long played an important part in all areas of healthcare, especially psychiatry and psychotherapy. There are numerous, highly individual accounts by clients about their experience of health and illness. As noted by medical ethicist Howard Brody, the training of health care professionals typically focuses on objective and scientific material; however, the most meaningful teaching moments often begin with the phrase: "I once had a client who ..." (Brody, 1987). Narratives are much more than a series of short quotes or objective summaries documented in the client's medical record. Rather, they are a tool for inquiry into the social, ethical, and therapeutic practice of client care. In this respect, narratives are useful as a means of exploration, interpretation, and a means of forming consensus between clients, families, and practitioners.

Narratives are a linguistic form that have a number of defining features. They have a definable structure and longitudinal time sequence (e.g., a beginning, a middle, and an end). The telling of the story will be affected by both the narrator and the listener, each with a different perspective that will affect how the story is told (Greenhalgh & Hurwitz, 1999). There is no definition of what is relevant or irrelevant in any particular narrative—the choice of what to tell lies entirely with the narrator, but may be modified by the questions or reactions of a listener (Greenhalgh & Hurwitz, 1999). Furthermore, narratives are subjective; different narrators will give different accounts of the same events, and one narrator's account may differ depending on the audience or the occasion in which it is shared.

Interest in the use of narratives can be traced to the influence of intellectual traditions in such disciplines as literary criticism, political science, and sociology, which critically examine historical accounts of dominant social groups through the lived experience of private individuals (Strand, 1997). Such interest is reflected in the increased use of qualitative methods of inquiry which seek to provide comprehensive pictures of complex phenomena, emphasizing the meanings, experiences, and views of all (Pope & Mays, 1995), as opposed to “getting the story right” (Flick, 1998).

NARRATIVE THERAPY

Appreciation of narratives as a tool for the creation of new meaning and understanding has been particularly important in the area of psychotherapeutic practice. In contrast to cybernetic models, which perceive the therapeutic relationship as a feedback loop in which the therapist helps lead clients to new information about themselves, narrative therapy focuses on the clients' experience and meaning (Zimmerman & Dickerson, 1994). Therapy, thus, becomes an opportunity to permit clients to explore and examine their narratives (through which they frame their experiences). The goal of therapy is to help clients “alter their lives by moving away from problem-dominated stories ... toward stories that highlight possibility and opportunity” (Strand, 1997, p. 325). The client determines what sort of narrative he or she constructs. Therapeutic narratives tend to be successful when they have both internal and external coherence. That is, when there are no contradictions within the story, and when they do not come into irresolvable conflict with others' accounts of relevant events (Focht & Beardslee, 1996; Schwartz, 1999). While it is not the therapist's role to dictate the content of the client's narrative, the therapist may challenge the client's interpretation of the narrative. In this way, unproductive life narratives can be altered (Kogan & Gale, 1997). Ultimately, the role of the therapist is to become a coparticipant in the “world-making and un-making process” (Weingarten, 1998, p. 5).

THERAPEUTIC VALUE OF NARRATIVES

Narratology was originally understood as a broadly based hermeneutic approach to literary criticism, interpreting written texts and combining rhetorical, psychological, and theoretical analysis. More recently, it has been expanded to examine not only written texts, but also oral narratives told by individuals in normal conversational situations (Labov & Waletzky, 1997). Narratological analysis examines the way in which the narrator emphasizes, sequences, and gives meaning to the elements of the account. Such analyses do not aim to validate theory, but only illustrate it, as a means to guide further inquiry and discussion (Riesman, 1993).

The importance of client narratives in the therapeutic process has been examined in a variety of populations, including cancer patients and trauma survivors (Carpenter, Brockopp, & Andrykowski, 1999; Facione & Giancarlo, 1998; Morse & O'Brien, 1995; Pennebaker & Seagal, 1999). More recently, authors have described methods for evaluating client and caregiver narratives, drawing upon the work of literary critics such as Paul Ricoeur (Frid,

Oehlen, & Bergbom, 2000; Walker, 1995) and Mikhail Bakhtin (Bowers & Moore, 1997; Harden, 2000).

Narratology examines narratives as dynamic, interpersonal, communicative acts spontaneously co-constructed through the interaction of the narrator (e.g., client or family member) and listener (e.g., a practitioner). Such a conceptualization is consistent with the suggestion that clinicians may provide useful therapeutic interventions through empathetic and critical listening to client narratives. This is done through directing and redirecting narratives in positive ways (Frid et al., 2000). So viewed, the clinician assists in the work of storytelling as the act of selecting, gathering, and organizing events, which fulfills a potential need for delimiting, ordering, and making explicit (Ricoeur, 1991).

An important difference is noted between narratives shared within a group and those told within an individual interview. Narratives told one-on-one to a clinician are subject to immediate feedback and co-construction between narrator and listener. Theories of interpersonal communication can be useful tools in the analysis of the structure and creation of these narratives. Narratives told, for example by survivors of suicide, in a group setting are somewhat different. These narratives are told to an audience which reduces listener participation, feedback, and co-construction. Analytical approaches borrowed from literary criticism, such as narratology, may be appropriate for examining the dimensions of narratives shared within a group setting.

ORGANIZATION OF NARRATIVES

A variety of paradigms have been suggested to describe and analyze the ways in which clients organize, edit, and communicate narratives. For example, Ezzy (2000) delineates three types of narratives used by HIV/AIDS patients: linear restitution narratives, linear chaotic narratives, and polyphonic narratives. Linear restitution narratives are optimistic in nature, reflecting the narrator's confidence that his or her future will be well-managed through medical and/or other human intervention. While linear chaotic narratives also reflect a belief that suffering and illness can be controlled by proper health or social interventions, the narrator expresses anxiety that he or she may not have proper access to these resources. In contrast to linear narratives, polyphonic illness narratives depict the future as uncertain, focusing instead on the present; they depict illness as the catalyst for increased self-understanding and spiritual insight (Ezzy, 2000).

When examining the organization of narratives, Stern and associates delineate two types of structures that characterize client accounts of traumatic life experiences: restitution and chaos (Stern, Doolan, Staples, Szmukler, & Eisler, 1999). In stories of restitution, the traumatic experience is turned into a meaningful event that becomes a formative event in the narrator's life story. In contrast, chaotic narratives recount a series of random events that retain the power to displace the narrator and prevent him or her from regaining mastery over daily life (Stern et al., 1999).

Along similar lines, Polkinghorne (1996) offers a paradigm of victimic and agentic narratives. These forms of narratives are closely related to plot structures, which have been carefully analyzed by literary theorists. Historiographer Hayden White (1990) notes that plot structures constitute not only the way in which the sequence of events is fashioned into a story, but also the type of story that is told. Agentic narratives depict the sequence of events in such a way as to suggest that the narrator is in control, despite disruption by traumatic life events (Frye, 1957; Polkinghorne, 1996). These narratives depict a purposeful, skillful protagonist actively engaged in the process of adapting to and overcoming challenges (White, 1990). Agentic elements may be seen in the narrative of an AIDS patient who speaks of his disease as a sort of disguised "gift from God." The narrator asserts that awareness of his disease and mortality

has enabled him to embrace a new life based on spirituality. Morse and O'Brien (1995) offer examples of agentic narratives provided by individuals with permanently disfiguring injuries, who speak of coming to terms with their diagnoses and getting on with the painful but necessary business of adjustment and reconstruction of their lives.

On the other hand, victimic narratives describe a situation that is governed by forces beyond the narrator's control (Frye, 1957; Polkinghorne, 1996). The individual perceives his or her life to be under the control of others. The victimic narrator's life outcomes are determined by both the actions of others and chance. The accomplishment or failure to achieve one's life goals depends on factors that are unable to be changed (Polkinghorne, 1996). These characteristics are seen in a narrative provided by a young man recounting his diagnosis of diabetes. Although sure he was suffering from diabetes and outlining his symptoms accurately for numerous doctors, he was repeatedly misdiagnosed. He encounters an occasional competent health care worker, who berates incompetent colleagues, and who "dumps me in a wheelchair" to be taken for immediate assistance. Invariably however, the clinic doors are closed, appointments are unobtainable or at least two weeks away, and soon he watches in despair as his health is again put in jeopardy (Greenhalgh & Hurwitz, 1999, p. 49). While the agentic narrative portrays a positive resolution of conflicts, victimic narratives move toward inexorable decline, chaos, and death (Frye, 1957).

AGENTIC AND VICTIMIC NARRATIVES

Bruner (1994) warns against oversimplification of agentic and victimic narratives as active versus passive or optimistic versus pessimistic. Victimic plots often obscure the passivity of the protagonist through a "reactive agent" (e.g., a rebel or resistance leader). An example of reactive agency in a victimic plot is illustrated in the narrative of a woman who relates how she became verbally abusive to an unfair social worker—an action which caused needed services to be delayed. Although the woman "stood up for herself," her defiance nevertheless resulted in further victimization, rather than in an improvement of her condition.

The optimism of agentic plots, on the other hand, may appear attenuated by frequent moments of self-critique, something Bruner refers to as "an arraignment of oneself against a set of normative standards" (Bruner, 1994, p. 49). This may be demonstrated in the example of a woman who is pleased by her success in obtaining permanent housing after living in a homeless shelter. She speaks critically and disparagingly of her inability to control her temper or speak articulately with the homeless shelter workers. She depicts this inability as a shortcoming that she must try to overcome in order to more effectively advocate for her rights.

In summary, Bruner's observations underscore the function of life-narratives as expressions of values. Often client narratives can be placed into one category that emphasizes control over the future and positive change, or another category that suggests powerlessness and an inability to change the present situation. In victimic plots, the narrator judges the actions of others, and reacts to those actions through acquiescence or rebellion. In contrast, the agentic narrator judges his or her own actions, and pronounces them to be either good or bad.

CONCLUSION

The values underlying the agentic narrative (self-determination and personal responsibility) are privileged in Western culture, while features of victimic narratives (inability to affect change in one's life and submission to the control of others) are devalued. Reflecting this Western cultural bias, agentic narratives may be viewed as a sign of psychological adjustment. A number of therapists have suggested that the role of therapeutic interventions is to help clients replace victimic with agentic-type narratives (Ezzy, 2000; Frid et al., 2000; Polkinghorne, 1996; Strand, 1997). However, because of this cultural specificity, therapists working across

and within non-Western cultures must look to other paradigms in the use of therapeutic narrative (Shonfeld-Ringel, 2001). Viewed from this perspective, the clinician's skills of listening, questioning, interpreting, and explaining (Greenhalgh & Hurwitz, 1999), as well as the narrator's "telling of the story," may have as much influence on the outcome of an illness or situation as the more scientific and technical aspects of a particular treatment. Although the purpose of psychotherapeutic groups vary, therapeutic interventions can be viewed as fostering the development of agentic narratives. Both group facilitators and other participants can encourage the development of agentic self-narratives. The reader is referred to a later article in this issue entitled, "The Use of Narrative Data to Inform the Psychotherapeutic Group Process with Suicide Survivors," in which an in-depth examination of group participant narratives from a survivors of suicide bereavement support group is presented.

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