Beyond Empowerment: Revering the storyteller

The Evidence of Story-making

Almost seventy years ago, in an attempt to describe the complex phenomena of psychosis, Harry Stack Sullivan coined the term 'problems of living' (Evans, 1996). Thomas Szasz (1961) later popularised the expression, by describing how a wide range of people experienced great problems in *living with others* and (often) in *living with themselves.* These facts of human living become obvious when we spend time with people who are 'mentally suffering' (Lynch, 2001). The nature of the distress associated with such suffering, and its effect on their private and public life, is gradually revealed as we are granted privileged access to their story. Indeed, aside from the often fanciful interpretations and observations, which professionals make about people in their care (Kirk and Kutchins,1997), all that we have to work with *is* the story, which embraces everything of any significance for the person. This is the heart of the person's human experience and, as such, should be the primary focus of any attempt to help the person.

Despite the increasing emphasis on 'evidence' the inescapable fact of mental health practice is that stories are the most valuable, yet neglected, form of evidence. Practitioners – whether nurse, psychologist or psychiatrist - only *know* that a person is making progress or getting, when they shape their own story of what has been said, heard, noticed or otherwise presented as 'evidence' to their professional senses. Ironically, such everyday evidence is often discounted in favour of counting, rating or framing diagnostic abstractions from the person's lived experience of problems of human living (Kirk and Kutchins, 1997).

Professionals also have long been encouraged to think and write in the third person, in an attempt to make their story appear more 'objective'; as if they were not an integral part of the story telling. History may well judge this practice to be deluded in its self-deception. This mimicry of the objectivity of the natural sciences ignores the critical facts of human behaviour: that when one person encounters another, a singularly unpredictable and creative exchange develops. Given that any story requires both a teller and a listener, it follows that each will bring different thoughts, feelings and other reactions to influence the story content. As the story-*teller* engages with the story-*hearer*, a *co-created story* emerges; one which belongs to neither alone, but to both as a shared

experience.

Re-Authoring the Story

These reflections are critical for any understanding of the role of story in mental health care. According to de Shazer's own story of psychotherapeutic change, all therapy "boils down to stories about the telling of stories, the shaping and reshaping of stories so that troubled people change their story" (de Shazer, 1994:p xvii).   This reflects as much the everyday practice of nursing, social work or medical practice, as it does the more formal listening process of psychotherapy. We have spent a combined 65 years listening to the stories of people, variously described as physically, mentally, emotionally or behaviourally, challenged, challenging, disturbed, distressed, disordered and otherwise upset, ill or abnormal. We long since came to the conclusion that the various labels, classifications, categories and definitions, which professionals conjure with, obscure rather than illuminate the person's story. However, the diagnostic story continues to hold its power in mental health practice, despite the increasing realisation that this is just one way of *condensing* a person's story of distress (Kirk and Kutchins, 1997; Parish, 2003).

The Finnish psychiatrist Yrjo Alanen and his colleagues developed a very pragmatic approach to the story of schizophrenia, recognising that (and their families) needed help to :

> "conceive of the situation (e.g. admission) as a consequence of the difficulties the patients and those close to them have encountered in their lives, rather than as a mysterious illness the patient has developed as an individual" (Alanen et al, 1991).

This attitude emphasised the centrality of the lived-experience of the person at the centre of the maelstrom of mental illness, and of those 'significant others' who are often indirectly influenced by it. Alanen's work displays a great sensitivity to, and respect for, the profound nature of the person's story (Alanen, 1997). It also recognised that the diagnostic story might erase completely the original understanding of the problems of living, which prompted the person or family to seek help in the first place. This does not mean that professionals have to abandon their various theoretical or professional perspectives entirely. However, Alanen's approach illustrated the virtue of respecting the critical starting point in the re-authoring of the story of mental distress.

We have been involved with a wide range of psychological and psychotherapeutic 'models' of human service (Barker, 1999). It is clear to us

now that the differing 'schools' of psychiatry, mental health, recovery, psychotherapy and counselling, are all part of the "rival storytelling industry," which emerged from what de Shazer called Freud's "Viennese tales" (de Shazer, 1994: p xiv). The psychiatric scientism, so popular today, has bred all manner of 'explanations' of human distress - from the perceived influence of the gene pool (Wildenauer et al, 1999) to the 'rationalism' of Rational Emotive Therapy (Ellis, 1980) or Cognitive Behavioural Therapy (Beck, 1976). Each represents versions of the detective story and involves digging beneath the story's surface to find some 'objective truth'. Freud was a great admirer of the Sherlock Holmes stories and his sleuthing style of human inquiry remains popular. The facts of the matter may, however, be simpler, yet paradoxically more complex, than Freud or any of his 21st century neuro-psychiatric-cognitive descendants envisaged.

Talking the Story

As Hilda Peplau once observed, in conversation: "People make themselves up as they talk" (Peplau, 1994). The stories, which people tell about their lives, are part of a work in progress. However, their various meanings, significant events, and associated emotional, behavioural and situational 'anchors', are as much a function of who is *listening* to the story, as who is telling it. The assumption that the stories of our lives are based on facts that exist 'out there', in some objective space, is naïve in the extreme. What we are willing to tell of the story of our lives is always contextually bound (Mishler, 1979). Story telling is a dynamic process. As professionals, our first important contribution to this process should be to respect the awesome nature of this story, and to revere the storyteller.

The Power of the Story

These assumptions underpin the *narrative* approach to helping people with problems of human living (Brunner, 1990; Caee, 1998; Crossley, 2000; Sarbin, 1986). Forty years ago Berger and Luckman (1963) argued that:

> "Identity is formed by social processes (however) the identities produced by the interplay of organism, individual consciousness and social structure react upon the given social structure, maintaining it, modifying it, or even reshaping it (p. 173)".

Despite all our talk of individual responsibility and this is largely illusory. The 'individual' does not stand alone, but rather is part of a reflexive web of influence, within which meaning making flows back and forth.

In the contemporary psychiatric/mental health field much emphasis is given to the importance of 'empowering' people (Barker et al 2000). However, Alanen showed that there was no need to 'empower' people: since they already possessed their own power – which was framed in one sense by their story of their problems of living. By offering (and especially by imposing) diagnoses, which people have not asked for, we disempower them by subjugating their original story, and invalidating all the lived experiences associated with it.

Many psychiatric professionals display divided loyalties. On the one hand they earnestly wish to respect the person who has become the patient, but at the same time many try to view the person through the highly distorting lens of professional 'objectivity' (Parish, 2003). For generations, psychiatric medicine (and more recently psychology and nursing) has tried to shape itself into a scientific discipline, which might reveal fundamental, predictable, 'truths' about the human conditions of 'illness' and 'wellness'. The narrative approach challenges this scientific posturing, by suggesting that people *write* the story of their lives, through the 'lived experience' (Weingarten, 1998). The human states that we label mental 'illness' or 'health' are *co-created* by the person, those around the person and other, immediate and historical aspects of the person's 'world of experience'.

Learning from the Person

Mental 'illness' does not *happen* to people, in the way that they may be struck down by a passing virus, or a passing car. Rather, people are involved in the construction of their mental distress, which is not to say that they 'make it up', any more than any of us could say that we 'made up' the story of our miserable childhood. However, people are intimately involved in the construction of their life stories. When we swim, we become *at one* with the water. We influence the water, which envelops us, to move through it, towards our destination. However, at no time are we in control of it; and at no time does the water control us – unless we begin to drown. In the same way, it could be said that, to some extent, we *live* our lives but our lives also *live us*. When people tell us their stories they often tussle with this paradox, which lies at the heart of our lived experience. That people try to *make sense* of what is happening to them, what it *means* to them, what part they may or may not have played in *generating* such experiences, illustrates why we should learn from them.

The person who has become the patient is the teacher and, if supported by family or friends, represents a small 'university' for the professional. Here, metaphorically, at the person's feet, we can learn what 'needs to be done' to help the person address, approach or resolve, their problems of living. We can

also learn what part we, or others, might play in enacting the kind of response to these problems of living that makes sense to the person. Here, in this shared experience, begins the re-authoring of the story of distress.

The Primacy of the Person

By revering the storyteller we begin to appreciate the person's hidden depths, acknowledging that – given the vast ocean of the person's experience - we can only ever hope to know a tiny amount of *who* and *what* they are, as persons. Knowing *patients* is fairly easy, since we have a pre-formed template in our head, informed by diagnosis or theory. *People* are, metaphorically, a quite different kettle of fish.

The *Tidal Model* (Barker, 2002; Stevenson and Fletcher, 2002) holds that the narrative is the metaphorical rudder for the practitioner. We seek an understanding of *how* the person became emotionally, physically or spiritually *'shipwrecked',* and seek to identify what might help them repair the evident damage to their life stories, so that they may begin again to chart the course of their life journey*.*

But first, professionals must dip their toes in the water to begin the engagement process. To do so we need to believe:

- that recovery is *possible*
- that change is *inevitable* - nothing lasts
- that *ultimately,* people know what is best for them
- that the person possess all the *resources* needed to begin the recovery journey
- that the person is the *teacher* and we, the helpers, are the pupils
- that we need to be creatively *curious*, to learn what needs to be done to help the person, **now**!

The first step towards becoming an effective helper is to recognise that our beliefs about the person, and the possibility of their recovery, will make a crucial difference to our practice. The 'self-fulfilling prophecy' is of critical importance to the therapeutic outlook (Merton, 1968). If we believe people can move forward, they probably will and if we believe that they can't, they probably won't.

The Tidal Model practitioner believes that change is ongoing - people are constantly changing, albeit in subtle ways. Consequently, the therapeutic attention is focused on helping the person develop her or his awareness of what is happening in the 'me-now'.

- What does the person feel, or think, or believe is happening right now?

- How does the person explain or otherwise make sense of this 'happening'?
- Finally, and most importantly, what does the person believe needs to happen next?

This focus on the person's 'lived-experience' lies at the heart of the Tidal Model and, critically, the person's story is always framed in the first person – whether in the various assessments or in the development of the care plan (Barker, 2002). This acknowledges that, despite the legislative and bureaucratic emphasis on medical and nursing records, the story of the experience of distress and the story of the experience of care and treatment, belong entirely to the person in care.

Stories from Practice

Sally Clay's experience of the mental health system began in the Bronx, New York almost forty years ago, and she believes that she continues to sail in and out of the many states of madness (Clay, 1999). However, she also believes that:

> "…health, or sanity, can be achieved even within an affliction or a disability (but) it is important to expand our definition of sanity to include clarity and compassion that can exist within so-called 'symptoms' " (Clay, 1999: p32).

Such views led her to comment that:

> "The *Tidal Modal* makes authentic communication and the telling of our stories the whole focus of therapy. Thus the treatment of mental illness becomes a personal and human endeavour, in contrast to the impersonality and objectivity of treatment within the conventional mental health system. One feels that one is working with friends and colleagues rather than some kind of "higher-up" providers. One becomes connected with oneself and others rather than isolated in a dysfunctional world of one's own"(Clay, 2003).

On the other side of the world, *Rangipapa* is a secure psychiatric facility for people with serious mental health problems in North Island, New Zealand. Many

of the residents originate from the indigenous Maori or Pacific Island communities, which often reject the Western 'story' of 'mental illness'. Ngaire Cook's (2002) ongoing evaluation of the Tidal Model at *Rangipapa* illustrates the residents' positive view of the narrative focus, and also the 'optimistic' expectation that 'change is a constant'.

- "The Tidal Model requires the nurse to work in collaboration with the client".

- "The Model gives direction - such as the solution groups, which helps me to reflect on my issues".

- "It helps us to feel we are working in a communal situation for our own gain"

- "I feel that the nurses are more along side us as opposed to being on the other side of the fence"

- "The Tidal Model makes you feel you matter".

The Journey towards Self-Healing

Hubble and his colleagues (1999) showed that the actual *methods* or *techniques* of psychotherapy accounted for less than 15% of the change effect. *Placebo effects*, *hope* and *expectancy of change*, account for 15% of the change effect; the person's *relationship with the therapist* accounted for 30% and more than 40% of the change effect depended on the *clients themselves*. This led them to describe this as the 'engine' that makes therapy work:

"The client's own generative, self-healing capacities allow them to take what therapies have to offer and use them to self-heal"(p 14).

Therapists of all kinds certainly set the stage and serve as assistants. "They do not provide the magic, although they may provide the means for mobilizing, challenging, and focusing clients' magic" (Hubble et al, 1999: p 95).

The experience of distress and the experience of care and treatment represent critical chapters in the autobiography of the person who becomes the patient. The evaluative stories from the Tidal Model that are emerging from the different parts of the world offer an everyday confirmation of the power of the story-teller, alluded to by Hubble et al. They also suggest how nurses can play a critical role in optimising the power of the story, in the person's journey towards self-healing. Perhaps reverence for the story-teller is the oldest form of empowerment.

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