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Narrative practices in medicine and therapy: Philosophical reflections

Abstract

This article examines two important movements-narrative medicine and narrative therapy-that aim to put narrative practices at the heart of medicine and therapeutic practices. It exposes the core assumptions of these movements and identifies ways in which attention to those assumptions can benefit from philosophical clarification and further investigation. Overall, our analysis defends the view that being a competent narrator matters for understanding and building trust with others, and that it also matters for shaping ourselves because the narratives we weave can help us to see "live options" and improve our chances of flourishing and living well.

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Narrative Practices in Medicine and Therapy:

Philosophical Reflections

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Narrative Practices in Medicine and Therapy:

Philosophical Reflections

Daniel D. Hutto, Nicolle Brancazio and Jarrah Aubourg

> "By telling stories to ourselves and others …we grow slowly not only to know who we are but also to become who we are."
>
> - Charon, p. vii

Being a competent narrator matters. It matters for understanding and engaging with others, and it also matters for shaping ourselves, to see 'live options' and to improve our chances of flourishing and living well. The importance of developing narrative skills and their transformative potential is becoming more recognized. This paper examines two important movements – narrative medicine and narrative therapy – that aim to put narrative practices at the heart of medicine and therapeutic practices. It exposes the core assumptions of these movements and identifies ways in which attention to those assumptions can benefit from philosophical clarification and further investigation.

Taken together these two initiatives are bent on improving the narrative

competencies not only of those who care for suffering individuals, but also of suffering individuals themselves, with an eye to improved outcomes. The programs of narrative medicine and narrative therapy are united in seeing enhanced narrative skills as a key to better outcomes for health care practitioners, therapists and those who are seeking to address persistent problems in their own lives. Crucially, the point of these efforts is to enable better results for individuals seeking help and relief.

Both initiatives are founded on the view that narrative practices play fundamental roles in improving health and mental health. Narrative medicine and narrative therapy seek to accomplish this in different ways, by helping us to better understand others and by transforming the prospects for achieving psychosocial wellbeing, respectively. Crucially, the cornerstone of both narrative medicine and narrative therapy is the assumption that becoming skilled in narrative practices –becoming more narratively competent– can transform our ways of interacting and engaging with others, and also making a fundamental difference to what we see the world as offering to us as well as our potential to respond to such offerings.

This paper attempts to lend philosophical support to these narrative-focused movements in healthcare and therapeutic practice. Section one introduces the motivating insights that have inspired and driven the narrative medicine movement. Section two takes the analysis two steps further. First, it refines our understanding of the goods narrative medicine promises – of what it aims to deliver. Second, it asks us to rethink the program narrative medicine uses to instill the relevant narrative competence. Section three considers how attention to patients' narratives yields insight into their attitudes in ways that can help health care practitioners to understand

and thus build trusting relationships with their patients. This not only treats patients respectfully but also provides predictive grip on their medically relevant behaviors. Section four switches gears and introduces the central tenets of narrative therapy. Narrative therapy's ambition is to improve the life skills of patients by enabling them to tell richer life stories. The practice raises a puzzling question: how are the remarkable transformations that narrative therapy promises brought about by clients telling more robust stories about their lives? The paper concludes by showing that a promising answer is to understand how clients can change their responsiveness to affordances –their possibilities for acting– by enriching the narratives they tell about themselves.

1. What's the Story with Narrative Medicine?

There is something rotten in contemporary medical practice, if the proponents of narrative medicine are to be believed. According to their diagnosis, today's medical practice is so much in the thrall of dealing with disease efficiently and in evidence-based ways that it has downplayed the human side of the profession. This is reflected in, and put down to the training received by health professionals. Chapple, a medical student herself, highlights the issue when describing her education in the field in the following terms:

> Modern medical training emphasizes the scientific, technical and practical. Although patient communication, empathy and professionalism are rightfully given

> prominent places in modern medical school curricula … we never discussed the bigger questions that underlie all this effort to appear caring, for example, *how to stimulate and sustain genuine interest in the … people we will meet as patients* (Chapple 63, emphasis added).

The need to address this failing in standard medical education is pressing because a number of intellectual and emotional barriers separate health care professionals from those in their care.

Advocates of narrative medicine propose a solution. They hold that the state of medicine can be improved, at least partly, by providing specialized narrative training to healthcare professionals. The key idea behind the narrative medicine movement is that strengthening the narrative capacities of those charged with the care of others will bring about better 'healing relationships' with patients, thus improving "individual practice, clinical education, health professional standards, national policy, and global health concerns" (Charon viii).

Charon, the founder of the movement in the United States, promotes a vision of narrative medicine as "medicine practiced with these narrative skills of recognizing, absorbing, interpreting, and being moved by the stories of illness" (Charon 4). Arguably, the mastery of narrative competencies and skills is needed to achieve an understanding of reasons for action involves producing and consuming explanations of actions in the form of personal narratives (Hutto, *Folk Psychological Narratives*).

The key assumption of narrative medicine is that by improving the narrative skills of health professionals, the program of narrative medicine deepens their empathetic

ability to listen to and learn from their patients. Genuine engagement with the stories of patients helps to bring them back into the fold: by understanding and appreciating the narratives of those who are ill, medical professionals provide better company and better support, by enabling patients "to feel included among those who are not ill" (Charon 21).

It is through a greater ability to appreciate the narratives of patients that it becomes possible to maintain stronger, more reliable and more trusting relations between doctors and patients.

What is the putative payoff of such efforts? There is the immediate consequence that when health care professionals are able to bear witness to suffering, through such acts alone, they help to alleviate it. Chapple enumerates the potential benefits of developing these skills as including "the preservation of empathy throughout medical training, reduced doctor burnout, exhaustion and disillusionment, and better outcomes for our patients" (Chapple 65).[1] Charon also identifies a range of other –more instrumental– anticipated results that she regards as being:

> bound to enhance clinical effectiveness, not only by guiding choices of treatment interventions but also by alerting doctors to all considerations that might help or hinder patients from following medical recommendations and becoming true partners in achieving and maintaining the best health within their reach (Charon 27).

In sum, Charon and Chapple identify the source of failings in the education of

medical professionals in their specialized training that focuses on technical at the expense of the humane.

2. Rethinking The What and How of Narrative Medicine

With respect to what narrative medicine hopes to achieve, its proponents typically emphasize the prospects of improving empathy by improving narrative competence. Their standard assumption is that improved narrative capacities “will lead to more humane, more ethical … care” (Charon vii). Yet, despite the great attention they give to the importance of promoting empathy, the link between empathy and better ethical outcomes has been questioned. Skeptics of the whole approach, such as Rafael Campo, are quick to observe that, “no one has proven that injecting the humanities in any form into medical settings translates to more humane physicians or better cared-for patients” (as reported in Gordon 420).

This may not be surprising in light of arguments that empathy is not only unnecessary for ethical conduct but that it can detract from it. For example, empathy can lead to unwarranted preferential treatment, is prone to in-group biases, and so on (Prinz 13). Thus it is questionable whether in general promoting empathy is desirable in-and-of-itself since it does not necessarily, or reliably, result in ethical behavior.

Charon holds that to appreciate the plight of patients in a properly empathetic way, with full and nuanced understanding and appreciation, “requires that doctors enter the worlds of their patients, if only imaginatively, and to see and interpret these worlds from the patients’ point of view” (Charon 9). In this regard she speaks of the lack of

understanding on the part of health professionals as creating ‘unbridgeable chasms’ between them and their patients (Charon 19).

We think narrative medicine is right to focus on developing a *narrative* competence when it comes to helping healthcare professionals to better understand others. However, what matters is not that empathy, and thus assumed better ethical conduct, *per se* is gained through improved narrative competence but that such understanding is itself enriched.

Importantly, the understanding in question cannot be reliably achieved by just any old act of the imagination, and certainly not by means of third personal speculation or ‘mind guessing’. Charon’s account of a real-life encounter with one of her patients and subsequent attempt to narrate the event brings out this point quite vividly. She was stopped by a patient while hurrying out of her office and asked to sign a disability form for her. Late for a meeting and thinking the patient lacked adequate grounds for her request, Charon was irritated but signed the form anyway, with some impatience (Charon 5).

Feeling some guilt at her behavior, Charon later attempted to imagine what might have motivated her patient’s behavior. She crafted a completely fictitious and wholly misleading story, in which the patient’s – who Charon dubbed Luz – disability payments were being used to fuel her dream of becoming fashion model.

Charon later discovered the truth behind Luz’s actions was much, much darker; the real motivation for the request was a desperate need to escape sexual abuse. Thus Charon came to realize that “My hypothesis about the modeling career was all wrong —in my story, Luz was running toward something, when, in fact, she was running

away" (Charon 6).

Charon claims that her "acts of guessing at the patient's situation and trying, imaginatively, to make sense of her behavior had some profound dividends" (Charon 6). She holds that "this narrative act helped [her] to get closer to the patient" (Charon 6). Yet at most the act of producing such a false narrative only did so by serving as a spur to go beyond spectating and to actively engage the other: "I had tried, in my imagination, to make sense of her unexplained behavior while realizing what my own behavior must have connoted. *And so I asked her with great interest and regard about the situation*" (Charon 5).

This is a perfect example of –what Hutto elsewhere labeled– the Horse's Mouth Principle in action (see Hutto, *Folk Psychological Narratives*). According to that principle, an understanding of another's reasons for acting is achieved most reliably, though still fallibly, through direct second personal dialogue rather than by means of third personal theorizing or imaginative simulation (Hutto, "The Limits of Spectatorial Folk Psychology").

When we want to genuinely understand another's situation we have no choice but to move beyond adopting a merely spectatorial stance. We need to access their narratives, not speculatively theorize or imagine what the other's circumstances and state of mind might be.

Why do we need narratives to obtain such an understanding? It is because only narratives provide the requisite "rich, particularized, and unified histories of cycles of thoughts, actions and contingencies" (Currie 36). In other words, narratives are special because they focus on particulars not generalities. They:

> provide explanations of why someone had a particular motive, or why someone has a particular character or personality trait, or why someone was drunk, depressed or angry. And the explanations we get are narrative-historical explanations, they locate the motive, the trait, the undue influence on thinking, within a wider nexus, in a way that enables us to understand more deeply why someone did the thing they did through appeal to aspects of their personal history or circumstances (Goldie 20).

It is for this reason that, as Charon observes, it is no accident that "when we human beings want to *understand or describe singular people in particular situations* that unfold over time, we reach naturally for narrative, or storytelling, to do so" (Charon vii, emphasis added).

These considerations lend strength to the idea that health care professionals will benefit from a narrative training since learning to appreciate another's situation by engaging with his or her narrative is surely a "means to singularize the care of patients" (Charon viii). By coming to know another's story we gain "a rich, resonant grasp of another person's situation as it unfolds in time" (Charon 9).

In sum, these brief philosophical considerations – discussed and defended at length elsewhere – give strong grounds for thinking that narratives play a central role in enabling us to understand others.

If so, this lends strong support to the claim made by advocates of narrative medicine that storytelling "offers up the opportunity for democratizing the experience

of the teller and listener … [and] by expressing individual differences we uncover common ground" (Jones 60).

This leaves open the question of how to instill the kind of narrative competence that yields the requisite understanding for achieving such ends. In this regard it is important to note that the narrative medicine initiative is designed to provide health care professionals with "*practical wisdom* in comprehending what patients endure in illness and what they themselves undergo in the care of the sick" (Charon vii, emphasis added). This practical wisdom is to be inculcated through improved narrative competence.

Charon is clear that the ultimate focus is to get nurses, doctors, social workers, and therapists to transform their practice in quite basic ways through mastery of the art of appreciating and telling stories:

> Becoming competent in narrative skills *opens up practice*. It does not simply shift some habits or routines. It *changes what we do* with patients, with colleagues, with students, and with the self (Charon x).

Yet, as Charon describes it, health care professionals improve their relationship with patients not simply by engaging in the relevant practice, but via "the theory and practice of reading, writing, telling, and receiving of stories" (Charon viii). As she sees it, gaining narrative competence is not only a matter of mastering specialized narrative practices, but also gaining an understanding of the "conceptual relations in which it nests" (Charon viii).

With respect to the latter, she observes a need to gain a “sophisticated *knowledge of how stories work*” – one which is not attained without mastery of “*narrative theory*” (Charon ix, emphases added). It is for this reason, by her lights, that to become a fully-fledged practitioner of narrative demands specialist theory.

It is not obvious why narrative theory *per se* would be required. Indeed, whereas extended exposure to and practice with stories seems necessary, it is not evident precisely that having a theoretical grasp of how stories work figures in or would improve first order narrative capacities. Even if one knew such theory explicitly and tried to apply it on-the-fly, we would expect this to disrupt rather than enhance performance, as in other domains.

A deeper worry is that some trainees have found the theoretical focus problematic in a more fundamental way, making the training unfit for practical purposes. One reports of close reading exercises that, “I find that it is too cold, cerebral, intellectual; to practice it somehow further objectifies the ‘patient’ and holds them at arm’s length in order to dissect and measure. I have come to that conclusion by applying it to my own clinical practice as well as to my teaching of health professional students.” (Ensign)

3. Narratives in the scientific image

There are other barriers that keep health care professionals and patients apart. Medical professionals are, on the whole, strongly committed to the medical model – a vision of their mission that seeks only to use the best scientific means to locate and, in ideal

cases, directly respond to the causes of disease.

As a result, the views of health care professionals and patients can become estranged to such an extent that they "speak different languages, hold different beliefs about the material world, operate according to different unspoken codes of conduct" (Charon 21). It is unsurprising, therefore, that when this occurs both sides are, "ready to blame one another should things go badly" (Charon 21). This kind of division arises because the two parties hold apparently conflicting and incommensurable beliefs. Patients may, due to narratively expressed worldviews sponsored by their specific religious or cultural backgrounds, account for the source or cause of an illness in ways that clash with the clinical, scientifically rigorous explanations proposed by those entrusted to their care.

The ultimate source of difference of stance and attitude is that, "Doctors tend to consider the events of sickness rather narrowly as biological phenomena requiring medical or behavioral intervention while patients tend to see illness within the frame and scope of their entire lives" (Charon 22). In the extreme, commitment to the medical model has been charged with promoting a style of clinical practice that is "objectified by impersonal care" (Charon 21). For many, it seems that these intellectual differences are irreconcilable, that we face an either/or "forced choice between attentiveness and competence, between sympathy and science" (Charon 21).

It is possible to avoid having to make such a hard choice by recognizing that many of these convictions are narratively grounded and do not answer to, nor seek to answer to, the same epistemic standards as scientifically grounded beliefs. As such, narratively based attitudes are not in fact advanced as empirical hypotheses; they are

not evaluated against “competing narratives for accuracy or utility” (Gerrans 77).

A crucial contrast becomes evident if we compare the uncritical use of narratives that don’t aim at truth with the intense critical scrutiny of beliefs and claims that do. The latter are subject to the norms of scientific testing, where we seek to fix what we believe only “according to standards of consistency and empirical adequacy” (Gerrans 13).

Accepting that narratively– as opposed to scientifically– sponsored attitudes have different epistemic properties and serve different functions in our lives, may alleviate the need to see such stances as directly competing to do the same kind of work. Nevertheless, this will not resolve the tensions between medical professionals and their patients –indeed, it may serve to exacerbate the situation– for anyone who holds that, for the reasons stated above, our love of narratives is what prevents us from seeing the world as it really is. Alex Rosenberg, the chief spokesperson for a thoroughgoing eliminativist and nihilist outlook, holds that “our demand for plotted narratives is the greatest obstacle to getting a grip on reality” (Rosenberg, “Disenchanted Naturalism” 18).

By his lights, the reason we cannot understand the answers to fundamental questions about the state of things is that they “don’t come in the form of stories with plots. The fundamental laws of nature are mostly timeless mathematical truths.” (Rosenberg, “Disenchanted Naturalism” 18). Our “insatiable hunger for stories” (“Disenchanted Naturalism” 28) is also, according to Rosenberg, what “greases the skids down the slippery slope to religion’s ‘greatest story ever told’.” (“Disenchanted Naturalism” 18). This is what mistakenly drives us to “account for ideas and artifacts,

actions and events, in terms of their meanings" ("Disenchanted Naturalism" 28).

Leaving aside the large question of whether, in the end, an exclusively scientistic vision of the sort Rosenberg advocates is coherent, even Rosenberg cannot, and apparently does not, deny that narratives are a part of the fabric of our psychological reality. We are deeply prone and wedded to understanding the world in narrative ways, for good or ill. It is not possible, even on the vision of reality Rosenberg seeks to paint, to deny the prominence and power of narratively sponsored thinking within the human sphere. Thus, even if medical practitioners cannot always take seriously the content of the narratives to which their patients are attracted, they can respect and take seriously the fact that such narratives can have a powerful and efficacious grip on us – and hence even the most scientifically minded ought not to underestimate the importance of narratives to their patients' attempts to make meaning within and of their lives and situations.

In line with his uncompromising, self-styled 'mad dog' naturalism, Rosenberg also insists that "science can't accept interpretation as providing knowledge of human affairs if it can't at least in principle be absorbed into, perhaps even reduced to, neuroscience" ("Why I am a Naturalist" 41). This too seems a bridge too far. As just noted above, even if narratives do not provide a window onto reality, they feature heavily in human affairs, and we need to understand how and why they do so if we are to understand ourselves. Moreover, contra Rosenberg, to fully understand the power of stories and how they shape us we need not, and indeed ought not attempt to absorb or reduce the interpretive disciplines into neuroscience.

While it is important to understand what work brains do in support of our

capacities to understand, produce and enjoy narratives, it would be misguided to think that such narrative capacities can be understood by looking solely at what goes on in brains. Given that we are not natural-born narrators, we might wonder how we came to be able to weave stories. We might be interested to know why a given genre of story or particular narrative content is more compelling to some populations than others. Or we might want to know why the narratives of people haling from different populations take this form rather than some other. To explain and understand these features of narratives we must look to the surrounding narrative practices that enable their generation. This requires looking at socio-cultural, and not only neural, factors (see Hutto, *Folk Psychological Narratives* and Hutto and Kirchhoff for extended arguments along these lines).

Of course, in defending the idea that narratives matter powerfully in our lives we should be cautious about advancing overly strong necessity claims. Thus, we need not hold that “Without narrative acts, the patient *cannot* convey to anyone else what he or she is going through. More radically and perhaps equally true, without narrative acts, the patient *cannot* himself or herself grasp what the events of illness mean” (Charon 13, emphases added).[2]

Notoriously, Strawson has advanced arguments that there are non-narrative ways of being and of experiencing oneself that also deserve to be recognized, and that failure to do so promotes an unwarranted and ethically problematic narrative imperialism. Barring a knock-down argument that might rule out the possibility of such non-narrative ways of being, little is lost in conceding the point to Strawson and allowing that narratives are at least one of the primary and most important ways that

many have of understanding and making sense of themselves and others (for a fuller discussion, see Hutto, “Narrative Self-shaping”).

4. What’s the story with narrative therapy?

Having come this far, it is useful to finish by considering another prominent approach –narrative therapy– which is a kind of therapy that assumes that how we narrate our lives can make a pivotal difference in diminishing or promoting wellbeing.

Narrative therapy, developed by White and Epston in the early 1990s, stands out in seeking to empower individuals and groups by getting them to look again at their habits of self-narration and to explore the possibility of telling new stories about their individual or collective lives. The main assumption of the approach is that: “As people become more narratively resourced … they find that they have available to them options for action that would not have otherwise been imaginable” (White, *Narrative Practice* 5).

For many people, deficiency-centred stories constrain and limit options for action (White, “Folk Psychology and Narrative Practices” 34). Such stories pathologize and disempower us, making it seem as if their problems are an *essential* part of who we are. Prêt-à-porter narratives – those inherited uncritically from the surrounding culture – tend to foster such negative and limited ways of thinking. Such narratives restrict a person’s vision, allowing only a limited array of options. Those who only operate with thin narratives of this sort perceive a limited range of possibilities for action, fewer affordances.

In passively buying into and repeating narrow and negative narratives we unnecessarily restrict our life possibilities. Advocates of narrative therapy hold that, "All too often, the stories we believe about ourselves have been written by others" (Denborough 8).

Narrative therapy seeks to protect against these outcomes by insisting on the need for people to reclaim and take back their "storytelling rights" (Denborough 8, 10, 22). Narrative therapy aims to improve narrative skills so as to empower people, enabling them "to break from thin conclusions about their lives, about their identities, and about their relationships" (White, *Reflections on Narrative Practice* 4).

A main way narrative therapy combats the effects of life-limiting stories is through externalizing conversations. These conversations create opportunities "for people to redefine or revise their relationships with a problem" (White, "Folk Psychology and Narrative Practices" 32). Its approach "refuses to locate problems inside people ... [it] refuses to pathologize people" (Denborough 26). Hence its slogan: "the person is not the problem, the problem is the problem" (Denborough 26).

The main narrative therapy strategy is to find new, richer stories to tell about one's life, and thus augment the resources of individuals; (Denborough 49). Such narratives cannot simply be taken off the shelf; empirical findings reveal that rich storied content, used in particular ways for particular purposes, correlates positively with mental health. A number of findings demonstrate that people "who are able to narrate the emotional events *of their lives in more self-reflective ways* show better physical and psychological health" (Fivush et al. 46).

The end result of the narrative therapy process of re-storying (if all goes well) is increased “response-ability” – enabling people to become “more able to respond” (Denborough 36). This involves developing and mobilizing one’s practical know-how and life skills (White, “Folk Psychology and Narrative Practices” 39, 40): these new habits ensure that the richer storylines and the expanded possibilities for action take root and flourish.

All of this works because narratives are necessarily selective. Whichever story we tell about our lives, there are *always other* stories we could tell –other possibilities not foregrounded, not mentioned, not attended to: “there are many different events in our lives, but only some of them get formed into the storylines of our identities” (Denborough 6). Equally, there are other options for narrating or telling our familiar stories.

Dominant stories can occlude and discourage alternative storylines – those that possibly “provide the gateway ... to the exploration of other … skills of living or practices of life” (White, *Narrative Practice* 9).

At first sight, narrative therapy might appear to be a puzzling, counterintuitive approach. For it eschews using talking cures to divine and deal with past causes of current trauma. Rather it asks therapists to ‘reverse the polarity’ of many psychodynamic therapies and to focus instead on “constructing a future trajectory rather than achieving past accuracy” (Graham 14). Given this, it might be wondered how, simply by getting clients to tell different stories about their lives, narrative therapy could bring about positive changes in behavior without divining or dealing with the root, underlying causes of a client’s problems. Skeptics that hold all talking

cures are really just 'talk', are likely to think that talking therapies which don't even try to, or pretend to address underlying problems, are blatantly so. The onus is on defenders of narrative therapy, and related solution-focused therapies, to say why and how by changing a person's narrative it is possible to make a difference to who we are and what we do.

One natural explanation would be to hold that the link between how we narrate our lives and who we are is so deep that any change to the former automatically changes who we are. This answer will be attractive to those who endorse the strong narrativist view that our narratives determine who we are by constituting not merely our sense of self but our selfhood itself (Schechtman, *The Constitution of Selves*; "Stories, Lives, and Basic Survival"; "The Narrative Self"; Rudd).

However, once again, Strawson sounds a cautionary note. He worries that strong narrativist, self-constitution views must assume that all of our structured actions have a narrative character and basis. Yet he argues that narrativist views of this strong stripe become trivially true –not in a good way, but as a kind of empty stipulation– if it is held, for example, that "making coffee is a Narrative that involves Narrativity, because you have to think ahead, do things in the right order" (Strawson 439).

It is not clear that everyday embodied activities, such as reaching for objects or making cups of coffee involve representing the sequence of events in question in such a way that would qualify as implicit narrativizing. A major agenda item of the more radical embodied and enactivist approaches to mind has been to establish that not all or even most of our goal-directed everyday activities depend on contentful mental representations at any level or in any fashion (see Chemero; Hutto and Myin,

Radicalizing Enactivism; Thompson). According to such views the idea that we might be implicitly narrativizing all of our embodied doings is a non-starter.

A different answer to the puzzling question about how narrative therapy might get its work done steers clear of the self-constitution views of strong narrativists, and instead assumes, much more modestly, that how we narrate – how we think about and describe things – can have a direct influence on the affordances we perceive. It accepts that, "In human life, the regularities to which agents are sensitive are densely mediated … by cultural symbols, narratives, and metaphors … These mechanisms shape social experience and in turn are shaped by broader social contexts" (Ramstead et al. 14, see also Hutto and Myin, *Evolving Enactivism*).

It must be acknowledged that, "at the centre of this is, of course, the self: the person who is doing the thinking and feeling about the past and the future, the person who can deliberate about how to act as well as how to think and feel" (Goldie 76). Yet we should be careful when characterizing what selves are and how they are constituted. It seems uncontroversial to allow that we can have a "narrative sense of self, a sense of oneself with a past and a future for which one can be responsible" (Goldie 76). Fair enough – but we must be careful to recognize that "one's narrative sense of self … has no direct connection with the metaphysical question of one's identity over time" (Goldie 115). Or, to put the point more carefully, we should avoid assuming that because we can have a narrative sense of self that we are, at bottom, wholly constituted by narrativizing activity. Indeed, the notion of a narrative self is philosophically questionable on a number of grounds, and not least, as Goldie

observes, because there are good reasons to consider it “to be otiose” (115, see also Menary; Hutto, “Narrative Self-shaping”).

In the final analysis, we need not assume that we are constituted by narrative activity in order to allow that re-authoring our lives – seeing things through a new narrative frame – can re-direct our attention and open our eyes to possibilities for action that were not salient to us before. Although much more needs to be said to provide anything like a fully developed account of how changing one’s narrative can change one’s affordances, even this minimal sketch of an answer reveals that there need be no deep mystery about how restructuring our thinking through acts of re-narrating could alter the opportunities perceived in one’s field of affordances.

Seen through this metaphysically frugal lens, there should be no puzzle about how improving narrative skills and changing our narrative tendencies might make a material difference to our possibilities for embodied engagement in ways that matter to what we can and are likely to do. How we narrate matters. How we narrate can make a difference to the quality of our engagements with and our understanding others. How we narrate can shape who we are and what we do. It would seem then that the key assumptions of narrative medicine and narrative therapy are in good philosophical order and hence, at least in this respect, these movements ought to be taken seriously as potentially very valuable ways of promoting human flourishing.

Notes

1. Haslam provides an even fuller list of benefits:

> More empathic medical students received higher ratings of clinical competence and performed better on history-taking and standardized physical examinations. More empathic medical students and doctors received higher patient satisfaction ratings. Patients judge empathy to be very important in consultations, and show better treatment adherence and greater enablement with more empathic doctors. When doctors report a loss of empathy they subsequently show an increase in their rate of major medical errors. Doctors' communication skills are associated with a variety of positive outcomes for patients and with reduced risk of malpractice claims, and patients judge their doctors' empathy on the basis of such skills (e.g., being reassuring, showing understanding, explaining procedures, not ignoring their concerns). (381)

2. In another passage, Charon speaks of a narrative shift that is underway such that "Medicine is joining other disciplines such as anthropology, history, psychology, social science, law, and even mathematics in recognizing the *elemental and irreplaceable* nature of narrative knowledge" (11). Yet in other places Charon pitches her claim on behalf of narratives more softly: "It remains to be proven—although it appears a most compelling hypothesis—that such narrative vision is required in order to offer compassionate and effective care to the sick" (13).

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