



INTERACTION, LANGUAGE AND THE “NARRATIVE TURN” IN PSYCHOTHERAPY AND PSYCHIATRY

BRIAN BROWN,^{1*} PETER NOLAN,² PAUL CRAWFORD² and ALISON LEWIS³

¹School of Social Sciences, De Montfort University, Milton Keynes MK7 6HP, U.K. and ²Departments of Nursing and ³English, The Medical School, University of Birmingham, Edgbaston, Birmingham B15 2TT, U.K.

Abstract—The traditional emphasis in psychiatry about “listening to patients” has recently been added to by the development of what we call the “narrative turn” in mental health care where clients’ narratives are emphasised. We shall argue however that both approaches tend to embody similar assumptions about therapeutic transactions and roles, and that much work emphasising narratives reveals little about how therapists and researchers work to reconstruct the clients’ accounts. It is therefore vital that the emphasis on narratives be supplemented by a more thoroughgoing approach to shared structures of knowledge which act to prefigure clients’ distress, how professional records are a profoundly transformative medium, and how therapeutic encounters work to co-construct clients’ narratives, rather than simply reflect or explore them. The radical implications of thinking about therapy in terms of narrative and language need to be more fully discussed in the therapy literature, so the narrative turn does not simply reproduce the common-sense assumptions of more conventional approaches. Copyright © 1996 Elsevier Science Ltd

Key words—narratives, psychiatry, psychotherapy, language

INTRODUCTION

In this paper we shall be concerned with therapeutic language in mental health care. The aim is to outline some of the characteristics of what we shall call the “narrative turn”—the growing interest in clients’ narratives—and to offer some critique and reformulation of this development. We take the expression “narrative turn” to denote the recent attention given by many social science scholars [1–3] to the way human conduct can be seen as the expression and enactment of different kinds of stories. It is increasingly argued in this body of work that understanding how we organise accounts of both nature itself and our own activity into meaningful, logically organised stories is crucial in making sense of our world. It is our contention that the use of language is particularly crucial in therapeutic encounters and research since it is through this medium that much psychiatry is constructed and transacted. Thus, considering the narrative turn in relation to the helping professions is especially important. At the same time a “climate of problematisation” is developing in the social sciences [4] where attention is explicitly focused on what constitutes knowledge in this area. Thus, because at a practical level of care a great deal of psychotherapy, psychiatry and mental health nursing is mediated through language it seems to us that this is a particularly rich field of enquiry. In particular we will be looking at both traditional and more recent

narrative-oriented approaches to human distress and arguing that both of these approaches are incomplete without a similar focus on how the narrative constructions of professionals interact with those of clients and are crucial in authoring the accounts which find their way into print, too.

“Listening to patients” in mainstream psychiatry: two examples

In mainstream psychiatry the position that it is important to listen to patients is so well established it is difficult to argue with. This is sometimes delivered most explicitly in introductory textbooks. There is a long historical tradition of exhorting workers in mental health disciplines to take their cue from “patients”—*The Concise Oxford Textbook of Psychiatry* [5] introduces the student to the discipline thus: “It is emphasised here . . . that psychiatry can best be learnt from the experience of talking to patients, . . .” (p. i) and “The student is recommended to talk to as many patients as feasible” (p. 1).

Yet at the same time, in this more traditional incarnation of the discipline, relatively less attention has been paid to the narratives constructed and presented by those in the patient role themselves. Moreover little attention has been paid to the way in which the language of the “caring professions” (e.g. nursing, psychology and psychiatry) is formed to construct its own distinctive narratives of “mental illness”. There is presumably a range of theories whereby we establish in practical contexts what the virtues of “patient’s talk” are, what is to be done with “patient’s talk”, and what therapists and staff are

*Author for correspondence.

expected to do with it. These must rely on particular practices of listening and storytelling by the professionals to accomplish the intelligible “fiction” of an account of the patient’s symptoms, history, therapy and in some cases “cure”.

Stafford-Clarke *et al.* [6] provide at the end of their widely used textbook the following valedictory note to the student:

“Attention must be paid to the individual man and woman, no matter what the nature of their sickness or suffering, no matter how severe the distortion of their world or their contact with others, no matter how strange or frightening they may appear, no matter how sordid or ignominious their predicament. In the special context of the phrase, “attention” means not simply interest, not even simply compassion, but the active, dedicated, detached but uncompromising love for other human beings which alone can inspire and ultimately crown the highest endeavours of medicine” (p. 308).

This provides a particularly candid account of the posture of psychiatry towards people. Whereas the uncompromising love is necessary, the authors seem to be saying that this will usually have to be exercised despite the scariness or sordidness of those in the “patient” role and that the training of student psychiatrists is about fostering these finer feelings in spite of their tendency to recoil. Whereas it seems to be arguing the opposite, this passage is almost affording the tendency of students to see their patients in terms of sickness, suffering and ignominity. It is out of these feelings that psychiatric understanding will eventually emerge. Rather than, for example feeling that the patients have a point, or are like ourselves.

These two examples then beg a number of questions about how the corporate attitude of psychiatry is established, and how the patients’ narratives become intelligible within this framework.

Making sense of psychiatry: vignettes from ethnomethodology

There is a lively tradition of work by ethnomethodologists on the processes of institutional record keeping which is germane to this problem. Tony Hak [7] addresses the process by which it is possible for mental health workers as social actors to make sense of these documents. He argues, controversially, that “... there is no reality against which psychiatric records can be compared” (p. 139). Drawing on the work of Garfinkel and Bittner [8, 9], Sacks [10], Schegloff [11] and Cicourel [12], Hak argues that “psychiatric interpretation, as presented in a psychiatric record, can be understood as a specific transformation of ‘raw material’ into a description, under both common-sense and ‘psychiatric’ auspices” (p. 145). Hak emphasises the transformational aspects of record keeping and psychiatric interpretation, the operation of “background expectancies” (p. 151), and cites a case study where interview fragments are reformulated. However, he does not sufficiently emphasise the problematic nature of this

process. Instead, he asserts: “Psychiatric practice can be described as the transformation of both ‘original’ and ‘second-hand’ accounts into a competent interpretation” (p. 153). He therefore does not distinguish between the varieties of competency which participants in the psychiatric enterprise might exhibit. Practical professional competence may well differ from and be exhibited in different contexts than epistemological competencies concerning, for example, science and human nature. Hak describes as the interweaving of “the representation of a particular person and the evocation of specific ‘knowledge’” (p. 154) into what he calls a “case” seems to be an account which is much more multiply fictionalised than he acknowledges. Hak thus appears to support a “common-sensical” approach to the interpretation of reports. Perhaps we could argue instead that there are a *number* of “competent” readings of patients and their records which might be accomplished by different professionals depending on their location and intentions. Records may be written and read differently depending on whether the people involved are nurses, doctors, psychologists, and what they are intending to do, for example take a person into hospital, discharge the person, undertake psychotherapy or recommend medication. We would argue therefore that the competencies identified by Hak are rather more fluid and capable of strategic deployment than he allows.

The “narrative turn” in the caring professions

A further aspect of recent scholarship which explicitly addresses the nature of language in therapeutic contexts deserves consideration, namely what we call the “narrative turn” in work on mental health issues, where the process of health care is increasingly thought of in terms of narratives and stories [13–15]. Parry and Doan [14], for example, in their book *Story Re-visions* advocate a kind of therapy which involves encouraging the client to go through a process of deconstructing and re-visioning their life story. Even though they advocate redevelopments of clients’ stories “[t]his is not to suggest that the client’s interpretation is trivial; rather it is one that has been ‘living the client’, actually inhabiting him/her in the form of meanings and views of the world” (p. 43). This “strong form” of the narrative turn in therapeutic discourse works alongside similar developments on a variety of fronts. There are narrative approaches developing in a number of areas. The discourse of survivors of domestic violence has been studied [16, 17] as has that of incest survivors [18]. In the area of eating disorders there is a proliferation of personal accounts [19] as well as parents’ narratives being included in more conventional texts on the topic [20]. The phenomenology of medical and surgical procedures, e.g. in heart disease, is under investigation also [21]. Indeed, the concern with narratives and the construction of meaning is capturing the attention of medically trained psychia-

trists as well as more psychologically-oriented practitioners [22], especially in the area of supportive psychotherapy. Including some acknowledgement of the storied, subjective, linguistic nature of distress and treatment, then, is increasingly modish [21, 24].

However, there is some dispute over what exactly a narrative is. Reissman [3] suggests that a very broad definition tends to be used in the clinical literature, yet linguists such as Labov [25] use the term to refer to specific stories about particular past events. Moreover, whether we are considering narratives in ethnographic research or as an aspect of psychotherapy, what a narrative means may differ radically—from something that is taken to be reflective of a person's "true feelings" to a contextually co-occurred production which is produced through interaction and does not necessarily relate to any inner mental state at all.

As regards psychotherapy, there are different formulations of how narrative therapy operates. In addition to the "story re-vision" outlined above, Wigren [26] argues that "attention to incomplete narrative processing is a useful focus for listening to patients' stories in psychotherapy" (p. 416) and that 'patients' need help "... to put themselves into their stories so that emotions and meaning are created. These patients need help in associating affects to description, and help making sense of dissociated affects at times when they feel overwhelming" (p. 419). Thus, the assumptions underlying narrative therapies run all the way from the postmodernism espoused by Parry and Doan [14] to the much more familiar foundationalist cognitivism of Wigren [26]—where the narratives somehow inhere in the "patient's" mind prior to therapy—complete with her predefined roles for "patient" and "therapist".

It is our intention to develop the notions surrounding narrative therapies considering 3 main points. First, they invite epistemological and practical issues which are very important for any attempt at therapeutic change. Second, both the mainstream and many of the new narrative-oriented therapeutic approaches leave out a great deal. Often we are given few clues about how therapists or research authors have worked to construct the account which is presented to us as readers. Thus, we wish to highlight the editorial or "redactive" role of therapists, and the role of culturally available therapeutic formulations of problems which clients may deploy to make sense of their difficulties. Thirdly, another omission is that there is often little attention given to the microstructure of therapeutic interaction and thus to precisely how active therapists are in co-constructing the clients' narratives. Thus we would argue that there are some important lessons for psychotherapy from conversation analytic studies of doctor patient interaction in medicine.

As Louis Althusser notes in his autobiography *The Future Lasts a Long Time* [27] relating to interviews with his psychiatrist at Sante-Anne hospital in Paris:

"... my doctor's attention was fixed on a specific anxiety which he passed to me rather than observed in me, thus shifting it from its 'object', or rather from the absence or loss of any 'object' to the representation of his own anxiety passed on to me..." (p. 274).

The under-theorisation of these 3 areas of concern is all the more troubling when we consider that there are some well established traditions in the social sciences which aim to address these concerns. It is vital that researchers and practitioners grapple with these issues, otherwise the emphasis on narratives will close off avenues of enquiry, rather than opening them up to scrutiny.

(1) THERAPY, EPISTEMOLOGY AND POSTMODERNISM

With reference to our first point, there are a great many implications for therapeutic knowledge in the new narrative turn in the helping professions. The narrative-oriented therapeutic body of work often makes reference to postmodernism, so it is worthwhile trying to get to grips with what this means in order to understand its implications for therapeutic disciplines. The "climate of problematisation" fostered by postmodernism has invited scholars to look at the process of structuring the problems that confront "patients", "therapists", "nurses" and "psychiatrists". Most implementations of postmodernist philosophies are anti-foundationalist—that is they do not propose that our knowledge rests on a single version of reason, or a single essence possessed by the things we study [28]. Thus, our attention is drawn to the ways in which truth is established interpersonally, how systems of logic are often parochial and "local" [29] and how this fits with the frames of understanding which societies, scientific disciplines and people deploy.

The vocabulary of words, concepts, mental illnesses and care plans in psychiatry and mental nursing in the U.K. is, in this perspective, not a simple reflection of patients and their problems. Language has a specific genealogy and a set of contemporary social functions. In understanding how psychiatric language works it is important to understand the history of the language as it is occasioned by scientific, institutional and educational practice. All these feed into the way a community of understanding is established where technical terms like "agoraphobia" or "schizophrenia" have a common meaning, and moreover where commonplace terms like "progress" are managed and occasioned so that the evolution in patients' behaviour is formulated to ensure it looks like the therapy is being effective.

The idea of a "community of understanding" has much in common with the idea of "genre" in literary studies, where the language used in a particular context is believed to be characterised by certain regularities. Of particular value here would be further

analysis of the regularities of psychiatric language. The work of Bhatia [30], Martin [31], Swales [32] and Ventola [33] is useful. For example, Bhatia and Swales comprehensively define genre as:

“... a recognisable communicative event characterised by a set of communicative purpose(s) identified and mutually understood by the members of the professional and academic community in which it regularly occurs. Most often it is highly structured and conventionalised with constraints on allowable contributions in terms of their intent, positioning, form and functional value. These constraints, however, are often exploited by the expert member of the community to achieve private intentions within the framework of socially recognised purpose(s)” (p. 13).

Martin provides a more precise definition which focuses on culture:

“a genre is a staged, goal oriented purposeful activity in which speakers engage as members of our culture ... Virtually everything we do involves you participating in one or other genre. Culture seen in these terms can be defined as a set of generically interpretable activities” [31] (p. 25).

Martin and Ventola’s systemic approach fits genre into a system of “three semiotic communication planes, namely GENRE, REGISTER and LANGUAGE” [33] (p. 57). These systems are placed hierarchically so that language functions as the phonology or register, and both language and register function as the “phonology of genre” [31] (p. 25). Language, for Ventola, consists of lexicogrammar and phonology; register consists of field, tenor and mode, and genre consists of “schematic structures” [33] (p. 71). Genre analysis then, combines all these constituents of genre into a framework of analysis which searches for “the rationale behind particular genre features” [32] (p. 7). Thus in psychiatric discourse we need to locate “those conventions which arise from preferred ways of communicating knowledge within particular communities” [32] (p. 4). We need to “seek out the *determinants*” of “linguistic effects” [32] (p. 4). Bhatia sums up the aims of applied genre analysis as twofold:

“first, to characterize typical or conventional features of any genre specific text in an attempt to identify ... form-functional relations; and second, to explain such a characterization in the context of the socio-cultural as well as the cognitive constraints operating in the relevant area of specialization, whether professional or academic” [30] (p. 16).

Whereas the study of genre is characterised more by an interest in the form of communicative acts, we must also attend to the conventionalised patterns of content or meaning. In psychiatry, psychology and psychotherapy a great many words and ideas are used whose original authorship lies elsewhere. This rather striking assertion can perhaps be illuminated further by looking back to the symbolic interactionist tradition. Goffman [34] introduced the idea of “footing” which might be relevant here. Footing describes the way in which speakers signal they are

reporting the speech of others. Goffman contrasts the *animator*, the current speaker who is doing the talking and the *composer* who originally made up the words. Moreover the composer may be different from the *origin* of the viewpoint or position. Footing is one of the ways in which speakers display the accountability of what they say. In psychiatry this may be explicit as when we quote some textbook, manual, paper or some scientific study or authoritative source to add credentials to a course of action. However, this need not be explicit. Simply using a particular technical or esoteric vocabulary can signal that the speaker is familiar with the work of the (often prestigious) composers of the terminology and thus saying something fundamentally rational.

The idea of footing itself has been called into question however in the light of the post structuralist attack on the priority of authorship, as exemplified by Roland Barthes [35]. Edwards and Potter [36] in discussing these ideas also identify problems with the concept of footing because a great deal of the talk in everyday contexts is made up of widely held views, ideas and commonplaces and conventionalised devices for telling factual accounts [see *inter alia* 37–40] where the composers and originators of the language are obscure. In addition, the focus on narratives in the social sciences has resulted in a re-reading of the ideas of Lacan and Foucault [41, 42]. One implication of this latter turn is that the focus shifts from authors and originators to texts, discourses and frames of understanding that transcend individuals. So the discourses of psychiatry, constrained by the genre of psychiatric language and register, while they may be recirculated and reproduced in its technical literature, do not necessarily have identifiable originators. What we can detect however is a correspondence between the technical literature and what people say—an intertextuality [4] of discursive practice. This incorporates the “absorption and transformation” [43] (p. 37) of prior texts, a bricolage which is that “... use of a new structure [of] the remains of previous constructions and deconstructions” [44] (p. 63).

Shotter’s [45] ideas about “social accountability” are also relevant in understanding the language of psychiatry. He argues that in order to be competent social actors we must be able to account for our actions as being those of properly autonomous, socially competent adults. At the same time we have to assemble those accounts “within essentially dialogical and thus intrinsically unaccountable, and disorderly joint transactions” [45] (p. 168) with other people. By “accountable” Shotter does not mean that we are continually justifying our behaviour. Rather, what is meant is that we are more or less aware that we could do so if required. We are reflexively aware of whether our actions match the socially mandated rules of intelligibility and rationality. To take an example with which we are familiar, the use of nursing records in the mental health services in

Birmingham embodies some of these processes. In formulating nursing records the messy, mutually afforded process of talking with patients is compressed into a socially sanctioned rationality [46] of technical terms like "agoraphobia". The complexity of patients' or clients' feelings and expressions about their problems are formulated into goals and the subsequent activity is collapsed into concerns as to whether these goals are achieved. Moreover, this rationality on the part of those who complete the records is accountable—i.e. it fits in a justifiable way into the forms of rationality enshrined in education for doctors, nurses and other therapists and fits in with the institutional practices of mental health care. Perhaps we can further itemise this practice by examining the way that language is used to accomplish different communicative tasks, such as diagnoses, classifications, observations, prescriptions, and analyses. We must therefore radically revise the assumption that the narratives which find their way into the literature on psychotherapy are a transparent rendering of what is going on inside clients' heads and the field of narrative psychotherapy must open itself to the possibility that the narratives might be crucially mediated by other factors, notably the generic context in which the narratives are produced.

(2) FORMULATING ACCOUNTS: MYSTERIOUS AUTHORS, "OTHERING" AND THERAPEUTIC AUTHORITY AS A WAY OF EXPLAINING YOUR LIFE

In describing the clients or patients, the clinicians, observers, researchers and authors of records are able to deflect attention away from themselves. The operation of making things intelligible to the reader is often opaque. In a sense the writers of these stories about "patients" are able to do what Haraway [47] describes as "the God trick" where the other is described as if from "nowhere". As Fine [48] puts it "Researchers/writers self-consciously carry no voice, body, race, class or gender and no interests in their texts. Narrators seek to shelter themselves in the text as if they were transparent (Spivak, 1988)" [48, 49] (p. 74). Easthope [50] argues that this "clear and transparent style" was developed in the period surrounding the English Civil War by writers determined to argue clearly about religious and political issues. It purports to be "... styleless, a clear window on reality that presents the truth nakedly and objectively as it is without any subjective feeling or attitude getting in the way" (p. 79). This mode of writing, in medico-nursing records and in social science, is pre-eminently about someone else, someone "other" than the author. Fine [48] describes how social science research has been active in constructing "others" particularly when researchers have studied "marginal" groups like "the poor", blacks, women, people who have been sexually abused, one parent families and so forth. At the same time the middle classes, elites or the wealthy have

been relatively less investigated. On the relatively rare occasions when they have they are good at presenting a relatively unproblematic life narrative which reveals few domestic, work or interpersonal difficulties. In this context it is instructive that Thomas [51] identifies many problems attached to interviewing senior executives who in any case are apt to regurgitate the company's official publicity material. So the "others" in social science are disproportionately members of less empowered groups such as the ill, the poor or the proverbial psychology undergraduate participating in research to gain course credit in North American universities.

Of course, authors who describe psychotherapeutic interventions that are informed by narrative metaphors do not simply hide behind their own texts. They often have well-developed accounts of what the clients' stories mean, how they get produced, the dynamics of the therapeutic relationship, power in therapy, and the interpretations they can draw. Let us briefly consider some recent writings on this theme. Social constructivist, narrative therapy may involve "... the assignment of positive meaning to what appear to be negative situations" [22] (p. 441). The therapy process might be more of an art than a science—whereas Makari and Shapiro [24] admit that clear, logical guidelines on what it means to "listen" in therapeutic encounters are missing, they still advocate attention to the "patient's" unspoken, perhaps unconscious "shadow narrative". Thus, unspoken, pragmatic communication can be made "... semantic, public and *open to dispute*." [24] (p. 42, our emphasis).

The self aware, storytelling subjectivity of clients is frequently emphasised: "Thus as part of their personhood the clients were conscious, and within that consciousness they were reflexive" [23] (p. 237). Note that even within this narrative-oriented genre of therapy, authors seem reluctant to abandon what seems to be a very traditional view of clients as having inner characteristics and properties—such as the familiar layers of conscious and unconscious. This has a great deal in common with conventional psychological formulations of people and seems rather shy of the more radical implications of narrative theory, linguistics or postmodern philosophy we have outlined.

Clients are even formulated as having powers over therapists—"Patients present with a set of pragmatic needs and wants and they teach therapists how to help them" [52] (p. 182) and analogies are drawn with everyday conversation, which has the effect of making the process seem more equitable. The empowerment of clients through therapy may involve therapy itself being "demystified" [53, 54] (p. 592) so they can make informed choices. Moreover, "The process of effective psychotherapy gives considerable power and respect to the patient" [54] (p. 592). Indeed, even the well-known critiques of psychotherapy as an abuse of power by Jeffrey Masson [55, 56]

can apparently be neutralised from within this perspective, according to some more optimistic advocates. For example, Owen [57] (p. 105) advocates “self realisation” whereby the clients have a knowledge of the field and are competent to judge the quality of the therapeutic relationship in which they participate. The therapeutic mainstay of “empathy” is being increasingly reconceptualised in linguistic terms which emphasise the “co-creation of shared meanings” [58] (p. 241) between family members in therapy and between therapist and client. There are exhortations that therapists be “patient” when clients are telling a story [23] (p. 241).

So, the manifest position of psychotherapy, especially from the point of view of authors interested in new narrative formulations of therapeutic processes, emphasises a virtuous mutuality and empowerment of clients. However, this apparent beneficence sets alarm bells ringing for us. Even within this literature there are hints that the therapist’s putative expertise is not fully erased. For example, Rennie [23] suggests that the client may be using stories to mask or avoid contact with “deeper” issues [23] (p. 241) which consolidates the therapist’s role as a superordinate judge of the proceedings. Clients’ narratives are explicitly described as occasioning management by the therapist to move on to these putative deeper issues [23] (p. 242).

A further source of concern for us is that many writings on the helping professions emphasise a rather different process at work. Above, we briefly mentioned the process of “othering”. Let us now consider this in relation to health care in more detail. The “othering” of client groups in medicine occurs partly in terms of the way professionals develop informal and formal diagnostic criteria and category names for patients. In a by now classic example, Becker [59] describes how medical students in Kansas in the 1950s characterised some patients as “crocks”. Whereas at first even accomplished users of the term were at a loss to define it, discussions between Becker and the students concluded that “crocks” were patients who had complaints but no observable physical pathology. This conclusion was by no means obvious however, because the students began by suggesting that the “crocks” had psychosomatic complaints. However this was eventually decided not to be the meaning, particularly as a senior physician had used the term when discussing a patient with an observable physical pathology in the form of an ulcer. The process of creating others, then, is by no means obvious, even to people who do it.

The kind of definition of an individual as “other” which the social and medical sciences achieve is in part constructed by the kind of investigative procedures involved. In this vein, Angrosino [60] describes how researchers, when describing “mentally disabled” individuals, often restrict their observations to interviews conducted in clinical settings and thus tend not to understand the person “. . . as a

contextualised participant in a world outside the clinical setting . . .” [61] (p. 14).

Thus, we can see how a number of authors and researchers have contributed to the kind of “climate of problematisation” in research in clinical contexts. A key feature of these approaches is the assumption that knowledge is not neutrally describing the “patient” but that it is created by and interacts with other kinds of social business which is being conducted in the clinical or research context. Indeed, there is some suggestion that the very categories of “patient” and “clinician” are afforded and sustained by this social interaction.

The kinds of understanding engendered in clinical settings have much broader implications for how clients or patients understand their lives. This is of particular relevance for postmodernism with its “emphasis on the constructivist and fluid aspects of how selves are created and enriched” [26] (p. 186). It is also important in terms of how the social sciences have long been recognised to contain a “double hermeneutic” [61] in that humans interpret themselves as well as the “natural world” around them. Thus it comes as no surprise that individuals can be seen enriching their identities with psychiatric or medical knowledge. For example Karp [62] reports on a group of people who attended a self help group for individuals with affective disorders. The group participants were assembling a bricolage of accounts of their condition from medical and other frames of understanding. For example, Karp says that one participant, probably in his 60s reported:

“At first I thought I needed more sleep than other people. Then I realised that I had mood swings. Then I learned that I had depressive periods. Then I learned that I had bipolar depression. Then I learned from the doctors that I inherited this from my grandmother. This was a learning process that took several years” [62] (p. 149).

Members of the group “wanted to accept medical definitions of the situation while avoiding personally troublesome labels” [62] (p. 151). Likewise, other groups of clients in receipt of medical and social care are active fabricators of narratives about their positions. Angrosino [63] identifies a set of strategies which “mentally retarded” (*sic*) adults use to construct their autobiographies. “People whose self-image is ambivalent . . . select autobiographical structures that enable them to symbolise the conflict between their backgrounds and their current situations” [63] (p. 195).

In some cases the strategies of employing medical terminology and theories are well-developed parts of ex-psychiatric patients’ self management strategies. Herman [64] calls these medical disclaimers. For example one of Herman’s informants reports “. . . I’m careful to emphasise that the three times I was admitted was due to a biochemical imbalance—something that millions of people get. I couldn’t do anything to help myself . . .” [64] (p. 314).

In addition to these more formally managed identities that some researchers have documented, there are many more aspects of the way therapeutic talk and ways of conceiving of oneself have colonised twentieth century understanding [65]. Miller and Rose [66] detect "... the formation of a complex and heterogeneous 'therapeutic machine' which has attached itself to diverse problems concerning the government of life conduct... its potency has lain in its availability to spread a particular way of understanding, judging and intervening over a wide surface of practices and issues" (pp. 58–59).

Thus, whereas the last few years have seen a development in understanding therapy as an accomplishment of particular liberatory kinds of stories on the part of clients there are 2 important points which must be made about this. First, the relatively under-explored role of authors in constructing accounts, which Haraway calls "the God trick". This is a phenomenon which deserves further investigation in the case of therapies and care practices in the field of mental health. Second, the stories clients tell are not naïve constructions. They are precisely knowledgeable and informed, often by versions of personhood, mental "health" and "illness" which have clear links with the versions already in use by professionals. The "self realisation" which Owen [57] advocates as a way of promoting clients' autonomy is surely mediated by a range of professional and cultural processes which undermine the sense in which the consumers of mental health services can be empowered.

(3) "UPPITY VOICES": CONVERSATION, ORGANISATION AND CONTROL IN THERAPEUTIC CONTEXTS

Fine [48] argues that we can perhaps reduce the "othering" process in social science by "rupturing texts with uppity voices" and probing the consciousness of those in a position of dominance.

On the face of it, this seems possible within narrative psychotherapy. If we take at face value the concerns in the literature we have described earlier with the storying by clients, listening by therapists and the mutuality which exists between them, then this ideal might be actualised.

However, as we have also argued, clients absorb a great deal of the therapeutic ways of narrating their problems even before they arrive at the therapy session, and professionals may easily adopt tacit derogatory forms of understanding in dealing with clients or patients. Isolated snapshots in clinical settings do not necessarily lead to an appreciation of what people do in their everyday lives.

A further constraint on the ideals expressed in the narrative therapy literature is apparent if we look at a related field of enquiry, namely the study of doctor–patient interaction. Whereas we are not suggesting a direct correspondence between medical encounters and psychotherapy, this work is import-

ant because it highlights the way conversational practice reflects institutional roles. This is especially a source of insight because some scholars have noted how the "frames" or boundaries of how clients' problems are formulated are worked—e.g. the elisions between bio-medical frames and psycho-social frames.

Generally, authors have agreed that doctors' talk operates within a bio-medical "frame" in Goffman's [67] sense of the term [68]. Furthermore, doctors' handling of questioning sequences where patients are asked about themselves and their symptoms forms a primary instrument of interactional control [69]. The possibility of "uppity" voices finding their way into the process or records seems even more remote when we consider the form of the medical interaction in more detail, where it has often been noted that doctors are apparently able to impose a set of priorities on their patients [70, 71]. Doctors' sequences of questions are often of a kind which allows only for short factual answers [72, 73] and that the interaction sequences initiated by doctors' questions often have a three part structure. The doctor typically initiates the topic/question, hears the patient's answer and maintains control of the process by means of a "third position" assessment [71–74]. In addition, question asking by patients has been noted to be "dispreferred" [73–76]. Despite all these suggestions that the doctor–patient interaction works predominantly in the interests of, and at the behest of doctors, there is some evidence that patients are well disposed towards the controlling behaviours of doctors [77]. These examples come predominantly from medicine addressed to physical rather than psychological distress, and involve physicians rather than the broad range of professionals in psychology, nursing, psychiatry and social work who deal with "psychiatric" problems. However there are implications here for understanding psychotherapeutic encounters too. The microstructure of encounters deserves much greater attention from researchers addressing the therapeutic process. The grander narratives which clients produce are surely emergent properties of an interactive process which is addressed only at a general level in the glowing manifestos for narrative psychotherapy we have reviewed earlier.

The picture of medical consultations presented by this kind of scholarship on doctor–patient interaction is rapidly being complicated even further however by new studies which detect the coexistence of several "frames" in medical encounters. For example, Coupland *et al.* [68] emphasise the use of what they call "socio-relational frames" in interactions they studied between doctors and elderly patients, which prioritise social relationships and psycho-social issues. This, the authors argue, fits in with the emphasis in contemporary geriatric medicine on relationships and autonomous living arrangements. This diversity of frames which doctors can employ simultaneously might signal a desirable attentiveness

and flexibility. On the other hand it might be that their ready deployment of frames and registers of enquiry enables the controlling behaviour identified in studies of medical interaction.

This is not to argue that medical encounters are inevitably managed by the doctor in a way which brooks no dissent from the patient. Ethnomethodologists such as Tony Hak [78] are at pains to point out how clients are able to retain some control over the encounter. A U.S. study of women's interactions with their physicians [79] provides the spectacle of women working in the encounter to get their doctors to adopt a *more* medical approach to their problems and prescribe them tranquillisers, despite the doctor trying to get them to "...understand that it isn't going to cure any of your problems" [79] (p. 39). In any case, the work cited above does not represent a monolithic bloc of homogenous findings.

Our purpose in describing it is to highlight the way that this literature foregrounds the possibility of professionals interactionally managing encounters and attempts to identify how they do this. This contrasts with the equity, empowerment of clients and mutuality asserted in much of the literature on psychotherapy. We would suggest, crucially, that this difference in emphasis reflects the orientation of different researchers as well as any difference between psychotherapy and general practice. Certainly, writers on psychotherapy have noted how clients may refuse or respond sarcastically to therapists' interpretations [80]. Yet the very fact that therapists are the ones doing the interpreting, empowering and so forth suggests a level of interactional management that surely demands greater acknowledgement on the part of many authors who are concerned with narratives in psychotherapy.

Thus, the possibility that texts might be punctured by the "uppity" voices preferred by Fine [48] recedes even more, because it is increasingly difficult to tell where such voices might come from, as interactions may occur so as to rule out much of this unruliness. Moreover, the "uppity" voices may even puncture the text to demand more medication [79]. The implications of this body of work for narrative therapies are important. First, the conversation analytic studies of interactions between professionals and clients have an orientation which takes very seriously the management of interaction by the parties. In the conversation analytic tradition these are not simply tellings of clients' troubles which reflect a narrative inherent in the client, but are carefully organised joint productions. Second, with its attention to "frame shifts" and "frame negotiation", this work can provide a more thoroughgoing test of the ideals of mutuality espoused by many authors on psychotherapy.

CONCLUSIONS AND REVISIONS

We have argued elsewhere [81] that professional processes of record-keeping effectively fictionalise "patients" in a similar way to literary and biographical writing. What we have attempted to illustrate in this article is that a variety of other processes intervene to constitute the person's distress, mediate it in therapeutic encounters and give it form. Both traditional and new narrative style therapies have addressed the business of the clients' stories. However, both have to an extent avoided some important questions concerning the social functions of therapeutic language use, the way that clients' descriptions of their problems are often already storied along psychiatric lines, and the constraints which may well be at work in the microstructure of therapeutic encounters.

Some of these concerns are already being addressed in the literature on therapy. Parry and Doan [14] are concerned that therapists take on a role like "editorial catalysts" in their clients' life stories and advocate a focus on therapists' own stories of professional development too. This invites an attractive plurality of self interpretations from clients and therapists alike, but this kind of work does not yet address in detail the practitioner's role in constructing the story along the lines we have indicated above.

Shotter [82] on the other hand is concerned that we do not get seduced by "a nice, coherent well-organised narrative" (pp. 127-128). This, he argues, does not allow a full appreciation of the context in which people are embedded and the way it surrounds us with possibilities. A therapeutically re-visioned story is not necessarily more true, even if it results in greater happiness for the client. In Shotter's view it has become more *intelligible*, however.

Perhaps the most useful way of extending the ideas presented here is to focus more fully on how this intelligibility gets established. We would advocate further research on a variety of fronts, ranging from the study of professional systems of organising and establishing knowledge and practice, to clients' descriptions and explanations concerning their problems, through to fine-grained conversation analysis of therapeutic and diagnostic encounters, and lexico-grammatical analyses of medico-nursing *reportage*. Clients' own narratives are occasioned amongst a much broader set of narratives which are equally important and worthy of investigation. Certainly, any progress along these lines would advance the disabuse of prevailing narratives governing psychiatric discourse.

Perhaps the final word on institutional formulations of people should go to Mikhail Bulgakov [83] who neatly illustrates the problematics of *reportage* in his novel "The Master and Margarita":

"... various officials filed reports describing this man. A comparison of these reports can only cause astonishment. Thus, the first says the man was short, had gold teeth, and limped on the right foot. The second, that the man was of enormous height, had platinum crowns and limped on the left foot. The third states laconically that the man had no special distinguishing characteristics. We must discard all these reports as quite worthless" (pp. 6-7).

We are at a turning point in the development of the "narrative turn" in understanding mental health. Either it can reproduce the assumptions, and even the practices, of conventional psychiatry and psychotherapy, or it can open up liberatory possibilities for a reflexive understanding of therapy. It can replicate a naïve common-sense version of therapeutic transactions or it can illuminate them as topics in their own right. The radical implications of the "narrative turn" must not be ignored.

REFERENCES

1. Sarbin T. R. (Ed.) *Narrative Psychology: The Storied Nature of Human Conduct*. Praeger, New York, 1986.
2. Bruner J. *Acts of Meaning*. Harvard Univ. Press, Cambridge, Mass., 1990.
3. Reissman C. K. *Narrative Analysis*. Sage, Newbury Park, Calif., 1993.
4. Curt B. *Textuality and Tectonics*. Open Univ. Press, Buckingham, 1994.
5. Gelder M., Gath D. and Mayou R. *Concise Oxford Textbook of Psychiatry*. Oxford Univ. Press, Oxford, 1994.
6. Stafford-Clarke D., Bridges P. and Black D. *Psychiatry for Students*. Unwin Hyman, London, 1990.
7. Hak T. Psychiatric records as transformations of other texts. In *Text in Context: Contributions to Ethnomethodology* (Edited by Watson G. and Seiler R. M.). Sage, London, 1992.
8. Garfinkel H. and Bittner E. Methodological adequacy in the quantitative study of selection criteria and selection activities in psychiatric outpatient clinics. In *Studies in Ethnomethodology* (Edited by Garfinkel H.). Prentice Hall, New York, 1967.
9. Garfinkel H. and Bittner E. "Good" organisational reasons for "bad" clinic records. In *Studies in Ethnomethodology* (Edited by Garfinkel H.). Prentice Hall, New York, 1967.
10. Sacks H. On the analysability of stories by children. In *Directions in Sociolinguistics: The Ethnography of Communication* (Edited by Gumperz J. J. and Hymes D.). Blackwell, Oxford, 1972.
11. Schegloff E. A. Sequencing in conversational openings. In *Directions in Sociolinguistics: The Ethnography of Communication* (Edited by Gumperz J. J. and Hymes D.). Blackwell, Oxford, 1972.
12. Cicourel A. *Method and Measurement in Sociology*. Collier Macmillan, London, 1962.
13. McNamee S. and Gergen K. J. *Therapy as Social Construction*. Sage, London, 1992.
14. Parry A. and Doan R. E. *Story Re-Visions: Narrative Therapy in the Post-modern World*. Guilford Press, London, 1994.
15. Saleebey D. Culture, theory and narrative: the intersection of meanings in practice. *Social Work* 39, 351, 1994.
16. Hyden M. and McCarthy I. C. Woman battering and father-daughter incest disclosure: discourses of denial and acknowledgement. *Discourse and Society* 5, 543, 1994.
17. Lempert L. B. A narrative analysis of abuse: connecting the personal, the rhetorical and the structural. *J. Contemp. Ethnogr.* 22, 411, 1994.
18. Gold-Steinberg S. and Buttenheim M. C. 'Telling one's story' in an incest survivors group. *Int. J. Group Psychother.* 43, 173, 1994.
19. Newman L. *Eating Our Hearts Out: Personal Accounts of Women's Relationship to Food*. The Crossing Press, Freedom, Calif., 1993.
20. Lask B. and Bryant-Waugh R. *Childhood Onset Anorexia Nervosa and Related Eating Disorders*. Erlbaum, Hove, 1993.
21. Moustakas C. *Phenomenological Research Methods*. Sage, London, 1994.
22. Holmes J. Supportive psychotherapy: the search for positive meanings. *Br. J. Psychiat.* 167, 439, 1995.
23. Rennie D. L. Storytelling in psychotherapy: the client's subjective experience. *Psychotherapy* 31, 234, 1994.
24. Makari G. J. and Shapiro T. A linguistic model of psychotherapeutic listening. *J. Psychother. Pract. Res.* 3, (1) 37, 1994.
25. Labov W. (Ed.) *Language in the Inner City: Studies in the Black English Vernacular*. Univ. of Pennsylvania Press, Philadelphia, 1972.
26. Wigren J. Narrative completion in the treatment of trauma. *Psychotherapy* 31, 415, 1994.
27. Althusser L. *The Future Lasts a Long Time and the Facts*. (Edited by Corpet O. and Boutang Y. M., translated by Veasey R.). Vintage, London, 1994.
28. Hollinger R. *Postmodernism and the Social Sciences*. Sage, Thousand Oaks, Calif., 1994.
29. Geertz C. *Local Knowledge: Further Essays in Interpretive Anthropology*. Basic Books, New York, 1983.
30. Bhatia V. K., *Analysing Genre: Language Use in Professional Settings*. Longman, London, 1993.
31. Martin J. R. Language, register and genre. In *Children Writing: A Reader* (Edited by Martin J. R.). Deakin Univ. Press, 1984.
32. Swales J. M. *Genre Analysis*. Cambridge Univ. Press, 1990.
33. Ventola E. Text analysis in operation. In *New Developments in Systematic Linguistics* (Edited by Fawcett R. P. and Young D.), Vol. 2. Pinter, London, 1988.
34. Goffman E. *Forms of Talk*. Blackwell, Oxford, 1981.
35. Barthes R. *Image-Music-Text*. Fontana, London, 1977.
36. Edwards D. and Potter J. *Discursive Psychology*. Sage, London, 1992.
37. Billig M. The argumentative nature of holding strong views: a case study. *Eur. J. Soc. Psychol.* 19, 203 1989.
38. Billig M. Psychology, rhetoric and cognition. *Hist. Hum. Sci.* 2, 289, 1989.
39. Moscovici S. The phenomenon of social representations. In *Social Representations* (Edited by Farr R. M. and Moscovici S.). Cambridge Univ. Press, Cambridge, 1984.
40. Wooffitt R. *Telling Tales of the Unexpected*. Harvester Wheatsheaf, Brighton, 1992.
41. Lacan J. *The Four Fundamental Concepts of Psychoanalysis*. Hogarth, London, 1977.
42. Foucault M. *Madness and Civilisation*. Random House, New York, 1965.
43. Moi T. (Ed.) *The Kristeva Reader*. Blackwell, Oxford, 1986.
44. Genette G. Structuralism and literary criticism. In *Modern Criticism and Theory: A Reader* (Edited by Lodge D.). Longman, London, 1988.
45. Shotter J. *The Cultural Politics of Everyday Life*. Open Univ. Press, Buckingham, 1993.

46. Fairclough N. *Language and Power*. Longman, London, 1989.
47. Haraway D. Situated knowledge. *Fem. Stud.* **14**, 575, 1988.
48. Fine M. Working the hyphens: reinventing self and other in qualitative research. In *Handbook of Qualitative Research* (Edited by Denzin N. and Lincoln Y. S.). Sage, Thousand Oaks, Calif., 1994.
49. Spivak G. Can the subaltern speak? In *Marxism and the Interpretation of Culture* (Edited by Nelson C. and Grossberg L.). Univ. of Illinois Press, Urbana, 1988.
50. Easthope A. *What a Man's Gotta Do: The Masculine Myth in Popular Culture*. Paladin, London, 1986.
51. Thomas R. J. Interviewing important people in big companies. *J. Contemp. Ethnogr.* **22**, 80, 1993.
52. Gross H. S. Supportive therapy and the model of natural conversation. *J. Psychother. Prac. Res.* **4**, 182, 1995.
53. Hare-Mustin R. T. A feminist approach to family therapy. In *Family Therapy* (Edited by Erickson G. D. and Hogan T. P.). Brooks/Cole, Monterey, 1981.
54. DeVaris J. The dynamics of power in psychotherapy. *Psychotherapy* **31**, 588, 1994.
55. Masson J. *Against Therapy*. Collins, London, 1989.
56. Masson J. The question of power in the psychotherapy. *J. Soc. Exist. Anal.* **5**, 24, 1994.
57. Owen I. R. Power, boundaries, intersubjectivity. *Br. J. Med. Psychol.* **68**, 97, 1995.
58. Snyder M. 'Becoming': a method for expanding systemic thinking and deepening empathic accuracy. *Family Process* **34**, 241, 1995.
59. Becker H. S. How I learned what a crock was. *J. Contemp. Ethnogr.* **22**, (1), 28.
60. Angrosino M. V. On the bus with Vonnie Lee: explorations in life history and metaphor. *J. Contemp. Ethnogr.* **23**, 14, 1994.
61. Giddens A. *New Rules of Sociological Method*. Hutchinson, London, 1976.
62. Karp D. A. Illness ambiguity and the search for meaning. *J. Contemp. Ethnogr.* **21**, 139, 1992.
63. Angrosino M. V. Metaphors of stigma. *J. Contemp. Ethnogr.* **21**, 171, 1992.
64. Herman N. J. Return to sender: reintegrative stigma management strategies of ex-psychiatric patients. *J. Contemp. Ethnogr.* **22**, 295, 1993.
65. Rose N. *Governing the Soul: The Shaping of the Private Self*. Routledge, London, 1990.
66. Miller P. and Rose N. On therapeutic authority: psychoanalytical expertise under advanced liberalism. *Hist. Hum. Sci.* **7**, (3) 29, 1994.
67. Goffman E. *Frame Analysis*. Harper and Row, New York, 1974.
68. Coupland J., Robinson J. D. and Coupland N. Frame negotiation in doctor-elderly patient interactions. *Discourse and Society* **5**, 89, 1994.
69. ten Have P. Talk and institution: a reconsideration of the 'asymmetry' of doctor-patient interaction. In *Talk and Social Structure: Studies in Ethnomethodology and Conversation Analysis* (Edited by Boden D. and Zimmerman D. H.), pp. 138-163. Univ. of California Press, Berkeley, 1991.
70. Fisher S. A discourse of the social: medical talk/power talk/oppositional talk. *Discourse and Society* **2**, 157, 1991.
71. Mishler E. *The Discourse of Medicine: The Dialectics of Medical Interviews*. Ablex, Norwood, NJ, 1984.
72. Frankel R. M. From sentence to sequence: understanding the medical encounter through microinteractional analysis. *Discourse Processes* **7**, 135, 1990.
73. Frankel R. M. Talking in interviews: a dispreference for patient-initiated questions in doctor patient encounters. In *Interactional Competence* (Edited by Psathas G.), pp. 231-262. Univ. Press of America, Lanham, MD, 1990.
74. Todd A. D. The prescription of contraception: negotiating between doctors and patients. *Discourse Processes* **7**, 171, 1984.
75. Frankel R. M. The laying on of hands: aspects of the organisation of gaze, touch and talk in a medical encounter. In *The social Organisation of Doctor-Patient Communication* (Edited by Fisher S. and Todd A.). Center for Applied Linguistics, Washington, DC, 1983.
76. West C. *Routine Complications: Trouble with Talk Between Doctors and Patients*. Indiana Univ. Press, Bloomington, 1984.
77. West C. and Frankel R. M. Miscommunication in medicine. In *Miscommunication and Problematic Talk* (Edited by Coupland N., Giles H. and Wiemann J.). Sage, Newbury Park, 1991.
78. Hak T. The interactional form of professional dominance. *Soc. Hlth Illness* **16**, 469, 1994.
79. Borges S. and Waitzkin H. Women's narratives in primary care medical encounters. *Women Hlth* **23**, (1) 29, 1995.
80. Madill A. and Doherty K. 'So you did what you wanted then': discourse analysis, personal agency and psychotherapy. *J. Commun. App. Soc. Psychol.* in press.
81. Crawford P., Nolan P. and Brown B. Linguistic entrapment: medico-nursing biographies as fictions. *J. Adv. Nurs.* **22**, 1141.
82. Shotter J. *Conversational Realities: Constructing Life Through Language*. Sage, London, 1993.
83. Bulgakov M. *The Master and Margarita* (Translated by Ginsburg M.). Picador, London, 1989 (originally published 1967).