Looking for the 'I', 'Me' and 'Other' in Patient Stories

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A B S T R A C T

The following paper looks at how 'story telling' can help in the recovery from illness. The drive to make sense of our experiences, ills and life is profound and deeply rooted in the human psyche. Story telling allows the patient to make sense of their world and adjust to change brought about by their illness. In locating the self (the 'I', 'Me', and 'Other') in story, the person may come to think of recovery in a more positive and productive manner. Allowing a person to tell their story can provide access and insight to understanding and learning that would otherwise remain hidden, even to the people themselves, as well as the clinician.

Key words: Recovery, 'story telling', meaning making

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INTRODUCTION

An important factor facilitating recovery from any illness, be that physical or mental illness is the creation of new meaning out of the illness experience. The following essay explores this process of meaning making through 'story telling'. The approach to 'story telling' considered in this paper places emphasises on the social nature of consciousness and the innate drive for people to share and tell their story. There is growing recognition as to the importance of locating the patient 'voice' as part of the care episode and the contribution that patient 'stories' play in this and in particular recovery. Frank (1995) suggested patients' lives become reconstructed in the construct of illness, and that 'telling stories of illness is the attempt, instigated by the body's disease, to give voice to an experience that medicine cannot describe'. Clinicians need to listen, and value, the patient story if they are to truly understand those that they care for and support.

Brody (2003) proposed that story telling serves to 'unify the temporal and historical dimensions of our existence'. It is through the telling of stories, both public and kept (those stories that we tell to ourselves and not to others), that the person integrates their life experiences into an internalized, coherent sequence of events by which the person makes sense of the world (Brawn et al. 2015). Events are selected that have significance for the person and given a sense of cohesion and direction, on which decisions are made and played out. By telling 'a story' the person is, consciously or unconsciously, 'inventing formulae and concepts, which appear to give coherence to what is really disconnected' (Fordham 1963). Past events are reshaped and retold while future aspirations or plans are in a state of flux can be re-evaluated and reset depending on lived experiences (Lemley & Mitchell 2011). As the author Adam Johnson famously said,

> 'our job as people and characters is to find our own motivations and desires, to overcome conflicts and obstacles toward defining ourselves so that we grow and change'

This drive to make sense of our experiences, ills and life is profound and deeply rooted in the human psyche. It is through story telling that we learn things about our self and our place in the world. Story telling helps the person organize their understanding and interpretation of their experience into a body of practical knowledge (Drumm 2013), which forms the foundation of decision-making.

'Story telling' is particularly concerned with human relationships, and with the value of people, their actions and behaviour towards one another. It is not surprising then that 'stories' tend to be built around value systems that reflect what is important to the person. Listening to a person's story engenders greater understanding, empathy and reflection, and can provide a deeper insight into the lived experience (McAdams 2007).

During our lifetime we are all presented with challenges that can impact on our physical or psychological wellbeing. For some the required resolution occurs without the need

for too much thought or intervention. For others the journey to recovery can be significantly more complex and challenging. It is in such moments as these that the person will ask questions about the permanence of their situation, and of their ability to cope.

The 'stories' that people tell of their illness are important to recovery and their belief in themselves. The German word for healing, Heilsweg, is an interesting and useful one when thinking about the link between story telling and recovery. Translated it signifies both healing and salvation at the same time. It is argued here, that story telling has the potential to bring about 'deep healing' (Heil) and through this recovery (salvation). Making time for a person to tell their story is one means of promoting recovery, the other is listening to what the story contains and responding appropriately. For the purposes of this paper, the authors understand recovery to be:

> '… a deeply personal, unique process of changing one's attitudes, values, feelings and goals, skills and roles. It is a way of living a satisfying, hopeful and contributing life, even with the limitations caused by illness' (Anthony 1993).

From the above definition we get a sense of recovery as being a lived state, which is both fluid and dynamic, built upon both a desire and ability to change one's thinking and behaviour. Stories then are not the experience of the person as experienced but its meaning. Allowing a person to tell their story can provide access and insight to understanding and learning that would otherwise remain hidden, even to the people themself. The telling of a story helps organize information about how people have interpreted events; the values, beliefs and experiences that guide those interpretations; and their hopes, intentions and plans for the future. We hear struggles to make sense of the past and create meanings as they tell us what happened to them. Stories capture the complexities of life as lived.

MEANING MAKING

The idea and drive of 'meaning making' is insightfully illustrated by the following quote from the psychiatrist and holocaust survivor Victor Frankl (1946).

Man's search for meaning is the primary motivation in his life. This meaning is unique and specific in that it must and can be fulfilled by him alone; only then does it achieve a significance which will satisfy his own *will* to meaning' (p160).

Writing of his own experiences of surviving Auschwitz, Dr Frankl sought to make sense of not only his time as a prisoner but at the loss of his wife to the concentration camp and the madness of the world. It was the search of meaning that kept Dr Frankl going and one that he has related through story in books and interviews.

The innateness of story telling means that patients often feel compelled to tell their story, and indeed are often asked by health care personnel to recount certain aspects of it. Time constraints often mean that the clinicians will take elements of a person's story and give credence to that which supports a particular diagnosis or treatment intervention, inadvertently bracketing out other aspects of the patients story. This risks missing out important aspects that could be relevant to the person's story and recovery.

The central premise to understanding a person's stories is the emphasis it places on the intersubjective process of talking, listening and healing. Sense making is created and constructed through the stories telling / retelling and provide an opportunity through which to examine personal values and beliefs. The fundamental presupposition of story telling is consistent with liberal and humanistic thought, namely that the solution to a person's problem lies in the person. The person is thought to possess the means and resources that can be tapped by the use of non-directive techniques as championed by the psychologist Carl Rodgers. 'The non-directive viewpoint,' says Rodgers, 'places high value on the right of every individual to be psychologically independent' (1951: 127). By the act of telling and re-telling the person gains insight into their problem and gradually devises a solution or understanding.

INTERPRETING PATIENT STORIES

The beginning of a story has been described as negotiating entry into the field of situation (Connelly & Clandinin 2006) and that the telling of a story requires a warm collaborative relationship and sharing. In deconstructing and reconstructing patient stories we are interested in not only the story but also the narrative account (the telling of the story). A story is not the experience of the speaker as experienced but it's meaning. The experience is conveyed as an expression, not only through the act of speech but also the intersubjective exchange itself from which understanding and insight is gained and garnered. In this way the lived experience remains private, but its sense, it's meaning, becomes public through the telling of the story. Knowledge gained in this way is 'situated, transient, partial and provisional' and open to exploration and explanation (Etherington 2006) by both the person telling the story and those listening to it. In this way stories can be viewed as a means of knowledge construction that values messiness, differences, and the depth and texture of life as experienced (Polkinghorne 1995).

The context in which a story is related, the person's reason for telling it, the person's competence in telling it, and the nature of the audience are all important elements in developing an understanding of the stories that people hold and tell. The 'stories' people tell quickly focuses on the formation of interpersonal relationships, the sequencing of messages contained in the story, and the patterns of stories as told over time into relationships of

understanding. Having a sustained voice is central in the construction and understanding of self.

Through interpretation the story takes on a new life to form something new. At first this understanding is fairly superficial. However, through exploration, the clinician can begin to take into account a number of other factors. The first is what they know of the person, informed by the case notes and past history and then by what the person reveals about themselves. Interpretation moves from immature understanding to deeper understanding through exploration and explanation of the story being told. In this way, new thinking emerges in the space between the spoken and attended to through active listening. For some active listening is almost second nature for others it is an essential skill that needs to be developed. By practicing reflexivity one can gain a sense of what is being both said and heard. In deconstructing and reconstructing patient stories we are interested in not only the story has told, but also the narrative account (the telling of the story).

LOOKING FOR THE I, ME AND OTHER IN STORIES (KNOWING ONESELF)

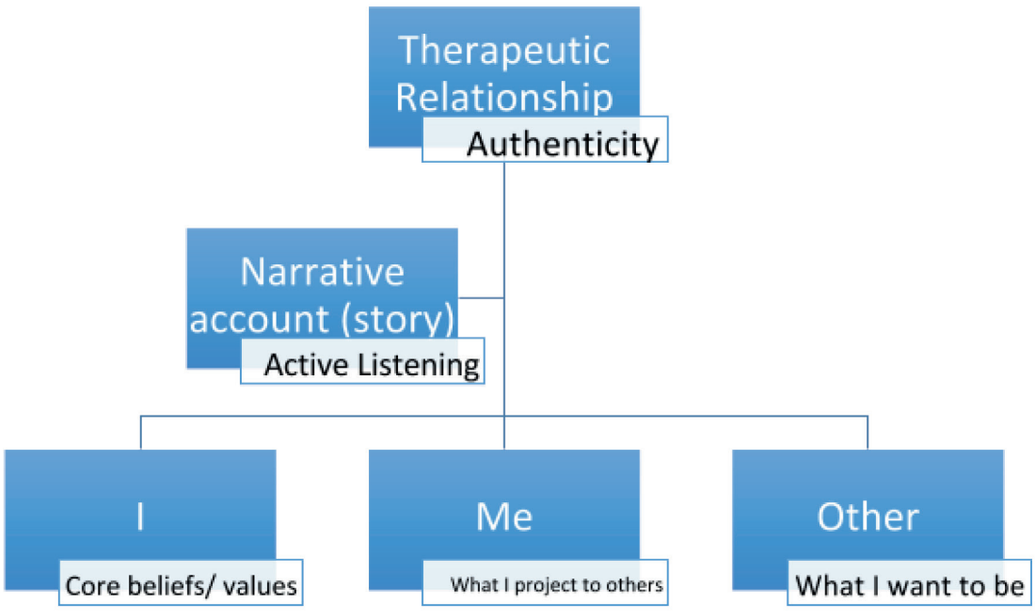
The construction and understanding of self is an important part of recovery. Self refers to the understanding a person has of themselves. The identify of 'self' is a construct created from stories of a self in the past (I) and present (me) and that these reflections go on to form a future self which we strive to become (the other). Conceptualization of the self stems from William James' (1890) distinction between I and Me. According to this division, I refers to 'self-as-knower', whereas Me symbolizes 'self-as-known', which is acknowledged by the objective agent – I. In other words, I as a subject perceives I as an object (Me/Mine). The grouping of I and me is a phenomenon in which subject (I) and object (Me) are brought together to form self, although it is important to recognize the two as being different when listening to a person's story. The other is the potential contained in the I and Me for the person to become more than the they are currently and to grow and develop new ways of thinking about themselves (that change and achievement are possible).

It is while listening that the clinician will begin to identify traits of I, Me and Other. By compartmentalising these traits, it benefits the clinician in gaining a better understanding of the person as a whole. The person, with support and guidance from the clinician can gradually start to recognise the divisions of I and Me woven through the layers of their own narrative and in turn, move closer towards the 'other' and recovery. In paraphrasing Nicoll (1952: 21-22) and adding our words in italics we see the formation of I, Me and Other through storytelling and consciousness.

> 'When a man begins to observe himself from the angle that he is not one but many, he begins the work on his being. He cannot do this if he remains under the conviction that he is one, for then he will not be able to separate himself from himself, for he will take everything in him, every thought, mood, feeling, impulse, desire, emotion, and so on, as himself – that is as 'I'. But if he begins to observe himself, he will then, at that moment, become two – an observing side *(I) and observed side (me). In making this distinction he will be able to contemplate and make the shift from where he is to where he could be and in doing so contemplate the other (a future self).*

This self-dialogue, captured and played out, in this case, through story, can be seen as being a continuous dynamic movement. In this way we are not speaking of consciousness but the consciousness process of becoming, both as an identity and as a manifestation of self (the I , Me, and 'other'). As far as the authors' are concerned, one does not just become conscious: consciousness is not simply something that we strive to achieve. Consciousness is a process that we live out through the telling and retelling of a story and through dialogue – an evolutionary process continually changing, fluctuating, from one telling of the story to the next.

The emphasis is on co-construction of meaning between the clinician and the person. While being involved in listening to a person's story the clinician takes in what is being said and compares it with his or her own personal understandings of the situation, without filing in any gaps in understanding with 'grand narratives' of their own, but rather inquiring about how pieces of the story fit together. Life is never static. Past events are shaped and retold while future aspirations or plans are in a state of flux and can be re-evaluated and reset depending on lived experiences.



Within this notion, the role of the clinician can be seen as a filter, separating each entity of I, Me and Other. The 'Narrative Filter' (diagram above) depicts how the interplay between storyteller and recipient, the patient and clinician, are both required to be part of the process for the filter to work effectively. With this in mind, the blue boxes can be associated with the storyteller and white with the clinician.

Before this filtering system can become an effective tool, the clinician must first ensure that they have built a relationship of trust and authenticity. Arguably this can be seen as one the more important aspects to the process, as no one is going to want to reveal a potential vulnerability by sharing personal stories if they feel the recipient is not interested. Next, the narrative account – the story. It is imperative that the clinician is truly receptive to the story being told. Active listening was coined by Carl Rogers who proposed that:

> "Until we can demonstrate a spirit which genuinely respects the potential worth of the individual, which considers his sights and trusts his capacity for self-direction, we cannot begin to be effective listeners" (Rodgers & Farson, 1987, p1).

This again, draws on not only the importance of the person's perception of the clinician to be an authentic, genuine one but also of the need to avoid abstracting and instead attempt to uncover each narratives hidden meaning. As with so many of these things, there needs to be a willingness on the part of the clinician to engage with the other on a level of personal understanding. In this unmediated encounter of two authentic beings, there is "scant security, only the meeting with the unknown, the unique, the never-before experienced" (Hycner, 1991, p. 42). The direct consequence of this relationship is the transformation of interpretation into a dynamic dialectic between two people who have a better understanding of the other.

SUMMARY

In trying to gain a true understanding of the patient a medium needs to be set up where the patient is given time to discuss/explore their whole story. This process can be both cathartic and validating. It is important not to add value to one story over another for professional gain (i.e. for a risk assessment or care plan) but instead, to acknowledge each story is being told for a reason and it is the job of the clinician to uncover the deeper meaning, the hidden truth. Emphasise is placed on listening and responding to the patients story, as told by the person, rather than simply treating his or her symptoms. Central to the process of recovery is 'meaning making' of the illness experience and the construct of self in relationship to this, in this case through story telling. The construction and understanding of self is an important part of recovery that can be accessed through story telling. In order to gain value from this the clinician needs to provide the patient with the opportunity to tell their story.

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