Title Page

Title The Limits of Narrative: Provocations for the Medical Humanities

Author
Angela Woods
Lecturer in Medical Humanities
Centre for Medical Humanities
Durham University
House 4, Trevelyan College
Elvet Hill Road, Durham DH1 3LN
e angela.woods@durham.ac.uk
t +44(0)191 33 47063
w http://www.dur.ac.uk/cmh/
b http://medicalhumanities.wordpress.com/

Key words
Narrative
Medical humanities
Narrative identity
Galen Strawson

Word Count 4425 excluding references

Revised October 2011, as detailed in the report attached.

Abstract

This paper aims to (re)ignite debate about the role of narrative in the medical humanities. It begins with a critical review of the ways in which narrative has been mobilised by humanities and social science scholars to understand the experience of health and illness. I highlight seven dangers or blind spots in the dominant medical humanities approach to narrative, including the frequently unexamined assumption that all human beings are "naturally narrative." I then explore this assumption further through an analysis of philosopher Galen Strawson's influential article "Against Narrativity." Strawson rejects the descriptive claim that "human beings typically see or live or experience their lives as a narrative" and the normative claim that "a richly Narrative outlook is essential to a well-lived life, to true or full personhood." His work has been taken up across a range of disciplines but its implications in the context of health and illness have not yet been sufficiently discussed. This article argues that "Against Narrativity" can and should stimulate robust debate within the medical humanities regarding the limits of narrative, and concludes by discussing a range of possibilities for venturing "beyond narrative."

The Limits of Narrative: Provocations for the Medical Humanities

Narrative in the Field of Medicine: Six Uses, Five Debates, Seven Dangers

The role of narrative in medicine, and its importance both to clinical practice and to understanding the illness experience, has expanded considerably in recent years. Across clinical disciplines, as well as in the medical humanities, medical sociology and anthropology, narrative is called upon to fulfil an increasingly wide range of functions. First and foremost, narrative is understood to provide privileged access to the subjective experience of illness, and is frequently promoted as the primary vehicle through which the ill person can express her changing sense of self and identity, explore new social roles and gain membership of new communities [1-3]. Here, narrative is regarded as not merely expressive but as transformative and even therapeutic [4-6]. Turning from patient to practitioner, narrative has long been valued for the insights it offers into the experience of all those who care for the sick [7-10], but more recently, and more radically, "narrative competence" has come to be seen as an essential skill in clinical diagnosis and treatment [11-13]. In the sphere of health research, narrative offers new methodologies for qualitative and quantitative studies of the illness experience [14-17], and at the societal level, narrative is seen by some to challenge the hegemony of naturalistic and biomedical approaches to illness and so provide the foundation for a new ethics and politics of healthcare [3].

The difficulty of giving precise definitions of narrative [18, p. 1] – and reluctance of many to do so – further complicates the ways we can see it in operation in the field of medicine. Some have argued that the concept of narrative adds little but academic pretention to the experience-near and "probably universal" concept of "story." As Unni Wikan puts it: "people bleed stories, but academics gather narratives" [19, p. 217].

Others reserve the term "story" to denote a sequence of events which are then discursively rendered in "narratives," or argue that "stories" belong to the realm of the individual while "narratives" refer to the organizing culturally-variable frameworks through which stories are told [20, p. 12]. The concept of "narrativity" – the thick or thin, minimal or rich, quality of being narrative – raises further complications for plotting the relationship between narratives, stories and events [21]. Scholars working in sociology, narratology and psychology continue to debate whether "big" or "little" stories give us the richer insights into experience and identity [22-28] and whether the most valuable way of engaging with narrative is as "story-analysts" or "story-tellers" [17, 29-33]. Some anthropological accounts of narrative emphasise its performative, embodied, temporal, and interpersonal dimensions; others, following the lead of literary theory, adopt a more semiotic approach to the narrative as text [34, 35]. Amidst this diversity of perspectives, methodologies, and scholarly aims (and notwithstanding a few notable exceptions [29, 31, 36, 37]) it is frequently the case that a person's narrative or story, however defined, is assumed to be coextensive with their subjective experience, their psychological health and indeed their very humanity.

With this in mind, it is not surprising that narrative should enjoy an exceptionally privileged role in medical humanities scholarship. Advocates for the use of narrative have a commitment to understanding the centrality of the illness experience in the medical treatment of disease, taking seriously stories of illness, and valuing the individual as the empowered author-narrator of her own story. These goals are, without doubt, commendable both in scholarly and practical terms. At the same time, and from a broadly sympathetic standpoint, I would argue that there are still some pressing questions – seven, to be precise – about the use of narrative in medical humanities scholarship which have yet to be comprehensively addressed and so require our sustained analytic attention.

(As I hope the reader will have already suspected, this delimitation of seven questions is itself something of a provocation. Any attempt to survey an interdisciplinary debate of this complexity in a single paper will be obliged to engage a kind of academic shorthand against which all sorts of very valid objections can be levelled. Of course, my intention

here is not to present a definitive or otherwise closed set of conclusions, but rather to (re)ignite critical debate around these topics. I also wish to emphasise the relevance of this discussion to the medical humanities in its most inclusive sense: references to "narrative in medicine" or "narrative in the field of medicine" should be understood in the broadest possible terms to include all aspects of healthcare and the study of health and illness.)

The first so-called "ethical hazard" [38] routinely encountered in the study of narrative in medicine, albeit one that has been agonised over repeatedly, concerns the truth-value of narrative. To what extent can we trust that people's stories of illness faithfully describe "what it was really like"? As Mark Freeman has noted in relation to qualitative research more broadly, there is "widespread concern that 'narratives are untrue to "life itself"'. Whether this is cause for alarm (the data are distorted!) or celebration (a toast to the imagination!) depends on who is offering the critique" [23, p. 132]. The issue of whether narratives are "true" of course immediately prompts us to ask "for whom, and in what situation?" This in turn calls attention to the uses of narrative, and to a second hitherto neglected area of inquiry suggested by the question: "Can narrative coherence be a *harmful* phenomenon, how, and in which context?" [39, p. 7]. As Yiannis Gabriel notes, "while stories can be vehicles of contestation, opposition, and self-empowerment, they can also act as vehicles of oppression, self-delusions, and dissimulation" [40, p. 169].

A third danger – more troubling, in my view, if only because it is less frequently acknowledged – lies in overinflating what counts as narrative. In some accounts of narrative in the field of medicine virtually all forms of creative self-expression, including painting, poetry and dance, are included under the "narrative" umbrella [41, p. 1], which I think risks mistaking a specific form of primarily linguistic expression for the master-trope of subjective experience. Related to this is the tendency for some authors to collapse distinctions between different narrative forms and contexts. Emphasising the continuities between, for example, hospital anecdotes, published autobiographies and diagnostic interviews, diverts attention away from systemic analysis of the diverse

functions and effects of specific types of storytelling [36]. Fifth, and despite repeated efforts to present definitive typologies of illness narratives (as in [3, 42, 43, p. 1840]), a sophisticated account of genre is largely absent from literary and semiotic approaches to medicine-related and illness narrative. Genre, with its three dimensions of formal organization, rhetorical structure and thematic content, is a universal feature of all textuality [44], and a careful examination of how it enables and constrains the production of certain kinds of narratives in an array of medical and broader cultural contexts is, I would argue, overdue.

This leads in on to my sixth concern: that scholars and practitioners working with narrative in the field of medicine frequently overlook the cultural and historical dimensions of narrative form. Too often particular kinds of narrative are presented as transcultural, transhistorical truths of the human experience, a view that operates at the expense of a more historically and anthropologically grounded approach to understanding the cultural specificity of idioms of distress. Arthur Frank's much-celebrated book *The Wounded Storyteller* [3] is a case in point here. Although he writes at length about the specific contours of the "postmodern remission society," Frank turns to monomyth, the archetypal story of a hero's journey, as the ideal narrative form of illness experience. With this in mind, the seventh warning I would like to issue is that promoting (particular forms of) narrative as *the* mode of human self-expression, in turn promotes a specific model of the self – as an agentic, authentic, autonomous storyteller; as someone with unique insight into an essentially private and emotionally rich inner world; as someone who possesses a drive for storytelling, and whose stories reflect and (re)affirm a sense of enduring, individual identity.

These last two dangers direct our attention to the philosophical foundations of narrative self-hood and identity and will be the focus of the rest of this paper. The literature on narrative and the self comes from psychology, philosophy, sociology, literary studies, anthropology, psychiatry and neuroscience; it encompasses memory, identity, ethics and emotions; and it seems to be growing exponentially [45]. Rather than attempt anything like an overview of this terrain, I want instead to concentrate on

philosopher Galen Strawson's "Against Narrativity"[46], an article which remains at the high water mark of critiques of so-called "narrative orthodoxy." Although his central quarrel is with philosophers (as in [47-51]), Strawson has in his sights the narrative turn across the humanities and social sciences, and his ideas have been taken up in disciplines as diverse as organisational studies, education, and life-writing. Passionate and polemical, "Against Narrativity" raises questions which go to the heart of narrative in medicine, but which have yet to be adequately addressed by scholars and practitioners in the medical humanities.

"Against Narrativity"

"Against Narrativity" begins by identifying two major currents in the tide of interdisciplinary interest in narrative: (i) the *psychological narrativity thesis*, which holds "that human beings typically see or live or experience their lives as a narrative or story of some sort," and (ii) the *ethical narrativity thesis*, which "states that experiencing or conceiving one's life as a narrative is a good thing; a richly Narrative outlook is essential to a well-lived life, to true or full personhood" [46, p. 428]. Strawson rejects both theses as false:

> It's just not true that there is only one good way for human beings to experience their being in time. There are deeply non-Narrative people and there are good ways to live that are deeply non-Narrative. [Views which subscribe to the ethical narrativity thesis] hinder human self-understanding, close down important avenues of thought, impoverish our grasp of ethical possibilities, needlessly and wrongly distress those who do not fit their model, and are potentially destructive in psychotherapeutic contexts. [46, p. 429]

Strawson's account of the differences between narrative and non-narrative people begins with a distinction between two forms of temporal experience. In the diachronic mode, "one naturally figures oneself, considered as a self, as something that was there in the further) past and will be there in the (further) future" [46, p. 429]. In the episodic mode, by contrast, while the *capacity* to remember past and anticipate future experiences remains intact, there is no felt sense of an inner mental entity persisting through time. Using himself as an example, Strawson illustrates episodic self-experience as follows:

> I have a past, like any human being, and I know perfectly well that I have a past. I have a respectable amount of factual knowledge about it, and I also remember some of my past experiences 'from the inside', as philosophers say. And yet I have absolutely no sense of my life as a narrative with form, or indeed as a narrative without form. Absolutely none. Nor do I have any great or special interest in my past. Nor do I have a great deal of concern for my future. [46, p. 432]

Strawson maintains that being diachronic is necessary but not sufficient for being a (naturally) narrative person, as "one can be Diachronic without actively conceiving of one's life, consciously or unconsciously, as some sort of ethical-historical-characterological developmental unity, or in terms of a story, a *Bildung* or 'quest'" [46, p. 441]. Narrativity, then, which for Strawson is the special quality of narrative people, requires not just a particular sense of temporally enduring self, but an active drive or tendency towards form-finding, story-telling, and revision.

It is important to note here that Strawson's account of narrativity relates specifically to what are elsewhere described as the "big stories" of biographical identity. The idea that narrativity is marshalled in the services of the "small stories" of everyday life, such as making coffee or recounting the journey to work, Strawson dismisses as trivial. So-called non-narrative people are, on his model, perfectly capable of understanding events sequentially and grasping causal relationships. What they lack is the propensity or orientation towards narrativity: the feeling of deep psychological continuity with one's past self married with the desire to frame experience, tell stories, and revise the past. It is in the context of structural or foundational self-perception that Strawson moves swiftly from seeing narrativity as sometimes useful to condemning it as almost always harmful:

> The aspiration to explicit Narrative self-articulation is natural for some – for some, perhaps, it may even be helpful – but in others it is highly unnatural and ruinous. My guess is that it almost always does more harm than good – that the Narrative tendency to look for story or narrative coherence in one's life is, in general, a gross hindrance to self-understanding: to a just, general, practically real sense, implicit or explicit, of one's nature. [46, p. 447]

"Against Narrativity" and the Medical Humanities

While Strawson does not rule out the possibility of what could be called mixed types – people who have an episodic experience of time but also a strong penchant for form-finding, or are diachronic but evince no interest in storytelling – critics have been right to note that subtlety and nuance are not chief among the virtues of "Against Narrativity." Strawson effectively proposes a dichotomy between episodic-non-narrative and diachronic-narrative selfhood that is radical, fixed, and thin on phenomenological and psychological detail. Philosophers have been quick to interrogate the logical foundations and ethical implications of this distinction, and Strawson's broader claims about the injunction to narrate have similarly caught the attention and raised the ire of academics in psychology, literary studies and related disciplines [52-56]. Rather than offer a comprehensive review of these objections, or adjudicate in advance a debate between Strawson and scholars working in the medical humanities, I want to argue here for the importance of his and others' work in stimulating a robust discussion about the limits of narrative in our field. In the final section of this paper I will outline what I see as some of the most productive topics for further analysis.

The most obvious starting point for such a discussion is one of narrative medicine's foundational, normative claims: that *self-expression through narrative is fundamentally healthy and desirable, particularly in the case of illness*. As we have already seen, one of the most famous expositors of this view is Arthur Frank. According to Frank, the ill person is a "narrative wreck" [3, p.54], and it is task of a humane medicine – or, better, a humane society – to support the ill person in telling their story. Frank suggests that illness narratives can only take a finite number of narrative forms, and his account accords pride of place to the "quest narrative" as the form best suited to restoring the ill storyteller to her sense of self. Quest narratives can take the shape of memoir, manifesto or automythology; what is important is that the ill person becomes, effectively, the hero of her own story, such that the creation and performance of narrative is a form of testimony which re-claims and re-orients the self.

A Strawsonian response to Frank and others' celebration of illness narrative hardly needs elaboration. If the psychological and ethical narrativity theses are false, as Strawson argues, then the injunction to narrate is not only misguided but quite possibly harmful, particularly for those people who are 'naturally' episodic. Frank, in turn, might reply that Strawson fundamentally misunderstands both identity and narrative by representing them as essentially private, interior affairs. Interlocutors, audiences, co-authors and communities of meaning are worryingly absent from Strawson's discussion of narrativity, and he offers no insight into the way in which different modes of self-experience are *valued*, legitimized and endorsed in different (historical, social, cultural, familial, professional) contexts. As I discuss in detail elsewhere [57], the sparks that fly from the collision of these diametrically opposed views have the potential to (re)ignite long-smouldering debates about the embodied and social significance of illness as well as its temporality. Strawson bizarrely asserts that "the fundamentals of temporal temperament are genetically determined," while conceding that "one's exact position in Episodic/Diachronic/Narrative/non-Narrative state-space may vary significantly over time" [46, p. 431]. How, and to what extent, does illness alter our temporal and hence narrative orientation? Does illness propel us in the direction of diachronicity, forcing us to mourn a healthy past which cannot be recuperated and a future which feels more fraught, more finite? Or is it the case that illness demands instead that we attend to the right now, either because pain returns us to the immediacy of the body, or because the uncertainty of the future encourages us to invest more intensely in the self-experience of the present? While it seems reasonable to suggest that illness significantly disrupts temporal self-experience [58, 59]; Strawson's work forces us to question whether narrative should remain the privileged form for the interpretation or restitution of that self-experience.

We need not necessarily follow Strawson in the wholesale rejection of the psychological and ethical narrativity theses to realise that there is much to be gained by challenging the assumption of their ubiquity and universality. Narrative is not, and never has been, innocent; it is not, and never has been, inherently oriented towards the good. A major

shift in Frank's own work has been to foreground the dangers inherent in stories and storytelling [60], but for me an even more pressing concern is the assumption of an innate a-historical narrative identity upon which his work (and indeed virtually all mainstream medical humanities thinking) is based. Writing of narrative psychology, Brian Schiff [61, p. 21] states:

> In describing our project as narrative, we are reifying a Western, arguably middle and upper class, concept as a universal mode of shaping and articulating subjective experience. The narrative metaphor has wide intellectual currency in our literature culture where autobiographies and memoirs are common technologies for organizing experience, making known our insides, and carving out a place for ourselves in the social world. These vehicles are accepted and available in our daily life, that's why the metaphor is so compelling. Our mistake was to think that everyone must be like us.

Schiff's observations resonate with Terrence Holt's observation that "the confessional" has now become the "dominant mode of medical discourse" in the West [62, p. 318]. The rise of narrative medicine in the clinic and the classroom, the proliferation of doctors' autobiographies and memoirs of illness, the growing number of opportunities and incentives for patients to share stories through support groups, in online diaries and journals, and even on reality television: while these specific "technologies of organizing experience" *as* narrative multiply across the field of medicine, we must question the extent to which they function to produce Western middle-class, liberal and neo-liberal modes of being [19, p. 227, 29, 39, p. 6, 63, p. 3, 64, Ch 2, 65]. Writing in this journal, Rebecca Garden has called for narratives of disability to be "taught with a critical framework that challenges the individualisation of disability and that identifies and resists normative scripts of disability as tragedy and of triumphing over that tragedy through a struggle for normalcy" [66, p. 73]. While I agree with Garden that the medical humanities can do more to foster a critical approach to the normative scripts of particular *kinds* of narrative, I am arguing, more radically, that our field can also do more to highlight the normativity of narrative *per se*.

Can we do without narrative? Should we discourage patients and doctors from telling stories? Should we view with suspicion anyone whose sense of self is articulated in narrative terms? Of course not. I am not suggesting that we somehow "do away" with narrative. What I am suggesting is that scholars in the medical humanities can do more

to denaturalise narrative, to acknowledge not only that different cultures (including familial, institutional, and professional cultures) will tell and find meaningful different kinds of stories, but also, more fundamentally, that the attachment to and valorisation of narrativity is not universally shared [67].

Beyond Narrative?

"Is there some burden on me to explain the popularity of [the psychological and ethical narrativity theses], given that I think that they're false?" Strawson has asked. "Hardly," comes his swift reply [46, p. 439], indicating his disregard for what in my view is one of the most fascinating questions to arise in the study of narrative in the field of medicine. Strawson's evident disinterest in the complex factors giving rise to the narrative turn does not detract from the fact that "Against Narrativity" is, as I have already argued, a provocative and therefore productive starting-point for recognising the limits of narrative. In what might be considered a more positive vein, it also challenges us to explore non-narrative ways of understanding and articulating the experience of illness and its impact on the self.

So if not narrative, then what?

Space does not permit an extensive discussion of alternatives to narrative which might be more amenable to or at least accommodating of episodic self-experience; here, I mention only a few examples from the medical humanities in the spirit of stimulating further inquiry. In his work in transcultural psychiatry and medical anthropology, Lawrence Kirmayer has argued persuasively that metaphor "occupies an intermediate ground between embodied experience and the overarching narrative structures of plots, myths, and ideologies":

> Just as fragments of poetry can be written with no overarching narrative, or only the briefest strand hinted at, so can we articulate our suffering without appeal to elaborate stories of origins, motives, obstacles, and change. Instead, we may

> create metaphors that lack the larger temporal structure of narrative but are no less persistent and powerful. Such fragments of poetic thought may be the building blocks of narrative: moments of evocative and potential meaning that serve as turning points, narrative opportunities, irreducible feelings and intuitions that drive the story onward. [68, p. 155, 69]

We can only find "a way into the making and breaking of narrative" in clinical settings if we attend first "to what is unfinished, incomplete, and tentative – the myriad forms of 'nonnarrative' communication" including all the dimensions of embodied interaction [68, p 174]. Philosophy and specifically phenomenology can also offer a way of grasping the transformations – subtle and profound – to embodiment and 'enworldedness' in illness [59, 70]. The "Phenomenological Toolkit for Patients" currently being developed by philosopher Havi Carel has the potential to offer patients new resources for framing and communicating their experiences in ways which do not presuppose an orientation towards storytelling or narrative self-presentation. Drawing on the work of Merleau-Ponty and Husserl, Carel aims to provide patients with the tools to undertake their own philosophical reflection; at the same time, her workshops will use a range of media, including film and music, to encourage non-linguistic forms of self-expression. A third example, this time from the visual arts, also reminds us that language is not the only medium for communicating matters of medicine, health, and illness. Photographer Deborah Padfield's work on visualizing pain is a strong example of how creative processes structured around images, visual symbols, and spatial composition can have profound therapeutic effects as well as produce powerful aesthetic works [71].

The work of Kirmayer, Carel, and Padfield suggests that metaphor, phenomenology, and photography might be useful 'ways in' to the meanings of experience generally and of illness specifically; avenues of exploration which might well intersect with or contribute to narrative but do not take storytelling as starting-point or telos. As Paul Ulhas Macneill shows in his article on the challenging relationship between art and medicine [72], the work of body-modifying, cyborgian performance artists Stelarc and Orlan suggests even more innovative and extreme ways of exploring the discontinuities and disruptions of embodied self-experience. Their performances, and postmodern and posthuman theory with which they are in dialogue, resist the principle comforts of

narrative – continuity, closure and containment – in the pursuit of the paradoxical, the ambiguous and undecidable.

Mark Freeman has observed that "Whether we're narrativists or antinarrativists, the pressure for meaning, for significance, remains much the same" [73, p. 175]. The final point I wish to consider is the extent to which being "against narrativity" actually encompasses a deeper resistance towards this pressure, this imperative to find life meaning*ful*? In his polemical book *End of Story: Toward an Annihilation of Language and History*, philosopher Crispin Sartwell reminds us that:

> Narrative comes apart at the extremes…it comes apart in ecstasy, in writhing pain, at death. But it has already also come apart everywhere, all the time, wherever people are breathing, or walking around, or watching TV, and not getting anywhere narratively speaking. What narrative is inadequate to is not just the shattering moment, but the moment of indifference….Pull yourself away from significance for a moment and let yourself feel the sweet, deep, all-enveloping insignificance all around you. And take comfort in your own insignificance; take comfort in the triviality of your culture; take comfort in the triviality of your life-project and your failure in realizing it. [67, p. 65]

Sartwell's work, like Strawson's, may not ultimately prove comforting to many in the field of the medical humanities, but the *dis*comfort it produces I hope would be an inspiration for some.

Conclusion

As the corpus of articles on narrative in *Medical Humanities Journal* alone attests, the importance of narrative to the understanding and even treatment of illness should not be underestimated. Narrative, or, rather, the wealth of possible forms of storytelling and framing of experience brought together under its elusive sign, is a vehicle for foregrounding those qualities of personhood so often thought to be excluded from the narrow biomedical approach to medicine and disease [74, p. viii]. But it is not the only one. This paper has argued against the claim that "constituting an identity *requires* that an individual conceive of his [sic] life having the form and the logic of a story – more

specifically, the story of a person's life – where 'story' is understood as a conventional, linear narrative" [75, p. 96, emphasis added], and the related idea that illness specifically calls for or requires stories [3, p. 2]. "Against Narrativity" makes a moral appeal to philosophers and, as I have suggested, scholars and practitioners in the medical humanities, to guard against "needlessly and wrongly distress[ing] those who do not fit their model." If we limit ourselves to specific forms of narrative, and to narrativity per se, we run the risk of both isolating and distressing people, such as Strawson, who conceive of themselves as "Episodics," and of shutting down the very diversity of perspectives and forms of self-expression it has long been the task of the humanities, arts and social sciences to argue are vital in the context of medicine and healthcare.

Acknowledgements

Earlier versions of this paper were presented at the Concepts of Health and Illness conference (Bristol, September 2010) and at the Beijing Forum (Beijing, November 2010). I am grateful to the organisers and event-participants for their valuable feedback, to Professor Martyn Evans (Durham University) for his comments on successive drafts, and to two anonymous reviewers for their helpful suggestions. This paper benefited enormously from ongoing discussions with Dr Claire Hooker (University of Sydney), Professor John Warner (Yale), and Professor Paul Ulhas Macneill (National University of Singapore) on the topic of "critical perspectives on the medical humanities" and I would like to thank them for their feedback and encouragement.

References

1. Brody H. Stories of sickness. New Haven: Yale University Press; 1987.
2. Kleinman A. The illness narratives: suffering, healing, and the human condition. New York: Basic Books; 1988.
3. Frank A. The Wounded Storyteller: Body, Illness, and Ethics. Chicago and London: University of Chicago Press; 1995.
4. Hunt L. Strategic Suffering: Illness Narratives as Social Empowerment among Mexican Cancer Patients. In: Mattingly C, Garro LC, editors. Narrative and the Cultural Construction of Illness and Healing. Berkeley and Los Angeles: University of California Press; 2000. p. 88-107.
5. Ramírez-Esparza N, Pennebaker JW. Do good stories produce good health? Exploring words, language, and culture. Narrative Inquiry. 2006;16(1):211-9.
6. Peterkin AD, Prettyman AA. Finding a voice: revisiting the history of therapeutic writing. Medical Humanities. 2009;2009(35):80-8.
7. Montgomery K. Doctors' Stories: The Narrative Structure of Medical Knowledge Princeton: Princeton University Press; 1993.
8. Greenhalgh T, Hurwitz B, editors. Narrative Based Medicine: Dialogue and Discourse in Clinical Practice. London: BMJ Books; 1998.
9. Good BJ, Good M-JD. 'Fiction' and 'Historicity' in Doctors' Stories: Social and Narrative Dimensions of Learning Medicine. In: Mattingly C, Garro LC, editors. Narrative and the Cultural Construction of Illness and Healing. Berkeley and Los Angeles: University of California Press; 2000. p. 50-69.
10. Pollock D. Physician Autobiography: Narrative and the Social History of Medicine. In: Mattingly C, Garro LC, editors. Narrative and the Cultural Construction of Illness and Healing. Berkeley and Los Angeles: University of California Press; 2000. p. 108-27.
11. Charon R. The Self-Telling Body. Narrative Inquiry. 2006;16(1):191-200.
12. Charon R. Listening for the Self-Telling Body. Caring for the Caregiver: *Literature & Medicine* National Conference; November 9 & 10; Manchester, New Hampshire2007.
13. Charon R. Narrative Medicine: Honoring the Stories of Illness. New York: Oxford University Press; 2008.
14. Hurwitz B, Greenhalgh T, Skultans V, editors. Narrative Research in Health and Illness. London: Blackwell; 2004.
15. Davidson L. Living Outside Mental Illness: Qualitative Studies of Recovery in Schizophrenia. New York: New York University Press; 2003.
16. Cohen B. Mental Health User Narratives: New Perspectives on Illness and Recovery. Basingstoke: Palgrave Macmillan; 2008.
17. Frank A. The Standpoint of the Storyteller. Qualitative Health Research. 2000;10(3):354-65.
18. Hutto DD. Narrative and Understanding Persons In: Hutto DD, editor. Narrative and Understanding Persons. Cambridge: Cambridge University Press; 2007.
19. Wikan U. With Life in One's Lap: The Story of an Eye/I. In: Mattingly C, Garro LC, editors. Narrative and the Cultural Construction of Illness and Healing. Berkeley and Los Angeles: University of California Press; 2000. p. 212-36.
20. Garro LC, Mattingly C. Narrative as Construct and Construction. In: Mattingly C, Garro LC, editors. Narrative and the Cultural Construction of Illness and Healing. Berkeley and Los Angeles: University of California Press; 2000. p. 1-49.
21. Paley J. Narrative machinery. In: Gunaratnam Y, Oliviere D, editors. Narrative and Stories in Health Care: Illness, dying and bereavement Oxford: Oxford University Press; 2009. p. 17-32.
22. Georgakopoulou A. Thinking big with small stories in narrative and identity analysis . Narrative Inquiry. 2006;16(1):122-30.
23. Freeman M. Life 'on holiday?' In defense of big stories. Narrative Inquiry. 2006;16(1):131-8.

24. Bamberg M. Stories: Big or Small: Why do we care? Narrative Inquiry. 2006;16(1):139-47.
25. Bamberg M. *Who am I*? Narration and its contribution to self and identity. Theory and Psychology. 2011;21(3):3-23.
26. Bamberg M. *Who am I*? Big or Small - Shallow or Deep? Theory and Psychology. 2011;21(3):122-9.
27. Schachter EP. Narrative identity construction as a goal-oriented endeavor: Reframing the issue of "big vs. small" story research. Theory and Psychology. 2011;21(3):107-13.
28. Freeman M. Stories, big and small: Toward a synthesis. Theory and Psychology. 2011;21(3):114-21.
29. Atkinson P. Narrative Turn or Blind Alley? Qualitative Health Research. 1997;7(3):325-44.
30. Thomas C. Negotiating the contested terrain of narrative methods in illness contexts. Sociology of Health and Illness. 2010;32(4):647-60.
31. Atkinson P. The contested terrain of narrative analysis – an appreciative response. Sociology of Health and Illness. 2010;32(4):661–7.
32. Frank A. In defence of narrative exceptionalism. Sociology of Health and Illness. 2010;32(4):661–7.
33. Bochner AP. Resisting the mystification of narrative inquiry:unmasking the real conflict between story analysts and storytellers. Sociology of Health and Illness. 2010;32(4):661-7.
34. Mattingly C. Emergent Narratives. In: Mattingly C, Garro LC, editors. Narrative and the Cultural Construction of Illness and Healing. Berkeley and Los Angeles: University of California Press; 2000. p. 181-211.
35. Skultans V. Culture and dialogue in medical psychiatric narratives. Anthropology & Medicine. 2003;10(2):155-65.
36. Atkinson P, Delamont S. Rescuing Narrative from Qualitative Research. Narrative Inquiry. 2006;16(1):164-72.
37. Atkinson P. Illness Narratives Revisited: The Failure of Narrative Reductionism. Sociological Research Online 2009;14(5).
38. Olsen LG, Terry W. The missing future tense in medical narrative. Medical Humanities. 2006;32:88-91.
39. Hyvärinen M, Hydén L-C, Saarenheimo M, Tamboukou M. Beyond Narrative Coherence: An Introduction. In: Hyvärinen M, Hydén L-C, Saarenheimo M, Tamboukou M, editors. Beyond Narrative Coherence. Amsterdam/Philadelphia: John Benjamins Publishing Company; 2010.
40. Gabriel Y. The voice of experience and the voice of the expert – Can they speak to each other? In: Hurwitz B, Greenhalgh T, Skultans V, editors. Narrative Research in Health and Illness. London: Blackwell; 2004.
41. Hurwitz B, Greenhalgh T, Skultans V. Introduction. In: Hurwitz B, Greenhalgh T, Skultans V, editors. Narrative Research in Health and Illness. London: Blackwell; 2004.
42. Hawkins AH. Reconstructing illness: studies in pathography. 2nd ed. West Lafeyette: Purdue University Press; 1999.
43. Hanninen V, Koski-Jannes A. Narratives of Recovery from Addictive Behaviours. Addiction. 1999;94(12):1837-48.
44. Frow J. Genre. London and New York: Routledge; 2006.
45. Smith B, Sparkes AC. Narrative inquiry in psychology: exploring the tensions within. Qualitative Research in Psychology. 2006;3(3):169-92.
46. Strawson G. Against Narrativity. Ratio. 2004;17:428-52.
47. MacIntyre A. After Virtue. London: Duckworth; 1981.
48. Taylor C. Sources of the Self. Cambridge: Cambridge University Press; 1989.
49. Bruner J. Acts of Meaning. Cambridge, MA: Harvard University Press; 1990.
50. Ricoeur P. Time and Narrative, Volume 1 (Time & Narrative). Chicago: University of Chicago Press; 1990.
51. Campbell J. Past, Space, and Self. Cambridge, MA: MIT Press; 1994.

52. Phelan J. Editor's Column: Who's Here? Thoughts on Narrative Identity and Narrative Imperialism. Narrative. 2005;13(3):205-10.
53. Battersby JL. Narrativity, Self, and Self-Representation. Narrative. 2006;14(1):27-44.
54. Tammi P. Against Narrative ("A Boring Story"). Partial Answers: Journal of Literature and the History of Ideas,. 2006;4(2):19-40.
55. Schechtman M. Basic Survival: A Refinement and Defense of the Narrative View. In: Hutto DD, editor. Narrative and Understanding Persons. Cambridge: Cambridge University Press; 2007.
56. Mackenzie C, Poltera J. Narrative Integration, Fragmented Selves, and Autonomy. Hypatia. 2010;25(1):32-54.
57. Woods A. Beyond the Wounded Storyteller: Rethinking Narrativity, Illness and Embodied Self-Experience. In: Carel H, Cooper R, editors. Contemporary Topics in Philosophy of Medicine. Newcastle: Acumen; In Press.
58. Toombs SK. The Temporality of Illness: Four Levels of Experience. Theoretical Medicine. 1990;11:227-41.
59. Carel H. Phenomenology and its application in medicine. Theoretical Medicine and Bioethics. 2011;In Press.
60. Frank A. Letting Stories Breathe:A Socio-Narratology. Chicago: University of Chicago Press; 2010.
61. Schiff B. The Promise (and challenge) of an innovative narrative psychology. Narrative Inquiry. 2006;16(1):19-27.
62. Holt T. Narrative Medicine and Negative Capability. Literature and Medicine. 2004;23(2):318–33.
63. Linde C. Life Stories: The Creation of Coherence. Oxford: Oxford University Press; 1993.
64. Watters E. Crazy Like Us: The Globalization of the American Psyche. New York: Free Press; 2010.
65. Scott A, Wilson L. Valued identities and deficit identities: Wellness Recovery Action Planning and self-management in mental health. Nursing Inquiry. 2011;18(1):40-9.
66. Garden R. Disability and narrative: new directions for medicine and the medical humanities. Medical Humanities. 2010;36:70-4.
67. Sartwell C. End of Story: Toward an Annihilation of Language and History. Albany: State University of New York Press; 2000.
68. Kirmayer LJ. Broken narratives: Clinical encounters and the poetics of illness experience. In: Mattingly C, Garro LC, editors. Narrative and the Cultural Construction of Illness and Healing. Berkeley and Los Angeles: University of California Press; 2000. p. 153-80.
69. Kirmayer LJ. The Body's Insistence on Meaning: Metaphor as Presentation and Representation in Illness. Medical Anthropology Quarterly. 1992;6(4):323-46.
70. Carel H. Illness. Stocksfield: Acumen; 2008.
71. Padfield D, Hurwitz B, Pither C. Perceptions of Pain. London: Dewi Lewis Publishing; 2003.
72. Macneill PU. Art and medicine: a challenging relationship. Medical Humanities. In press.
73. Freeman M. Beyond Narrative: Dementia's Tragic Promise. In: Hydén L-C, Brockmeier J, editors. Health, Illness and Culture: Broken Narratives. London and New York: Routledge; 2008.
74. Sacks O. The man who mistook his wife for a hat and other clinical tales. New York: Perennial Library; 1987.
75. Schechtman M. The Constitution of Selves. Ithaca: Cornell University Press; 1996.