

Post-Narrative – An Appeal

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Abstract: As the narrative turn enters its fourth decade, the task of identifying the limits of narrative and of exploring alternative approaches to interpreting the self and social world is growing in urgency. This article calls for scholars in the medical humanities to undertake this project through critically (re)engaging the work of Galen Strawson, Paul Atkinson and Crispin Sartwell.

Post-Narrative – A Plea

...no one can ever say anything new about stories or storytelling. Academics value original contribution. But, as the gateway to Dante's inferno warns those who pass through it to abandon all hope, so the gateway to narrative analysis should caution scholars to abandon all pretense of saying anything original. That does not mean abandoning the hope of saying something useful and interesting...

– *Arthur Frank (2010, p. 17)*

Re-reading Jerome Bruner's masterful essay, "The Narrative Construction of Reality" (Bruner, 1991) I am struck by two things. The first is the care he takes to locate his analysis at a particular historical juncture: 1991, exactly a decade after *Critical Inquiry's* "On Narrative" (Mitchell, 1981) ushered in a paradigm shift across the humanities and social sciences. It is a time when, as Bruner notes, "although we know altogether too little about how we go about constructing and representing the rich and messy domain of human interaction," it has become increasingly clear that "we do not achieve our mastery of social reality by growing up as 'little scientists,' 'little logicians,' or 'little mathematicians'" (Bruner, 1991, pp. 4-5). The second thing that struck me was the adverb in this oft-quoted sentence: "we organize our experience and our memory of human happenings mainly in the form of narrative—stories, excuses, myths, reasons for doing and not doing" (Bruner, 1991, p. 4).

As we enter the fourth decade of the narrative turn, the question "Why narrative?" has been answered, if not definitely, then certainly resoundingly. The voluminous scholarship on

narrative – from philosophy, psychology, narratology, anthropology, sociology, literary and cultural studies, healthcare, law and education – has demonstrated its centrality to understanding “the rich and messy domain of human interaction.” Without downplaying the divergences and ongoing debates across this interdisciplinary field, it seems there is broad agreement that narrative plays a valuable, some would say indispensable, role in constituting and interpreting the self and social world. Broad enough, that is, for me not to have to rehearse here the many virtues, complexities and nuances of narrative. The more pressing question, as I see it, and one that is already hinted at in Bruner’s essay, is “Why narrative *now*?” And this leads to a second but no less important area of inquiry: “What else, apart from narrative, lies in our ‘culture’s treasury of tool kits’?” (Bruner, 1991, p. 2).

Narrative and the Medical Humanities

My field – the medical or health humanities – is under the thrall of narrative.

Like narrative, medical humanities inquiry is difficult to define. It is seen, on occasion, to overlap with, subsume or trespass into the territory of biomedical ethics, the history and philosophy of medicine, medical sociology and medical anthropology, to say nothing of the clinical disciplines with which it routinely engages. Comprised of researchers from the arts, humanities and social sciences, a majority of whom seem to be reliably promiscuous in their disciplinary allegiances, the medical humanities face in (at least) two directions: one looks to practice and the practitioner (clinicians, psychiatrists, nurses, allied health professionals and carers), the other to the subjective experience of illness, health and dis/ability. One of the reasons that narrative has become an exceptionally privileged concept in the medical humanities is because it illuminates and knits together both of these spheres.

If doctors have always told stories, it is only in the last twenty years that the narrative turn has come, decisively, to clinical practice. Narrative is seen as salvation from the biomedical reductionism; it is a humanizing force, a vehicle through which to recover those qualities (empathy, care, attentiveness to the whole person) deemed to be most sorely lacking from contemporary healthcare (Greenhalgh & Hurwitz, 1998; Hurwitz, Greenhalgh, & Skultans, 2004). “Narrative medicine” formalises these convictions into a holistic practice. It names an exercise in empathy, imagination and humility, as well as a set of competencies, techniques and skills which can be taught and refined (Charon, 2008; Lewis, 2011).

Underlying these developments, perhaps even driving them, is the rise to scholarly and popular prominence of the illness narrative. The pioneering work of Arthur Kleinman (1988) and Arthur Frank (1995), the affluent Anglophone reading public’s growing thirst for pathography (Hawkins, 1999), the use of narrative methods in qualitative health research, and the rise of narrative and storytelling as therapy (Peterkin & Prettyman, 2009) have encouraged a growing number of “wounded storytellers” to narrate their illness experience in a myriad of written and spoken forms. Scholars in the medical humanities have espoused a deep and ongoing commitment to honouring the illness experience and championing narrative as the form best suited to giving voice to its complexity. However, and only insofar as generalisations of any kind are ever welcome, I think that as narrative is increasingly becoming a culturally and clinically sanctioned imperative, narrating one’s *illness* experience is on the verge of becoming a compulsory activity in certain contexts. Tell us your story, because it is true (to the human condition), because it is yours (an authentic expression of your individual experience), and because it is good for you (as part of the healing process).

I think these claims are questionable at best and downright dangerous at worst. The remainder of this paper will address each of them in turn. Here, following Frank, I make no claim to originality, but hope instead to provide something “useful and interesting” by briefly

introducing some of the critics whose work can be summoned in support of this minority view.

Narrative: It is true to the human condition?

Philosopher Galen Strawson has mounted one of the most polemic, and perhaps important, challenges to what he calls the psychological and ethical narrativity theses. The former holds “that human beings typically see or live or experience their lives as a narrative or story of some sort,” while the latter “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” (Strawson, 2004, p. 428). Strawson is not interested in a person’s *capacity* to understand patterns of causation and continuity or even to tell stories about themselves according to socially-agreed conventions. Rather, it is the felt sense of narrativity, the *propensity* or desire to view life in narrative terms, that most concerns him. Strawson sees the world as divided between “diachronics” and “episodics”: those who feel a strong continuity in self-experience across time, and those who do not. Narrativity is the special property of diachronic people who are also oriented towards form-finding, story-telling and the ongoing revision of past experience. Some, like Strawson himself, have no such orientation and so are, as the title of his article proclaims, “Against Narrativity.”

Strawson’s work has given rise to a substantial debate (Phelan, 2005; Battersby, 2006; Tammi, 2006; Schechtman, 2007; Mackenzie & Poltera, 2010) but one that has yet to register in or influence the medical humanities. As I have argued elsewhere (Woods, In Press-a, In press-b), while the scholarship on illness narrative can illuminate some of the blind spots and limitations of Strawson’s argument, “Against Narrativity” serves as a powerful reminder that a propensity for narrativity should not be universally assumed.

“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, 2004, p. 439). Strawson points to another loose thread in the conceptual fabric of narrative but refuses to pull at it further. Pressing the point: is it the case that the narrative self speaks to and of the truth of the human condition, or are we, as Brian Schiff argues, “reifying a Western, arguably middle and upper class, concept as a universal mode of shaping and articulating subjective experience?” (Schiff, 2006, p. 21) Schiff continues: “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.” Observing that ours is a society of confession, Foucault in 1978 (p. 59) had already shown how the imperative to disclose one’s innermost experience is produced through specific cultural logics, discourses and practices. Our opportunities and appetite for self-disclosure seem to have increased steadily in the late twentieth- and early twenty-first century, through such technologies as published autobiographical illness narrative (Aronson, 2000), blogging (McCosker, 2008), social media and narrative-based patient support groups. Whether narrative medicine and the medical humanities more broadly are responding to or fuelling these wider trends is an important question. For now, it is enough to note a more basic point – that scholars in this field would do well to interrogate notions of the narrative self as a transcultural transhistorical “truth.”

Narrative: My story?

The second seldom-acknowledged assumption underpinning the medical humanities’ enchantment with narrative is the view of illness narrative as the distinctive, authentic,

autonomous expression of a unique individual. Of course on one level this is simply common sense: one of the defining features of Jane's story of living with endometriosis is that it has a special relationship to Jane's and only Jane's bodily identity. The prevailing view in the medical humanities is that narrative opens a window onto the "subjective" experience of illness in contrast to modern medicine's impersonal focus on the "objective" reality of disease. The problem, as Paul Atkinson (2009, 2.14) notes, is that:

Individuals narrators are portrayed as just that: they speak alone, about themselves and for themselves, in a social vacuum. ... Individualised and personalised, but devoid of social identity or cultural resources, the narrating speaker is celebrated as an atomised subject.

Rather than approach narrative as embodied and socially contextualised practice, the biographical approach here construes life as text (Bamberg, 2011). The scholarship on illness narrative privileges individuality, interiority and authenticity, downplaying the interpersonal, the performative, and the culturally contingent dimensions of narrative.

"We sell short ourselves and the possibility of systematic social analysis if we implicitly assume that autobiographical accounts or narratives of personal experience grant us untrammelled access to a realm of hyperauthenticity" (Atkinson, 1997, p. 341). To continue Atkinson's provocation, we could say that Jane's story of living with endometriosis is *not* Jane's story – it is an interpersonal accomplishment, constructed through the embodied, dialogic act of narrating; it becomes intelligible as a particular kind of illness narrative through adhering to culturally specific generic codes; it does not give us direct access to some kernel of being called "Jane" but is a linguistic performance and a social phenomenon. Does this approach to illness narrative inflict further suffering on the already "wounded" storyteller? To my mind, recognising that stories of illness emerge as artefacts of a shared

social world in no way detracts from the potential of those narratives to illuminate an individual's experience; on the contrary, it goes some way to explaining why illness narratives effect personal and social transformation.

Narrative: Is it good for you?

According to Howard Brody, "suffering is produced, and alleviated, primarily by the meaning that one attaches to one's experience" and the "primary human mechanism for attaching meaning to particular experiences is to tell stories about them" (Brody, 1987, p. 5). From here it is a short step to the idea that storytelling has a role to play in alleviating suffering; that the construction and articulation of illness narrative is itself as part of the healing process (Kleinman, 1988; Frank, 1995). The idea that narrative form can help make sense of the painful, turbulent, and frightening experiences of illness again to be commonsensical, and is supported by empirical research into the beneficial effects of narrative and particularly writing therapies (Peterkin & Prettyman, 2009).

However, in its enthusiasm for the many benefits of narrative, mainstream work in the medical humanities encounters at least two difficulties. The first is a tendency to treat narrative as both the primary and the best and most important mechanism through which to make meaning of illness. This has led to a neglect of other modes of reflecting upon and representing experience, such as poetry, phenomenological philosophy, or photography (Woods, In press-b). Second, in focussing on the healing powers and potential of narrative, medical humanities scholars have tended to overlook its capacity to harm and hinder. Strawson is unequivocal, if typically under-elaborated, on this point:

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. (2004, p. 447)

Narrativity is also dangerous in excessive doses: the hermeneutic project, if pushed to extremes, can blur into paranoia, as novels such as Thomas Pynchon’s *The Crying of Lot 49* so brilliantly illustrate. Perhaps, as Crispin Sartwell (2000) and Sara Maitland (2008) suggest, our ongoing mistake is to think that language is everything.

Final Thoughts

This short paper has argued that the pressing question for the medical humanities is not “Why narrative?” but “What is post-narrative?” I agree with Paul Atkinson and Sara Delamont that as we enter the second decade of the twenty-first century

There need be no advocacy of narrative work, nor need there be any ‘defence’ of narrative. Narratives are social phenomena. They are among the many forms through which social life is enacted. They do not, therefore, need endorsement any more than they deserve to be neglected. (2006, p 165)

I am not calling for an end to narrative research in the medical humanities, nor do I propose we surrender the struggle to challenge reductionist accounts of the self and of human interaction in biomedicine or elsewhere. Rather, I think we need to look again at what else lies in “our culture’s treasury of tool kits” that could illuminate “the rich and messy domain

of human interaction,” especially in the context of medicine, health and illness. I urge scholars in my field to engage with the critiques and the critical possibilities offered by the work of Strawson, Atkinson, and especially Sartwell, to whom I cede the final word:

Even though my work is thought of as opposed to narrative, I like a good story myself, and I don't begrudge this pleasure to anyone, or deny the centrality of narrative a form of personal or cultural construction or as the zone of much that is best or most typical to central in the art and information of our culture. What I object to and think is an unaccountable temporary aberration is the neglect of other ways of organizing experience or the importance at times of leaving experience unorganized. I object to the identification of narrative with meaning or culture or identity. I object, first of all, on the grounds that none of these features of human beings — experience, meaning, culture, identity — is exclusively linguistic. And I object on the grounds that even the portions of these admittedly extremely or maybe uselessly or meaninglessly vague aspects of human life that are fundamentally linguistic — whatever, as the saying goes again, that means — are only sometimes or partly narratively oriented. (2006, p. 156)

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