Narrative Practices in Medicine and Therapy:
Philosophical Reflections

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> "By telling stories to ourselves and others …we grow slowly not only to know who we are but also to become who we are."
>
> - Charon, 2006, p. vii

Being a competent narrator matters. It matters for understanding, engaging and empathizing with others, and it also matters for shaping ourselves, to see 'live options' and to improve our chances of flourishing and living well. Recognizing the importance of developing narrative skills and their transformative potential, there are two important movements afoot that aim to put narrative practices at the heart of medicine and therapeutic practices.

Taken together these initiatives – narrative medicine and narrative therapy – are bent on improving the narrative competences not only of those who care for suffering individuals, but also of suffering individuals themselves, with an eye to improved outcomes. The programs of narrative medicine and narrative therapy are united in seeing enhanced narrative skills as a key to better outcomes for health care practitioners, therapists and those who are seeking to address persistent problems in their own lives. Crucially, the point of efforts is not to enable the telling of stories in order to gloss over or distract from a patient's or client's problems but to enable better results for individuals seeking help and relief.

Both initiatives are founded, in different ways, on the view that narratives play fundamental roles in making us who we are. As such, both narrative medicine and narrative therapy hold that becoming skilled in narrative practices –becoming more narratively competent– can transform our ways of interacting and engaging with others, and also making a fundamental difference to what we see the world as offering to us as well as our potential to respond to such offerings.

This paper attempts to lend philosophical support to these narrative-focused movements in healthcare and therapeutic practice. **Section one** introduces the motivating insights that have inspired and driven the narrative medicine movement, highlighting the perceived lack that it seeks to answer and what fruits its training programs promise. **Section two** focuses on a particular case study from Charon (2006) and draws on philosophical considerations about the nature of social cognition and empathy to lend support to narrative medicine's general assumptions. In particular, it is shown why it is plausible to suppose bridging the gap in understanding and empathizing with others requires engaging in second-personal narrative practices as

opposed to third-person speculation or imaginative projection. **Section three** considers how philosophical reflection on the narrative nature and character of patients' attitudes might help health care practitioners to take seriously the views some patients espouse –and to treat those views respectfully– without having to regard them as coming into conflict with the scientific world view enshrined in modern medicine. **Section four** introduces the central tenets of narrative therapy and its ambition to improve the life skills of patients by making them more competent in telling their life stories. Yet this raises a puzzling question: how by simply getting better at telling stories about our lives could the remarkable transformations that narrative therapy promises be brought about? The paper concludes by showing why we ought to avoid one possible way of answering that question and then providing an initial sketch and promoting the fortunes of an alternative answer: namely, that through enriching narratives about our selves, we can change our responsiveness to affordances – and hence our possibilities for acting, thereby shaping ourselves in modest ways, over time.

1. What's the Story with Narrative Medicine?

There is something rotten in contemporary medical practice, if the proponents of narrative medicine are to be believed. According to their diagnosis, today's medical practice is so much in the thrall of dealing with disease efficiently and in evidence-based ways that it has downplayed the human side of the profession. This in is reflected and put down to the training received by health professionals. Chapple (2015), a medical student herself, highlights the issue when describing her education in the field in the following terms:

> Modern medical training emphasizes the scientific, technical and practical. Although patient communication, empathy and professionalism are rightfully given prominent places in modern medical school curricula … we never discussed the bigger questions that underlie all this effort to appear caring, for example, *how to stimulate and sustain genuine interest in the* endless stream of *people we will meet as patients* (p. 63, emphasis added).

The need to address this failing in standard medical education is pressing because a number of intellectual and emotional barriers separate health care professionals from those in their care – barriers which increase the risk of rendering the care given "inhumane and therefore ineffective" (Charon 2006, p. 19).[1]

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

standards, national policy, and global health concerns" (Charon 2006, p. viii).

Charon, the founder of the movement in the United States, promotes a vision of narrative medicine as "medicine practiced with these narrative skills of recognizing, absorbing, interpreting, and being moved by the stories of illness" (Charon 2006, p. 4). By her lights:

> A medicine practiced with narrative competence will more ably recognize patients and diseases, convey knowledge and regard, join humbly with colleagues, and accompany patients and their families through the ordeals of illness. These capacities *will lead to more humane, more ethical, and perhaps more effective care* (Charon 2006, p. vii, emphasis added).

The key assumption is that by improving the narrative skills of health professionals, the program of narrative medicine deepens their ability to listen to and learn from their patients. Genuine engagement with the stories of patients helps to bring them back into the fold: by understanding and appreciating the narratives of those who are ill, medical professionals provide better company and better support, by enabling patients to "to feel included among those who are not ill" (Charon 2006, p. 21). It is through a greater ability to appreciate the narratives of patients that it becomes possible to maintain stronger, more reliable and more trusting relations between doctors and patients.

What is the payoff of such empathetic efforts? There is the immediate consequence that when health care professionals are able to bear witness to suffering, through such acts alone, they help to alleviate it. Chapple (2015) enumerates the potential benefits of developing these skills as including "the preservation of empathy throughout medical training, reduced doctor burnout, exhaustion and disillusionment, and better outcomes for our patients" (p. 65).[2] Charon (2006) also identifies a range of other – more instrumental– anticipated results that she regards a being:

> bound to enhance clinical effectiveness, not only by guiding choices of treatment interventions but also by alerting doctors to all considerations that might help or hinder patients from following medical recommendations and becoming true partners in achieving and maintaining the best health within their reach (Charon 2006, p. 27).

Importantly, all of this might be the case –improved narrative skills might improve capacities for empathizing with others– even if empathy does not necessarily or reliably lead to more ethical behavior, as some philosophers have argued (see, e.g, Prinz 2011).

Ultimately, the narrative medicine initiative is designed to provide health care professionals with "*practical wisdom* in comprehending what patients endure in illness and what they themselves undergo in the care of the sick" (Charon 2006, p. vii, emphasis added). This practical wisdom is to be inculcated through improved

narrative competence, where it is understood that achieving narrative competence is not a simple undertaking.

As Charon (2006) describes it, clinical practice is enhanced as health care professionals improve how they relate to their patients by informing what they do via "the theory and practice of reading, writing, telling, and receiving of stories" (Charon 2006, p. viii). As she sees it, this not only involves the mastery of specialized narrative practices, but also gaining an understanding of the "conceptual relations in which it nests" (Charon 2006, p. viii).

With respect to the latter, she observes that a "sophisticated *knowledge of how stories work* is not attained without considerable effort and commitment", and notes that "*narrative theory* is not easy to master" (Charon 2006, p. ix, emphases added). It is for this reason, apparently, that to become a fully-fledged practitioner of narrative demands long and demanding specialist education.

Given, however, that the emphasis is on mastery of practical narrative skills needed for better relating to others, it is not obvious why narrative theory *per se* would be required. Indeed, whereas extend exposure to and practice with stories seems necessary, it is not evident precisely how having a theoretical grasp of how stories work might figure in or necessarily improve first order narrative capacities.

In any case, Charon (2006) is clear that ultimate focus is not on getting nurses, doctors, social workers, and therapists to absorb narrative theory but on transforming their practice in quite basic ways through mastery of the art of appreciating and telling stories:

> Becoming competent in narrative skills *opens up practice*. It does not simply shift some habits or routines. It *changes what we do* with patients, with colleagues, with students, and with the self (Charon 2006, p. x).

Proponents of narrative medicine are not naïve about the quite fundamental change in thinking and practice that the initiative demands and hopes to achieve. What is on offer is nothing short of "a new frame for clinical work" (p. 13). Consequently, Charon (2006) openly acknowledges "the radical challenges thrown up by the decision to infuse medicine with narrative competence" (p. x).

2. Understanding others through narrative engagement

What, if anything, justifies narrative medicine's special focus on developing a *narrative* competence when it comes to help healthcare professionals to better understand and empathize with others? After all, skeptics of the whole medical humanities approach, such as Rafael Campo, are quick to observe that, "no one has proven that injecting the humanities in any form into medical settings translates to more humane physicians or better cared-for patients" (as reported in Gordon 2008, p. 420).

Recall that Charon (2006) and Chapple (2015) identify the source of failings in the

education of medical professionals in their specialized training that focuses on technical at the expense of the humane. Putting the eradication of disease as the first and foremost agenda item, it turns out that:

> doctors often lack the human capacities to recognize the plights of their patients, to extend empathy toward those who suffer, and to join honestly and courageously with patients in their struggles toward recovery, with chronic illness, or in facing death (p. 2).

A major barrier that prevents medical professionals from connecting with their patients is thrown up by the emotions that "saturate illness and add immeasurably to the suffering it causes" (Charon 2006, p. 22). She identifies shame, blame, and fear as key architects of such wall building, and holds that "Unless explicitly acknowledged and examined, these emotions and the suffering they cause can irrevocably separate doctor from patient, therefore preventing effective care" (Charon 2006, p. 22). In this regard she speaks of the lack of understanding on the part of health professionals as creating 'unbridgeable chasms' between them and their patients (Charon 2006, p. 19).

It is one thing for doctors to know, in the abstract "that patients fear for their health" (Charon 2006, p. 32). But to appreciate the plight of patients in a properly empathetic way, with full and nuanced understanding and appreciation, "requires that doctors enter the worlds of their patients, if only imaginatively, and to see and interpret these worlds from the patients' point of view" (Charon 2006, p. 9).

However, this cannot be reliably achieved by just any old act of the imagination, and certainly not by means of third personal speculation or 'mind guessing'. Charon's (2006) account of a real-life encounter with one of her patients and subsequent attempt to narrate the event brings out this point quite vividly. Charon (2006) describes the original encounter as follows:

> I was picking up some papers from my office, in a hurry, and was stopped by a young woman patient who had dropped in to ask me to sign a disability form for her. I had seen her a couple of times in the office for the evaluation of headaches, headaches that I had not considered terribly worrisome and for which I had prescribed acetaminophen. I remember being irritated, not only that she thought she deserved disability on such slim clinical grounds but that she would appear, without an appointment, and expect me to make time to fill out the form. But I was late for a meeting and did not have the time to inquire about the situation, so, without even putting down the stack of papers in my arms, I quickly scrawled a diagnosis and signed the form, no doubt conveying my displeasure at the patient's request (Charon 2006, p. 5).

Feeling some guilt at her behavior, Charon (2006) later attempted to imagine what might have motivated her patient's behavior and thus she crafted the following account:

> In my story, the patient—I called her Luz—had a chance at achieving her dream of becoming a fashion model. Her aunt in Manhattan had met a contact at a big

> agency and urged Luz to move in with her from Yonkers while preparing for auditions. The disability payments, in my story, would give Luz a needed income while she got a portfolio together and tried to make her dream come true. I wrote the story from Luz's point of view, and the story ends with Luz musing about how hurried her doctor was and how scornful she seemed to be (Charon 2006, p. 5).

The point of interest is that Charon (2006) relates that she later discovered that the truth behind 'Luz's' actions was much, much darker; the real motivation for Luz's request was a desperate need to escape sexual abuse. Thus Charon (2006) came to realize that "My hypothesis about the modeling career was all wrong—in my story, Luz was running toward something, when, in fact, she was running away" (Charon 2006, p. 6). But, she goes on to note "—and yet my acts of guessing at the patient's situation and trying, imaginatively, to make sense of her behavior had some profound dividends. The hypothesis acted like a prosthetic device or a tool with which to get to the truth, like a crowbar or a periscope will enable you to see under a rock or over a wall. Also, this narrative act helped me to get closer to the patient" (Charon 2006, p. 6). In the end, the imagined narrative acted as a spur to go beyond spectating and to actively engage the other: "I had tried, in my imagination, to make sense of her unexplained behavior while realizing what my own behavior must have connoted. *And so I asked her with great interest and regard about the situation*" (Charon 2006, p. 5).

This is a perfect example of –what I elsewhere dubbed– the Horse's Mouth Principle in action (see Hutto 2008). According to that principle, achieving an understanding of another's reasons for acting is achieved most reliably, though still fallibly, through direct one-to-one second personal dialogue rather than by means of third personal theorizing or imaginative simulation (Hutto 2004).

When we want to genuinely understand and empathize with another's situation we have no choice but to move beyond adopting a merely spectatorial stance. We need to access their narratives, not speculatively theorize or imagine what the other's circumstances and state of mind might be. Only their narratives will do since they alone provide "rich, particularized, and unified histories of cycles of thoughts, actions and contingencies" (Currie 2010, p. 36). In other words, narratives are special because they:

> provide explanations of why someone had a particular motive, or why someone has a particular character or personality trait, or why someone was drunk, depressed or angry. And the explanations we get are narrative-historical explanations, they locate the motive, the trait, the undue influence on thinking, within a wider nexus, in a way that enables us to understand more deeply why someone did the thing they did through appeal to aspects of their personal history or circumstances (Goldie 2012, p. 20).

It is for this reason that, as Charon (2006) observes, it is no accident that "when we human beings want to *understand or describe singular people in particular situations* that unfold over time, we reach naturally for narrative, or storytelling, to do so" (p. vii, emphasis added).

This is also why, adding philosophical support to motivating assumptions of the

programme of narrative medicine, it is plausibly the case that to gain a genuine understanding, of both ourselves and others, requires the development and exercise of a narrative competence, and not –as is widely supposed– the deployment of a 'theory of mind' or simulative procedures. Moreover, arguably, the mastery of the special kind of narrative competence that is needed to achieve such understanding involves producing and consuming explanations of actions in the form of personal narratives (Hutto 2004, 2008).

These considerations lend strength to the idea that health care professionals will benefit from a narrative training since learning to appreciate another's situation by engaging with his or her narrative is surely a "means to singularize the care of patients" (Charon 2006, p. viii). By coming to know another's story we gain "a rich, resonant grasp of another person's situation as it unfolds in time" (Charon 2006, p. 9).

This is an important reminder that, to the extent that empathy inherently involves and depends on understanding the particulars of another's situation, then it is not an innate or built-in capacity, but something that needs to be cultivated (Zahavi 2010, p. 291).[3]

In sum, these brief philosophical considerations – discussed and defended at length elsewhere – give strong ground for thinking that narratives play a central role in enabling us to understand and engage empathically with others. If so, this lends strong support to the claim made by advocates of narrative medicine that "Narrative competence permits caregivers to fathom what their patients go through, to attain that illuminated grasp of another's experience that provides them with diagnostic accuracy and therapeutic direction" (Charon 2006, p. 11).

3. Narratives in the scientific image

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

As a result, the views of health care professionals and patients become estranged to such an extent that they "speak different languages, hold different beliefs about the material world, operate according to different unspoken codes of conduct" (Charon 2006, p. 21). It is unsurprising, therefore, that when this occurs both sides are, "ready to blame one another should things go badly" (Charon 2006, p. 21). This kind of division arises because the two parties hold apparently conflicting and incommensurable beliefs. Patients may, due to worldviews sponsored by their specific religious or cultural backgrounds, account for the source or cause of an illness in ways that clash with the clinical, scientifically rigorous explanations proposed by those entrusted to their care.

The ultimate source of difference of stance and attitude is that, "Doctors tend to consider the events of sickness rather narrowly as biological phenomena requiring medical or behavioral intervention while patients tend to see illness within the frame and scope of their entire lives" (Charon 2006, p. 22). In the extreme, commitment to

the medical model has been charged with promoting a style of clinical practice that is "objectified by impersonal care" (Charon 2006, p. 21). For many, it seems that these intellectual differences are irreconcilable, that we face an either/or "forced choice between attentiveness and competence, between sympathy and science" (Charon 2006, p. 21).

Yet it is possible to avoid having to make such a hard choice by recognizing that many of these convictions are narratively grounded and do not answer to, nor seek to answer to, the same epistemic standards as scientifically grounded beliefs. As such, narratively based attitudes are not in fact advanced as empirical hypotheses; they are not scrutinized for consistency or veridicality; they are not evaluated against "competing narratives for accuracy or utility" (Gerrans 2014, p. 77).

The great bulk of narratives do not aim at truth. Although narratives all share certain basic structural properties, the semantic properties of any given narrative is fixed by its context of use. Thus as Goldie (2012) points out "Fictional narratives do not aspire to be true, whereas real life narratives do. A narrative is fictional not in virtue of its content being false, but in virtue of its being narrated, and read or heard, *as part of a practice of a special sort"* (pp. 152-3, emphasis added). Thus fictional narratives, offered up as fictions, invite "the audience to imagine or make believe that what is being narrated actually happened, even when it is known that it did not. Thus the question of reference and of truth simply does not arise within the 'fictive stance'" (Goldie 2012, pp. 152-3). For these reasons, Goldie concludes that, "reference and truth have no application in fiction, but do have application in historical and everyday explanation" (Goldie 2012, p. 154). Different kinds of narratives exhibit different kinds of semantic properties, and we understand these differences if we are alert to the roles that these different kinds of narratives play in our lives and thinking.

A crucial contrast becomes evident if we compare the uncritical use of narratives that don't aim at truth with the intense critical scrutiny of beliefs and claims that do. The latter are subject to the norms of scientific testing, where we seek to fix what we believe only "according to standards of consistency and empirical adequacy" (Gerrans 2014, p. 13). But narratively sponsored attitudes lack these features; they do not involve any "attempt to confirm an empirical hypothesis" (Gerrans 2014, p. 76).

Accepting that narratively– as opposed to scientifically– sponsored attitudes have different epistemic properties and serve different functions in our lives, may alleviate the need to see such stances as directly competing to do the same kind of work. Nevertheless, this will not resolve the tensions between medical professionals and their patients –indeed, it may serve to exacerbate the situation– for anyone who holds that, for the reasons stated above, our love of narratives is what prevents us from seeing the world as it really is. Alex Rosenberg, the chief spokesperson for a thoroughgoing eliminativist and nihilist outlook, holds that "our demand for plotted narratives is the greatest obstacle to getting a grip on reality" (Rosenberg 2014a, p. 18).

By his lights, the reason we cannot understand the answers to fundamental questions about the state of things is that they "don't come in the form of stories with

plots. The fundamental laws of nature are mostly timeless mathematical truths." (Rosenberg 2014a, p. 18). Our "insatiable hunger for stories" (p. 28) is also, according to Rosenberg, what "greases the skids down the slippery slope to religion's 'greatest story ever told'." (Rosenberg 2014a, p.18). This is what mistakenly drives us to "account for ideas and artifacts, actions and events, in terms of their meanings" (Rosenberg 2014a, p. 28).

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

In line with his uncompressing, self-styled 'mad dog' naturalism, Rosenberg (2014b) also insists that "science can't accept interpretation as providing knowledge of human affairs if it can't at least in principle be absorbed into, perhaps even reduced to, neuroscience" (p. 41). This too seems a bridge too far. As just noted above, even if narratives do not provide a window onto reality, they feature heavily in human affairs, and we need to understand how and why they do so if we are to understand ourselves. Moreover, contra Rosenberg, to fully understand the power of stories and how they shape us we need not, and indeed ought not attempt to absorb or reduce the interpretive disciplines into neuroscience.

While it is important to understand what work brains do in support of our capacities to understand, produce and enjoy narratives, it would be misguided to think that such narrative capacities can be understood by looking solely at what goes on in brains. Given that we are not natural-born narrators, we might wonder how we came to be able to weave stories. We might be interested to know why a given genre of story or particular narrative content is more compelling to some populations than others. Or we might want to know why the narratives of people haling from different populations take this form rather than some other. To explain and understand these features of narratives we must look to the surrounding narrative practices that enable their generation. This requires looking at socio-cultural, and not only neural, factors (see Hutto 2008; Hutto and Kirchhoff 2015 for extended arguments along these lines).

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

2006, p. 13, emphases added).[4]

Notoriously, Strawson (2004) has advanced arguments that there are non-narrative ways of being and of experiencing oneself that also deserve to be recognized, and that failure to do so promotes an unwarranted and ethically problematic narrative imperialism. Barring a knock-down argument that might rule out the possibility of such non-narrative ways of being, little is lost in conceding the point to Strawson and allowing that narratives are at least one of the primary and most important ways that many have of understanding and making sense of themselves and others (for a fuller discussion, see Hutto 2016).

4. What's the story with narrative therapy?

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

Narrative therapy, developed by White and Epston in the early 1990s, stands out in seeking to empower individuals and groups by getting them to look again at their habits of self-narration and to explore the possibility of telling new stories about their individual or collective lives. The main assumption of the approach is that: "As people become more narratively resourced … they find that they have available to them options for action that would not have otherwise been imaginable" (White 2011, p. 5).

For many people, deficiency-centred stories constrain and limit options for action (White 2004, p. 34). Such stories pathologize and disempower us, making it seem as if their problems are an *essential* part of who we are. Prêt-à-porter narratives – those inherited uncritically from the surrounding culture – tend to foster such negative and limited ways of thinking. Such narratives restrict a person's vision, allowing only a limited array of options. Those who only operate with thin narratives of this sort perceive a limited range of possibilities for action, fewer affordances.

In passively buying into and repeating narrow and negative narratives we unnecessarily restrict our life possibilities. Advocates of narrative therapy hold that, "All too often, the stories we believe about ourselves have been written by others" (Denborough 2014, p. 8).

Narrative therapy seeks to protect against these outcomes by insisting on the need for people to reclaim and take back their "storytelling rights" (Denborough 2014, p. 8, 10, 22). Narrative therapy aims to improve narrative skills so as to empower people, enabling them "to break from thin conclusions about their lives, about their identities, and about their relationships" (White 2000, p. 4).

A main way narrative therapy combats the effects of life-limiting stories is through externalizing conversations. These conversations create opportunities "for people to redefine or revise their relationships with a problem" (White 2004, p. 32). Its approach "refuses to locate problems inside people ... [it] refuses to pathologize people" (Denborough 2014, p. 26). Hence its slogan: "the person is not the problem, the problem is the problem" (Denborough 2014, 26).

The main narrative therapy strategy is to find new, richer stories to tell about one's life, and thus augment the resources of individuals; (Denborough 2014, p. 49). The end result of this process of re-storying (if all goes well) is increased "response-

ability" – enabling people to become "more able to respond" (Denborough 2014, p. 36). This involves developing and mobilizing one's practical know-how and life skills (White 2004, p. 39, 40): these new habits ensure that the richer storylines and the expanded possibilities for action take root and flourish.

All of this works because narratives are necessarily selective. Whichever story we tell about our lives, there are *always other* stories we could tell –other possibilities not foregrounded, not mentioned, not attended to: "there are many different events in our lives, but only some of them get formed into the storylines of our identities" (Denborough 2014, p. 6). Equally, there are other options for narrating or telling our familiar stories.

Dominant stories need not be false to be pernicious; it is enough that they occlude and discourage alternative storylines – those that possibly "provide the gateway ... to the exploration of other … skills of living or practices of life" (White 2011, p. 9).

At first sight, narrative therapy might appear to be a puzzling, counterintuitive approach. For it eschews using talking cures to divine and deal with past causes of current trauma. Rather it asks therapists to 'reverse the polarity' of many psychodynamic therapies and to focus instead on "constructing a future trajectory rather than achieving past accuracy" (Graham 2009, p. 14). Given this, it might be wondered how, simply by getting clients to tell different stories about their lives, narrative therapy could bring about positive changes in behavior without divining or dealing with the root, underlying causes of a client's problems. Skeptics that hold all talking cures are really just 'talk', are likely to think that talking therapies which don't even try to, or pretend to address underlying problems, are blatantly so. The onus is on defenders of narrative therapy, and related solution-focused therapies, to say why and how by changing a person's narrative it is possible to make a difference to who we are and what we do.

One natural explanation would be to hold that the link between how we narrate our lives and who we are is so deep that any change to the former automatically changes who we are. This answer will be attractive to those who endorse the strong narrativist view that our narratives determine who we are by constituting not merely our sense of self but our selfhood itself (Schechtman 1996; 2007; 2011; Rudd 2012).

However, once again, Strawson (2004) sounds a cautionary note. He worries that strong narrativist, self-constitution views must assume that all of our structured actions have a narrative character and basis. Yet he argues that narrativist views of this strong stripe become trivially true –not in a good way, but as a kind of empty stipulation– if it is held, for example, that "making coffee is a Narrative that involves Narrativity, because you have to think ahead, do things in the right order" (Strawson 2004, 439).

It is not clear that everyday embodied activities, such as reaching for objects or making cups of coffee involve representing the sequence of events in question in such a way that would qualify as implicit narrativizing. A major agenda item of the more radical embodied and enactivist approaches to mind has been to establish that all or even most of our goal-directed everyday activities do not depend on contentful mental representations at any level or in any fashion (see Chemero 2009; Hutto and Myin 2013; Thompson 2007). According to such views the idea that we might be implicitly narrativizing all of our embodied doings is a non-starter.

A different answer to the puzzling question about how narrative therapy might get its work done steers clear of the self-constitution views of strong narrativists, and instead assumes, much more modestly, that how we narrate – how we think about and describe things – can have a direct influence on the affordances we perceive. It accepts that, "In human life, the regularities to which agents are sensitive are densely mediated … by cultural symbols, narratives, and metaphors … These mechanisms shape social experience and in turn are shaped by broader social contexts" (Ramstead et al. 2016. p. 14, see also Hutto and Myin 2017).

It must be acknowledged that, "at the centre of this is, of course, the self: the person who is doing the thinking and feeling about the past and the future, the person who can deliberate about how to act as well as how to think and feel" (Goldie 2012, p. 76). Yet we should be careful when in characterizing what selves are and how they are constituted. It seems uncontroversial to allow that we can have a "narrative sense of self, a sense of oneself with a past and a future for which one can be responsible" (Goldie 2012, p. 76). Fair enough – but we must be careful to recognize that "one's narrative sense of self … has no direct connection with the metaphysical question of one's identity over time" (Goldie 2012, p. 115). Or, to put the point more carefully, we should avoid assuming that because we can have a narrative sense of self that we are, at bottom, wholly constituted by narrativizing activity. Indeed, the notion of a narrative self is philosophically questionable on a number of grounds, and not least, as Goldie (2012) observes, because there are good reasons to consider it "to be otiose" (p. 115, see also Menary 2008; Hutto 2016).

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

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

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[1] As Chapple (205) observes, “Competent medical practice necessarily requires compassion and imagination, and cannot avoid ‘big’ questions such as the nature and meaning of pain, suffering and death. However, a doctor who is able to respond usefully to these fundamental questions requires training and skills beyond the merely technical and scientific” (Chapple 2015, p. 65).

[2] Haslam (2007) provides an even fuller list of benefits: “More empathic medical students received higher ratings of clinical competence and performed better on history-taking and standardized physical examinations. More empathic medical students and doctors received higher patient satisfaction ratings. Patients judge empathy to be very important in consultations, and show better treatment adherence and greater enablement with more empathic doctors. When doctors report a loss of empathy they subsequently show an increase in their rate of major medical errors. Doctors’ communication skills are associated with a variety of positive outcomes for patients and with reduced risk of malpractice claims, and patients judge their doctors’ empathy on the basis of such skills (e.g., being reassuring, showing understanding, explaining procedures, not ignoring their concerns)” (p. 381).

[3] For this reason, *a fortiori*, even if it is true that not all doctors are as empathic as they ought to be, it is not likely their “innate” capacity for empathy will have diminished over the course of their medical training (cf. Charon 2006 p. 8).

[4] In another passage, Charon (2006) speaks of a narrative shift that is underway such that “Medicine is joining other disciplines such as anthropology, history, psychology, social science, law, and even mathematics in recognizing the *elemental and irreplaceable* nature of narrative knowledge” (Charon 2006, p. 11). Yet in other places Charon (2006) pitches her claim on behalf of narratives more softly: “It remains to be proven—although it appears a most compelling hypothesis—that such narrative vision is required in order to offer compassionate and effective care to the sick” (p. 13).