Journal of Medicine and Philosophy, 40: 511–528, 2015
doi:10.1093/jmp/jhv021
Advance Access publication August 4, 2015

Can I Author Myself? The Limits of Transformation

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Narrative medicine is predicated on the importance of narrative to human life. Although that in itself is not controversial, an extension of this principle that has sprung up in narrative psychiatry—namely, that by coming to imagine a different life story one can become a different person—ought to be. One reason one cannot remake one's life in the image of a story is that life is not to be mistaken for a story in the first place. The seminal study of psychotherapy, Persuasion and Healing*, although recommending that the demoralized absorb more uplifting stories about themselves, appears to recognize some limit to the possibility of modeling life on story. The same study likens therapeutic stories to placebos, but as it happens, placebos themselves have their limits, alleviating symptoms but not curing or "healing." In order for someone to become a different person through the agency of the placebo effect, it would have to be more robust than it is. The argument that life follows narrative is an ironic one for a discipline devoted to narrative to make, given the salience in the tradition of the novel, from* Don Quixote *forward, of works that explore the fallacies of that presumption. In keeping with its attention to narrative, this article challenges the use of a short story by Chitra Divakaruni as an illustration of the principles of narrative psychiatry.*

Keywords: *narrative psychiatry, narrative, placebo, polyvalence, transformation*

I. INTRODUCTION

Inspired by a desire to broaden the prevailing model of medicine and give sympathetic understanding its rightful place at the center of care, the theory of narrative medicine envisions the clinical encounter as one between a

teller of a story (the patient) and an active listener (the doctor). In contrast to the statistical canons of evidence-based medicine, narrative medicine seeks to understand the patient as the bearer of a unique history. In the case of psychiatry, the narrative model emphasizes in one way or another the investigation of this history rather than the diagnosis of disorders presumed to be biochemical in origin. Because of a unique power thought to inhere in narrative, however, the act of putting one's experience in narrative form has—some say—the potential to change experience itself. As a thinker cited in narrative studies puts it, "our experience of human affairs comes to take the form of the narratives we use to tell about them" (Bruner, 1991, 5). This would seem to imply that if only I, the patient, can bring myself to frame a happy outcome for my story, my experience will follow suit.

According to an idealized conception of psychotherapy, in the course of treatment "the narrative 'I' will have been transformed—if that is not too strong a word—from a narrative subject that can only imagine scenarios of defeat into one that can also imagine scenarios of triumph" (Phillips, 1999, 27). As if this tale of victory snatched from the jaws of defeat were too much of a cliché to be true, the possibility of such a complete reversal of fortune is skeptically qualified even as it is posed. Some, applying in full the principle that experience follows narrative, allege that the narrative subject (that is, the patient or client) not only comes to imagine alternative story lines but lives them, in the process of reinventing him- or herself. This claim finds philosophical support in narrative psychiatry, less a school than a movement alive to the importance of stories in the therapeutic encounter and critical of the narrowness of the biomedical model of human problems now in command. As Bradley Lewis writes in his articulate exposition of the principles and practice of narrative psychiatry, "narrative provides a much-needed counterbalance to contemporary efforts to ground psychiatry in genetics, bioscience, and neuropharmacology" (Lewis, 2011, viii). The detail and nuance liable to be lost to more reductive ways of understanding flourish in stories, though this in itself may not be enough to account for their appeal as an antidote to "bioscience." In part because their richness figures alternative possibilities, stories suggest what we might be, not only what we are. A strong version of the same principle takes us to the claim examined in this paper—that we can remake ourselves by making stories about ourselves. "Narrative psychiatry," writes Lewis, "understands that reworking the stories people tell about themselves is a powerful way to make changes and to reauthor their lives" (2011, 67). By telling a story, one "makes a choice about who one wants to become" and activates the process of becoming that person (2011, 82). In the rhetoric of narrative therapy, the undoubted fact that patients have unique histories can slide into the questionable claim that by some kind of story work they become their own author.

As I see it, the seemingly attractive theory that John Doe's life is a story written by John himself, subject to his own revisions, is actually a tower

of misconceptions, one stacked atop another. Life is not to be mistaken for story in the first place, and if only for this reason John cannot possibly remake his life as he might compose or revise a story. I think it important to work through this issue not only because the understanding of selfhood is at stake, but because narrative psychiatry presents itself as something more than one school of psychotherapy among many. Because of its insight into the way stories work—in particular, into the import of polyvalence as a narrative principle—narrative psychiatry offers (it is said) a master key to psychotherapy itself. "Narrative theory provides not only an open-minded alternative to contemporary psychotherapy turf wars but also a metatheoretical framework for integrating and making sense of the many available therapeutic options," writes Lewis (2011, 32). On this showing, narrative psychiatry is uniquely free to survey therapeutic possibilities. The patient who chooses to create a new self exercises the same freedom on a different level.

II. LIFE AND STORY

Despite the enthusiasm for narrative that has sprung up in different disciplines and spawned such terms as "narrativity" and such notions as the narrative unity of the person, it should be noted that a story is an artifact, a constructed thing, as a life is not. The potter fashions a pot, but that doesn't mean his or her life is pot-like. That I might of course tell a story about something that happened to me does not establish that my life is the same kind of entity as a story. Just as history itself "has no plot" while "history books have to have beginnings, middles, and ends" (Wells, 2012), so too a life and a story told of a life are things of different orders. This point bears emphasis if only because *Narrative Psychiatry* does not really distinguish between patients authoring their stories and patients authoring their lives. Thus, on one and the same page we read that a certain fictional character "could use psychotherapy . . . to develop new plot structures for her life" and that therapies in general "help people reauthor their stories" (Lewis, 2011, 52). Taking a fictional character out of the frame of her story in order to put her into psychotherapy might itself constitute a confusion of fiction and life.

Narratives are shaped in ways a life isn't, or to put it the other way around, life is messy in a way narratives aren't. Far from being an incidental matter, the messiness of reality is a powerful confounder, advising us of the limitations of theories, models, and indeed stories. Gary Saul Morson's remarkable study of *Anna Karenina*, which reminds us that "Life is not a work of any genre" (Morson, 2007, 227), contains in its index a number of entries for "Mess." A thoughtful inquiry into the presumed narrative unity of the person observes, "We are the subjects of countless life events during the course of a typical day, most of them trivial and quickly forgotten (if noticed at all)" (Christman, 2004, 702–3); that is, the very element we live in is

messy. Something seemingly trivial may prove significant, and the reverse. The ambition of working a teeming multitude of purely contingent, artistically unruly daily events into narrative form helps account for the singularity of Joyce's *Ulysses*. The question of what is significant and what is not applies of course to medicine as well, set as it is in "a noisy environment that makes a judgment about a symptom difficult" (Benedetti, 2009, 25), and the implications of messiness extend even into projects designed to control variables and exclude disorder. A number of trials of screening or treatment for prostate cancer have been faulted on the grounds that the observation group was significantly "contaminated" by men in the active category. So too, in a review of data from the landmark Prostate Cancer Prevention Trial, the Food and Drug Administration discovered that more than 200 biopsies were misclassified, evidently as a result of a slew of clerical errors (Food and Drug Administration, 2010).

If, as some say, experience conforms to narrative patterns, essential to the shape of a narrative is the ending. The ending of a story is a structural feature of particular importance, serving not just to bring events to a close but to sum up in some way the story as a whole, as a catastrophic ending traditionally proclaims a plot as tragic and a happy ending as comic (hence the *Divine Comedy*). "Look to the ending" was at one time a sort of precept of literary theory. The conventional endings derided by Henry James as "a distribution at the last of prizes, pensions, husbands, wives, babies, millions, appended paragraphs, and cheerful remarks" tell much about the novels in which they occur (James, 1967, 655). The iconoclastic Tolstoy, in disputing the construction of the novel, took care to dispute the convention of the ending (hence the epilogues of *War and Peace*). While episodes in life do end, as when we graduate from school and go on to something else, I cannot possibly rewrite the story of my life, as the rhetoric of narrative psychiatry has it, if only because life itself is open ended. In life the end of one thing is just the beginning of another; we call graduation "commencement." Asks Frank Kermode in *The Sense of an Ending* (often cited by theorists of narrative medicine), what does a clock say? "We agree that it says *tick-tock*," with the *tick* denoting a sort of beginning and the *tock* an ending (Kermode, 1966, 44–45). The point, of course, is that the clock says no such thing.

In the psychological literature we meet with vignettes of patients treated successfully, and there the clock strikes finality, the curtain falls. Like a tale that ends with marriage, the vignettes don't say what happened afterward.

III. THE FASHIONING OF AN ALTERNATIVE SELF

Just as it is now understood that patients who improve under medical treatment have not necessarily improved because of the treatment (it might have been as a result of the placebo effect or natural history), the psychiatrist

Jerome Frank understood decades ago that patients who respond to this or that mode of psychotherapy do not necessarily improve as a result of its specific methods. They might fare equally well under a quite different method, provided only that they were instilled with a sense of mastery and hope. Although Frank's conclusions will not satisfy those who look to the empirical validation of particular therapeutic methods such as those of cognitive behavioral therapy, they remain provocative and account for "the finding of outcome equivalence so often reported in the literature" (Wampold and Weinberger, 2012, 18). More important, in Frank's view, than any given technique is the story delivered to demoralized—today we might say depressed—patients. In particular, Frank believed the demoralized need to absorb a story about themselves with a happy ending. Transposing the literary term "plot" into a therapeutic context, he and Julia Frank assert in the influential *Persuasion and Healing* that "The psychotherapist must collaborate with the patient to construct a new plot, preferably one that sustains a better self-image. . . . A therapeutic plot must offer the prospect of a happy ending. It must hold out the hope that if the patient accepts the changes in assumptions, perceptions, and behaviors that the plot incorporates, he or she will experience less distress, enhanced self-worth, [etc.]" (Frank and Frank, 1991, 72–73).

Much as *Persuasion and Healing* identifies a common thread running through effective therapies, the theory of narrative psychiatry, according to Bradley Lewis, "helps makes sense of the diversity of psychotherapies and provides a conceptual handle on many of the common factors within them" (Lewis, 2011, 52). (The term "common factors" usually refers to practices like sympathetic attention common to modes of psychotherapy regardless of their several theories and methods; as a "nonspecific" component of therapy, it is sometimes likened to a placebo.) Indeed, Jerome Frank is identified by Lewis as a precursor of narrative psychiatry in that he understood that no therapy has a monopoly on truth and no therapeutic insight has a claim to unique objectivity. In this sense, narrative psychiatry inherits the Frank and Frank argument, with the story worked out by patient and therapist serving in theory to map out a better life. Note that the sort of storytelling authorized by Frank and Frank appears to go well beyond correcting the distorting effects of (say) depression and setting the patient's strengths in a more accurate light. Rejecting the position that "the therapeutic power of an interpretation depends on how closely it approximates objective truth," Frank and Frank distinctly imply that an embellished or judiciously fabricated story will do quite well for therapeutic purposes, provided only that the patient finds it convincing and inspiring (Frank and Frank, 1991, 72). We are left wondering if a quite untrue story could become true through the influence of therapy, by analogy with a placebo that acts like a medication because the patient finds it, too, convincing and inspirational. Some who agree with Frank and Frank about the importance of combating demoralization would say that the

therapist offers judiciously inspirational fictions, in effect benign lies (Blease, 2011)—but fictions and lies with the fortunate potential to materialize in some degree, owing to the self-fulfilling nature of expectations under the auspices of the placebo effect. More about this presently.

However, I can't turn my life into a story with a happy ending, because endings in the story sense do not apply to life at large. Frank and Frank themselves appear to recognize some limit on the possibility of modeling life on story. A therapeutic plot, they say, "must hold out the hope that if the patient accepts the changes in assumptions, perceptions, and behaviors that the plot incorporates, he or she will experience less distress, enhanced self-worth" (Frank and Frank, 2011, 73). If I could script my life, I would be more generous. I wouldn't just enhance my self-esteem, I would make it positively robust; I wouldn't just reduce my distress, I would give myself only enough to make life piquant. Then too, according to Frank and Frank, a therapeutic story does not promise, still less constitute, a new life, but merely offers the "hope" or "prospect" of one. The prospect of a new life seems more like an enticement than a roadmap. (Upon reflection, the prospective happy ending reads virtually like a tautology: once you change your assumptions, perceptions, and behavior for the better, things will seem brighter.) The reader of Frank and Frank is left with the sense that although story can serve a sort of uplifting function, our potential to transform ourselves by fashioning or buying into a story is actually limited.

Just as life does not admit the convention of the happy ending (because, being life, it does not end at all except with its own cessation), neither does it conform to other conventions that are the grammar of narrative. The narrative touches in my stories about myself are likely to be my own invention. "When events resemble a well-plotted story, it is usually because we are imitating that story or misperceiving reality so as to omit everything else" (Morson, 2007, 227). If my story is too strongly patterned with connections, if it owes too much to heightenings and omissions, if it observes too faithfully the convention of the turning point, others may have reason to think I embellish. To say, as some now do, that we qualify as a self insofar as our experience can be cast in conventional narrative form is to enshrine many possibilities of distortion in the concept of self. The claim that storytelling is constitutive of selfhood may also imply that by making new stories about ourselves we become new selves, which is the trope I seek to dismantle.

The position that by creating a story we create ourselves seems to ignore the ironic potential of all this construction work. "It's well known that telling and retelling one's past leads to changes, smoothings, enhancements, shifts away from the facts. . . . The implication is plain: the more you recall, retell, narrate yourself, the further you are likely to move away from accurate self-understanding, from the truth of your being. Some are constantly telling their daily experiences to others in a storying way and with great gusto. They are drifting ever further from the truth" (Strawson, 2008, 205). Written

reconstructions are also liable to drift. From Rousseau's *Confessions*, in which he vows to show himself as he really is and ends up the victim of a grand conspiracy, to Benjamin Franklin's tale of a prodigal son who becomes "a rather bland and featureless adult" (Spengemann, 1980, 56), which we can be sure he was not; from James Frey's celebrated autobiographical fabrication *A Million Little Pieces*; to political self-portraits that cannot withstand the scrutiny of historians, many autobiographies are laced with fiction, wittingly or not. Attorneys for Penguin, publisher of an autobiographical work of questioned authenticity, recently argued in an American court that "While it is possible (and perhaps even common) for autobiographies to contain intentional falsehoods, it is impossible that such intentional falsehoods can amount to fraud because nobody can justifiably rely on the contents of such a book" (Murphy, 2012). Philip Roth speaks of the autobiographer's temptation "to dramatize untruthfully the insufficiently dramatic, to complicate the essentially simple, to charge with implication what implied very little"—to overegg the custard, as he later puts it (Roth, 1988, 7, 92). (In a coda to his autobiography, however, Roth's alter-ego accuses him of making it too simple altogether.) Nor is this sort of thing excluded from the therapeutic encounter by the high standards of truth there prevailing. Frank and Frank themselves concede that the patient's reports "are not impartial statements of fact but are colored to an indeterminate degree by distortions of memory, the impression the patient seeks to make on the therapist, and many other influences" (Frank and Frank, 1991, 71). It would be surprising to say the least if we could modify our very selves as readily as we can and do modify our self-narratives.

Although autobiography is subject to omissions, added eggs, and other sorts of revisionism, at least the events of the past have taken place. Those of the future have not. I cannot write my prospective autobiography, still less transform myself through such an exercise into someone I decide to become. The sheer improbability of reauthoring oneself is suggested by the example of someone supposedly doing just that in *Narrative Psychiatry*, which refers throughout to a story by Chitra Divakaruni, "Mrs. Dutta Writes a Letter," telling of an Indian widow, a Hindu, who has moved to California to live with her son and his family only to find herself not only torn from her roots but the object of the pointed hostility of her Americanized daughter-in-law. It is a sensitive tale of exile and dispossession, of cultural loss and conflicting attachments. Using it as a sort of touchstone, *Narrative Psychiatry* asks what sort of alternative life Mrs. Dutta might author by committing to one or another kind of psychotherapy. Should she choose cognitive behavioral therapy? Psychoanalysis? Humanistic therapy? Expressive therapy? Feminist therapy? *Narrative Psychiatry* leaves us, or Mrs. Dutta, in just the sort of wilderness of arbitrary choices rejected by Alasdair MacIntyre in *After Virtue* (2007), sometimes cited as a work of foundational importance for narrative medicine (see, for example, Michel, 2011). Each and every school of therapy "provides

the fundamental plot structure of a new narrative identity," which is to say, a new identity per se (Lewis, 2011, 145). Just as a narrative psychiatrist is a psychiatrist and the term "narrative outcome" in the parlance of *Narrative Psychiatry* refers to an outcome, so a "narrative identity" refers to an identity. The narrative approaches people take "shape their identity and their future" (Lewis, 2011, 151). Narrative psychiatry poses "deeply ethical decisions about what kind of person the client wants to be" (Lewis, 2011, 168).

However, there is not the slightest warrant in the text of "Mrs. Dutta Writes a Letter" for the supposition that Mrs. Dutta—"a woman well over sixty"—is thinking of becoming another kind of person (Lewis, 2011, 174). Nor is she shown pondering her therapeutic alternatives, and the reason is not hard to find. If she envisioned herself as a consumer choosing among the many styles of therapy on offer in the marketplace, Mrs. Dutta would not be in a state of exile from her homeland; she would already be as naturalized an American as her daughter-in-law. In other words, in the name of investigating the therapeutic potential of stories, *Narrative Psychiatry* removes Mrs. Dutta from the context of her own story—the only context in which she exists—and posits her doing things that lie completely outside the field of her being as given by Chitra Divakaruni. According to *Narrative Psychiatry*, "If Mrs. Dutta felt open to engaging in political struggle, she could use feminist therapy to see her move to Calcutta as a resistance against the notion that the 'West is best'" (Lewis, 2011, 142). Perhaps the author of *Narrative Psychiatry* thinks it possible to invent another self because the political fighter here sketched has, in fact, nothing to do with the peaceable sexagenarian we meet in the story itself: a woman who in the end wishes for nothing more than to be with her friend and neighbor in Calcutta, "two old women drinking cha in your downstairs flat . . . while around us gossip falls—but lightly, like summer rain, for that is all we will allow it to be" (Lewis, 2011, 188). Imagining Mrs. Dutta engaged in political struggle, or taking up any number of other possibilities offered in the course of *Narrative Therapy*, is like imagining Huckleberry Finn on a cruise ship.

Narrative Psychiatry does not offer examples of actual persons fashioning themselves by doing story work. It does not even offer examples of fictional characters doing so. It offers fictions of its own devising about a fictional character presumed to be interested in becoming her own author—according to one such invention, Mrs. Dutta actually ends up "with a writing voice similar to that of Chitra Divakaruni, the author of 'Mrs. Dutta Writes a Letter'"—but not shown in the original with any such intention (Lewis, 2011, 134). This is not a strong foundation for the claim that by authoring stories we author ourselves.

IV. STORIES AND PLACEBOS

The prototype of the success story, Benjamin Franklin's autobiography was intended less to record his life than to set an example for posterity. "The

aim of the *Autobiography* . . . is not so much to explain how his life is justified by some universal principle as to justify his life by persuading others to make its conclusions universal. . . . By imitating his success, men can fulfill his prophecy and bring about the rule of human Reason" (Spengemann, 1980, 54). The sort of inspirational fable or "therapeutic plot" that Frank and Frank prescribe for the demoralized works in theory by a similar alchemy of suggestion and persuasion. To create the life we wish to have by composing a story about it, as envisioned in *Narrative Psychiatry*—this too seems like an attempt to engineer a self-fulfilling prophecy. Say someone who views herself as well-organized tells stories that show her in that light—leaving out the counterevidence—and then proceeds to try to live up to them (Walker, 2012). Her stories act like positive expectations that point to their own realization, somewhat like placebos. Placebo effects are in fact often called "meaning effects," which is not far from "story effects," and *Narrative Psychiatry* itself recognizes a link between stories and placebos—so let us look into this matter a little more deeply.

The literature on the placebo effect suggests that it is something very like a self-fulfilling prophecy, or in the language used, a self-fulfilling expectation. "Most of the research on placebos has focused on expectations as the main factor involved in placebo responsiveness" (Benedetti, 2009, 39). A therapeutic story as recommended by Frank and Frank theoretically creates the possibility of its own fulfillment much as the expectation of medical benefit fosters the possibility (but not the automatic fact) of benefit. "[Jerome] Frank and the Johns Hopkins group began investigating psychotherapy just as medicine was beginning to use placebo comparisons with control for various psychological factors, such as hope, expectancy, and the relationship with the physician" (Wampold and Weinberger, 2012, 5), and a chapter of *Persuasion and Healing* is devoted to "The Placebo Response and the Role of Expectations in Medical and Psychological Treatment." However, placebo responses in the medical realm may lead us to moderate our own expectations regarding narrative therapy and its possibilities.

Placebo responses in medicine—their original venue—tend to be time limited. Most clinical trials are short because patients drop out over time, and if too many are lost, the trial's validity suffers (Kirsch, 2010). The effects of placebo pills, too, are temporary, like those of the pills they stand in for, and in any case may wane with the passing of fads and fashions. Perhaps because of the solemnity of its rituals we have particularly high expectations of surgery, so that the effects of sham ("placebo") surgery may persist for some time. In a study comparing the implant of fetal tissue and sham surgery as treatments of Parkinson's disease, those who believed they received transplanted tissue had better outcomes, even better physical outcomes, at 12 months, regardless of the treatment actually received (Benedetti, 2009). Placebo effects of long duration appear to be the exception, however, and there is little, if any, evidence that they can last indefinitely.

According to *Narrative Psychiatry*, stories told in therapy are themselves vehicles of the placebo effect, promoting healing by providing the patient with "a sense of mastery and control" among other benefits (Lewis, 2011, 26). A life reauthored under the influence of an inspiring fiction like this would be, in essence, a permanent placebo effect. There is no warrant in the literature for a placebo effect at once so durable and so encompassing. Placebo effects are often impressionistic and, in any case, are not weighty enough to sustain the sort of profound changes envisioned by the rhetoric of narrative psychiatry. The first meaning for "heal" given in the Oxford English Dictionary is "to make whole or sound in bodily condition; to free from disease or ailment, restore to health or soundness; to cure." Contrary to the notion that therapeutic stories are placebos that heal (in accordance with the very title, *Persuasion and Healing*), placebos per se do not heal—that is, cure—at all. Placebos allay symptoms. They can alleviate depression without doing anything about the chemical imbalance that is its theorized cause; they can improve mobility in the case of Parkinsonism but do not cure Parkinsonism; they can relieve cancer symptoms but certainly do not cure cancer. "There is little reliable evidence that the placebo effect can cure or control disease by modifying patho-physiology" (Miller, Colloca, and Kaptchuk, 2009, 523–24).

In other ways, too, the power of the placebo is limited. Experiments where placebo is deceptively presented as an active medication, the better to engender positive expectations, may boost the performance of the placebo; rarely, however, will it perform at a level tantamount to a medication per se. (Thus it would be unethical to run a study in which postsurgical patients requesting painkiller were treated with placebo, even though placebo may well have some analgesic effect.) Implying, as it does, that expectation automatically generates its own realization, the view of the placebo effect as a self-fulfilling prophecy contains considerable exaggeration (Justman, 2013). In a classic of the placebo literature, a British general practitioner reports that by telling patients positively they would soon be better, he hastened their recovery even if they were treated with nothing but placebo or, indeed, not treated at all (Thomas, 1987). However, the complaints they presented—most commonly coughs and sore throat—are the sort that would have cleared up in short order anyway. Not all ailments lend themselves to reassuring prophecy, and even in the case at hand, about a third of the reassured patients failed to recover faster than most of the unreassured.

That a patient with a cold can expect to get better, that experiments raising deceptive expectations are carefully designed to be believable—this reminds us that expectations themselves are constrained by credibility. The limits of what can credibly be expected also bear on narrative psychiatry. The celebrated power of the placebo does not allow us to conjure another self into being by telling stories, or by any other means. In the case of the organized woman, it would be an exaggeration to claim that by trying to live up

to her own stories she reinvents herself. For one thing, she was somewhat organized to begin with; she is just becoming or trying to become more so. Probably those around her would see her as the same person before and after the telling of her stories. Trying to tie up loose ends by bringing her life into conformity with her story is perhaps just what someone who likes things tidy, but still has tidying up to do, would do. Building on our own capacities is exactly the way we change without becoming another person.

By analogy with positive expectations (medical and otherwise) that may become self-confirming, an influential argument holds that "positive illusions" such as an unrealistically high opinion of oneself actually contribute to well-being. "Research evidence indicates that self-enhancement [that is, a higher-than-warranted opinion of oneself], exaggerated beliefs in control, and unrealistic optimism can be associated with higher motivation, greater persistence, more effective performance, and ultimately greater success. A chief value of these illusions may be that they can create self-fulfilling prophecies" (Taylor and Brown, 1988, 199). If optimistic illusions can trigger their own fulfillment, couldn't inspiring fictions worked into story form in the course of therapy do the same? We can't say. The magical thinking the authors are concerned with is allegedly a native endowment of healthy people; nowhere do they suggest it can be instilled or acquired in the course of therapy. Implanting illusions that "can" come true, but might not, in people who are not used to them and might or might not be well served by them—this would be a risky undertaking. What would it mean, for example, to instill "an exaggerated belief in their ability to control their environment" (Taylor and Brown, 1988, 197)—only one of the illusions allegedly beneficial in people who function normally—in people who do not function well? Would it be a prompt toward well-being or a formula for disaster? For that matter, what's the practical difference between an exaggerated belief in one's ability to control things and "the sense of mastery and control" fostered by therapeutic storytelling, according to *Narrative Psychiatry*?

Even in those who function well, however, there are limits to the success-breeding capacity of positive illusions. We can't just write our own ticket. For example, "a falsely positive sense of accomplishment may lead people to pursue careers and interests for which they are ill-suited" (Taylor and Brown, 1988, 204). Such "long-term limitations" of positive illusions, as the authors denote them, suggest an analogy with placebos, which are not panaceas and do only so much. The most emphasized conclusion in the most comprehensive study of the placebo effect on record—*The Powerful Placebo*, coauthored by the psychiatrist Arthur Shapiro (Shapiro and Shapiro, 1997) and published by the same press as Frank and Frank's *Persuasion and Healing*—concerns the strong placebo component of psychotherapy as such. Nowhere does this study imply that the patient in therapy acquires the ability to author a new self.

V. FREE CHOICE

Psychotherapists are likened in *Persuasion and Healing* to rhetoricians, including—disturbingly—"such rhetoricians as evangelists and demagogues [who] seek to influence discontented or disconnected persons" (Frank and Frank, 1991, 67). Much of the language of *Narrative Psychiatry* is itself rhetorical, not in the trivial sense of seeking to influence the reader but in its use of the principal figures of rhetoric: repetition and exaggeration. Maintaining that people can change the story line of their life with appropriate professional help, *Narrative Psychiatry* stresses first of all the importance of choosing a school of therapy, drumming on the word "choice" and its variants.

> Narrative integration can help Marina [a fictional character] see that her choice between alternative psychotherapies is less about knowing which is superior across time and space and more about which therapy or combination of therapies fits best with her goals and desires. Marina's choice of therapeutic options is momentous. . . . Despite the importance of this choice, most psychotherapists spend little time considering the issues at stake. . . . In contrast, narrative integration of psychotherapy brings the question of choice into the therapeutic process itself. (Lewis, 2011, 55)

It is because the act of selecting a therapist is tantamount, theoretically, to choosing one's life that it seems "momentous." "Ultimately, it's a choice about who one wants to become" (Lewis, 2011, 82). According to another prominent theorist of narrative, in therapy we dig up the stories that have served as "a kind of instruction manual" and replace them with "other instructions from other stories" (Frank, 2010, 157), a formulation that figures us, dubiously, as programmed beings who become self-programmed beings. Presumably, the school of therapy we enter has something to do with the story we end up with as our instruction manual.

In itself, the question of which of a dozen schools of therapy to commit to matters both less and more than such lines of reasoning maintain. If "most brand-name treatments, when offered with conviction, are equally effective" (Wampold and Weinberger, 2012, 6), the differences between them are more apparent than real and the choice of a brand is not very consequential as long as the branding itself is convincing. (One thinks of a study that found brand-name aspirin superior to its generic counterpart in treating headaches—and branded placebo superior to generic placebo [Branthwaite and Cooper, 1981].) One of the foremost researchers of the placebo effect concludes that "All psychotherapies work more or less pretty well . . . . In other words, psychotherapy might be nothing more than good human interaction between patient and therapist, so that trust, belief, expectation, motivation, and hope, that are common in all types of psychotherapy, would be the factors responsible for the successful therapeutic outcomes" (Benedetti, 2011, 141). *Narrative Psychiatry* itself comes very close to this conclusion about the relative merits of different therapeutic brands. How can the changes

brought about by therapy be as profound as *Narrative Psychiatry* would have it if they can be induced by nothing more than good human interaction? To commit to a therapy is not to author a new self—an implausibly absolute exercise of freedom—but to invest in a belief system, a brand, which the therapy will tend to bear out. Humanistic therapy will make its own terms, postulates, and methods seem valid, perhaps even uniquely valid, as will psychoanalysis, as will feminist therapy. It is in this respect that the choice of a therapy certainly matters. Which magic circle should I enter? Therapy is strongly suggestive; perhaps it's just as well that our suggestibility is not so complete that our very self takes the shape called for by the preferred therapeutic system. Of course, the placebo effect too works by suggestion, and the finding that all psychotherapies work more or less well is consistent with the theory that psychotherapy cultivates the placebo effect (Justman, 2011), playing on belief and expectation, making people feel better, and alleviating symptoms but not transforming the person bearing the symptoms.

Just as placebos can relieve symptoms without touching the underlying condition, so story placebos and narrative therapy itself can conceivably make you feel better without changing who you are. That it's possible to choose a course of action by no means entails the possibility of choosing the person doing the choosing. By insisting that we can script our own existence quite as freely as if we were creating a fictional character out of thin air, the rhetoric of narrative therapy both exaggerates our possibilities and distorts the concept of freedom. Rhetoric likes either/or propositions, and by making an absolute of choice, the rhetoric of *Narrative Psychiatry* suggests that we either choose our life story or languish in a state of domination. "The first task of clinicians and clients is to escape from the domination of the current story the client tells in order to imagine alternatives" (Lewis, 2011, 81). What automatically makes the current story tantamount to a prison sentence the author does not say.

In a powerful critique of the pretense of psychological expertise, Robyn Dawes objects to stories proffered by therapists that place the "cause" of the client's distress in childhood. "My own concern is that such a good story can be more of a trap than a liberator," because it plays to the fallacies of retrospective memory and implies that the patient's actions in the present can do nothing to relieve his or her distress as long as the "cause" is in place (Dawes, 1994, 217). Neither the claim that psychotherapy liberates nor the claim that the vehicle of liberation is story can be assumed uncritically.

VI. LITERARY COUNTEREXAMPLES

Among the most ancient and compelling uses of story is to hold up a mirror of truth, as when the prophet Nathan induces King David to recognize himself through the parable of the rich man who seizes the poor man's lamb. The most

renowned of storytellers, Shahrazad, follows the opposite course in *not* rebuking the king her husband, instead putting his madness to sleep by the cunning of entertainment. In each case, story is certainly potent, but its power lies in recalling errant minds to themselves. The idea that stories confer the freedom to make yourself what you choose—that is, that they confer unlimited freedom—contradicts the enriching sense of reality that runs through the traditions of narrative, without which they would have far less of a claim on us. There is little in these traditions to support the more extravagant theories of narrative psychiatry.

According to *Narrative Psychiatry*, "literary fiction does not usually present characters as having static or stereotyped traits, but rather the characters are very much in process" (Lewis, 2011, 79). This is a very questionable generalization. Even in the realist novel where the figure of the character-in-process comes into its own, evolving characters are surrounded by static ones, types, caricatures, persons defined and seemingly incapable of process, from the incorrigible Mrs. Bennet of *Pride and Prejudice* to 1,001 characters in Dickens who act like repeating mechanisms, to the Tom Buchanans who stand blockish and unalterable like boulders in a stream, to ordinary background characters who set off more dynamic or ambiguous figures. However we wish to classify them, though, characters in "literary fiction"—of which the novel is but one branch—tend strongly to remain *in* character. They do not change into a new person and they certainly do not play their own author. Maybe there are manipulators who decide from time to time who to become (as Richard, soon to be Richard III, vows that he can out-Proteus Proteus), but throughout all this they will remain manipulators. For that matter, even when slipping out of character, characters may remain who they are, as Odysseus—arguably the archetypal character in the Western tradition—does not cease to be himself when he forgets his own celebrated attributes of prudence and self-command and fatefully blurts out his name to the Cyclops. Self-celebration is also one of his attributes.

One example of a character attempting to forge a new identity and story for himself suggests itself to me, an example all the more notable in that the attempt is an outstanding failure. In Tolstoy's *Death of Ivan Ilych*, the hero, we are told, reinvents himself when the reform of Russia's judicial institutions in the 1860s creates an opening for a certain "new" kind of man (presumably a Westernizing professional with mildly liberal views).

> Ivan Ilych served for five years and then came a change in his official life. The new and reformed judicial institutions were introduced, and new men were needed. Ivan Ilych became such a new man. He was offered the post of examining magistrate, and he accepted it though the post was in another province and required him to give up the connections he had formed and to make new ones. . . . Ivan Ilych was one of the first new men to apply the new code of 1864. (Tolstoy, 1991, 131–32)

By a Tolstoyan irony, Ivan Ilych becomes a new man, makes new connections, applies a new law code, moves to a new town, and yet remains the

same person, a follower of social examples and ideological fashions. In short order he decides to marry Praskovya Fedorovna in exactly the same automatic way he became a new man, which suggests that both decisions belong to the same pattern of an unthinking careerist acting in accordance with his character. His wife is simply a new connection. When we later try to figure out when his downfall began, we could say it was when he slipped on a stepladder, but we could also say it was either when he married (for his marriage too was a misstep, and closes in on him much as his disease does) or when he became a judge (he who judges will be judged). He never, in fact, became a new person, and instead of writing a new life for himself, saw the consequences of his habitual practices descend on him. (For what it's worth, *The Death of Ivan Ilych* also poses caustic commentaries on the placebo effect, as when the protagonist experiences a purely transient feeling of relief and hope on taking communion.)

Although those looking for models of self-authorship to pattern themselves on will not find much to work with in the history of the novel, they will certainly find characters who foolishly imitate fictive originals or assume that their own experience follows fictive models. The life-is-a-story argument broadly ignores the critique of fiction itself that runs through the tradition of the novel, for well over a century the dominant mode of literary expression. The modern novel was set on its path by *Don Quixote*, its hero enchanted by the fallacy that reality itself conforms to the established conventions of romance. In the tradition of *Don Quixote* are many a canonical novel, from *Joseph Andrews* to *Huckleberry Finn*, from *Great Expectations* (a work whose title comments on the romance of positive illusions) to *Lord Jim*. But among those possessed by what we might call the narrative imagination, none surpasses Emma Bovary. An addict of the imaginary and avid consumer of second-hand fantasies, she "remembered the heroines in the books she had read, and the lyrical legion of these adulterous women began to sing in her memory with the sisterly voices enchanting her. She herself became a part of these fantasies" (Flaubert, 1964, 163). And later: "She was the *amoureuse* in every novel, the heroine of every drama, the vague 'she' of every book of poetry" (Flaubert, 1964, 251). But it is all indeed a fiction.

VII. MRS. DUTTA'S WISDOM

With the wisdom that knows it does not know, and that does not advertise or profess itself as wisdom, Mrs. Dutta in the end writes her friend, "I cannot answer your question about whether I am happy, for I am no longer sure I know what happiness is. All I know is that it isn't what I thought it to be" (Lewis, 2011, 188). Also wisely, Mrs. Dutta does what she can under painful circumstances without either denying reality, taking refuge in resentment, or, for that matter, reaching for remedies that are more like placebos. Instead of

choosing to author a new existence for herself in this, her seventh decade of life, she appears to elect, more practically, to return to Calcutta to live with her friend and abide the absence of her beloved son. Let us note that that story ends with Mrs. Dutta intending to return, not actually doing so.

Suppose she did return. At that point she could not imaginably take up arms against "the notion that the 'West is best'" in the name of self-creation, because taking an ideological revenge on the Western world is not in her character; in order to become that person she would have to sacrifice all of her richly evoked particularity to the clichés and foregone conclusions of political therapy.

What if, contrary to everything, Mrs. Dutta did embrace political therapy? Like other therapies discussed in the course of *Narrative Psychiatry*, political therapy would mold her in the image of its doctrines, whatever its rhetoric of self-creation. In so doing, it would mock the legitimate aim of narrative medicine, namely, to understand the patient in her specificity and uniqueness; and the same is true of other cliché-filled treatment options offered Mrs. Dutta in *Narrative Psychiatry*.

Evidence-based medicine, although indispensable, cannot understand the patient in her own right either, precisely because its evidence is statistical. Comparatively little of medicine is actually evidence-based in the sense of being validated by randomized, double-blind clinical trials (many of whose findings are of slender clinical utility [Healy, 2012]), and in any case medicine and psychiatry, to say nothing of psychology, are driven not only by evidence but interests, trends, customs, and other propellants. So too, disorders of the mind codified in successive editions of the *Diagnostic and Statistical Manual* acquire not only diagnostic criteria designed to bring different clinical observers to the same conclusions, but also, in some cases, advocates, constituencies, and even story-lore powerful in its own right (such as the popular mythology surrounding Prozac). And patients can take such lore into their lives. As Elaine Showalter observed a decade ago in a work of cultural history whose reference points include *Madame Bovary*, once models of new disorders are established and capture the public imagination (among her examples is multiple personality disorder, which was of interest to theorists of narrative writing around the same time), some patients "come to believe that the laws of a disorder describe their lives" and with the aid of a therapist "rewrite their personal narratives." Owing in good part to the appeal of the stories they both produce and consume, such patients "may become addicted to their symptoms" (Showalter, 1997, 19). In the case of a patient who constructs a story that justifies a sense of illness, narrative therapy seems to induce a reverse placebo, or nocebo, effect—not allaying but reinforcing symptoms.

The postulate that "our experience of human affairs comes to take the form of the narratives we use to tell about them" cannot then be taken as a foundation of clinical practice. In some cases, it may bear good fruit in

the form of less distress, though as just noted it can also prove harmful. As for the strong form of the postulate—the principle that one can and should author oneself—it may lead to nothing but misguided efforts to shore it up against its own impossibility. It is another sign of Mrs. Dutta's wisdom that the thought of authoring herself in conformity with a therapeutic imperative never crossed her mind.

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