

## CHAPTER 1

# Narrative in psychiatry, theology and spirituality

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We all have stories to tell: our own stories, stories we have heard, stories of what we have seen, stories of what we imagine or dream. The telling of stories, and listening to them, seems to be a fundamentally human activity. It is not necessarily the case that happy stories are better than sad stories, and any story can be told well, or badly. But some stories are important and, in some way, they need to be told and listened to. Among these are stories of difficult, traumatic and emotional experiences, stories of life and death, stories of illness. Storytelling is thus at the heart of both medicine and pastoral care. The doctor, like the priest, needs to be good at listening to stories.

If stories are important, the word ‘narrative’ might immediately appear to be an unhelpful synonym. It sounds more technical and, being employed frequently in academic discourse, could easily be seen to distance the everyday telling of stories from serious academic or professional work. Conversely, it might be understood as a technical term which cuts across various professional and academic disciplines, use of which demonstrates that stories are taken seriously by professionals and academics. This ambiguity is perhaps not unhelpful, for it turns out that narratives, stories, can be told and heard in importantly different ways, some of which are creative and can bring healing, and some of which are harmful and destructive.

## Narrative in medicine and psychiatry

Trisha Greenhalgh and Brian Hurwitz (1998) identify a number of important features of a narrative:

- 1 There is a finite temporal chronology, with a beginning, a series of events and an end.
- 2 It presupposes the existence of narrator and listener, whose differing viewpoints influence how the story is told and heard (another narrator and another listener might tell and respond to the same story quite differently).

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- 3 There is a concern with characters, with individual people and with how they feel about themselves and others.
- 4 Information is provided that is more than simply a definable list of facts directly concerned with events. What is included and not included is important.
- 5 It is absorbing and engaging, and invites interpretation.

Greenhalgh & Hurwitz argue (convincingly, I think) that narrative is important in medicine:

‘The narrative provides meaning, context and perspective for the patient’s predicament. It defines how, why, and in what way he or she is ill. It offers, in short, a possibility of understanding which cannot be arrived at by any other means’ (p. 6).

Narratives provide a holistic and patient-centred approach to clinical problems, identify diagnostic and therapeutic possibilities, are educative – of patient and professional – and stimulate research. Narratives invite multiple possible interpretations – by both doctor and patient – and interpretation offers the possibility of finding meaning. Mutual awareness by doctor and patient of the possible meanings of a particular episode of illness is, or should be, an important objective of clinical practice.

However, narrative is more important even than this brief perspective on clinical relevance might suggest. Narrative, as it emerges in our self-reflection and in our dialogues with others, is increasingly understood as central to the way in which we construct our self-identity (Kinsella, 2006). Because of the power of language, and the social power that doctors hold, it is easy for doctors inadvertently to impose a narrative account which may be harmful to a patient’s sense of self. Ethical practice therefore requires a willingness to be self-reflective, to acknowledge in humility the limits of one’s own account of things, and the courage to challenge narratives of self or illness which are demeaning, harmful or unhelpful. It also requires the skill of allowing and enabling patients to tell their own stories in ways that are helpful and affirming. Further, there is reason to believe that narratives constructed jointly by physicians and patients have the potential to be healing (Egnew, 2005). Conversely, such narratives also have the potential to impede healing.

One woman, reflecting on a period of mental healthcare experienced more than 10 years previously, wrote:

For eight years (and teenage years at that) my narrative was challenged by the unadorned, unelaborated threat. ‘If you don’t obey the System, we will section you and that will make the rest of your life a whole lot harder for you.’ That located the authority to provide a correct narrative about me and my self-understanding in the minds of others and not of me, with the full weight of the legal and social authority of the whole state in which I live, subsequently extended to the whole of humanity by the words of the staff nurse, as I said.

Arthur Frank (2013: p. 69) has suggested that illness narratives are a particular kind of self-story, related to and overlapping with, but

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not replacing, other kinds of narrative of the self, such as the spiritual autobiography, stories of becoming a man or a woman, and narratives of surviving trauma. He identifies three types of illness narrative as aids to listening. In doing this, he stresses that there are clearly other types of illness narrative, and that far from being mutually exclusive these three types of illness narrative are told, repeatedly and in turn, in any particular illness suffered by any particular person. They are: the restitution narrative, the chaos narrative and the quest narrative.

The basic plot of the restitution narrative is ‘Yesterday I was healthy, today I am sick, but tomorrow I’ll be healthy again’ (p. 77). According to Frank this is the culturally preferred narrative (presumably, the culturally preferred narrative of the Western world). Behind it lies the power of medicine to heal, and this in turn takes the focus away from the ill person to those professionals who hold the power to bring healing. It thus silences the narrative of the ill person. A further problem is that this is a narrative of modernity. Once an illness is chronic or terminal, when restitution is not achieved, other stories are needed. These other stories might be potentially helpful but effectively unavailable, as in the case of the religious or spiritual narrative that cannot be discussed with the atheist or agnostic health professional (Cook, 2011). Or they might be available and unhelpful, as in the case of the narrative provided by the staff nurse in the account quoted above.

The plot of the chaos narrative is the opposite of the restitution narrative. Life never gets better. Such stories provoke anxiety and are hard to hear. They are also hard to tell. Frank suggests that they are ‘anti-narrative’, they lose temporal sequence, they go beyond what can be said, they incur relentless repetition. Although it is desirable to move on from such narratives, Frank sees it as deeply unhelpful to try and rush people along or to dismiss such stories. Interestingly, one of the ways in which he sees this happening is by relabelling such narratives with a diagnosis of depression, a label that enables a shift back to a restitution narrative, the story of a treatable condition.

In the quest narrative, however, the illness is a journey, and the person with the illness, the teller of the story, is afforded a voice in a way that they are not in restitution and chaos narratives, the former because the narrator becomes the professional and the latter because they are almost impossible to tell and hard to hear. Drawing on the work of Joseph Campbell, Frank identifies three stages to the journey: departure, initiation and return. Here, illness is a vocation, which confers a responsibility that the story be told. The outcome is not necessarily restitution, but in this it also surpasses the restitution narrative; it has something to say when an illness is chronic or terminal.

In the field of mental health, narrative plays a particular part in promoting recovery (Care Services Improvement Partnership *et al*, 2007). However, as Fallot (1998) has pointed out:

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‘When the very illness around which recovery is sought may function to disturb mood or to cloud cognitive clarity, the process of consistent meaning making is itself at risk’ (p. 36).

It is thus all the more important, and yet also all the more difficult, for people with mental health problems to construct the very narratives that might be expected to help in bringing about their own recovery.

Brown & Kandirikirira (2008), in their report on narrative investigation of mental health recovery in Scotland, have identified six internal and six external elements of narratives that helped to promote recovery (Table 1.1).

Narrative, then, has appeared in recent years to be a useful and important tool for research and for clinical work. However, it also has its potential dangers. Angela Woods (2011) identifies seven:

- 1 There is a question as to whether narratives reflect real life. Are they true? If so, for whom are they true, and in what situation?
- 2 Narratives can be harmful – especially if they are used for oppression or dissimulation.
- 3 The category of narrative can be overinflated.
- 4 Distinctions between different types of narratives can be blurred. A short case study is not the same as an autobiography, for example.
- 5 Notwithstanding the work of Frank (see above) and others, there is a lack of adequate attention to the different genres of illness narrative.
- 6 Researchers and clinicians tend not to be good at recognising the importance of cultural and historical context in the interpretation of narrative.
- 7 Particular narratives, or kinds of narratives, easily become idealised as the normal or proper mode of self-expression, and thus a particular understanding of the self is privileged.

**Table 1.1** Elements of narratives associated with mental health recovery

Internal elements	External elements
Belief in self and developing a positive identity	Having friends and family who are supportive, but do not undermine the narrator’s self-determination
Knowing that recovery is possible	Being told recovery is possible
Having meaningful activities in life	Having contributions recognised and valued
Developing positive relationships with others and your environment	Having formal support that is responsive and reflective of changing needs
Understanding your illness, mental health and general well-being	Living and working in a community where other people could see beyond your illness
Actively engaging in strategies to stay well and manage setbacks	Having life choices accepted and validated

Source: Brown & Kandirikirira, 2008.

In the context of clinical psychiatry, we might also note that an undue focus on narrative can obscure scientific clarity. Diagnosis remains important for the practice of psychiatry and, at least in some cases, might be obscured rather than clarified by preoccupation with narrative. The clinician needs to see the narrative and the diagnosis, not just one or the other.

## Narrative in spirituality and theology

Spirituality and religion are associated with, and perhaps even constituted by, beliefs, practices, attitudes and motivations that reflect core concerns of human beings. Although it must be acknowledged that some people consider themselves to be neither spiritual nor religious, there are increasingly many people who identify as spiritual but not religious, among whom at least some are atheists (Comte-Sponville, 2008). And there do not seem to be many people who self-identify as religious but not spiritual. It is therefore arguable that spirituality is a universal attribute of human beings, although it has also been argued that this is an imposition of particular Western ways of thinking upon the wider world (Hornborg, 2011).

Spirituality is notoriously difficult to define. A definition that has been used in previous Royal College of Psychiatrists' publications (Cook, 2013a; Cook *et al*, 2009), and which seeks to be inclusive, defines spirituality as:

'a distinctive, potentially creative, and universal dimension of human experience arising both within the inner subjective awareness of individuals and within communities, social groups and traditions. It may be experienced as a relationship with that which is intimately "inner" immanent and personal, within the self and others, and/or as relationship with that which is wholly "other", transcendent and beyond the self. It is experienced as being of fundamental or ultimate importance and is thus concerned with matters of meaning and purpose in life, truth, and values' (Cook, 2004: pp. 548–549).

Such a definition at least incorporates the key areas of debate, and has its uses in clinical practice, but it is not succinct. (Fred Craigie offers some succinct definitions in Chapter 6, 'Stories of joy and sorrow: spirituality and affective disorder'.) The operationalising of the concept of spirituality for research has been understood by some to be so problematic as to be best abandoned, in favour of the study of religion (Koenig, 2008), and moves to address spirituality and religion more widely in clinical practice have been controversial among psychiatrists (Cook, 2013b). However, service users indicate that spirituality and religion are important to them, and that they wish to see these matters addressed in treatment (Mental Health Foundation, 2002; McCord *et al*, 2004). There is also reason to believe that there is a 'religiosity gap' between mental health professionals and their patients, and that there is need to avoid the misunderstandings that arise as a result of this discrepancy of perspective between the often less religious professional and the often more religiously inclined patient (Cook, 2011). To this end, the Royal College of Psychiatrists has published a position

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statement providing recommendations for psychiatrists on spirituality and religion (Cook, 2013a).

The above definition of spirituality makes no reference to narrative, and narratives are not necessarily concerned with spiritual matters. However, it should be immediately apparent that there are various important points of contact between the worlds of spirituality and narrative. First, both are concerned with processes of interpretation and the finding of meaning and purpose. Second, both are concerned with how people understand themselves in relation to others, and others in relation to themselves. Third, although it is certainly possible to convey spiritual truths without recourse to narrative, it must be remarked that in many cases spirituality is communicated by recourse to narrative. Thus, many of the great spiritual classics are autobiographical, biographical or allegorical narratives. For example, we might take note of St Augustine's *Confessions*, Bunyan's *Pilgrim's Progress*, and the parables of Jesus. However, we should also note Anton Boisen's (1951) pastoral concern with learning to read 'living human documents' or, to paraphrase here, we might say the spiritual narratives of the service users, patients or other people with whom we work. These are not necessarily written narratives, but they are the narratives of people's lives – recounted to us first hand, or observed by us during pastoral or clinical practice.

The definition of spirituality given above also refers to experiences of the immanent and the transcendent. I have related elsewhere how these dual aspects of spirituality are properly inseparable, albeit differently emphasised and expressed within different spiritual traditions (Cook, 2013c). While an argument can be made that transcendence is a central concept in spirituality, in fact many spiritual traditions are expressed in stories, rituals and other practices that relate to the experience of the immanent, observable, 'this worldly' order of things. The transcendent order, while it may be variously conceived and understood, is almost inevitably either an interpretation of narratives of the immanent realm or else is expressed as an allegorical narrative of the immanent realm (e.g. as in *Pilgrim's Progress*), since something that is completely transcendent is by definition beyond human experience. In our human capacity to interpret narratives we find a place within which the immanent and transcendent meet and are mutually expressed.

Stephen Crites (1971) argues that 'the formal quality of experience through time is inherently narrative' (p. 291). This observation on its own has relevance to the practice of psychiatry, for it reminds us that human experiences are by nature narrational in form. Crites goes on to distinguish within the broader category of narrative between mundane stories and sacred stories. Sacred stories are, he says, 'fundamental narrative forms' (p. 295). They are sacred 'not so much because gods are commonly celebrated in them, but because men's sense of self and world is created through them'. These 'stories within stories' are stories 'which inform people's



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sense of the story of which their own lives are a part, of the moving course of their own action and experience'. Such stories are 'dwelling places', and people 'live in them'. But such stories 'cannot be fully and directly told'. The stories that actually are told Crites calls mundane stories. In order to be told, stories must adopt the conscious everyday language, narrative devices and imagination of a particular world, or *mundus*.

According to Crites, narrative is fundamental to both our conscious and unconscious experiences of the world. It links us with one another and with a sacred or transcendent order. It frames our self-identity and our understanding of the wider order within which we live. Although Crites does not use the word 'spirituality', we might argue that narrative looks very much like spirituality, or at least that it is the medium within which it can be expressed.

All of this becomes particularly interesting when Crites identifies the strategies that we employ whereby our sense of narrative time is broken. One is to engage in abstractions, whereby general principles are formed that are non-narrative and atemporal. The other is to engage in exactly the opposite process, which Crites calls contraction. Here we constrict our attention to focus on the immediate, concrete, present experience. Both are evident in mental health practice – the former in the abstractions of psychiatric terminology and diagnosis, and the latter in the contractions of evidence-based medicine.

We should note that religious traditions often refer to significant narratives – such as those of creation (Van Wolde, 1996), redemption (e.g. the Exodus narrative in Judaism) or resurrection (e.g. the gospel narratives of encounters with the risen Jesus in Christianity). According to Crites, these are mundane stories – not sacred – since the sacred narrative is the story within these stories, rather than the scriptural or religious narrative itself. However, the study of them, reflection upon them and interpretation of them has traditionally been an important concern for people of faith and this raises a very significant issue. The study of narratives that are important to other people, whether spiritually or religiously or in other ways, is very different to the study of narratives that are important to me. Thus, the study of religion, or the study of spirituality, both of which are important academic fields, is not the same as theology (which usually implies a committed perspective) or spirituality as a *modus vivendi*. A brief excursus on theology and narrative may therefore be helpful at this point, by way of dispelling some misunderstandings about the nature of theology and facilitating a better understanding of what it means to study the religious/spiritual narratives of one's own tradition.

Johann Metz (1973) has argued that

'Theology is above all concerned with direct experiences expressed in narrative language... reasoning is not the original form of theological expression, which is above all that of narrative' (p. 85).

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All human experience, but perhaps especially spiritual and religious experience, has a narrative quality. Indeed, if we try to avoid this – by focusing too much on the abstract on the one hand (whether that be theological or philosophical abstraction), or the scientific, objective and empirical evidence base on the other, we miss something very important about the nature of human experience. Abstraction and objectification can be ways of avoiding the personal significance of the narrative – whether it be my own narrative or that of someone else. Psychopathology, for example, may be viewed as a way of labelling symptoms, thus objectifying them and using them as evidence in support of abstract diagnoses, or else it may be a means of gaining understanding and finding meaning (see Chapter 3, ‘Psychotherapy and the clinical story’).

Theological reflection relies quite significantly on narrative, since it is an engagement both with the narratives of lived experience and the spiritual/religious narratives of tradition. The methods of theological reflection are not dependent on the doctrines and traditions of specific religions, but are capable of accommodating the narratives of different faith traditions. Elaine Graham and her colleagues (Graham *et al*, 2005), writing from the Christian tradition, identify seven methods of theological reflection, most of which employ narrative methods in one way or another. Thus, for example, the notion of the ‘living human document’, takes up the work of Anton Boisen, already referred to above. Or, in constructive narrative theology, the writing of autobiographical accounts – narratives – of experience is emphasised. In canonical narrative theology the narrative of scripture is emphasised. However, all methods of theological reflection necessarily involve some level of engagement between the personal narrative and the narrative of the tradition (in the form of scripture, but also potentially other narratives too). Only the method referred to by Graham and colleagues as ‘theology in action’ is explicitly non-narrative, in that it sees theology as something to be ‘done’ and lived out, rather than merely written or spoken about. But even here, the generation of new narratives is an important outcome of the process. Indeed, it could be said that praxis, theology in action, is inherently narrative-creating.

An interesting case, offered by Graham *et al* as an example of constructive narrative theology, is that of Margery Kempe, a controversial English mystic of the 14th/15th century who appears to have suffered a puerperal psychosis, although there is much debate about the most appropriate diagnosis (Freeman *et al*, 1990; Lawes, 2000). According to her own account, her illness (which she distinguished as different from her later religious experiences) included visual and auditory hallucinations:

‘And in this time she saw, as she thought, devils opening their mouths all alight with burning flames of fire, as if they would have swallowed her in, sometimes pawing at her, sometimes threatening her, sometimes pulling her and hauling her about both night and day...’ (Windeatt, 1994: pp. 41–42).



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The narrative of Kempe's life (Graham *et al*, 2005: pp. 55–58) affirms a personal relationship with God despite her early mental illness and the later contrary opinions and narratives offered by those around her. Her advisors, friends and acquaintances seem to have been variously polarised in her support or else in opposition to her. Her own narrative (written down by a priest, as she herself was illiterate) is often lacking in temporal sequence and is at times a little chaotic. However, it is said to be the earliest autobiographical narrative in the English language, and it reveals some striking similarities with contemporary narratives of mental disorder, especially in regard to the associated stigma and humiliation of her condition:

'Then this creature – of whom this treatise, through the mercy of Jesus, shall show in part the life – was touched by the hand of our Lord with great bodily sickness, through which she lost her reason for a long time, until our Lord by grace restored her again, as shall be shown more openly later. Her worldly goods, which were plentiful and abundant at that date, were a little while afterwards quite barren and bare. Then was pomp and pride cast down and laid aside. Those who before had respected her, afterwards most sharply rebuked her; her kin and those who had been friends were now her greatest enemies' (pp. 33–34).

Margery Kempe's narrative is an account of the meaning and purpose that she finds despite these humiliating experiences. It transforms an account of madness into one of mystical experience (Torn, 2008).

## Spiritual narratives in psychiatry

Roger Fallot (1998) points to seven key religious and spiritual themes identifiable in narratives of recovery from mental illness, which are intended to be illustrative, rather than exhaustive:

- 1 Whole-person recovery takes whole-person involvement
- 2 True recovery is a long-term and often effortful journey
- 3 Hope is an essential ingredient for continuing recovery
- 4 Recovery depends on the experience of loving relationships
- 5 The 'serenity prayer' expresses a key process in recovery
- 6 Recovery is a journey towards genuineness and authenticity
- 7 Recovery is a story of action and pragmatism as well as conviction.

Fallot understands recovery narratives as drawing primarily on elements of Frank's quest narratives, these narratives involving as they do a developing sense of meaning and purpose that move beyond the limitations of illness and of social stigma. Fallot's work is based on clinical experience with a predominantly Christian African–American population with severe mental illness living in the inner city of Washington, DC. They are therefore not necessarily representative for all other people in recovery. However, the similarities with elements of narrative identified in Table 1.1,

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based on people in recovery in Scotland, are striking and this raises the question as to whether these are peculiarly religious and spiritual themes, or whether the language of spirituality and religion is at all necessary to convey the key elements of recovery narratives.

Doubtless it is pointless to argue whether or not words such as hope and love are necessarily spiritual. The importance of compassion in healthcare, for example, can be argued effectively without the need to resort to religious language, or even to the language of secular spirituality (Ballatt & Campling, 2011). However, in at least some cases, it is clear that the explicitly religious or spiritual context of recovery does demand a spiritual and/or religious vocabulary. Such contexts are often, but not exclusively, encountered in rehabilitation, mutual help and treatment for people recovering from substance misuse. Many such programmes are either explicitly religious or else adopt the 'spiritual but not religious' approach associated with Alcoholics Anonymous and its sister organisations (Cook, 2010). A recent publication (Sremac, 2014) providing a narrative theological analysis of stories of four addicts who underwent a religious conversion experience during recovery suggested that the traditional Christian virtues of faith, hope and love may be related respectively to the past, future and present realities of these recovery narratives.

In other cases, it is not so much the context that demands religious or spiritual language, as the religious content of the narrative itself, as determined by the narrator. Glòria Durà-Vilà and her colleagues (2013) showed that contemplative nuns who had suffered the trauma of sexual abuse by priests found that the trauma was transformed into a symbolic religious narrative which in turn shaped their sense of self-identity. In particular, religious themes of forgiveness, sacrifice and salvation were important in the process of finding meaning. In a related study (Durà-Vilà *et al.*, 2010), based in the same monastery, symptoms that might otherwise have been taken as the basis for a diagnosis of depression were understood by the sisters as being an experience of the 'dark night of the soul'. This study is of particular interest here as it shows how the personal narratives provided by the sisters are shaped in turn by key religious narratives – notably those of scripture and of the *Dark Night* (a 16th-century poem and spiritual treatise written by the Spanish mystic St John of the Cross). An excerpt from one of the interviews illustrates this with reference both to the New Testament narratives of the suffering of Jesus (e.g. Mark 14: 26–42; 15: 34), and to the *Dark Night* (Kavanaugh & Rodriguez, 1991: pp. 353–457):

'When I was in my Mount of Olives and I felt abandoned and in despair, crying, I implored God with all my might to take the cup from me if it was possible, this was my Dark Night, my cross and I also cried to God: Why have you forsaken me?' (Durà-Vilà *et al.*, 2010: p. 563)

The majority of patients in mental health services are neither engaged in explicitly religious/spiritual programmes of recovery nor as deeply personally influenced by spiritual/religious texts and language as were the

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sisters who were the subject of this study. Nor, for that matter, are they likely to be living in a monastery! However, either explicitly or implicitly, spiritual and religious themes find their way into the narratives of people who use mental health services and are easily overlooked. It is also the case that users of mental health services have found themselves unable to discuss spiritual and religious matters when they would like to have been able to do so, having feared that such topics will be interpreted in purely pathological terms (Cook, 2011). It is therefore important for the clinician to be able to make sensitive and appropriate enquiry about such matters without either imposing their own personal agenda (or that of a broader social narrative) or avoiding the patient's agenda (Vankatwyk, 2008; Leach *et al*, 2009; Cook, 2013a).

The woman quoted at the start of this chapter (p. 2), whose narrative had been so unhelpfully and coercively formed by the threat of the Mental Health Act and all that that implied, wrote of how she longed for her narrative to be shaped by what she referred to as 'God's narrative':

Yes, for the whole of that time I tried to retain a sense that ultimately it's God's narrative that matters, but if we turn to today, a) I don't expect God to have anything at all nice to say about me when it comes to passing judgement; b) eventually I did give up, and I just have very ordinary eating problems (as well as some other problems), but c) the most debilitating thing of all is to get myself into a situation that reawakens the sense of any identity other than the one I strive and fail and long to find in church and before God.

We might debate whether and how it is possible to know exactly what 'God's narrative' is. We might also be tempted to impose a 'restitution narrative' of the form that Frank describes, by way of imposing a diagnosis of depression or of an eating disorder. But I think that the clinically helpful task here is actually to affirm the longing for the self-identity that is sought and owned, and to listen carefully, ensuring that space is given for the story to be told.

## Reflections

Spiritual narratives may convey a theistic or atheistic world view, and they may eschew the language of traditional religion, but they will be narratives of personal experiences, reflected upon in the light of what is held to be most important. The methodology of theological reflection, with the important place that it gives to narrative, provides a way of drawing together such reflections from any or all traditions and belief systems.

It is important to note that narratives can be harmful as well as helpful. A good psychiatrist needs to be alert to ways of helping to affirm patients in telling their own story, and also alert to the narrative (or counter-narrative) that could impede healing or even cause harm. Undue abstraction on the one hand, and excessive preoccupation with the 'evidence base' on the other, can get in the way of the process of listening

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well to spiritual narratives, which are always deserving of our undivided time and attention.

My first ever publication in a medical journal was a narrative – a story – of my first wife's illness and death (Cook, 1985). Although I did not realise it at the time, I think that this narrative significantly formed my approach to my work as a doctor and perhaps indirectly, after a long delay in time, it also formed my vocation as a priest. It caused me to reflect on illness in the light of what I believed to be most important, and to see my patients, their families and their illnesses differently as a result. It helped me to realise that the real story of illness is concerned with relationships, meaning and purpose, with the spirituality that inheres in experiences of encounter with suffering, death and grief. Of course, there are many such stories, and I have learned also not to expect other people's stories always to be the same as mine. However, when told with honesty, I think that they all share integrity and a quality – I would say 'spirituality' – that binds them together. Perhaps this does not need to be called 'spirituality' – and I respect those who wish to tell their stories under another name. Perhaps they are simply stories of what it is to be reflectively human.

## References

- Ballatt, J. & Campling, P. (2011) *Intelligent Kindness: Reforming the Culture of Healthcare*. RCPsych Publications.
- Boisen, A.T. (1951) The period of beginnings. *Journal of Pastoral Care*, **5**, 13–6.
- Brown, W. & Kandirikirira, N. (2008) *Recovering Mental Health in Scotland*. Scottish Recovery Network.
- Care Services Improvement Partnership, Royal College of Psychiatrists, Social Care Institute for Excellence (2007) *A Common Purpose: Recovery in Future Mental Health Services*. SCIE.
- Comte-Sponville, A. (2008) *The Book of Atheist Spirituality*. Bantam.
- Cook, C.C.H. (1985) Leukaemia in the family. *BMJ*, **291**, 1810–1.
- Cook, C.C.H. (2004) Addiction and spirituality. *Addiction*, **99**, 539–51.
- Cook, C.C.H. (2010) Spiritual and religious issues in treatment. In *The Treatment of Drinking Problems*, 5th edn (eds E.J. Marshall, K. Humphreys, D.M. Ball): pp. 227–35. Cambridge University Press.
- Cook, C.C.H. (2011) The faith of the psychiatrist. *Mental Health Religion and Culture*, **14**, 9–17.
- Cook, C.C.H. (2013a) *Recommendations for Psychiatrists on Spirituality and Religion* (Position Statement PS03/2013). Royal College of Psychiatrists.
- Cook, C.C.H. (2013b) Controversies on the place of spirituality and religion in psychiatric practice. In *Spirituality, Theology and Mental Health* (ed. C.C.H. Cook): pp. 1–19. SCM Press.
- Cook, C.C.H. (2013c) Transcendence immanence and mental health. In *Spirituality, Theology and Mental Health* (ed. C.C.H. Cook): pp. 141–59. SCM Press.
- Cook, C.C.H., Powell, A. & Sims, A. (eds) (2009) *Spirituality and Psychiatry*. RCPsych Publications.
- Crites, S. (1971) The narrative quality of experience. *Journal of the American Academy of Religion*, **39**, 291–311.
- Durà-Vilà, G., Dein, S., Littlewood, R., et al (2010) The dark night of the soul: causes and resolution of emotional distress among contemplative nuns. *Transcultural Psychiatry*, **47**, 548–70.

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- Durà-Vilà, G., Littlewood, R. & Leavey, G. (2013) Integration of sexual trauma in a religious narrative: transformation resolution and growth among contemplative nuns. *Transcultural Psychiatry*, **50**, 21–46.
- Egnew, T.R. (2005) The meaning of healing: transcending suffering. *Annals of Family Medicine*, **3**, 255–62.
- Fallot, R.D. (1998) Spiritual and religious dimensions of mental illness recovery narratives. *New Directions for Mental Health Services*, **80**, 35–44.
- Frank, A.W. (2013) *The Wounded Storyteller*. University of Chicago Press.
- Freeman, P.R., Bogarad, C.R. & Sholomskas, D.E. (1990) Margery Kempe a new theory: the inadequacy of hysteria and postpartum psychosis as diagnostic categories. *History of Psychiatry*, **1**, 169–90.
- Graham, E., Walton, H. & Ward, F. (2005) *Theological Reflection: Methods*. SCM Press.
- Greenhalgh, T. & Hurwitz, B. (1998) Why study narrative? In *Narrative Based Medicine: Dialogue and Discourse in Clinical Practice*: pp. 3–16. BMA.
- Hornborg, A.-C. (2011) Are we all spiritual? A comparative perspective on the appropriation of a new concept of spirituality. *Journal for the Study of Spirituality*, **1**, 249–68.
- Kavanaugh, K. & Rodriguez, O. (1991) *The Collected Works of St John of the Cross*. Institute of Carmelite Studies.
- Kinsella, E.A. (2006) Constructions of self: ethical overtones in surprising locations. In *The Self in Health and Illness: Patients, Professionals and Narrative Identity* (eds F. Rapport & P. Wainwright): pp. 21–31. Radcliffe.
- Koenig, H.G. (2008) Concerns about measuring ‘spirituality’ in research. *Journal of Nervous and Mental Disease*, **196**, 349–55.
- Lawes, R. (2000) Psychological disorder and the autobiographical impulse in Julian of Norwich, Margery Kempe and Thomas Hoccleve. In *Writing Religious Women: Female Spiritual and Textual Practices in Late Medieval England* (eds D. Renevey & C. Whitehead): pp. 217–43. University of Wales Press.
- Leach, M.M., Aten, J.D., Wade, N.G., *et al* (2009) Noting the importance of spirituality during the clinical intake. In *Spirituality and the Therapeutic Process: A Comprehensive Resource from Intake to Termination* (eds J.D. Aten & M.M. Leach): pp. 75–91. American Psychological Association.
- McCord, G., Gilchrist, V.J., Grossman, S.D., *et al* (2004) Discussing spirituality with patients: a rational and ethical approach. *Annals of Family Medicine*, **2**, 356–61.
- Mental Health Foundation (2002) *Taken Seriously: The Somerset Spirituality Project*. Mental Health Foundation.
- Metz, J.B. (1973) A short apology of narrative. *Concilium*, **9**, 84–96.
- Sremac, S. (2014) Faith, hope, and love. *Practical Theology*, **7**, 34–49.
- Torn, A. (2008) Margery Kempe: madwoman or mystic – a narrative approach to the representation of madness and mysticism in medieval England. In *Narrative and Fiction: An Interdisciplinary Approach* (ed. A. Torn): pp. 79–89. University of Huddersfield.
- Van Wolde, E. (1996) *Stories of the Beginning: Genesis 1–11 and Other Creation Stories*. SCM Press.
- Vankatwyk, P.L. (2008) God-talk in therapeutic conversation. *Journal of Pastoral Care and Counseling*, **62**, 63–70.
- Windeatt, B.A. (ed.) (1994) *The Book of Margery Kempe*. Penguin.
- Woods, A. (2011) The limits of narrative: provocations for the medical humanities. *Medical Humanities*, **37**, 73–8.