

# *Narrative explorations in clinical health psychology*

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This paper documents the author's experience as a clinical psychologist using narrative approaches with people living with diabetes. The paper begins by contrasting narrative and poststructuralist approaches with those of contemporary clinical health psychology, and gives some background on diabetes and the broader challenges this can bring to people's lives. Three narrative practices are then explored in relation to diabetes: externalising conversations, re-authoring conversations, and practices of circulation. This last practice is shown through a number of letters written to the referring community nurse in a regional diabetes service, but also serving as therapeutic documents for the person who consulted with the author.

Keywords: diabetes, externalising conversations, re-authoring conversations, circulation practices, therapeutic documents, narrative therapy, narrative practice

## INTRODUCTION

I work as a clinical psychologist in the National Health Service in England. While my main training was in structuralist therapeutic approaches, I have increasingly been incorporating narrative ideas in my work. A number of narrative practitioners have written about working narratively with those who are dying or are in grief (White, 1989; White & Epston, 1992), and with people with physical illnesses (Epston, 1999, 2001; Shapiro & Ross, 2002; Strong, 1997). I share with these authors a belief in the relevance and importance of a narrative perspective in working with people who live with illness.

In this paper, I explain some of the narrative practices that I have been exploring and highlight some of the resources I have drawn on, as well as offering some reflections on dominant models within contemporary clinical health psychology.

## THE SPIRIT OF NARRATIVE THERAPY AND CONTEMPORARY CLINICAL HEALTH PSYCHOLOGY

Before I discuss some of the specific narrative practices I have been incorporating in my work, I would like to elaborate on my understanding of the general ethos or spirit of narrative therapy that has significantly influenced my approach.

I have found narrative therapy's respectful, non-pathologising stance, which regards people as affected by problems rather than as problems in themselves, and which invites collaboration with people as they re-connect with all manner of skills and ideas about how to negotiate the challenges of life, enormously appealing as a framework for my work as a clinical health psychologist. This approach runs counter to the dominant culture of modern British healthcare, with its increasing emphasis on markets, competition, and economics over humanity, ethics, and compassion. The many ways in which recipients of healthcare can be objectified and dehumanised have been well charted over the years, but a brief story will illustrate the point. Recently, I was asked to see a very unwell woman on the coronary care unit. The previous day, she had been admitted to hospital after an internal defibrillator had given her a 'storm' of powerful electric shocks and she had feared, not unreasonably, for her life. She was terrified this

would happen again, but knew that if she had the device removed, she may die from a cardiac arrest. We were talking about her fears, as confidentially as one is able in a shared ward with only a curtain giving a semblance of privacy, when a nurse came in and, with neither a word nor any eye contact with either of us, stuck a thermometer in the woman's ear, looked at it, then promptly disappeared.

When a person becomes a 'patient', they become subject to the immense power of medicine. Doctors have the power to incarcerate people, to get them to undress, to touch them without asking permission, to make them unconscious, and to cut them open. Critiques of medical models in mental healthcare have a long history, but the dominance of medical models in physical healthcare are even more taken-for-granted. Of course, in contemporary healthcare in the UK, great care is taken to ensure that patients are helped to give informed consent to their treatment but, nonetheless, doctors (and other health professionals to differing extents, including clinical psychologists) are granted an enormous amount of power. It is true to say that people have the right to choose to disregard their doctor and his/her opinions, but there are circumstances where the doctor's say is final – particularly if the patient is deemed to lack the mental capacity to make wise decisions. Indeed, disagreeing with one's doctor is now a DSM IV diagnostic category ('V15.81 Noncompliance with treatment') – and hence inherently pathological (American Psychiatric Association, 1994). The 'patient' is characterised as 'other' – separate from the rest of us, and certainly separate from the healthcare professional. The category 'patient' is then subdivided into 'good' and 'bad' patients. Many of the people referred to me would be ascribed the latter label – they have generally failed to live up to the normalising specifications of what makes a 'good patient' (passivity, obedience, and so on) and are therefore marginalised, discounted, and in many ways significantly oppressed, particularly through labelling of them as 'difficult', 'resistant', or worse.

A number of narrative practitioners provide guidance in standing against the potentially pathologising practices of modern medicine and its bedfellow: contemporary clinical health psychology. Kaethe Weingarten, for example, drawing heavily on some of the ideas of Arthur Frank, writes movingly

of the importance above all else to bear witness to the stories people tell when affected by physical illness, to tolerate these stories, to honour them, and to try to help people make some kind of sense of them (Weingarten, 2001). Likewise, Miranda Worthen (2001) reflects on the complexity of developing identity in the context of uncertain physical health status, highlighting also the coexistence of different stories of identity – stories of physical pain and anxiety alongside physical joy and sexual self-expression. Her writing calls further into question the simplistic notions that have considerable currency in contemporary clinical health psychology about ‘adjustment to illness’, which, she suggests instead, is never complete – but always a dynamic, relational process of foregrounding and backgrounding. Similar expert notions such as ‘appropriate pacing’, ‘maladaptive coping strategies’, or ‘denial’ and ‘avoidance’ – applied particularly when people behave in ways that are inconsistent with the ‘reality’ (i.e., the professional ‘truth’) of their situation – are located firmly in the ‘good/bad patient’ dichotomies that can be so oppressive and unhelpful for those faced with a significant and unsettling health threat. Traditional clinical health psychology, so complicit with broader biomedical discourse, has produced countless continua and categories for adjudging people as failing to be good patients, or failing to ‘manage’ their illness. Clinical health psychology, in its current enthusiasm for cognitive-behavioural therapy (CBT), focuses overwhelmingly on the individual and models its ethical framework on medicine, with knowledgeable experts applying science to help misguided or otherwise disordered non-experts.

For me, narrative therapy provides a compelling alternative to the dominant discourses within clinical health psychology. I shall next describe some of the narrative practices that I have incorporated in my work with people with diabetes, and provide a brief account of a specific piece of work.

## DIABETES

First, I need to say a little about diabetes itself, though with the caveat that what follows is highly simplified. Before I started this work, I had a very inaccurate idea of what diabetes was. I thought people with diabetes needed to eat less sugar and

take insulin, or they would have an increased risk of getting heart disease in later life – maybe in their 60s rather than their 70s. I did not think it was a very serious condition. I was wrong.

Diabetes is an incurable condition characterised by inadequate or absent production of insulin by the pancreas. Insulin production regulates the sugar in the blood. Too little sugar and people can go ‘hypo’, which can be a very frightening (and potentially fatal) experience. Too much sugar in the short term and they run the risk of diabetic ketoacidosis (DKA – where the blood turns acidic, inducing a coma, which again can be fatal); too much sugar in the long term can cause a number of progressive complications which can result in blindness, renal failure, amputations, and premature death from cardiovascular disease. From the day of diagnosis, the life of a person with diabetes is complicated by the need to take action to avoid these extremes of too much or too little sugar in the blood. The actions required can be significant and intrusive – taking medication, injecting insulin, pricking the fingers and testing blood glucose levels (all potentially several times a day, every day), as well as eating a restrictive diet and taking care to exercise regularly.

Many of the people I see in my work have Type 1 diabetes, which generally means that their pancreas stopped producing any insulin quite early in life, and as such they may have grown up through later childhood and their teens having to balance insulin injections and watching what they eat with all the other myriad challenges of growing up. Diabetes forces itself onto the agenda, whether people want it to or not. Diabetes stories come to contribute to the stock of stories that people have about themselves – sometimes in positive ways (such as stories about competence and overcoming difficulties), but more often in my experience in more negative ways, particularly stories about ‘poor control’.

This is not always the case, though – it is important to note that I see only a small proportion of the people in Bradford who have diabetes – many people with diabetes successfully find a balance of managing to keep their sugar under control, and get on with living their lives. Public figures who are ‘sparkling exceptions’ to the general problem-saturated stories about diabetes, include Steven Redgrave, the multi-gold-winning Olympic athlete and Halle Berry, the Hollywood actor.

## PSYCHOLOGY AND DIABETES CARE

There is increasing recognition of the importance of psychological and behavioural factors in diabetes care. However, this recognition is firmly located within modernist traditions of thought which characterise people with diabetes as logical, rational beings who simply need to be given the correct information in order to self-manage effectively. One consequence of this can be that those who do not do as they are instructed cause great bewilderment and frustration to the health professionals charged with their care. These professionals can often become very genuinely concerned about the effects of non-adherence on their patients' bodies. (I use the word 'patient' with some hesitation, cognisant of the fact that it is not a neutral term, and only one of many social identities.)

One common response by healthcare professionals is to invoke fear in their patients – though in my experience (and according to a large body of research literature) this seldom works, and seems more likely to strain or even rupture the relationship between healthcare provider and patient. The bewilderment at some people's failure to adhere to treatment plans despite being both given the right information, including being told in no uncertain terms what will happen if they don't adhere, can lead to conjecture about the person's formative experiences, or core self, or 'deeper motivations' (in line with dominant narratives of psychopathology) and to pejorative and very negative conclusions about the identities of these people. 'Poor control' can come to be applied in a more totalising way than simply in reference to blood sugars, and this construction of the person with diabetes can be hazardous both to the quality of the relationship between health professional and patient, and to the physical and emotional well-being of the person with diabetes. In my experience, a number of narrative practices can provide an alternative or additional framework for 'helping people with diabetes to help themselves', and I shall consider these next.

## DIABETES STORIES AND NARRATIVE PRACTICES

People who come to see me tell me a variety of *stories* about themselves and their lives: whether I ask about 'cognitions', or 'emotions', or 'physical

experiences', or 'behaviours', what I will get back is always in the form of stories, whether I choose to construe them as such or not. And, as people tell me all kinds of stories about relationships, loss, trauma, and so on, I will often adopt narrative ways of working in these conversations. Indeed, some people never seem to want to talk about diabetes at all, and I take my lead from them. The stories I shall focus on here, though, are the diabetes stories.

## MAPPING THE EFFECTS OF THE PROBLEM AND EXTERNALISING CONVERSATIONS

Often I use the 'statement of position map 1' as my guide to these conversations (White, 2007). Prompted by my questions, the person provides an experience-near description of the problem, gives it a name, and evaluates its effects on them and their lives. Many of the people who come to see me have high average blood sugars. In general, they tell stories of the effects of this on them, in terms of how this can make them feel physically (lousy, lethargic), what effects it can have on their relationships (often negative due to the 'snappiness', and difficult interactions around 'control'), and their feelings (often despondency, hopelessness, sadness, anger, or worry).

In my initial engagement with narrative ideas, I hadn't appreciated the de-centred role of the therapist – I was used to working in other more expert ways where I regarded the naming of certain experiences (such as 'panic attacks') to be my responsibility, based on my knowledge about general theories of psychological distress. As a result, I assumed that 'diabetes' was the problem for the people who came to see me, and had a number of conversations that did not seem to have the effects I was hoping for.

As I have stepped back from this role and asked my clients to describe and name their problem for themselves, these conversations have gone rather better: some people have still named 'diabetes' as the problem; some have been more specific with 'unmanaged diabetes/sugar levels' or 'high sugars'; some have identified a broader lifestyle problem, such as 'a putting others first lifestyle', or a 'self-harming lifestyle' or 'gonna-do'. One person in particular described at length the many ways in which high blood sugar levels were

having a negative impact on her life, including some quite serious complications such as visual problems, peripheral and cardiac pain, but then did not evaluate her diabetic control as a problem. Instead, she kept her control deliberately high to avoid the 'hypos' which she regarded as the principal problem as these were physically disturbingly reminiscent of the panic attacks that affected her, following being raped as a child. For her, the various physical problems were an acceptable trade-off.

These developments in my explorations of externalising conversations have attenuated my initial reservations about this 'technique' – a lot of which were based on my early readings of narrative therapy with children and families. I could not see my clients – down-to-earth, no-nonsense folk from the north of England – responding well to externalising conversations along the lines of 'monster-taming' or 'sneaky poos'! These ways of talking seemed too distant from the discursive world of my clients; the playful tone of them too far from the seriousness of the subject matter. As I have continued to explore these ideas though, the more subtle externalising practices such as the 'nounification' of problems, or the use of prefixes such as '*this sense/feeling/idea of x*' have sat much more comfortably with both my clients and my preferred ways of working – though some clients have surprised me with their own personification/characterisation of diabetes. Two papers on community narrative projects, one focusing on diabetes and the other HIV/AIDS, invited me to reflect on the dominant assumption within the therapy world of the need for serious conversations about serious issues – I was struck by the very playful nature of the personification of these very serious conditions (Sliep, 1996; Wingard, 1996). These reflections opened room in my conversations with people who are ill, to metaphors and personification – diabetes as an annoying friend; or demanding child who, the more you try and ignore them, the more they increase their demands for attention; or someone whose intentions for one's life are counter to one's own. Recently, a member of a group I co-facilitated for people living with diabetes talked about her insulin pump in an innovative personified way – as a 'Tamagotchi' that bleeps when it needs attention.

As I have become more accustomed to ways of

externalising that fit with me and my clients, it has come to feel less of a 'technique' and more of a comfortable way of talking about problems. And, as was pointed out to me recently, using internalising language is a technique too! Nonetheless, though, I do not always engage in externalising conversations. My concern is to avoid contributing to conversations in ways that blame, invalidate, or oppress the people I work with, and particularly (and following White, 1995) to oppose totalising, negative, biomedical descriptions of people as 'poorly-controlled diabetics'. I agree with other authors, though, that externalising conversations are not the only way to achieve this (such as O'Hanlon, 1993).

## RE-AUTHORING CONVERSATIONS

Many of the people referred to see me have a whole host of stories that map the effects of diabetes on their lives. For the people who consult me, it seems as though there is very little in life that diabetes does not affect in some way and, for many of them, it seems to have pretty much taken over their lives. I often find myself in conversations about the reclamation of some of their life from the effects of diabetes. Often, in these conversations, I have in my mind's eye the diagram from Alice Morgan's *What is narrative therapy?* depicting the many events of a person's life, the events that constitute the dominant story of their life, and the many events that don't make this final edit (Morgan, 2000, p.7). This image reminds me to listen out for unique outcomes or initiatives – exceptions to the dominant story that tends to be about not engaging with diabetes self-management, not injecting insulin, eating and drinking the 'wrong' things, not attending appointments with healthcare professionals, going into hospital with frightening and serious complications, and so on. Often, these dominant stories centre on relational aspects of diabetes – other people not caring, being too controlling, or not acknowledging the expertise of the person with diabetes. Sometimes these stories can be about resistance to or rejection of diabetes and its adverse effects.

I have yet to meet anyone, however, whose life has been entirely taken over by these problematic stories. Even people who have shown remarkable tenacity in resisting efforts to persuade, cajole, and scare them into taking their insulin; or considerable

physical durability in surviving repeated emergency admissions from the consequences of chronically high blood sugars, tell of exceptions to the dominant stories if I listen out for them. Almost by definition, if they are well enough to come and meet with me, they must be taking some kind of action to keep themselves alive. Often, these people have a lot of skills in taking just enough insulin to keep themselves out of ICU (the intensive care unit) for example, or do actually go through periods of time when they will make a tremendous effort to manage their blood glucose, often with some success. For some people, these may be stories from long ago, but they are like openings to another world, or hyperlinks to another webpage. And, once attended to, they can provide all kinds of new ways of understanding the present and guidance for the future.

I have found Michael White's idea of intentional rather than internal state psychology useful in these conversations (White, 2007, pp.100-106) – asking questions about people's motivations for and understandings of these exceptions to the dominant story; what they say about what is important to them or what they value; what they were hoping for when they did x; and how these actions fit in with wider life projects. In my experience, quite simple questions about an occasion when a person took their insulin perfectly for a whole week, against a background of taking it very irregularly, has often led to uncharted and quite unpredictable conversational territory about plans for life: getting jobs, helping out other family members, or taking a stand against oppression in various ways. Thickening these storylines through further exploration and circulation then follows.

## **SPREADING THE ALTERNATIVE STORY**

My main method of circulating these alternative stories about people with diabetes is through the use of letters, although I also do what I can to circulate the alternative storylines verbally with the staff I work with: the admin staff, the medical and the nursing staff. Protocol in our service is that letters are sent to the referrer and copied to the person's GP and any other health professional. In recent years, there has been a drive to include the person with diabetes as a recipient of these letters. Some colleagues have expressed reservations about

this practice. In my opinion, however, this is an opportunity not to be missed. I write letters addressed to the referrer, but essentially to the person with diabetes. My letters are often very informal and tell the story of the conversations so far – hoping to strike a balance between acknowledging and honouring the problem, and highlighting the initiatives the person has taken in their efforts to free themselves from the effects of the problem.

The aim of these letters is to contribute to more hopeful stories about the person with diabetes. Sometimes these letters seem to have little effect. Often, though, people report that these letters are very helpful or sustaining. Never has anyone told me that they have had a negative or counterproductive effect. Frequently, people will say they showed the letter to other people in their lives, and that this was a positive experience for them, leading to further conversations. I always check out what makes the final edit of the letters with the person before I send it, and in some cases write the letter completely in session with them and we both sign it. The experience of contributing to formal letters that are then filed away in an official medical file, is often an empowering one for the people I work with. I have been particularly influenced in this practice by Sue Mann's paper where she describes collaborating with 'patients' in co-authoring the stories about them in their medical notes (Mann, 2001).

I shall now illustrate some of the above points with some letters from my meetings with Matt, who has kindly given his consent for me to share his story. I have edited out only the more personally identifiable content, and changed the names of all concerned.

## **MATT**

Matt was referred to me by Sue, one of the Community Nurses in the Bradford Diabetes Service:

*Please could you see this twenty-two-year-old lad who has had Type 1 diabetes for the last eleven years. He is finding his diabetes very difficult to come to terms with in terms of controlling his condition and the subsequent loss of temper control he experiences. States he is*

*taking things out on his family and friends and that this is just not his natural behaviour.*

Matt came to see me in December 2007. He had never been in paid employment, and lived a largely nocturnal lifestyle. Matt lived in one of the more socio-economically deprived areas of the city with his father who was on long-term disability benefit due to diabetes-related illnesses. Matt was very powerfully influenced by the story that having diabetes means you are permanently disabled, and that there is nothing you can do about this.

He described how his diabetes control had been good for the first few years but, when he reached fifteen or sixteen, he started to miss injections and stopped testing. He said this situation had continued pretty much to the present day. He said he was taking up to two-thirds of the injections he was supposed to. He had had a falling out with the staff at the hospital diabetes unit, and had been discharged from their caseload. He was feeling very

aggrieved at having been ‘unfairly dismissed’ by the hospital staff who he said had accused him of missing appointments and lying about it. He said he was sick of other people, both in his family and healthcare staff, ‘knowing best’ with regard to his diabetes and his life. The reference to his temper in the referral letter pertained to an incident on the ward where he had punched a doctor who was trying to take some blood from him. This ward admission was one of several for DKA – a potentially very dangerous consequence of not taking insulin for extended periods of time, indeed the leading cause of death for young people with diabetes.

Below are a number of letters I wrote to Matt over the nine months that I saw him, all of which I copied to Matt and his GP. (Please note that ‘HbA1c’ is a measure of average blood sugar for which the recommended range is 4.5–7.5%. Each 0.5% increase in HbA1c above this level *doubles* the risk of diabetes-related complications.)

## Letter 1

*Dear Sue,*

*Thank you for referring Matt to psychology for assessment. Matt agreed to me writing you a letter to keep you updated about our conversations so far.*

*Matt has made good use of our sessions so far, telling me how his diabetes is having all kinds of adverse effects on his life and his relationships. Matt is very clear that he has had enough of this situation. He told me that in the past he had an HbA1c of 18% – his most recent was 10.9%. We discussed how he has managed to achieve this and he has talked about:*

- taking insulin the great majority of the time now, where previously he missed it more frequently*
- eating healthily – certainly avoiding obviously sugary foods, and increasingly being aware of the ‘hidden sugar’ in a lot of food, particularly processed food*

- drinking diet drinks*
- monitoring his blood glucose and keeping a record of the results (though he mentioned that he may need a new meter as the ‘time/date’ setting on his current one is incorrect and he is unclear how to reset it)*
- keeping an eye on his ketone levels – indeed it was his recent self-testing that initiated his last admission to hospital.*

*Matt clearly has a lot of knowledge about diabetes self-management, and what works for him. He is committed to trying to continue with improving his diabetes control, and is positive about the input he has had from you so far. Better diabetes control fits in with a number of his wider goals in life, such as getting and staying healthy; getting some kind of work, ideally in some way connected to football*

coaching; becoming more involved in the lives of his sister's children; and visiting his grandfather in Scotland and his auntie in the north-east.

Matt has two close friends, Gaz and Lori, both are aware of his diabetes, what he needs to do to get control of it, and the reasons why this is so important – they sound like good allies in Matt's quest to get back on track with his diabetes.

We have agreed to keep meeting to continue looking at how he can get in control of his diabetes, rather than have his diabetes control

him. There are some barriers to be overcome, particularly Matt's current sleep pattern at the moment which is causing some problems with the timing of eating and injecting but, from our conversations so far, I have no doubt that Matt has the skills, commitment and support to succeed with this.

I shall keep you updated with our progress – please feel free to contact me at the above address if you would like to discuss this further.

Kind regards,

Rob.

## Letter 2

Dear Sue,

Further to my previous letter, I am writing to update you on my contact with Matt.

I have now seen Matt five times, which he has used to update me on his ongoing efforts to reclaim his life from the effects of diabetes.

A sign of Matt's considerable commitment to getting the diabetes under control is the work he puts into recording his injections, blood sugars, diet, hypos, etc. These are a great resource for him (and all others involved) to be able to see what is working, what is not, and to respond accordingly. Also, they make visible the very positive effects of the work he is putting in.

His 'hit-rate' for his injections continues to improve, and he is testing several times a day – these efforts can only help him get his sugars down to safer, more stable levels where he can avoid both hypos and the ketotic episodes. At our last session, Matt told me he has started on a new insulin regime which at that point he was managing without difficulty. We discussed that this new regime was more flexible and gave him more control – particularly in the context of his nocturnal lifestyle: i.e. that he could take his

insulin according to when he ate, rather than his mealtimes having to fit around his insulin.

Matt told me at our last session the story of when he was first diagnosed at age 11, and how, even at that young age, and despite the shock of being given the diagnosis, he decided that if he was going to have to take injections he may as well learn to do them himself as soon as he could and just got on with it, despite the pain and unpleasantness.

I feel that Matt is re-connecting with this spirit of 'getting on with it', and rediscovering the skills he has in organising himself, committing to things and following them through, seeking help as and when he needs it, and not allowing discouragement to take over when things don't go quite as hoped.

We have agreed to keep meeting for now; our next appointment is on 19 May at 4 pm. Please feel free to get in touch if you wish to discuss matters further.

Kind regards

Rob.

### Letter 3

Dear Sue,

Just a quick update on Matt's most recent achievements:

#### **Mastering his diabetes:**

- No hospital admissions for DKA since New Year's Eve
- Maintaining a healthy diet
- Testing several times a day – up from 3 or 4 a week to 6 or 7 a day
- Injecting insulin regularly – up from 3 or 4 a week to 3 to 5 a day
- No embarrassment about injecting in public.

HbA1c now 7.4% as a result – down from 10.9% on referral and an all-time low!

#### **Conquering his fear of dentistry**

He has arranged an appointment with the dental surgeons to discuss his forthcoming extractions and abscess treatment and is determined to follow this through.

Matt attributes these successes in part to his own change of attitude to diabetes in particular and looking after his health in general: he called it 'Recovery from being an idiot!' This change in attitude has enabled him to keep going with the hard work that underpins the successes outlined above. Also, he has mentioned your role in helping him – he has really appreciated your genuine understanding of the challenges of living with diabetes.

In view of Matt's achievements, I have asked him to join my 'Experience Consultants Register' – a list of people I am putting together who can act as expert advisors to join me in trying to help others struggling to master their own diabetes. I am pleased to say Matt has given his consent to be on the register.

I do not imagine I shall need to have much more contact with Matt, but I shall keep you updated.

Kind regards,

Rob.

### Letter 4

Dear Sue,

I am writing to update you on my contact with Matt who came to see me last week.

Matt had been having a difficult time recently: undergoing an assessment of his need for disability benefits, going to see the dentist about the extractions he needs, and also supporting his younger brother who was badly beaten up. Understandably, in the context of all this stress, Matt said he had not managed to test his sugars as often as in recent months. I wondered what it said about him that, despite all of these stressors, he had managed to continue:

- Injecting several times a day, using the sliding scale

- Testing his sugars at least twice a day
- Writing all of this down in his record book.

Matt said that these efforts to get his diabetes under control are part of a longer-term plan. He says he now has his disability payments secure until February 2010, and says that by then he wants to be living a life where diabetes is under control and causing him no problems. By this stage, he says he wants to be well enough to work – his plan is to start working his way up through the levels of being a football coach, which is his ultimate aim. He also said that, once he has his diabetes under control, he will feel confident enough to travel abroad

*(something he has never done) – particularly to watch football at some of the great stadiums of the world – the Bernabeu, the San Siro, etc. Matt said that these longer-term goals fitted with his appreciation that ‘you only get one life’, and that ‘unless you are positive, you will never achieve anything’.*

*We reflected too on the importance of taking some time to notice the progress he is making. For example, in our session, we needed to take a step back to notice that over recent months he is gradually experiencing fewer and fewer hypos. We wondered about the emphasis in diabetes care on what people can do better, rather than appreciating how far people have come – as I think he has also with you, Sue. We discussed the idea of ‘Perfection’ in diabetes management,*

*and how discouraging it can be. Matt had written in his book:*

*A wise old man said ‘Try to be Good,  
Don’t try to be Perfect;  
Diabetes lasts a lifetime,  
Perfection only lasts a moment’.*

*We also talked about my leaving Bradford, and whether Matt would like to continue seeing a psychologist for continued support with achieving his goals. Matt said he would, so I have referred him to my colleague Caroline Knott, Counselling Psychologist, who will send him an appointment over the next few weeks.*

*I have thoroughly enjoyed working with Matt and wish him every success with his plans.*

*Kind regards,  
Rob.*

## FINAL THOUGHTS

Increasingly, I see my primary task as co-authoring illness stories with the people who consult me. Sometimes, as in a chronic illness like diabetes, these stories can be long-established, sedimented stories that totalise, oppress, and marginalise, and my role as a therapist is to explore and thicken more hopeful and more empowering alternatives. Hopefully, this paper has demonstrated that, with these kinds of problem-saturated illness stories, narrative therapy can be easily and appropriately applied.

At other times, though, certain approaches will be inappropriate; at times when people have experienced traumas that have come utterly out of the blue (such as a heart attack), or are preparing for yet more trauma (i.e. heart surgery), long-term problem-saturated narratives may not have yet been established, and it behoves the therapist to provide a context for the telling and receiving of stories, however dreadful, terrifying, incoherent, or rambling. It is at these times that the spirit or the central values of narrative therapy are so vital in guiding this listening and this story co-construction.

Whatever I am doing in my role as a clinical health psychologist – individual sessions, case

discussions, writing letters, or even neuropsychological reports – my guiding principle is to maintain an awareness of the kinds of stories about people I am contributing to and circulating, and to do what I can to ensure that they offer some hope: that they represent people in ways that are respectful, collaborative, and non-oppressive. I have found the ideas and practices of narrative therapy to provide comprehensive guidance and great sustenance to me in my work with people who live with illness. I look forward to continuing my explorations.

## UPDATE

In preparing this paper for publication, I contacted Matt to double-check he was still okay with me publishing his letters. He said he was and told me his successes in living with diabetes has continued. He had in the end decided to decline further psychology input, feeling confident of his ability to manage with the other support he had. He said there were of course still difficulties with his diabetes management, which he described as an ongoing battle, but he said that when we first met things were 20% Good and 80% Bad; now they are 60% Good and 40% Bad. He told me his most

recent HbA1c was 7.6% and had recently been reflecting with Sue that he has had no further inpatient admissions since we met. Thanks again to Matt for allowing me to share the story of our work together.

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