Narrative Formulation Revisited: On Seeing the Person in Mental Health Recovery

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The use of narrative in mental health contexts models consciousness as something necessarily embodied, as already part of the world, in an inherently value-laden and perspectival way (Bergqvist 2021). As such narrative presents a powerful tool for critical re-assessment and re-evaluation of preconceived ideas in relating to difficult concepts in clinical interactions.

Narrative structures can reveal psychological differences between persons in a way that matters for the provision of effective treatment and management. As emphasised by Solomon (2015), narrative reasoning is also motivated by distinctly first-personal concerns that are operative in the practitioner-client *relationship*. I maintain that the dynamics of that interpersonal relationship are part and parcel of what it means to address the patient's needs to be seen *as* a person in humanistic empathetic care – without thereby reducing truth to an individual person's perspective to encourage positive transformation.[1]

The notion of empowering narratives to encourage positive change is a central concept behind the emphasis on the critical role of empathy in explaining human development and psychoanalytic change within the self-psychology tradition but is also key to recovery-based models of the significance of person-centred *quality of life* in medicine more generally. This is defined in mental health as recovering a good quality of life as determined by the values of (by what matters or is important to) the individual concerned (Allott et al., 2002; Fulford, 1989, 2004, 2012). The importance of strengths in this regard was reflected for example in the UK government programme on values-based mental health assessment. The *3 Keys* programme, as it was called (National Institute for Mental Health in England, NIMHE, and the Care Services Improvement Partnership, 2008[2]) identified three shared 'keys' to good practice in mental health assessment: three things that were identified in a wide-ranging consultation as being

[1] Here I side with Goldie (2012) and Solomon (2015), who warn against confusing the notion of autographical narrative (clinical or otherwise) with its intentional object.

[2] A copy of the full report is available at valuesbasedpractice.org/More about VBP/Fulltext downloads

important alike by health professionals of all kinds and by 'service users' thus understood as patients and carers (Fulford 2015a, 2015b). The third of these keys was defined in the subsequently published Good Practice Guidance, as 'a person-centred focus that builds on the *strengths, resiliencies and aspirations* of the individual service user as well as identifying his or her needs and challenges' (NIMHE 2008: 6); and the guidance included a number of real-life case examples of best recovery practice reflecting this aspect of mental health care (Slade et al., 2014).

What my (Bergqvist 2018, 2020, 2022, forthcoming) account adds to this claim is that while such choices are revelatory or expressive of a distinctly first-personal stance, they do not constitute or determine self-hood and self-interpretation in a fixed way. And the reason is that one can also adopt a second-personal stance on one's own experience and address oneself, where the relationship between the first- and the second-personal narrative perspective *on* experience and self-understanding is itself a dynamic and open-ended evaluative process.

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