A first person principle:

Philosophical reflections on narrative practice within a mainstream psychiatric service for young people

by Philippa Byers and David Newman

Philippa is working at the Plunkett Centre for Ethics (Australian Catholic University and St Vincent's Health, Australia) and teaching moral philosophy and applied moral philosophy at the Australian Catholic University. She has recently completed a social work qualification at The University of Sydney. Philippa can be contacted by email at: Philippa.Byers@acu.edu.au

David is a member of the Dulwich Centre faculty and an Honorary Clinical Fellow at Melbourne University's School of Social Work. He works in Sydney in independent practice at Sydney Narrative Therapy as well as in 'Uspace', a psychiatric unit for young people. David can be contacted by email at: david@sydneynarrativetherapy.com.au

Abstract

This paper is a collaboration between David Newman, an experienced narrative therapy practitioner and teacher, and Philippa Byers, a narrative therapy student with an academic background in philosophy. The paper charts ideas developed during Philippa's student placement with David, as they discussed narrative practice, other mental health practices and philosophy. The paper draws on philosophy of language and the philosophy of Paul Ricoeur, applying this to Michael White's injunction to look (and listen) for the experience-near in the words and phrases that are offered to narrative therapists. It offers philosophical reflections on an ethical principle of narrative practice which Philippa and David call a first person principle. The first person principle is elaborated in a discussion of David's narrative practice with young people. This offers philosophical and practical insights to some of the issues and questions that may arise for narrative therapists who, like David, practice within mainstream services, encountering 'neuro' and other professionalised discourses and accompanying expectations.

Key words: ethics, philosophy of language, Paul Ricoeur, neuro discourse, narrative therapy, gratitude, decentred practice, first person principle

Introduction

This paper is a collaboration between Philippa, a social work student with a background in philosophy, and David, an experienced narrative therapy practitioner with an interest in developing ideas and resources for narrative practice from new sources. Working with young people in creative ways has been a focus of David's practice over many years. The central theme of the paper is a philosophical and practical investigation of a principle within, or for, narrative practice that we call a *first person principle*. We summarise this practice principle as follows:

> As a narrative therapist speaks with an individual, they attend to what is offered as 'mine' in the first person speech they hear, and they also recognise and respect the distinctive authority that accompanies thoughts, actions, observations, descriptions, hopes and feelings that are offered as 'one's' own or as 'mine'. A narrative therapist then places a practice limit on their own speech, and their own authority: They are guided by the terms and phrases they hear, and do not substitute them with alternative terms and phrases from professional discourses.

The first half of the paper contains Philippa's observations of David's narrative therapy practice, from her perspective as a learner or beginner in narrative practice. This section also explains the first person principle in more detail, arising from philosophical ideas that came to mind as Philippa attempted to make sense of the differences between David's narrative practice and other mental health practices within a hospital setting.

In the second half of the paper, David reflects on the first person principle and describes some practice examples. This includes discussion of a distinction between personal and impersonal discourses, with specific reference to the increasing use of neuroscience discourse within therapeutic settings and in therapeutic conversations. There is discussion of the first person principle applied in narrative practice with the written word. And a discussion of how the principle assists in bringing distinctive meanings and insights to light, in contrast to a focus on types of mental illness and brain disorder as the primary causes of a young person's pain or distress.

David's reflections may be useful for other narrative therapists working within the mainstream psychiatric services where, as this paper suggests, the practice of narrative therapy may appear to lack the professional authority of other approaches. We believe the first person principle can be employed as a form of resistance to professionalised, and at times impersonal, discourses. And, as we hope will be clear to readers of Michael White's work, the paper is also a sustained reflection on his injunction to seek and retrieve words, phrases and meanings that are *experience-near* (White, 2007, p. 40) or *decentred* (White, 1997, p. 200).

Part 1—From Philippa

Developing a philosophical sense of David's practice

I recently undertook a student placement at a mental health service for young people within a hospital and was supervised by David Newman who is an experienced social worker and a dedicated narrative therapy practitioner and teacher. Although the practice of narrative therapy was new to me, philosophical ideas about narrative were not. I've previously studied and taught philosophy, with a focus on moral philosophy and theories of identity and agency. While I observed David's practice and talked with him about narrative therapy and working with young people, ideas from philosophy of language and Paul Ricoeur's seminal work on narrative identity and temporality often came to mind.[1]

I was new to the field of mental health and to hospital settings, and was trying to figure out who was who, and who did what. I attempted to grasp the 'why' of what gets done, and to find out about professional hierarchies and treatment priorities. I was very curious about how a narrative therapy practice fits within a multidisciplinary, mainstream psychiatric service, particularly when diagnostic categories and psychological therapies are given considerable priority. During this time, I also read some of David's work, and some of the early work on narrative therapy by Michael White and others.[2]

As time went on, I noticed that David's therapeutic skills with young people were highly valued by his hospital co-workers. However, I also wondered whether others understood that a distinctive discipline shaped those skills. Perhaps personal gifts are drawn on when working with people who are in pain. And among those with such gifts, my guess is that David would rate very highly. But I did wonder whether his narrative therapy practice was perhaps interpreted in terms of a personal style or a personal gift, and not recognised as a distinctive and disciplined practice with (what seemed to me) an ethical imperative or principle.

I initially wrote a version of this reflection to unpack the differences between David's practice and other mainstream approaches, and as a means to orient myself as a 'would-be' social worker. I was seeking an approach I could endorse in philosophical and ethical terms, and thought that David's narrative practice, specifically its distinction from other approaches, might provide a clue. David and I then discussed and reworked these written ideas and considered how to apply them in practice. This section of the paper is on the preliminary ideas, David's section later in the paper brings them to light in discussions of his practice with young people.

In my view, narrative therapy is not just one more branch of empirically based psychology.[3] I believe it to be a distinctive and disciplined practice, rather than a 'soft' or unscientific version of psychology. As I thought and wrote about the differences between narrative therapy and empirically based mental health practices, I also considered parallels between ideas in philosophy and what I was observing in David's practice.

I claim no expertise here, but it seems to me that psychiatry and clinical psychology claim or acquire legitimacy from their status as empirical sciences and that the two broad fields share some overarching commitments. These are: (i) to identify the possible causes of mental distress; (ii) to devise therapeutic interventions that counteract the effects of possible antecedent causes; (iii) to generalise from a number of specific instances to larger populations; (iv) to make predictions about the likelihood of specific effects arising from specific causes, and the likely efficacy of interventions. In contrast, it seems to me that narrative therapy does not characterise problems in the same terms, that is, in terms of causes and effects. And it does not draw inferences from small groups to larger populations of human 'subjects.'[4] This is a quick characterisation, and I acknowledge that the idea of 'cause' is not necessarily taken for granted in psychiatry and psychology, nor are the distinctions and interrelations between causes, correlations, influences and consequences.

Nonetheless, these thoughts did raise some questions: If narrative therapy does not identify antecedent causes of mental distress, what is its legitimacy as a therapeutic practice? Without a commitment to antecedent causes, from where, or on what basis, does narrative therapy devise therapeutic interventions? If narrative therapy does not specify norms of health or function, what does narrative therapy aim at in assisting people?

When I posed these questions to David, his usual response was to say that he saw his role within the service as privileging the knowledge of young people by 'retrieving' the words and phrases that they use to convey their own experience, and their quite specific and often unseen efforts to deal with the problems they face.

The retrieval and privileging of first person speech

On a number of occasions, I observed – or heard – the retrieval of distinctive words and phrases as David spoke with young people. Reflecting on what seemed to be David's insistence on retrieving the words and phrases of young people led me to think about ideas concerning first person speech, as discussed in philosophy of language. I then connected these ideas to several ideas in Ricoeur's work and in early phenomenological philosophy.

I'll begin with first person speech. First person speech, involving the first person referent – 'I' – is distinct in a number of ways, some more obvious than others, from second-person speech addressing 'you', and third-person speech in which 'they' are spoken of. Although I won't properly elaborate the point here, these three modes of address are more than convenient ways to identify who is being referred to when someone speaks. I suggest the differences between these modes of address are 'lived' or deeply experienced.[5]

There is a distinct phenomenological quality – a characteristic 'mineness' as Ricoeur would say – that is bound up with first person speech.[6] There is a specific 'something' that it is 'like' to refer to oneself in the first person, to narrate one's actions, experiences, thoughts and feelings with words such as 'I', 'my', 'mine', 'me' and 'myself'.

The phenomenological quality of first person speech – as 'mine' – is connected to a specific kind of authority. This is the authority that goes with being the person who is uniquely placed to narrate actions, experiences, thoughts and feelings as one's own, as 'mine'. Although it is related, the authority of first person speech is not the same as truthfulness. We can be mistaken in our first person claims, say, when memory fails us, and we can intentionally mislead when speaking about our thoughts, intentions, actions and feelings.

The authority of first person speech and, by extension, of first person narratives, is raised in a debate that starts

with Wittgenstein, about whether self-referring speech has an 'immunity to error through misidentification'.[7] We have a strong presumption that first person speech is immune to mistakes of identification, and thus of reference. When I speak in the first person, I don't need to check whether or not the person I refer to as 'I' is, in fact, me. When I say 'I', the referent of this term is invariably me.

While the 'immunity to error through misidentification' of self-referring speech is a related philosophical issue, my concern here is the *experience* of first personal authority. This is the experience that accompanies being uniquely placed to narrate one's own actions, experiences, thoughts, hopes and feelings. Others can narrate my actions, experiences, thoughts and feelings, but their words have a different sense and a different form of authority; they do not have first personal authority as they lack the lived experience that first person speech uniquely communicates.[8]

What I observed in David's practice was a stance of accepting and giving priority to the words of young people, and their descriptions of their experience. Their words and their descriptions were accepted and prioritised as uniquely authoritative in the first personal sense I've just described. Reflecting on this brought to mind a foundational idea in early phenomenology, which is that experience is the ground and returning point of philosophical investigation.[9] To put this another way, experience is not investigated philosophically to get to deeper forms of truth beyond or underlying experience; for phenomenology, the purpose of carefully describing experience is to show how meaning arises for a person out of their experience.[10]

As I observed David's work 'retrieving' and then 'privileging' the words and phrases of young people, I wondered whether the therapeutic effect of such conversations may stem from words and phrases being credited as authoritative, along with the agency and experience of agency that accompany speaking authoritatively about one's experiences. This may seem like a small point, or one so obvious it requires no special skills within a therapeutic setting such as a mainstream psychiatric service. But I think this would be a mistake.

At one point, David commented on his hope for young people: that they leave the psychiatric service having some 'experience of themselves as *knowledged*'. If I understood him correctly, I venture that components of the experience David hopes for young people are: (i) that they experience their own words as authoritative, from their perspective and that of others; (ii) that they experience their voice as an exercise of first personal agency.

This seems particularly important when mental health issues are often experienced as something that is happening *to* 'me' over which there is little control, and when hospitalisation and confinement are overwhelming experiences in and of themselves. What I observed in David's practice was that rather than focusing directly on gaining control when there seemed to be little, David used conversation and, moreover, listening, to provide opportunities for words to be acknowledged as authoritative and prized as expressions of worth and agency. I suggest that within a mainstream psychiatric service this is no small thing.

A first person principle in narrative practice

On first acquaintance, David's distinctive questioning and listening when talking with young people seemed modest and low key. But what became clear over time, as I became more familiar with it and thus could observe it more closely, was a strict discipline. And although David didn't use the term 'first person', he noticed and pointed out to me whenever I inadvertently reinterpreted a young person's words by using terms that were removed from the words that they had used, particularly where the effect of so doing was to redescribe or reinterpret their words, as if mine were more authoritative. David had a heightened sense of this distinction.

If I were to distil the discipline I observed in David's practice in terms of a single principle, I would say he prioritised first person speech and then limited what he said when speaking to and on behalf of the young people within that service setting to the words and phrases he had heard from them. I suggest this is a first person principle of narrative practice. I will describe it further, hopefully without sounding too prescriptive.

As a narrative therapist speaks with someone, they attend to what is offered as 'mine' in their speech. By asking questions carefully, a narrative therapist acknowledges that particular person's authoritative position with respect to the actions, experiences, thoughts, hopes and feelings that are shared in their words and phrases, and in their descriptions and narratives, as 'mine' or 'my own'. Acknowledging this

authority then places a limit on the therapist's authority. A narrative therapist takes care not to take a meaning that is given and then supply it with a further meaning – one that has not been experienced as 'mine' or 'ours' by the person with whom they are working.[11] As David pointed out to me, supplying a further meaning supplants a young person's own authority with a different kind of authority.

I mentioned above that, unlike psychiatry and psychology, narrative therapy has no specific commitment to identifying underlying causes.[12] The answers that are given in response to a narrative therapist's questions are not interpreted as symptoms or signs of underlying causes that require diagnostic or interpretive expertise by a therapist. Resisting diagnosis and expert interpretation privileges the knowledge and experience of the person with whom a narrative therapist speaks, rather than privileging the interpretive mastery of the expert questioner.

I would also say that interpretive mastery of another's speech presupposes knowledge that the speaker lacks and presupposes superior insight into the causal underpinnings of another's world. In contrast, a narrative therapist only asks questions that can be answered in the first person, in speech that is 'mine' or 'ours'. And, presumably, to an onlooker this may mean that narrative therapy looks a lot like ordinary conversation. Or that when David is working with young people, he and they are just chatting.

I suggest that narrative therapy is not at all like ordinary conversation; it is conversation with the ethical aim of privileging the words and experience of others, by acknowledging their first personal authority. And as such, I believe a first person principle is a principle of ethical practice.[13]

Part 2—From David

Philosophical reflections that build urgency and further critique

During our work together, Philippa presented me with questions and observations that made me think in new ways. I found this to be a rich process and told myself many times during her placement and since, 'I must read more philosophy!' Through the lens of Philippa's philosophical questions and observations, I was returned in new ways to the assumptions of narrative practice, and therefore of my own practice. I would like to share some of this and include some practice stories.

The notion of a first person principle that comes from Philippa's reading of philosophy has a strong resonance with Michael White's concept of decentred practice (1997, pp. 200–214), and his injunction to look for words and phrases that are 'experience-near' (White, 2007, p. 40). Yet it offers a philosophical reflection that emphasises a restraint or limit on what it is possible for us to do with regard to meaning-making and story-building. This philosophical reflection generated a sense of urgency, or an imperative to resist imposing our ideas and our meanings on the lives of those with whom we work.[14]

There was an example of the assistance I received from Philippa's questions and comments that I became most grateful for. I remember talking with her about the explosion of neuroscience and discourses on the brain in many areas, especially in psychiatric services. She spoke about a personal/impersonal distinction from Ricoeur, and how she was employing it to distinguish narrative therapy and social work, on the one hand, from discourses about mental health that draw on brain science, on the other hand.[15] Her point was not that science is wrong, but that perhaps as narrative practitioners we should pay careful attention to what can and can't be accessed from a first person perspective when we speak with young people. To clarify this point, she showed me a short passage from the French philosopher, Paul Ricoeur:

> The brain, indeed, differs from many other parts of the body, and from the body as a whole in terms of an integral experience, inasmuch as it is stripped of any phenomenological status and thus of the trait of belonging to me, of being my possession … It is only through the global detour by way of my body, inasmuch as my body is also a body and as the brain is contained in this body, that I can say: 'my brain'. The unsettling nature of this expression is reinforced by the fact that the brain does not fall under the category of objects perceived at a distance from one's body. Its proximity in my head gives it the strange character of nonexperienced interiority. (1990, pp. 132–133)

In this passage, Ricoeur writes that there is something peculiar but also distinctive about the brain. While an expression such as 'my brain' is deeply personal, the brain is a part of a person's body that is not directly experienced, unlike one's hand or, indeed, one's heart. Ricoeur's phrase is that the brain has a 'strange …

nonexperienced interiority' 1990, p. 132). He points out that from a first person perspective, the brain is unsettlingly personal *and* impersonal. Philippa suggested that there may be implications for young people when therapists, doctors and psychiatrists speak to them about their brains and do not take this into consideration.

If a mental health professional speaks to a young person about their brain, nothing could be more personal, but the young person has no access to what is spoken of via their own experience. A young person has no direct experience of their brain, so in this sense, their brain is impersonal. Young people (like all of us) are acquainted with their thoughts, feelings and experiences; it is these that they can talk about with the first personal authority that Philippa describes. Philippa and I talked about what it might be like for young people when the problems they face are described to them with phrases such as 'your brain gives you the wrong message'. Although we can note dualist or Cartesian assumptions in such phrases, what is unsettling about them is that they are simultaneously personal and highly impersonal. The impersonal character of the brain makes it difficult to resist information about it, especially when the source of that information has professional authority. I intend to fill in this point a little more below, emphasising why it matters: if resistance is unavailable, then the scene is set for domination.

A knowledge discourse that undermines resistance

Philippa's thoughts and Ricoeur's phrase helped me to articulate what I've found troubling about working in a psychiatric context for young people in which 'brain discourses' are more and more in favour. Such brain discourses introduce young people (or anyone else for that matter) to 'scientific' and highly technical knowledge. If anyone is at the receiving end of scientific, technical knowledge, I suspect it makes it difficult to negotiate or resist the messages that accompany such knowledge for two reasons. As Ricoeur's notion of 'nonexperienced interiority' suggests, there is no personal experience on which to draw when negotiating this knowledge discourse. Even if a person owns their own MRI machine or has advanced skills in interpreting MRI scans, this is still an impersonal or removed perspective. The image thus presented is not an image of one's own experience; it is an impersonal correlate of experience. Or, to invert Michael White's memorable phrase as a guide here, the image, or information about the image, is *not* experience-near.

The second reason I suspect that discourses about the brain can make it difficult to negotiate or resist professionalised meaning is because this discourse positions a young person as owing gratitude to a mental health professional for sharing their knowledge. In my view, it is extremely difficult for young people to resist the knowledge and attendant meanings of professional workers once they are positioned in this way. This matters because the difficulty in negotiating or resisting meaning and knowledge is so important when knowledge imposition overlaps with identity formation, when a person's very sense of themselves – of their history, their future and their stories – is at stake.

I've subsequently been on the lookout for practices that position young people as owing gratitude to me, brain discourses being a particular and intense example of this.[16] And, as I have suggested above, this is a critique that has been so very clarifying for me.

The first person principle and professional dilemmas

Philippa's proposal that narrative therapy includes a first person principle of practice, and her discussion with me of Ricoeur's phrase 'nonexperienced interiority', has made this hazard of introducing highly technical knowledge and brain discourses, and therefore potentially positioning people as having gratitude, much clearer to me. She has also written that I attempt to privilege the words and meanings that young people use. This is very relevant to my approach when meeting with young people and families at the psychiatric service where I work. It is also relevant when I'm required or invited to speak about young people when they are not present.

I will briefly include just a few of the intricacies of putting such a principle into practice. If I hold the position that I would rather young people speak for themselves than be spoken for, I end up saying less in clinical contexts. Likewise, if I hold a position that young people ought to interpret their own lives rather than having me interpret their lives for them, I can appear to have less professional insight. And if I don't use technical and professional terms, but instead use the language young people use, it can seem like I have less clinical *nous* or *know-how*.

These dilemmas highlight the mismatch between the principle of a first person limit the skills mental health

workers are often deemed to require and the ways of speaking that tend to be valued within psychiatric services. To put this more directly, in the mainstream service where I work, retrieving and privileging the words and phrases of young people can seem less professional than other approaches. However, the flipside of these dilemmas is that they build a quiet determination on my part to continue privileging the words and phrases of young people and continue to observe or enact a first person principle in my practice. I don't think such dilemmas will evaporate, but naming them and having this quiet determination helps me to stay on track with privileging the words and experiences of young people.

The first person principle and resisting professional language

One way of observing or enacting this principle is by refusing to rename the experiences of those who are admitted to a psychiatric service, by refusing to do what Escher & Romme (2010) describe as a 'moulding' of experience into models and forms of word based on psychiatry's models and forms of words.[17]The observance or enactment of a first person principle can also include what is required of us when the people we are meeting with are slowly trusting us with words and meanings that are tentatively forming, perhaps for the first time and that we perhaps have never heard before. And it can also include an ethical orientation – of respect and acknowledgement – when we speak to others about the tentative unfolding of such words and meanings.

In response to an invitation from David Denborough[18], the young people and I have been pulling together a 'dictionary of obscure sorrows/experiences' that is named after a website, The Dictionary of Obscure Sorrows (Koenig, 2009). As the name suggests, this involves creating a compendium of experiences and sorrows that are obscure or hard to find descriptions or words for, then finding descriptions for such experiences, whether they are new words or phrases, images or songs. For me, this has been one of the most regularly engaging group exercises I have done within the service. The young people can be entranced. They are often keen to contribute their own entry and offer creative and at times hilarious names for experiences that they see as having rarely been offered an airing, or given much attention or status.

I introduce the exercise to young people by saying that complex experience, which can be hard to name, often gets reinterpreted and renamed in mental health contexts. And then I say that this exercise will try to simply name an experience that is complex, or hard to name, using language and descriptions that you (the young people) use. In other words, the young people and I work together and a first person principle of practice is directly shared with them. Of course, I introduce the exercise and explain it, but their discussions about naming experience in their own words and their descriptions become the focus of our time together. And the point is to find first person language, meanings and experiences, as alternatives to professional language.

The first person principle, thinking about influence, and distinguishing meanings from causes

Tied in with and elaborating on the theme of a first person principle, and therefore work that treats seriously and supports first personal authority, was another theme that I started to consider as a result of reflections and conversations with Philippa about meaning-making as influencing or re-influencing the meanings of past events. This pulled my thinking in another generative direction, particularly as I thought about a young person called Beth.[19]

Beth had been admitted to the unit twice; the first time when she spoke about 'being mute' and then six months later with a difficulty she spoke of as obsessive compulsive disorder, among other things. During her second admission, she had been staying up increasingly late at night to perform particular rituals. Beth was quiet on the unit, so when she asked to speak with me one-to-one I was reasonably surprised. Not long into this conversation, Beth told me that she was about to tell me something that she had not told anyone before.

Beth then said in a quietly determined way that she had been sexually abused by her father for many years. And as we delicately sifted through what this meant in terms of who and when to tell this horrid news, as well as what it was like to start speaking of such experience, Beth said something that made me pause. She said 'I don't have a mental illness. This OCD has been a way of dealing with the effects of sexual abuse.'

Beth had turned things upside down and was making a strong claim. From her perspective, there was meaning in her actions that only she could speak of. Her actions

were not merely effects of underlying causes that she had no direct access to. Such a change in ascription, from being caused to act to speaking of her actions as having specific meanings for her, brought a radically different life and different commitments to light. In speaking about her past in her own words and defining her actions as meaningful, Beth was establishing her authority with respect to the meanings of those events.

I have subsequently spoken with Beth on a number of occasions. What is striking when she speaks of her experiences in the first person, as described in this paper, is her clarity and her authority. I have also witnessed her generous contributions in conversations with others who have experienced something similar to her, and in these conversations I notice her quiet authority.

I have reflected on Beth's strong stance and renaming of actions and experiences in light of several discussions I have had with Philippa about the notion of cause, of how it can be unpacked in a range of ways in a mental health or psychiatric context. We discussed how care is needed so that young people are not positioned as merely being caused to act or speak in certain ways due to a mental illness, or that their thoughts and feelings are simply caused by what their brains are doing.

On several occasions, Philippa mentioned to me that she is interested in the distinction between causes on the one hand, and meanings as influences on the other. She suggested that some things and some events are strictly causal, but that meanings are better thought of as influential as they are revisable and renewable, hence the potential of telling and re-telling stories. The influence of the meaning of an event is not one-directional – it is not fixed as an antecedent cause with a determinative effect, as something that is past (and thus unchangeable) that causally determines an effect in the present. Instead, the influence of a meaning can extend from the present to the past, and then from a revisited past to a reconfigured future.[20] Beth was making meaning in the present that revised and reshaped the meaning of events in her past, and also reconfigured her sense of the future and, as such, her meanings and her meaning-making were highly influential.

This idea that meanings are influential (rather than causal) and, as such, are potential sources of renewal and re-influence, has heightened my sense of the importance of a 'light touch' in my choice of words and phrases when working with young people, so as not to impose my meanings on their lives, and to highlight the potential of their own meaning-making to influence and enrich their lives.

I have also considered Philippa's suggestion of a possible over-emphasis on causes, in a strict sense, and subsequently noticed the prevalence of talking to and about young people in terms of causes. I will mention a few: that 'mental illness' causes the actions of young people; that trauma has strictly causal effects; and that chemical imbalances cause mental illness. In the psychiatric service where I work, the brain is regularly laid out as the cause of a young person's mental illness. What can then be overlooked or underestimated are the attempts that young people are already making to respond to and re-visit the meaning of events in their lives.

Returning to Beth, when she talked about her OCD as a way of dealing with abuse, she was talking about the meaning and impact of her life experiences and, crucially, the meaning of her subsequent actions as a response and resistance to abuse. I've reflected on the fact she did not say her actions were caused by her past. I suspect that crediting her actions as meaningful responses rather than effects of antecedent causes is very significant for Beth, as it is through her words that she regains authority and thus resists domination. Privileging her words, phrases and descriptions of her actions and experiences as meaningful and authoritative – observing a first person principle – helps to acknowledge just how significant this is.

Conclusion: From David and Philippa

We both see narrative practice as a rich resource for philosophical reflection, and we have attempted to share this perspective in this paper. We have suggested that a first person principle is a simple but philosophically grounded practice principle that respects and honours what is 'experience-near' for the people we work with. We have highlighted Ricoeur's very suggestive phrase of a 'nonexperienced interiority' which we have considered in the context of therapeutic discussions involving brains and neuroscience. We have suggested that care and subtlety is needed when language is simultaneously personal and highly impersonal, and noted how knowledge discourses potentially curtail opportunities for resistance, and potentially position others as owing gratitude. We have also suggested a first person principle is a means of carefully limiting a narrative therapist's authority, and highlights the need to do so, and discussed this with some practice examples. And finally, we have briefly considered how a first person principle highlights meaning and meaning-making as influential, and counters an emphasis on discourses that

focus on the ways that people are caused to think, feel and act, and can then fail to credit the words that people use as meaningful and uniquely authoritative.

Acknowledgement

We are grateful for reviewer comments that have helped to refine our language and ideas, and note that a discussion of 'boundary language' in Combs & Freedman (2002) has been very helpful. We have not included all reviewer suggestions, not because we disagree with them, but as they suggest ideas for elaboration we are yet to properly consider and take up. We would also like to gratefully acknowledge the generosity of Beth and the young people who have shared their ideas and particular languaging of their experience. Their stories, meanings and language have added enormously to the richness of the paper, bringing the link between ideas, practice and experience.

Notes

1. These included Morgan (2000); Newman (2008, 2012, 2016); White, M. (1997, 2004, 2007); White & Epston (1989).
2. Specific ideas from philosophy of language are discussed below and references are also included below. Some key works on narrative and temporality are Ricoeur (1984, 1985, 1990).
3. This assertion does not mean that it is not possible to empirically investigate narrative therapy in simple ways, say with the use of pre- and post-intervention measures such as questionnaires. In my view, this kind of 'before and after the fact' empirical investigation has no implications with regard to whether or not a practice is grounded in empirical sciences.
4. I also acknowledge that psychiatry and clinical psychology include philosophical inquiry and, as practice fields, can also incorporate and engage with narrative practice. See Angus & McCleod (2004) and Hamkins (2013).
5. An evocative philosophical examination of this point is Martin Buber's (1970) *I and thou.* This is a book about phenomenological modes of being, rather than modes of address.
6. For elaboration of Ricoeur's use of the term 'mineness' and an elaboration of a personal/impersonal distinction, drawn on later in the paper, see chapter 5 of *Oneself as another* (1990).
7. See Andy Hamilton (2013, chapter 2), and for a discussion of the issue of 'immunity to error through misidentification', as developed in Wittgenstein's thought and elsewhere. See Gareth Evans (1982, chapter 7) for a broader discussion of the specific characteristics of self-referring speech. Ricoeur was a close reader of analytic philosophy of language, and in this respect unusual for a European philosopher who is steeped in early phenomenology (Husserl), later phenomenology (Heidegger, Merleau-Ponty, Levinas), and also has what I call 'a critique and a debt' to Derrida's engagement with phenomenology. It is therefore no stretch to bring Ricoeur's thought together with ideas drawn from analytic philosophy of language.
8. I alternate between 'person' and 'personal' in referring to first person speech and first personal experience to observe the distinction between what is said and what is experienced. Hence with the expression 'first personal authority' I am trying to capture the experience of one's own speech as authoritative, so the emphasis is on experience more so than speech.
9. Metaphors of retrieval and excavation are not uncommon in phenomenology. Derrida notes that: 'Husserl would have liked to bring back the word "archeology" in the phenomenological sense, which is not that of "wordly" science' (2003, p. 182).
10. I believe a fruitful parallel can be drawn between the 'in principle' linking of experience and meaning within phenomenology and the 'in principle' linking of experience and meaning within narrative practice, but this task is beyond the scope of this paper.
11. And by extension, when narrative therapists work with a community or group, they attend to what is claimable as 'ours' and belonging to 'us'. However, this suggestion there is a direct extension requires qualification. It may be too quick to assume a direct extension from what is 'mine' in the experience of an individual to what is 'theirs' when the experiences of a group or community of people are collectively represented in speech and the written word.
12. This does not mean that talking to a young person about what they believe has caused something, or what they have been told about the causes of their problems is strictly ruled out.
13. I mentioned above that narrative therapy is not based on an empirical approach to 'the human subject'. In contrast, I believe it is based on an ethical stance regarding the relationship between a person who speaks and a person who listens.
14. Our work is informed by our ideas and understandings, as well as our critiques of dominant discourses, but we nonetheless take care not to supplant the authority of the words and phrases of those with whom we work.
15. This comes from *Oneself as Another* (1990), see chapter 5 in particular.
16. The point here is not that a brain scan is never useful. If I had an operable brain tumour, I would be grateful that others have expertise in reading scans. To reiterate, the point made here is that, in a therapeutic context, gratitude to those whose knowledge cannot be challenged is potentially dominating.
17. Escher and Romme are quoting the words of Ron Coleman, who is a voice hearer, who says that, 'Psychiatry takes away my experience, moulds it into their model and hands it back to me in a way that is unrecognisable to me.' (2010, p. 32).
18. David Denborough is a community practitioner and writer at Dulwich Centre.
19. Beth (not her real name) has given permission to repeat her words and write about her experiences in this paper.
20. Although meanings can change, there is no implication that meanings are thus 'untied' to what has actually happened. And although meanings are not strictly causal, this does not imply that they are 'free-floating' and can be 'unhinged' from events and actions, or that meanings exist only 'within' the minds of meaning-makers.

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Dear Reader