Visiting Scholars Series No. 7
Department of Psychology
Massey University
New Zealand
1997
ISSN 1173-9940
Do mo bhean chéile Áine agus do n-ár mbeirt mhac.
"True," I said, "but in this one there is no common acceptance, God has not given us this story to use, He has not revealed to us the meaning of it. So it has no meaning, it is only a death. Players are like other men, they must use God's meanings, they cannot make meanings of their own, that is heresy, it is the source of all our woes, it is the reason our first parents were cast out."

But already, looking around at their faces, I knew that my argument would fail. They were in some fear perhaps, but it was not fear of offending God, it was fear of the freedom Martin was holding out, the license to play anything in the world. Such license brings power.

CONTENTS

Preface / v

Acknowledgements / vi

CHAPTER 1  BACKGROUND AND POTENTIAL / 1

CHAPTER 2  CANCER STORIES / 16

CHAPTER 3  MAKING SENSE OF NARRATIVE ACCOUNTS / 33

REFERENCES / 50

AFTERWORD / 58
Preface

When I first began the professional study of psychology almost twenty-five years ago I had high hopes that I was setting out on the royal road of discovery of the nature of the human psyche. The following decades can, in retrospect, be described as a period of wandering in the wilderness searching for the holy grail. Instead of insight I acquired skills in the methods of positivist science which often seemed to direct me away from my original inquiry. However, much like a seeker after truth, I kept faith in my quest. Looking back it is clear that my quest had both a public and a private face. On the surface I toiled at the face of statistics and objectivity while privately I maintained a search for underlying meaning.

My move to Canada from Ireland about five years ago provided an added impetus to reassert my original search. The past five years has been a period in which I have delved into new fields and come back refreshed with ideas which I feel offer great promise for a revitalised psychology. One such field was that of the study of narrative.

Narrative psychology is one of the fastest growing approaches within discursive psychology. Many of the ideas and methods within this framework are unfamiliar to psychologists, in general, and to health psychologists, in particular. The purpose of this paper is to introduce some of these ideas and to consider their value in health psychology. The chapters that follow are the result of my initial readings in this area. As a block, they can be considered part of a work in progress.
Acknowledgements

This paper was prepared during my period as Visiting Scholar in the Department of Psychology at Massey University during their autumn of 1996. This was a wonderful time for me and I treasure so many delightful memories. I would like to thank my hosts at Massey for their hospitality, especially Kerry Chamberlain and John Spicer, and the many graduate students in health psychology. I would also like to thank Nigel Long, Robyn Knuth and all the staff at Massey for their support during my stay, Vivian McGregor for hosting all those meals and John Raftery for the many stories and the coffee. There were so many other people, especially those in the Cottage, who made my stay in Palmerston North so enjoyable. To all of them, a big thank you.

I would also like to thank my wife Anne and my two sons Matthew and Daniel for giving me the luxury of this time for reflection. This report is dedicated to them. Thanks also to Paula Hogan for organizing the typescript and for managing the office while I was away.

Previous versions of the first two chapters which follow were presented at the Annual Conferences of the European Health Psychology Society in Bergen, Norway and in Alicante, Spain and of the New Zealand Health Psychology Society in Okoroire. My stay at Massey gave me an opportunity to review these chapters and to add some additional thoughts on the character of narrative.
CHAPTER 1

BACKGROUND AND POTENTIAL

INTRODUCTION
Over the past ten years there has been increasing debate about the positivist assumptions underlying mainstream psychology and the other social, and indeed physical, sciences. A narrative approach to psychology has attracted substantial interest. This perspective argues, basically, that human beings are natural storytellers and that the exchange of stories permeates our everyday social interaction. The task of a narrative psychology, and of a narrative social science, is to explore the different stories told, not only for the insight they provide into the actual character of the experience described by the storyteller, but also for the insight they offer into the identity of the storyteller and of the culture in which she/he lives. The purpose of this chapter is to examine the background to this particular anti-positivist turn, to explore its impact on different disciplines and sub-disciplines of psychology, and to consider its potential contribution to health psychology.

It would seem that storytelling has always played a central role in human culture. From the earliest of recorded history human beings have involved themselves in the development and the exchange of stories. Indeed it was stories which provided any group or society with a means of entertainment, recording history and conveying a moral code (Chandler, 1990). From an early age children are told stories, we exchange stories throughout our lives, and even after we die stories are told about us.

Despite the central role of storytelling in everyday social interaction psychology has until recently taken limited interest in the subject. Admittedly, many early psychologists considered, in various forms, the character of narrative. For example, the work of Thomas and Znaniecki (1918-1920) included the study of a variety of personal documents such as letters and autobiographies. This work provoked substantial discussion as to
their value in understanding human thought and action. As a result the American Social Science Research Council commissioned a series of reports, including one by Gordon Allport (1942), on the value of such documents. Despite a guarded acceptance as to their value, the study of personal accounts continued to be considered unscientific. However, the value of studying storytelling has recently been reassessed as part of the overall process of renewal within psychology.

Since its inception psychology has accommodated conflicting epistemologies and methodologies. The dominant approach has been the positivist perspective which has fashioned itself on the natural sciences (Shotter, 1975). Its principle method has been the careful measurement and manipulation of supposedly objectively verifiable behavioural and cognitive data. The ultimate aim was the development of causal laws which could predict and explain human behaviour. This remains the dominant approach within health psychology (see Radley 1994; Stainton-Rogers 1991, 1996; Spicer and Chamberlain, 1996).

However, alongside this approach were those who preferred a more, let's say, "humanistic" perspective (e.g. Giorgi, 1970). Their concern was on developing an understanding of human experience. They placed greater emphasis not on the restrictive measurement of so-called variables but on obtaining more unrestricted personal accounts of particular experiences (see also Harr? and Secord, 1972). The ultimate aim was not the creation of universal laws but interpreting the particular meaning of those experiences to the individual or group of individuals concerned.

Over the past ten to twenty years there has been a growing reassessment of the positivist search for universal laws in psychology. This "interpretive turn" (Geertz, 1973) has grown in strength for a variety of reasons. Rosenwald and Ochberg (1992) suggest three such reasons. First, there has been the general decline in support for the empiricist program. In particular, there has been an increasing awareness that facts are not things in themselves but are dependent upon interpretation. The second reason they suggest is the increasing interest in hermeneutics (the study of meanings) in the humanities which transformed theories of literary criticism and of history. No longer
could there be a uniform assessment of work of literature or of particular historical periods but conflicting interpretations. The third suggested reason was the increasing demands of the disenfranchised that their voices and not those of the establishment be heard.

To these three reasons another, if not more, could be added. This fourth reason would be the increasing disillusion with the whole positive science enterprise and its promise of a more predictable and controllable world. In some ways there has been an anti-science revolt which is reflected in such developments as the growth of the ecological movement and in demands for alternative health care.

Within this reassessment a narrative approach to psychology has attracted substantial attention (Howard, 1991; Polkinghorne, 1988; Sarbin, 1986). According to this perspective stories pervade all of human thought and action. We are all story makers and tellers. These stories not only guide our interpretation of reality but our very identification of ourselves. We use and create stories not only to describe and understand events but also to define ourselves and others (McAdams, 1985).

According to Ricoeur (1984), a key philosopher of the study of narrative, events are not fixed but occur over time. The construction of narrative organises our interpretation of such events through the process of "emplotment" which is the means by which an array of events are psychologically integrated:

"to make up a plot is already to make the intelligible spring from the accidental, the universal from the singular, the necessary or the probable from the accidental".

Our world is a storied world which we construct and within which we live.

The stories which are of particular interest to the narrative psychologist are the personal stories which are developed about the author's own experience. It would seem that in our era there is much interest in what the ordinary person has to say. Published personal accounts of success and tragedy are best-sellers. Television talk shows invite not only celebrities but also ordinary people to narrate their experiences to an inquisitive public (see Shattuc, 1996).
Plummer (1995) has suggested that this interest in the personal story is particularly prominent in the United States since American culture is rooted in an intense individualism which is linked to a belief in self-reliance and self-actualization.

Stories are not only told in private but increasingly in public. Newspapers and magazines are filled with personal stories. Published memoirs and autobiographies have become one of the most popular forms of literature. There is also a ready market for books and manuals on self-actualization and various forms of therapy. Everywhere people are encouraged to "come out" and tell their personal story. There is also an intense interest in knowing about other people's lives. It has been argued that this provides a means of validating our own lives or possibly stimulating a demand for changes and travel - two of the passions of western society (Chandler, 1990).

This narrative context has fed on and contributed to the development of contemporary social movements, especially the women's movement, the gay and lesbian movement and the AIDS movement. An important ingredient of all of these movements has been the public telling of personal stories initially in support groups but then in more public arenas. This cycle is continued as the public stories are consumed by the audience who then begin to define themselves with reference to these recounted experiences and identities (Murray, 1996). It is not unusual for people to say that they did not know how they felt or even who they were until they had read about it in a book or saw it in a film (cf. Plummer, 1994).

In view of the pervasiveness of this storytelling culture it is not surprising that narrative ideas have begun to have an impact on the social sciences in general and on psychology in particular. In this chapter an attempt is made to briefly review some themes within narrative psychology and subsequently consider their relevance for the study of health and illness. It begins by considering two main approaches to the study of narrative, viz. the cognitive and the social, although individual psychologists (e.g. Bruner, 1990) deliberately attempt to combine both perspectives. It then considers its application in mental health and finally its potential application in health psychology. A similar approach has previously been
adopted to study lay representations of illness (Murray, 1990) and more recently to study the structure of narrative (K. Murray, 1995; Terrell and Lyddon, 1996)

NARRATIVE AS THINKING

From a cognitive perspective there is a natural tendency among humans to render the world in a narrative manner. Rather than a series of disconnected events, experience is construed as an interconnected sequence which has a temporal order and in which certain goals are achieved (Mancuso, 1986). As Gergen and Gergen (1984) state:

"Rather than seeing one's life as simply "one damned thing after another," the individual attempts to understand life-events as systematically related" (p.174).

This ability to organize the world in a narrative form is apparent from an early age. Ames (1966) found that two year olds could fashion a basic storyline when invited to do so. Fuller (1982) found that children's ability to read was related to their ability to tell a story. He concluded that "if story is the basis of intellectual cohesion, it could be the engram of our species".

As previously mentioned, several early psychologists considered the role of story both as a mental and social phenomenon. Bartlett (1923) considered in his early work the character of traditional folk tales. Subsequently he used a North American folk-tale entitled The War of the Ghosts to examine the process of remembering. In considering the character of the stories recalled in these experiments he noted that "the general form, or outline, is remarkably persistent"(p.93). This finding would agree with contemporary narrative psychologists who argue for the centrality of narrative as a way of thinking.

Currently there is an ongoing reassessment of the contribution of Bartlett, particularly with regard to the active and social nature of remembering (see Shotter, 1990; Costall, 1995). As Bartlett (1932) himself stated: "the past is being continually re-made, reconstructed in the interests of the present" (p.309). Although Bartlett's focus was not on the centrality of narrative in meaning-making, his emphasis on the dynamic
and social nature of remembering can be considered a precursor of subsequent narrative psychology.

Attribution theory can also be considered a precursor of much of narrative psychology. From Heider's (1958) early formulation it has been argued that there is a human tendency to seek causal connections between events. One of the classic early experiments in cognitive psychology, indeed before cognitive psychology was really established, is that on perceived causality which was conducted by Heider and Simmel (1944). In this study subjects were presented with a series of pictograms which contained a number of shapes in different positions. The subjects were asked to describe the pictures. Based on the subjects' replies the researchers concluded that human beings have an implicit tendency to infer causal connections between events since the subjects described the sequence of pictograms in causal terms. However, on rereading this article it is apparent that the subjects did not simply infer causal connections but actually created short stories to describe the pictograms. They inferred that the geometric shapes had certain personality attributes and these supposed people were trying to achieve something. Indeed, the stories reported had a simple structure - a beginning, a middle and an end.

In view of this background, it is not surprising to find that atttributional concepts are used in definitions of narrative. For example, Robinson and Hawpe (1986) define narrative as "accounts, attempts to explain and understand experience. Narrative thinking is, therefore, a type of causal thinking. The power and versatility of narrative thinking are rooted in the cognitive schemata which serves as the generative base for any story" (p.111).

Jerome Bruner has attempted to move cognitive interest away from simply formulating causal connections to a more extended concern with narrative construction. In his extended essay entitled "Acts of Meaning" (Bruner, 1990) he called for a "renewed cognitive revolution" which would provide "a more interpretive approach to cognition concerned with 'meaning-making'"(p.2). He recalls that when he and his colleagues began the so-called cognitive revolution back in the 1950s their aim was to encourage psychology to become a partner with what he describes as "its sister interpretive
disciplines in the humanities and in the social sciences" (p.2). However, he soon found that the new cognitive psychologists were less interested in exploring the "construction of meaning" and more in explaining the "processing of information" (p.4).

To start anew Bruner calls for a new cognitive revolution central to which would be the study of "folk psychology" which is the term he uses to describe the meaning system through which lay people "organize their experiences in, knowledge about, and transactions with the social world" (p.35). Unlike scientific thought, which is based upon abstract conceptual forms, this folk psychology, he argues, is based upon narrative thought. These two forms of thinking are considered "distinctive ways of ordering experience, of constructing reality." However, he adds, "the two (though complementary) are irreducible to one another."

While this distinction between narrative and abstract thought is interesting, its application is more awkward. In trying to explain abstract concepts we often resort to metaphor and stories, while conversely the very form of abstract thought draws upon such concepts (Romanyshyn, 1982). It is for this reason that other psychologists have considered this distinction less clear-cut and instead argued for the centrality of narrative thought. For example, Howard (1991) has argued that even explicitly "scientific theories represent refined stories (or rich metaphors) meant to depict complex causal processes in the world" (p.189) Even some physical scientists (e.g. Peat, 1993) have argued for the centrality and pervasiveness of narrative thinking.

In the remainder of his essay, Bruner (1990) considers the character of the narrative form of thinking. One important issue he considers is the different properties of narrative which he identifies as threefold:
1. a narrative is composed of a unique sequence of events, mental states, happenings involving human beings as characters or actors;
2. a narrative can be 'real' or 'imaginary' without loss of its power as a story;
3. a narrative specializes in the forging of links between the exceptional and the ordinary.

Although the cognitive approach to the study of narrative provides a
description of how people organize their interpretations of the world it is rather individualistic and ignores the questions as to why certain stories are preferred over others. Indeed, a similar criticism was levelled at attribution theory back in the 1980s (see Hewstone, 1983) leading to a search for more social processes.

NARRATIVE AS SOCIAL CONSTRUCTION

Some psychologists have attempted to move the discussion of narrative away from being defined as a purely mental process and to consider the context within which the story is told. Admittedly, many of the early psychologists discussed issues related to the social nature of narrative. We have already referred to the work of Bartlett (1932) in this respect. Wundt could be considered another historical forebear. In his *Volkerpsychologie* (1918-1920) Wundt discussed the role of myths and legends in society. Such processes he noted could not be explained in terms of individual cognition but rather are "created by a community of human life and are, therefore, inexplicable in terms merely of individual consciousness, since they presuppose the reciprocal action of the many" (see Farr, 1985, p.35). Such themes have been revitalised in the continuing discussion of social representation theory (Breakwell and Canter 1993; Farr and Moscovici 1984) although the link with narrative psychology is still underdeveloped (but see Farmer 1994).

More recently, Baumeister and Newman (1994) have considered the interpersonal context within which stories are told. They distinguish between interpretive and interpersonal motives which influence the telling of stories. Interpretive motives include the needs to interpret events, to have some fixed sense of right and wrong, to have a sense of being able to make a difference, and to construct stories which bolster self-worth. Interpersonal motives include the desire to obtain rewards, to have others validate their identity claims, to pass along information, and to attract other people.

Each of these motives, both interpretive and interpersonal, are useful in understanding not only why people tell stories but also their variation across different interpersonal settings. The character of the story told will depend upon the character of the setting.
Not surprisingly, narrative psychologists from the sociological tradition have placed great emphasis on understanding the social context within which stories are told. For example, David Maines (1993) has argued that storytelling is a social act which occurs within a certain context. Further, stories contain within them a certain perspective or argument, they "have a point; they convey a central theme through the use of emplotment." This comment emphasizes the need for the researcher to be aware of the underlying argument and the situational context within which the story is told.

These points are discussed more extensively by Ken Plummer (1995), a British sociologist of the symbolic interactionist tradition, in his detailed account of the narrative turn in sociology with particular reference to stories of human sexuality. He emphasizes that stories are not simply texts to be examined but rather social constructs which are formed in the dynamic interaction between the individual and society. He claims that: "a sociology of stories should be less concerned with analysing the formal structure of stories or narratives (as literary theory might), and more interested in inspecting the social role of stories: the ways they are produced, the ways they are read, the work they perform in the wider social order, how they change, and their role in the political process" (p.19).

Stories are not simply texts produced by storytellers but they emerge in certain situations because they are encouraged by certain coaxers, coaches and coercers and they are interpreted by certain consumers, readers and audiences.

This model is of particular relevance in understanding the character of the interview process and of the analysis of stories. In the research interview the interviewee does not tell a standard story but a particular story which is designed to present a particular image to the interviewer (see Radley and Billig, 1996). Similarly, in analyzing the story told the researcher begins to construct a new story which is acceptable to his or her audience. There is no way around this conundrum. It is for this reason that Plummer emphasizes that the real world is
basically unknowable.

Plummer (1995) also distinguished between four levels which influence the character of the story told. These are the personal level, the situational level, the organizational level, and the cultural/historical level (cf. Doise, 1986). An understanding of a story structure requires an awareness of the level within which it is constructed.

Several psychologists have considered the character of the socio-cultural rules which determine the structure stories take. Gergen and Gergen (1986) proposed that the structure of narratives is organised by the rules and conventions of public discourse within particular culture. They have described an overall structure which guides narrative accounts of experience. This is based upon an ability to demonstrate a connectedness or coherence and to demonstrate a sense of movement or direction through time.

They propose three broad narrative structures which they argue not only govern popular discourse about everyday events but also scientific discourse. These are:

1. Progressive: in which progress towards the achievement of a particular goal state is enhanced;
2. Regressive: those in which progress is impeded;
3. Stability: those in which no change occurs.

According to the Gergens, this classification is sufficient to describe the main dimensions of the dominant western narratives of comedy, romance, tragedy and satire (Frye, 1958). Further, they suggest that it can be used to describe the structure not only of popular but also of scientific narrative. This classification has proven useful in the analysis of illness narratives (e.g. Robinson, 1990).

**NARRATIVE AS THERAPY**

Within the different schools of psychotherapy there have been different degrees of support for the use of narrative as, to use Sarbin's (1986) phrase, a root metaphor. Within psychoanalysis there has been an ongoing discussion as to the role of narrative in explaining the development of psychological problems and its role in the therapeutic process. Although there are different schools of psychoanalysis, the more traditional school would posit that the cause of many adult neuroses are certain memories of early adverse
experiences which have been repressed in our unconscious.

In narrative terms, these memories can be characterized as poorly organised stories whose emotional components continue to lead to psychic suffering. The task of the analyst is to enable the analysee to reveal these stories, to enable these stories to come to the surface and take on some more concrete form. Admittedly, the analyst plays an important role since, it is argued, "the stories would not progress beyond the inchoate and fragmentary stage, would never grow into an increasingly authentic presentation of self, without the prompting of the analyst" (Wyatt, 1986, p.200). There will often be great psychic resistance to revealing these stories such that the analysee will often experience emotional turmoil and even drop out of treatment. It is also the reason, the analyst will argue, that therapy takes so long.

For the constructivist psychotherapist the client is experiencing difficulties because her/his life story has become "constraining or incoherent" (Neimeyer, 1995b). The task of the constructivist psychotherapist is to explore with the client the character of this constraining story and then to consider other more emancipating stories. As Robert Neimeyer (1995b) says:

"In contrast with cognitive therapists who seek to dismantle distorted automatic thoughts, irrational beliefs, and illogical inferences in a piecemeal fashion, constructivist therapists attempt to articulate the subtext that undergirds the plot of the client’s life.

The constructivists within psychoanalysis (e.g. Schaffer 1992) and clinical psychology (see Terrell and Lyddon 1996) have adopted a less mechanistic approach to the study of a narrative. The constructivists construe psychotherapy as a dynamic interplay between the contrasting interpretations of the therapist and of the client. For example, Neimeyer (1995a) defined psychotherapy as "the variegated and subtle interchange and negotiation of (inter) personal meanings. This is done in the service of articulating, elaborating, and revising those constructions that the client uses to organize her or his experience and action"(p.2).
and to help him or her experiment with new plots that open possibilities for fresh chapters" (p. 22).

However, the idea still remains that the story resides in the head of the individual and that it is a personal construction. Other psychotherapists have attempted to adopt a more social orientation. Miller Mair (1981), the British psychotherapist, is particularly eloquent in his description of the centrality of narrative. He writes: "Stories are habitations. We live in and through stories. They conjure worlds. We do not know the world other than as story world. Stories inform life. They hold us together and keep us apart. We inhabit the great stories of our culture. We live through stories. We are lived by the stories of our "race and place", they are all around us and it would seem that it is difficult to escape from them.

In this oft-quoted definition, Mair is clearly moving beyond the therapeutic encounter to consider stories as a defining characteristic of personhood and of society. We not only tell stories but we also live through them. Further, we live the stories of our "race and place", they are all around us and it would seem that it is difficult to escape from them.

Admittedly, there are ways to undermine these confining stories. An example is the approach proposed by White and Epston (1990). They have considered how some inhibiting stories which people tell reflect the dominant discourses in society. As they argue: "Persons experience problems, for which they frequently seek therapy, when the narratives in which they are "storying" their experience, and/or in which they are having their experience "storied" by others, do not sufficiently represent their lived experience, and that, in these circumstances, there will be significant aspects of their lived
experience that contradict these dominant narratives" (p. 14).

As theoretical support for their approach White and Epston refer to the ideas of Foucault (1980) on power and knowledge. Foucault argues that our lives are structured through the dominant knowledge discourses in our society. There are other forms of knowledge which have been subjugated and it is through the recovery of this disqualified knowledge that the dominant discourse can be undermined. To quote Foucault:

"it is through the re-emergence of these low-ranking knowledge, these unqualified, even directly disqualified knowledge ... that criticism performs its work" (p. 82).

White and Epston suggest that therapy should follow a similar strategy to undermine the dominant narrative which makes certain experiences problematic and to begin to build a new story which enhances alternative knowledge:

"Insofar as the desirable outcome of therapy is the generation of alternative stories that incorporate vital and previously neglected aspects of lived experience, and insofar as these stories incorporate alternative knowledge, it can be argued that the identification of and provision of the space for the performance of these knowledges is a central focus of the therapeutic endeavour" (p. 31).

While the work of White and Epston is still largely confined within the traditional psychotherapeutic dyad it also opens up the possibility of more social change through the proposal to undermine the dominant societal narratives. As they themselves admit: "in joining with persons to challenge these practices, we also accept that we are inevitably engaged in political activity" (p. 29).

STORIES ABOUT HEALTH AND ILLNESS: HEALTH PSYCHOLOGY

The preceding account was designed to briefly review the development of narrative psychology. This review revealed several themes consideration of which can provide a framework for
discussing the increasing amount of work on illness narratives. First, according to narrative psychology the person begins to grasp the meaning of a crisis by creating a story about it. The experience of illness represents a crisis for the patient and his/her family. Consider the case of a woman who has experienced breast cancer. Over the past ten years there have been a number of published accounts of the experience of surviving breast cancer. In reviewing them it is apparent that in writing them the women were quite self-consciously creating a story about their experience. Their accounts follow a typical narrative structure with a beginning, middle and end. Looking back on their lives before cancer (BC) the women portray themselves as healthy and blameless. Then there is the diagnosis of cancer, the subsequent surgery and the readjustment. In writing these stories the authors are attempting to exert control over a crisis and considering the options for the future. These stories have certain common features (see Chandler, 1992). Firstly, they provide an opportunity for the women to express in words their experience of a disease which evokes fear through the very silence of its public discourse (Blaxter, 1983). Through finding words for their experience the women begin to reduce this fear of the unknown and instead to construct a language of hope. Secondly, through the process of 'emplotment' (Ricoeur, 1984) the women begin to bring order to the crisis they have undergone. This gives them the opportunity to gain the narrative perspective of the author and so distance themselves from the threat of cancer. Thirdly, they use a progressive structure to organize their narratives (Gergen and Gergen, 1986) which enables them to redefine the crisis not as a disaster but as an opportunity for rebirth and growth (cf. Frank, 1993). Further details of these cancer stories are given in the next chapter.

Another example of the different structures of patient narratives is provided by the work of Robinson (1990). He analysed a sample of 50 written accounts submitted by people who suffered from multiple sclerosis. Using the framework suggested by Gergen and Gergen (1986) he found that 26 of them could be classified as progressive narratives, 10 as stable, 5 as regressive, and the remaining 9 could not be allocated to any one form.
However, unlike cancer MS is not a disease which the patient can "put behind" them. Rather, the patient must construct a story and a life which integrates the continuing presence of the disease. In analysing these narratives Robinson makes the valuable point that "a personal story may be ended before a life has physically finished" and conversely for some the storyline transcends the advent of physical death. This illustrates the separation of the physical being from the psychological being. Both of these studies illustrate the process through which the patient brings order and meaning to a crisis through the creation of a story.

A similar point is made by DelVecchio Good et al (1994) in their study of the accounts of Egyptian women with epilepsy. Like MS, epilepsy is not a disease with a limited time frame but an ongoing chronic condition. Thus these women cannot construct a finished story. Rather the story is still unfolding and the women must consider alternative plots. To help explain the character of these unfinished stories Good and DelVecchio Good (1994) refer to Bruner’s (1990) idea that narrative, through the process of "subjunctivizing reality", can consider "human possibilities" rather than "settled certainties". Using this process the Egyptian women can "negotiate right action in the face of uncertainty and... justify actions taken." Thus the narrative construction of illness is an ongoing process:

"Narratives change as events unfold. They portray the future as uncertain, often maintaining several "hypothetical" endings. And the potential endings suggest alternative readings of the past and present" (p.838).

A second broad theme in the study of narrative is that stories are constructed in both a personal and social context. These factors need to be taken into consideration in interpreting illness narratives. Personal context includes the life history of the author. The published cancer stories were written by women who were used to having control over their lives. As such their stories reflected the anxiety of losing control over their lives and their attempts to re-exert control.

Besides the personal context there is
the broader interpersonal, social and cultural context. Several researchers have considered these aspects in their analyses of narratives. An example of the role of the immediate audience, the interviewer, on the character of the narrative is discussed in the study by Riessman (1990). She considered the divorce account of a working class man with multiple sclerosis. Throughout the narrative it is apparent that the man is attempting to create a particular image of himself - a person who is not to blame for the breakdown of his marriage. In analysing this narrative Riessman refers to Goffman’s (1959) concept of impression management which emphasises the performative aspect of storytelling. Thus, in considering any illness story the psychologist cannot abstract the story from the context within which it is told.

Beyond the immediate context of the interviewer is the broader context of the audience. Consider again the published accounts of breast cancer. In developing a progressive narrative for their story the authors are conveying a message of hope to the women who read these accounts. It is written with them in mind. The authors are part of a broader community of women for whom the experience of breast cancer is a major threat. The progressive structure of their narrative speaks to this audience. It is designed to reduce this fear, to even inject the experience with humour and to recast the crisis as an opportunity for enrichment of one’s life.

Similarly the popularity of the progressive narrative in Robinson’s (1990) study of MS patients needs to be considered with reference the context in which it is told. Unlike breast cancer, MS is a chronic condition. In creating a story the patient is considering different options for the future. Garro (1994) described these narratives about chronic illness as "stories-in-progress". The popularity of the progressive structure in these stories reflects the broader cultural context within which personal control over crises is promoted. As Robinson (1990) argues, the study of these narratives illustrate "the importance of the personal quest for meaning, but more particularly for mastery over the unpredictable physical course of the disease" (p. 1185).

Another aspect of the context is how the broader social beliefs about specific diseases influence the character of the story. Matthews et al (1994) investigated the narratives of black
women with advanced breast cancer. They noted how in developing their personal narratives the women attempted to reconcile their personal experiences with the popular conceptions of the disease. It was also apparent that they changed their stories as they received official diagnosis which reduced their opportunity to deny the seriousness of their condition.

Narratives are not only shaped by the context within which the sick person lives and narrates his/her story but also conversely the development and exchange of stories actually contributes to the development of shared belief systems about particular illnesses. This process is illustrated in the study of collective representations of AIDS in Haiti conducted by Farmer (1994). He noted that when he first interviewed people in rural Haiti in the early 80s about AIDS he found little evidence of a shared cultural model. During the mid 80s he noticed how the "relative silence concerning it does give way to discussion ... and a more widely held representation slowly began to emerge"(p.802). A key element in this process was the exchange of stories about individuals who had contracted AIDS. This is an important issue and is particularly germane to the discussion about the evolution and change of social representations about health and illness (see Herzlich, 1974; Murray, 1990; Stainton-Rogers, 1991).

Finally, narratives can either create personal distress or have the potential to emancipate. The studies previously described illustrate these processes. The progressive narratives of the breast cancer survivors offer the prospect of hope. DelVecchio Good et al (1994) noted how oncologists deliberately promote this perspective in their narratives. They conducted interviews with a sample of American medical, surgical and radiation oncologists and observed their interactions with patients. They found that during these interactions the oncologists: "seek to 'emplot' therapeutic action,... to formulate experiences for patients designed to instil hope and lead them to invest in often arduous and toxic treatments, ... structure time and horizons in attempts to avoid creating a sense of false hope or despair, and ... choose metaphors to
engage patients in a struggle against disease and death." (p.856)

These therapeutic narratives were constructed in a particular sympathetic cultural context. DelVecchio Good et al (1994) argue that American oncologists "are given a cultural mandate to instill hope in the therapeutic narratives they create for and with patients" (p.856) who have been diagnosed with cancer and informed of their condition. Conversely, in Japan such narratives are less common since the tradition there is still largely to conceal the diagnosis of cancer from the patient.

Admittedly, DelVecchio Good et al (1994) note that the therapeutic narratives they have investigated should not be confused with the "purported therapeutic, cathartic or healing dimension of the telling of illness narratives" (p.861). While the reports of narrative therapists would suggest that the process of narrative recounting is beneficial, the empirical evidence for such change is more limited.

CONCLUDING/OPENING REMARKS

Oliver Sacks (1990) in his collection of stories about various neurological conditions recalls that after he learned about the features of the condition known as Tourette's Syndrome, he found examples of the condition all around him. In the same way, once the principles of narrative psychology are explained we find we are surrounded by stories. In closing their influential book on discourse analysis Potter and Wetherell (1987) note that one of the advantages of the method they advocate is that "the data are everywhere - in conversations, on television, in the newspapers, on advertising hoardings" (p.187). A similar conclusion is appropriate for this chapter. Stories about health and illness are everywhere in books, in magazines and in everyday conversation.

It is important to emphasize that narrative health psychology is not restricted to published accounts. Rather storytelling can occur in a wide variety of settings to describe a range of experiences. Elliot Mishler (1986), who has long promoted the use of interviews in health research, has commented on the traditional scientific neglect of the narrative in research:

"...interviewers interrupt
respondents’ answers and thereby suppress expression of their stories; when they appear, stories go unrecorded because they are viewed as irrelevant to the specific aims of specific questions; and stories that make it through these barriers are discarded at stages of coding and analysis” (p.106).

Research interviews can be filled with stories if we look for them rather than discarding them. Admittedly, the very interview process itself can either encourage or discourage storytelling. In a recent commentary Susan Chase (1995) noted that:

"If we take seriously the idea that people make sense of experience and communicate meaning through narration, then in-depth interviews should become occasions in which we ask for life stories” (p.2) [emphasis in original].

Narrative health psychology can also go beyond the story about particular health problems to consider the broader story of individual and community lives. Through an understanding of these stories it is possible to begin to understand the popularity of certain unhealthy behaviours, such as smoking or excessive drinking. These behaviours are not discrete 'variables' which can be explained/predicted by reference to other 'variables' (cf. Radley, 1994). Rather, they are part of an unfolding engagement between the actors and their world, in the language of symbolic interactionism they are 'joint actions'. Listening to the tales of joy and woe recounted by the actors the researcher can begin to understand their stories and also why they engage in these unhealthy practices.

There is also the issue of the whole of health psychology being nothing but stories told about health and illness. As Plummer (1995) has emphasized, this is a conundrum from within which it is difficult to escape. In constructing and presenting our stories we are also subject to the influence of the various coercers and audiences. It is for this reason there is a need to be explicit about theory but are also aware of the broader socio-moral dimensions of our work. In creating new stories the task is not to reflect prevailing dominant
stories within which disease and death are accommodated but rather to attempt to develop more subversive stories which can contribute to the creation of a healthier society.
CHAPTER 2

CANCER STORIES

INTRODUCTION
Over the past decade a large number of personal accounts of the experience of having certain diseases have been published. Despite their apparent popularity among the general public they have only slowly attracted the attention of researchers (e.g. Frank, 1995). The intention of this chapter is to consider the character of published accounts of breast cancer. It attempts to place these accounts within the wider literature on autobiography.

Increasingly it is accepted that the exchange of stories is an integral part of being human (Rosenwald and Ochberg, 1992). In traditional societies certain stories achieved mythical status and were used to help organize society. Today, the autobiography can be considered as serving a similar function. It provides for the reader "new possibilities or precedents by deriving general world views from personal experience" (Chandler, 1992). In an age with declining public support for established religions, autobiographies can be considered an alternative source of moral guidance. Moreover, the autobiography not only helps make sense of the past but also offers a guide to the future. As Bruner (1995) recently suggested: "The publicness of autobiography constitutes something like an opportunity for an ever-renewable 'conversation' about conceivable lives."

The writing of an autobiography also "serves to differentiate and validate individual experience against the backdrop of the whole culture" (Chandler, 1992). Through the process of writing, the author begins to exercise control over past events. The process of composition, description, narration, and argument are familiar tasks. Through the performance of these tasks they [the authors] regain some measure of control over powerful, chaotic feelings." The very act of writing helps bring order to a disordered world. This characterization of autobiography is in many ways similar to the recent findings of Pennebaker (1990, 1993) that writing can be psychologically
beneficial. However, it connects this apparently new therapy with the much longer tradition of story telling.

Through writing the author publicly creates him or herself. The role of narrative in the construction of identity has recently become the focus of much discussion. For example, Rosenwald and Ochberg (1992) argue that narrative is "not merely a way of telling someone (or oneself) about one's life; they are the means by which identities may be fashioned" (p.1). After the crisis the author is public defining herself as a certain sort of person.

It is important to emphasize that the autobiography is not a reflection of experience but a representation of that experience. It is written from a particular perspective and has a particular structure. The author must select certain events and ignore others. Chandler (1990) points out that autobiographies often focus on certain crisis moments or turning points in the author's life. This is seen as almost a psychological necessity, an attempt to bring order to chaos. "After things 'fall apart', one is left isolated and adrift in a metaphysical void. To survive one needs to construct some new vision of reality as a basis on which to reassemble the fragments of his shattered world into a new design" (Chandler, 1990, p.21).

In recollecting their earlier experiences it is often assumed that the writer starts at the beginning and proceeds to the end. But this is not the case - the writer is recollecting the past from the perspective of the present. Mark Freeman (1993) has argued this point cogently, "Consider again the word 'recollection' itself", he says, "while 're' makes reference to the past, 'collection' makes reference to a present act, an act ... of gathering together what might have been dispersed or lost" (p.47).

In gathering together these memories the author selects, rearranges and organizes. In doing so s/he creates an image of the past which is ordered and leads to the present. Certain experiences are emphasized while others are forgotten. Freeman (1993) continues: "without an act of historical imagination, designed to give meaning and significance to these events and to glean the possible nexus of their interrelationship, there would be no past and indeed no self, but only a sequence of dispersed accidents" (p.47).
It should also be borne in mind that the writer is not just writing for themselves but for a particular audience. The structure preferred is designed to elicit a particular response from the reader. Indeed, Bruner (1993) suggests that "its composition [cannot] be disembodied from the interlocutors who constitute the dialogic imagination of the teller." The reader needs to be drawn into the story and to sympathize with the author who is the central character. This and the previous points need to be borne in mind in the reading of these breast cancer accounts.

ACCOUNTS OF BREAST CANCER
In the case of breast cancer the popular perception is that it would seem that the number of accounts written by those who have experienced the disease is on the increase. From the publishers' perspective there would seem to be an expanding market for these books. The reasons for this are not difficult to find. In Western society, the most feared disease remains cancer. This has been confirmed in a number of public attitude surveys (e.g. Murray and McMillan, 1993). Among women this fear is particularly directed at breast cancer since this disease strikes at the very centre of female sexual identity. This fear would seem to be heightened by the apparent failure of medical science to find an effective treatment program. As Betty Rollins, one of the writers considered in this chapter, writes in the introduction to her account: "Nobody would be interested in reading a book about what its like to have breast cancer if one out of nine women did not get it and the other eight were not afraid of getting it" (p.vii). Reading these accounts allows the reader to feel part of a wider community of people who are dealing with similar problems. Their books offer hope to the wide community of women that this disease can be beaten. This chapter considers the autobiographies of three women who experienced breast cancer. At the outset it should be emphasized that the authors are not a typical cross-section of breast cancer survivors nor indeed of breast cancer patients. It is important to consider the social position of these authors and their previous life experiences. It is from within this context that they experience and write about cancer. The women are professional women who are at the prime of their lives. There are many as yet unexplored life possibilities which the onset of cancer jeopardizes. The
disease is particularly despised by these writers because it strikes at a time of their lives before they have had the opportunity of developing their full potential.

The first account by Betty Rollins, entitled *First You Cry*, was originally published in 1976. In it she recounts her initial experience of the disease and of having a mastectomy. At that time she was about forty. She was married but had no children. She lived in New York City where she was a very successful television news correspondent. Cancer was the last thing she expected. "Besides, piped up [her] unconscious, you're a reporter. You're immune" (p.8). After finding a lump in her breast, she, after much delay, went for a mammogram and then a biopsy.

After considering the various treatment options Betty underwent a modified radical mastectomy. Her account considers the actual experience of surgery, getting a prosthesis, "the phoney tit", fitted, and reorganizing her life. The book went out of print for a period but was republished in 1993. In a short introduction to this new edition Betty notes that she had another mastectomy: "it was a ghastly shock at the time but now it seems like no big deal. I'm alive, after all, and I feel great" (p.viii).

The second account, entitled *My Breast*, is by Joyce Wadler and was published in 1992. In many respects Joyce is very similar in terms of background to Betty Rollins. She moved to New York City when she was a young woman and became a successful writer for magazines. Although she did not marry she had a stable relationship. Then in her early forties she was diagnosed as having cancer.

After finding a lump in her breast she had a biopsy and then a lumpectomy. Following this surgery the oncologist suggests removal of the lymph glands. This is followed by radiotherapy. A year later, on follow-up, she undertakes a course of chemotherapy. The results are successful. She concludes her account:

"So that is it - that is the story of my breasts and me and our cancer. Score: Joyce, One; Cancer, Zero. Or should I say, Score: Joyce, One trillion, Cancer, Nothing" (p.165).
In closing her account, Georgia gives praise to the power of modern medicine and to the power of God. Optimistically she writes:

"For right now, I have won the battle. I have fought desperately to gain a few more years, and I plan to appreciate and celebrate every minute God gives me on this earth" (p.130).

The metaphor of the battle is one which has extremely wide currency with respect to the treatment of cancer (Sontag, 1978). In this case the battle assumes religious overtones as the victor goes on to glorify God who has helped defeat the evil which is cancer.

SOME COMMON THEMES
Chandler (1992) has itemized three literary problems which she considers endemic to all crisis narratives. These are finding words for the "inexpressible", obtaining narrative perspective, and choosing a suitable narrative form. Consideration of each of these problems can provide insight into the character of the cancer stories.

Finding Words
The ability to find words for the indescribable is one of the central
challenges facing the author. As Dumont (1977) states: "the author is not merely a faithful scribe. He must know not only of what he speaks, he must find a way to say it" (in Catani, 1995). This challenge is particularly acute for those issues which are publicly clothed in silence. Breast cancer, like all cancers, has been largely a secret disease. It was suffered in silence. Patterson (1987) in his review of the public perception of cancer noted that historically cancer was a hidden disease. Blaxter (1983) has noted how it is not a popular subject of discussion among women.

These published accounts can be said to break that silence. The authors almost feel they have a mission to declare that not only have they had breast cancer but that they have survived. As Nancy Reagan, who also had breast cancer, says in a comment on Joyce Wadler's account "I do think its important for everyone to get the message out." The message is that breast cancer does not mean death. These accounts are written by the survivors not by those who succumb to the disease. The aim of these accounts is to spread the good news. Indeed, Harper Collins, one of the publishers, catalogue them as "Inspirational Classics."

In these autobiographies the women are giving voice to something that has not traditionally been part of public discourse. Cosmopolitan Magazine in reviewing Betty Rollins book comments that it "takes the terror out of a nightmare that is uniquely female." By putting the experience into words the women reduce the fear associated with the disease and its treatment. The cancer accounts offer hope and reassurance to the reader because of the very fact that they are written by cancer survivors. Whether this is false hope, of course, depends upon the reader. Saillant (1990) in her study of the perceptions of cancer patients notes how there is a contradictory discourse. It oscillates between the old belief that cancer equals death and the new belief which centres on survival and the role of hope and the maintenance of morale. These published accounts support and reflect this latter discourse. The other discourse is the one which encourages silence (cf. Blaxter, 1983).

**Narrative Perspective**

Chandler (1992) emphasized the importance of narrative perspective when considering the therapeutic
value of autobiographical writing. Healing, she argues, "may be measured by the degree of authority, irony, and imaginative transformation the writer exercises upon the raw facts of experience. (p.ix)" The cancer survivors often looked back on their crisis with wit and irony. Joyce Wadler, perhaps, best epitomizes this stance. As far as she was concerned illness plays no role in her self-definition:

"I am not a hypochondriac. I lean toward the other extreme, a person who associates sickness with weakness and therefore denies being sick? (p.19).

Once she is diagnosed as having breast cancer she adopts a combative stance. "Look," she says to the surgeon, "I have no plans of dying of this thing, That's just not how I see my life. So what's the next step? (p.36).

The women write their accounts from the perspective of those who have not only survived cancer but beaten it. The very act of writing about the experience allows them to separate themselves from this invader of their bodies. Chandler (1992) describes this healing process well:

"When he is able to transform his personal crisis into a work of art the writer has taken possession of the thing that threatened to possess him. In the text he has defined another world, become a creator, an agent, an originator. When he has done that, the purgative ritual is complete, the damage is consigned to story, and some measure of healing, one assumes, is accomplished - if it is true as Isak Dinesen said, that "all sorrows can be borne when they are put in a story? (p.23).

In this passage, she argues that it is through the very construction of the story as text that the person begins to take control of the crisis.

Some of the breast cancer survivors seemed quite self-conscious about this healing potential of perspective-taking inherent in writing. Betty Rollins states this relationship clearly in describing why she wrote her account:

"I wrote it to make myself feel better, to tidy up the mess in my head and it
worked. When I was done
I felt right side up again,
different than before, but
okay - in some ways
better?(p.vii).

Problem of form
The third literary problem Chandler
considered was the problem of form.
She claimed that "until recently, a fairly
stable set of myths and paradigmatic
stories have provided models of
Western autobiographies." However,
in our present era recourse to these
popular myths are considered insufficient to cover the complexity of
modern life. Instead, "individuals must
shape reality to their own design." To
achieve this they use a mixture of old
and more experimental forms.

In the case of the cancer stories there is
limited recourse to experimental forms.
Admittedly, there is a mixture of
mythical parallels in the story content
but perhaps the most dominant theme
is that of the battle. It is sometimes a
short battle, sometimes a long drawn-
out battle with many defeats along the
way. However, in the end the narrator
wins, although not without much
suffering. This feature of suffering
forms another theme which is probably
best paralleled by the Christian stories
of birth and rebirth and of conversion
which Freeman (1993) indicates is a
popular theme of autobiographies.

The typical story has a beginning, a
middle and an end. The author
sketches out the background, details
the major action sequences, and brings
the story to a close usually with a
happy ending. As Chandler (1990)
states, this structure gives the story a
sense of gestalt, not only through
detailing the actual central incidents
but also by suggesting explanatory
devices and bringing the story to a
close.

Beginning
Most of the cancer accounts begin by
looking back on the days before cancer.
These were days of humdrum
existence, quiet family life, excitements,
work, relationships. Joyce Wadler
looks back on her Jewish family
upbringing in New York state. The
family were "large, noisy, [and]
opinionated" but they enjoyed life to
the full. Reflecting on the frenetic
lifestyle of those members of her family
who survived the Nazi death camps
she speculates "The longer death casts
a shadow, the faster you need to
dance? (p.5). Perhaps this comment is a
precursor of her own perspective after
she developed cancer. The impression Joyce creates of her family and of her subsequent working life is of a frenetic lifestyle but also of a life which has much ahead of it. Then cancer intrudes. Her immediate reaction is "I want to live. The things I haven't done flash before me, a long list of "But wait, I wanna...." (p.14).

Betty Rollins came from a similar New York Jewish family. The things she recalls now about her family is how healthy they were. She writes:

"I was always superbly healthy. My mother, true to the stereotype of Jewish mothers, used to make me eat. But, unlike the stereotype, she shovelled sirloin and wheatgerm into the mouth of her baby girl, not matzoh brei or fatty chicken soup ... it must have worked ... we Rollins... were beacons of good health" (p.8).

She became a news reporter and married. Life was busy but had so much potential. When she was advised to have surgery her immediate response was:

""Does it have to be right away?" I was vaguely alarmed, but mostly it sounded like another annoyance, more time wasted" (p.17).

Georgia Comfort also recalled those pre-cancer days when life seemed to offer so many opportunities. Once all her children were at school she would expand her piano teaching, perhaps go to graduate school, and get involved in a lot of new activities. She recollects this "would start the beginning of time spent on me." The diagnosis shattered these plans. She thought: "How could I, at thirty eight, die. My life was just getting together. It wasn't the right time to die. This isn't fair. It was time for me to be me, not time for me to die" (p.1).

This theme of unpreparedness and undeservedness was a frequent theme of the breast cancer accounts. Other work (e.g. Murray and McMillan, 1991) has commented on the popular belief in the unjust character of cancer. Whereas with heart disease you can suggest that it is partly caused by lifestyle and so the victim bears some responsibility, in the case of breast cancer it seems to strike young, healthy, blameless people. Pinell
(1987) in her analysis of letters written by cancer patients makes a similar comment about the blameless stance adopted by the authors. She argues that this stance of innocence is a requirement for subsequently expressing a critical discourse with regard to dominant representations and practices.

Looking back the women made limited reference to a search for a cause of breast cancer. Cancer was something which happened but about which the women felt there was no obvious cause. Instead the women often blamed the medical establishment for the apparent delay in detecting the disease. The evidence linking survival prospects with early detection of breast cancer has been widely publicized. Thus it could be argued that the women themselves bear some of the blame for any delay in detecting the disease. Indeed, some of the women accepted that they had felt a lump but delayed seeking medical advice. However, looking back they recalled that their immediate reaction was to blame the physician. George Comfort thought when she found out her cancer had spread "Why didn't my doctors find this earlier? Where will the cancer show up next?" (p.20).

Middle

The central portion of all of the accounts details the women's recollection of their preparation for surgery or other forms of medical intervention, the actual intervention, and the aftermath of that intervention. This central portion of the stories outlines the basic components of the crisis narrative. Chandler (1990) describes this as having three main components. The first stage is the descent into chaos which involves loss, degeneration and increasing confusion. This is followed by stasis which is a period of paralysis, isolation and silence. Finally, there is the reascent which is the experience of epiphany and the ability to relate to the world in a new way (see also Plummer, 1995).

This characterisation of the crisis narrative can also be subsumed within the main narrative forms proposed by Gergen and Gergen (1986). They suggested that narratives are either progressive, regressive or stable. Admittedly they can involve a combination of these such that the crisis narrative is initially regressive and then progressive. Robinson (1990) has applied this model in analysing the narratives of multiple sclerosis.
patients. He makes the point that the author can deliberately change the plot line to engage the reader such that, for example, initial optimism can be dashed as the progressive narrative takes a downward turn. This pattern was particularly apparent in Georgia Comfort's account.

A central concern of the authors of these cancer stories is the reassertion of control as the disease unwinds. This is particularly the case for these professional women who were used to being in control of their destiny unlike Saillant’s (1990) working class patient who was more accepting of the disease.

Prior to surgery the women adopted various intrapsychic coping strategies (Breakwell, 1986) designed to minimize the threat posed by the disease. A popular initial reaction was information search. For example, Joyce Wadler recalls:

"I read, Despite Dr. Luke's warning that I may misinterpret information, discarding research is an idea I've discarded. It's my body and my life. I read about drugs; I read about nutrition; I read about alternative therapies like visualization" (p.87).

A form of denial or wishful thinking was also apparent at this early stage. Betty Rollins recalls attempting to reassess her diagnosis:

"I kept repeating shrilly to myself, it still might not happen! ... All right, all right, I had to face the fact that was no longer probable. But probable didn't mean definite. Probable meant probable. Probable meant it was still possible that I was alright, the way I had always been alright" (p.36).

A combination of this information search and wishful thinking was the need for a second, third, or more opinions. Georgia Comfort recalls that after the initial diagnosis she "spent the whole day calling different surgeons and specialists."

One popular strategy was to focus on the positive. The value of this strategy for cancer patients has been widely debated not only in the research literature (e.g. Doan and Gray, 1992) but also in the popular press. Many of the women were self-consciously aware of this strategy. For example,
Narrative Health Psychology

Joyce Wadler felt that she had to try to adopt a positive outlook but found that this strategy held within it many problems. She recalled:

"If there is a chance positive thinking can work, I feel I should try it, but I'm sceptical. If being a worrier has contributed to this disease, am I going to be able to alter my personality quickly enough to stop it?" (p.67).

While Gloria Comfort, who was a strong Christian, used religion as a way of understanding her illness the other women were more sceptical. Betty had been brought up in a Jewish family but was now an atheist, "well, an agnostic (who knows for sure?)". After the surgery she reflected:

"I knew that disasters often made people religious. After all, had I not sort of prayed the weekend before? One hears about people who 'turn to God' when the jig is up. Notwithstanding my one prayer, that didn't seem to be happening to me. But then my jig wasn't up, and it still had not occurred to me that it might have been, or that it might yet be" (p.76).

Instead, Betty adopted a fighting attitude. The mastectomy was not going to stop her. Later she felt that this involved dealing with the procedure on a rational level and ignoring the emotional components:

"I knew what had happened to me, but only between the ears. I didn't know emotionally. Moreover, I didn't know that I didn't know. I thought what everyone else thought, that the reason I wasn't upset was that I was so gutsy and terrific."

Prior to surgery the women also faced the conflict of **telling** or **not telling**. Should they pretend that all is normal or tell others of their crisis? Different women adopted different strategies. The initial reaction of Joyce Wadler was not to tell. She was fearful that if many of her colleagues got to know she had developed cancer her career would be jeopardized. She reflects:

"I'll tell some close friends about the diagnosis, but
they have to keep it to themselves. Just on a professional level I don't want this around. Journalists are the biggest gossips in the world and the least reliable ... one lunch at Orso's and three hours later the word will be all over town that I'm dying, and I'll never sell another book" (p.46).

But Joyce realizes the dangers inherent in this strategy. If she doesn't tell anyone she'll have no one to help her. She delays telling her mother but then reassesses this decision:

"I never understood this, but now I do: you don't tell the people you love, because you want to protect them. But in doing so you cut yourself off" (p.50).

Betty Rollins has fewer inhibitions about telling others. After diagnosis, she recalls, "I started calling people right away." When in hospital she "loved the visitors" and recalls that "except when I slept I talked almost all the time. I talked to everyone who came, the nurses and the nurses aides, even the ones who didn't speak English" (p.59). Then when she was discharged from hospital she took steps to prevent herself becoming isolated:

At first I didn't telephone people, because I couldn't decide whom or whether to tell. But when a constant audience was no longer present in the room, there was only one thing to do: call the audience up" (p.76).

After surgery a primary focus of concern was reintegration into society. At this stage the conflict between telling and not telling became more pronounced. Goffman (1964), in his discussion of the effects of stigmatization, distinguishes between discredited and discreditable identities. In the discreditable situation the individual concerned has the opportunity to pass as normal, not to tell. Such was the case for several of the women in these accounts.

Betty Rollins describes the process of passing most vividly. Shortly after she was released from hospital she went to a cocktail party. She prepared herself carefully since this was her first big
social occasion since her mastectomy. She recalled that initially she was uncertain with the other party-goers: "I did my nice-to-see-yous and fines in response to everyone's how-are-yous, but I kept wondering who knows and were pretending they didn't? (p.102).

As the party progressed she began to realize that people were not aware of her recent operation: "I was drunk, but not so drunk that I knew I was passing. I was passing. Incredible. Nobody knew. Nobody could tell. They thought I looked wonderful" (p.103).

However, although she was passing, Betty still felt the assault on her personal identity due to the operation. She recollected: "Everybody at the party thought I was still pretty. I passed, all right. But transvestites pass, too. It's nice to fool everyone. It's nice to get a prize for your costume. But it doesn't stop you from knowing, yourself, what's underneath" (p.105).

After the initial euphoria of passing, Betty began to reassess her body: "I no longer found me attractive. I was damaged goods now, and I knew it. It had begun to dawn on me, that underneath the bandage was something very ugly" (p.108).

The converse of passing is telling. Several of the women reported this urge to tell, to gain sympathy for their distress and to gain praise for how they were coping with it. Sometimes this urge to tell led the women to mention this operation at unexpected times. Betty Rollins recalled going to a dinner party after discharge from the hospital: "I was seated next to the historian Emmet John Hughes, who once wrote presidential speeches for Eisenhower. He asked me one of those and-what-do-you-do questions, and I heard myself say, "I had a breast cut off recently, and I'm trying to get over it" (p.139).

She found that this form of self-disclosure was often mirrored as their companion shared a crisis they had
recently experienced. Her account emphasizes the positive features of disclosure. She scorns those who advise her to keep silent. She argues: "I approve of telling people. It's good for the teller and the tellee. Why should humans hide their misfortunes from other humans, who are also vulnerable?" (p.142).

**End, or New Beginning**

In closing their accounts the women deal with a number of interleaving issues. One such issue is the reaction of other people and how they coped with it. Joyce Wadler was fortunate since her breast "despite the size of the tumour that was removed, is the same size as the right breast, and looks fine". Naturally she has a scar which she is proud of it in the way a soldier is proud of a war wound. She recalls: "I see one funny little change in my behaviour: as the days grow warm, I find myself wearing very deep cut little dresses to parties. I also realize a deep kinship with the late Lyndon Johnson: I want to show everybody my scar" (p.145).

Betty Rollins recalls the social pressure to be normal, to conceal her operation, and, specifically, to have a prosthesis fitted: "Dammit, I thought, why can't I go to the store for a can of olives with one side of me sticking out and one side not sticking out? Who the hell would care? But I couldn't do it. Because I cared. People might notice. I couldn't face that. I couldn't face the possibility of shocking and repulsing my fellow shoppers. In America, bodies are whole, teeth are straight, and the sight of a deformed person - that's you, kid - is a turnoff. It's unpatriotic to be a freak" (p.145).

Georgia Comfort recalls the reaction of people to her loss of hair. She usually tried to wear a wig or a scarf when in public but occasionally was caught unaware. The reaction of people was often one of consternation and confusion. She became, in her own words, "an alien in my own world." However, as she grows in confidence
she found that this wasn't always the case. If she showed that she was able to cope with her loss of hair then other people were more relaxed.

Perhaps the most important theme in closing the accounts is the reassessment of identity. Arthur Frank (1993) considers this theme central to all illness narratives. He argues that at the core of any illness narrative is an epiphany, after which the person reassesses themselves and their place in the world. Frank distinguishes between different types of identity reassessment which describe the reaction of survivors to an illness.

The first type are those who reaffirm their beliefs through the crisis. Georgia Comfort, who had strong Christian beliefs, fits clearly into this category. In her account she gives a graphic description of an epiphany-type experience. It occurred after she had undergone double mastectomy and intense radiation treatment. The cancer was still apparent in her body. She and her husband decided to take a holiday in Hawaii to review the situation. One day they took a helicopter tour of the island:

"As we flew along, I felt overcome by the power, majesty, and longevity of the earth. How different from the frailty, ugliness, and shortness of human life! How tiny and insignificant is the human body compared to the vastness of the earth and the universe ... All my struggles and perplexing questions about sickness and earth seemed to dissipate as I spoke to the Lord. "God, its OK,' I whispered softly, 'You are the Lord. You are God. You are the Creator - You made all of this! You are the Potter, and we are the clay. You gave us life, and you have the power to take our life'" (p.38).

This spiritual moment transformed Georgia's approach to the disease. Now she became accepting of what she perceived as God's will.

Not only did she perceive her religion as helping her through this crisis and aiding in the healing process but the actual crisis itself had strengthened her religious faith. Since her recovery, she has spent a lot of time helping other women who are experiencing similar
crises. She concludes:

"Of all the women I have seen battle cancer, Christians fare the best. They endure the treatment with a better attitude and a certain buoyancy. Cancer is a huge giant, an attacking monster. Nothing seems bigger than cancer growing in one's body. Only the healing power of Christ - the same power that raised him from the dead - can beat it. People who don't have the knowledge of the Lord Jesus Christ in their lives feel helpless and powerless. These feelings of helplessness and powerlessness seem to allow the disease to take over rapidly" (p.114).

In another chapter, she recalls talking to a class of medical students about her experience. When one of the students asked her "How have you been able to deal with the question, Why do bad things happen to good people?" she recounted the story of her epiphany in Hawaii. She concluded this class with a passage from the Bible: "They that wait upon the Lord shall renew their strength. They shall mount up with wings like eagles; they shall run and not be weary; they shall walk and not faint" (Isaiah, 40:31) (p.109). The students gave her a standing ovation.

The second type of reaction to the cancer are those who feel their identity has been transformed by the experience. To a greater or lesser extent all of the women described this transformation. In looking back at their crisis they transform it, give it a positive meaning. Betty Rollins notes that during the treatment for the cancer there was no sign of this dramatic reassessment. Indeed, on reflection, Betty felt that the lack of assessment was perhaps surprising and sought to explain it:

"I never felt the classic 'Why me?' - not even during the bad days that were to follow, not even when I was feeling the sorriest for myself. Odd as it sounds, I think it had something to do with the Vietnamese war, which happened to be ending while I was in hospital, and like everyone else I watched it on television ..."
I thought, as everyone thought, 'Why them?'' (p.81).

After her mastectomy she was somewhat circumspect about any change. She writes:

"Fact is, I'm the same car I always was, except now I have a dent in my fender. Of course, I tend to overdramatize some of my (mostly imagined) personality changes" (p.204).

There is, however, an awareness, not yet clear, that she has the potential for change. This is somewhat similar to the stage of recognition described by St. Augustine (see Freeman, 1993). She writes:

"My raised consciousness about death has somewhat raised my consciousness about life. That is, I find a recurring jingle in my head:

'Am I doing What I would be doing If I were dying?'" (p.205).

However, four years later in a subsequent article which was included as an epilogue to the second edition of the book, Betty is much more definite about the transformative nature of having cancer. She writes:

"I also feel good about having gotten cancer in the first place. Here is the paradox: although cancer was the worst thing that ever happened to me, it was also the best. Cancer... enriched my life, made me wiser, made me happier. Another paradox: although I would do everything possible to avoid, I am glad I had it" (p.207).

In attaining distance from the disease, and perhaps experiencing less anxiety about recurrence Betty can begin to transform the crisis into a positive experience.

There is less reflection in Joyce Wadler's account. But she too comments on the positive changes:

"Death, I now see, may not come when I am eighty-five and weary, or after I have solved all my problems or met all my deadlines. It will come whenever it damn well
pleases. All I can control - for whatever fight I put up should a cancer make a comeback - is the time between. So when I see something I want, I grab it" (p.165).

It is the awareness of the very random nature of cancer, something over which she has no control, which changes her attitude to life. She has had "a dress rehearsal of my mortality", "the scythe nicked me."

Perhaps the most dramatic impact of this changed identity is on relationships. Betty Rollins divorced her husband and Joyce Wadler ended her relationship. Betty recalls this event and people's reaction to it:

"People asked me if my leaving Arthur [her husband] had anything to do with the operation. It did, of course, but not in the way they thought. It was not that Arthur was a swine about what had happened to me. He was not ... Really, he was the same as ever. We were the same as ever. But that was the problem. Because after the operation, the way we were suddenly scared me" (p.172).

Betty felt that she was not going to continue with this form of life any longer. Life was too short and precarious. When the opportunity arose for a new partner, she jumped at it.

The third reaction to illness described by Frank (1993) was cumulative epiphanies - an extended process of awakening and renewal. In some way this characterised the ongoing process of personal reassessment which the women experienced as they reintegrated themselves into everyday life.

Finally, Frank (1993) refers to a related residual category which he termed reluctant phoenixes. These individuals downplay the impact the crisis has had on their lives. In some ways Joyce Wadler typifies this type of person who tries to emphasize the lack of change in her life. Throughout her account she presents a self-deprecating sense of humour and a fighter mentality. The image she presents is of one who has had some hard knocks but continues to battle on. Cancer was another hard knock. There was little time to search for underlying meanings
or even to look to others for help:
"I feel, I am under serious attack, and when the Scud missiles are raining on your head, you don't have time to get on the phone with your girlfriend"
(p.46).

Another example of this fighter mentality is when she is receiving radiotherapy. She recalls that prior to treatment the oncologist opened up the wound and marked the targeted area with stainless steel clips:

"Looking at the x-rays, I see them - a funny little oval of staples, which will be with me for life. It makes me feel a little like a war hero, with shrapnel in my chest. I have two simultaneous desires: one to go sit on a bar stool, order something in a shot glass, and tell a war story: 'Yup, there I was in the shower, buck naked - always shower naked; embarrasses the hell outta my boyfriend, but that's the way I am - when I felt this lump. Goddam thing was as big as a watermelon! ' ... Or I want to go to a store, buy the kind of magnetic Snoopy you put on the refrigerator door, put it on my breast, and see if it will stick"
(p.140).

Throughout her account, Joyce is reaffirming her identity as a fighter, as a person who is healthy, not sick. Indeed, through her writing she is suggesting that she is not a victim or a survivor of breast cancer, rather she is a victor over breast cancer.

CONCLUDING COMMENTS
As emphasized at the outset, these accounts of past crisis are created from the present. As such, while they provide a certain insight into the experience of having cancer they should also be read from the stance of the author trying to leave the crisis behind and orient herself to the future.

In our analysis of these cancer stories we have considered certain themes. Perhaps the most important is that in the very writing of these stories the women have given words to a personal crisis and in doing so have reduced the fear associated with it.

Second, through the process of
'emplotment' (Ricoeur, 1984) they begin to bring order to the chaos of having cancer. They also become self-consciously the authors of their lives and through this process obtain a narrative perspective which psychologically distances them from the threat of cancer.

Thirdly, the stories have a certain structure which highlights the author’s role in overcoming adversity. It is a modernist tale which draws the reader into the action. The stories they create are ones in which they emerge as the victors. Unlike their peers who seem unaware of the broader existentialist issues, these women have faced death and now realise their own transientness. The personal tragedy of having cancer is recast as an opportunity for growth and rebirth. In doing so they are publicly defining a certain identity.

Finally, in writing their stories the women are to some extent aware of a sympathetic audience. In this sense their storytelling moves from the level of the personal to that of the political. The women become engaged in building an alliance with other women to collectively overcome the fear that surrounds breast cancer. Their story of victory over adversity is one which not only finds an echo with other broader myths but in their immediacy can provoke the sympathy and act as a model for many women (see Plummer, 1995). In doing so they help create that positive discourse which they themselves sometimes found difficult to handle.
CHAPTER 3

MAKING SENSE OF NARRATIVE ACCOUNTS

INTRODUCTION

A central concern in narrative research is the variability of stories told by research and other participants. This variability raises the question as to the actual character of the stories told and the nature of their representation. The aim of this chapter is to review a range of interleaving issues related to this variability. It begins by summarizing the problematic character of all interpretations of reality. It then proceeds to consider some factors particular to the character of narrative accounts. Specifically, it considers the subject of the story, who is telling the story, the motive for telling the story, the medium used for storytelling, and the structure of the story.

The revival of interest in constructivist ideas, such as those of narrative, has prompted renewed discussion (e.g. Paranjpe, 1993) about the criteria which can be used to assess the relative merits of conflicting representations of reality. From the constructivist perspective the meaning of reality is not readily available but, rather, variable meanings are imposed upon it. This approach is summarized by Tarras (1991) who says:

"... the world cannot be said to possess any features in principle prior to interpretation. The world does not exist prior to interpretation; rather it comes into being only in and through interpretations ... All human knowledge is mediated by signs and symbols of uncertain provenance, constituted by historically and culturally variable predisposition, and influenced by often unconscious human interests. Hence the nature of truth and reality, in science no less than in philosophy, religion, or art, is radically ambiguous."

Such a position is opposed to the
positivist perspective which argues that "reality is fixed and can be observed directly, uninfluenced by the observer" (Hare-Mustin and Marecek, 1988, p.456). The continued dominance of this positivist approach, argues Ibanez (1993), is sustained through the use of a certain "rhetoric of scientific truth" which includes claims to uniqueness, absolutism, supra-humanity, ideological legitimation, and production of power effects. The continuation of this rhetoric at a time of challenge derives from certain 'defence mechanisms' designed to prevent debate about the legitimacy of its position. These defence mechanisms have tended to denigrate opposing viewpoints and so avoided discussion about epistemological issues. This stance has often ridiculed the variability of accounts accepted within the constructivist perspective. This chapter considers some concerns about the variability of stories within the narrative approach.

A frequent criticism of the constructivist position, in general, is that we cannot be confident about the existence of any material reality. The adoption of such an idealistic perspective is vigorously rejected by most social constructionists. The exchange between Bury (1986) and Nicolson and McLaughlin (1987) highlighted the basis of this misperception. The latter quoted Barnes (1977) to illustrate how through the everyday use of a form of checking, conflicting interpretations are constantly subject to test:

"Knowledge arises out of our encounters with reality and is continually subject to feedback-correction from these encounters, as failures of prediction, manipulation and control occur"(Barnes, 1977; p.10).

Thus, while we may continue to argue about the nature of reality the legitimacy of any interpretation is open to test in everyday practice. Despite this it is still possible to have conflicting representations of reality. This concern about the relationship between representations and reality also applies to the study of narrative. Plummer (1995) admits confusion in trying to identify the character and substance of stories. While accepting that they are valuable entities he admits that their exact character remains nebulous:

"Whatever else a story is, it is not simply the lived life. It
Narrative Health Psychology

speaks all around the life: it provides routes into a life, lays down maps for lives to follow, suggests links between a life and a culture. It may indeed be one of the most important tools we have for understanding lives and the wider cultures they are part of. But it is not the life, which is in principle unknown and unknowable. Hence a key concern in looking at stories must be with the kinds of relationships the story bears to a life" (p.168).

Historians have pondered on this issue for a long time (see White, 1978). In what way do their accounts relate to past experience? How does contemporary historical work differ from the myths and legends of previous eras? Hans Kellner (1989), among others, summarizes the dilemma of contemporary historians:

"History is not 'about' the past as such, but rather about our ways of creating meaning from the scattered and profoundly meaningless debris we find around us ... There is no story there to be gotten straight; any story must arise from the act of contemplation."

In constructing a narrative account the author is creating something new and is not merely reflecting reality. Even more important from a narrative perspective, the narrative brings psychological cohesion and creates meaning. Without narrative there is only a disconnected and meaningless sequence of events.

Edward Bruner (1986) suggested a threefold distinction between Life-as-lived which is what actually happened, Life-as-experienced which are the images, feelings, desires, thoughts, and meanings known to the person whose life it is; and Life-as-told which is the actual narrative. This is a useful distinction because it emphasises the actual personal and socially constructed nature of the narrative. It is not simply a reflection of experience but rather a refraction of it (Murray, 1994). Admittedly, the process is not one-way but is rather interactive in that in the very telling the narrator constructs the life which is then lived
and so on.

However, the threefold distinction tends to separate out the story from the experience and from the life. The hermeneutic position emphasizes their mutual interaction. To quote Widderhoven (1993):

"A hermeneutic position holds that stories are interpretations of life. Story and life are similar, in that both are supposed to have a meaning. The story tells us in a meaningful way what life itself is about ... Hermeneutics also claims that there is no meaning prior to interpretation. This implies that the meaning of life does not exist independent of the stories that are told about it ... life and story are only meaningful through mutual interaction" (p.4).

Lives and stories exist in mutual interpenetration. While this may be so, there remains the issue as regards the variable quality of the story articulated. There are a variety of factors influencing the character of the story told and hence the meaning of the event. This chapter considers some of these factors.

**VERSIONS OF STORY**

**Content of story: What is the story about?**

In his description of narrative Jerome Bruner (1986, 1993, 1995) argued that it was a means of bringing something extraordinary into the world of the normal. In doing so the narrator begins to exert some control over the event. However, certain events are so extraordinary that the participant finds them difficult to describe in words. Edward Bruner (1986) outlined this problem:

"... some experiences are inchoate, in that we simply do not understand what we are experiencing, either because the experiences are not storyable, or because we lack the performative and narrative resources, or because vocabulary is lacking."

In everyday life we encounter events which we find difficult to render in language. These events render us 'speechless' because they are so
surprising or threatening, at least in the short-term. Over time, we can sometimes reflect upon the event and transform it into manageable narrative. However, we continue to have difficulty describing some events or experiences. For example, in western society individuals find it difficult to talk about death or disease, in particular those diseases which are life-threatening.

Blaxter (1983) conducted a study in Glasgow in the 1980s about the views of working class women on health and illness. One of the points she makes in her report was the silence of the women on the subject of cancer. Admittedly this disease was not the central focus of the study but rather Blaxter noticed this absence in reviewing the interviews. She suggested that this silence was a coping strategy used by the women to reduce the magnitude of the perceived threat. By not talking about the disease they reduced the likelihood of they themselves contracting it.

A similar finding was apparent in interviews we conducted with women in Northern Ireland (Murray and McMillan, 1989). These women were directly asked about involvement in widely promoted cancer screening programs, especially breast self-examination. Several of the women expressed the view that they would prefer not to perform these practices because the very examination might increase the likelihood of the disease developing. "It's better not to think of it" and "Let sleeping dogs lie" were typical comments.

One particular historical event of modern times provides an example of collective silence. In this century the Holocaust is perhaps the best documented recent example of human barbarity. Yet it is an event about which many of the survivors have been reluctant to speak. As Herman (1992) stated:

"Some experiences are extremely difficult to speak about. Political conditions constrain particular events from being narrated. The ordinary response is to banish them from awareness."

Jerome Bruner (1995) also comments on how the very obscenity of the Holocaust would seem to have silenced narrative. While it was
possible to record some immediate impressions, it was more difficult subsequently to construct a narrative account:

"... more than a few concentration camp inmates during the Holocaust were obsessed with making a record of the horrors that they were living through and often risked their lives to do so secretly. These memoirs almost always have the immediacy of witness. But few attempted to go beyond that, nor could one imagine that Auschwitz or Ravensbruck would have provided the distancing needed for invention in the art of self-representation. Prisons and torture chambers defeat radical reflection about the shape that life can take. Suffering finally silences autobiography."

Several historians have deliberately attempted to redress this silence - to hear what the survivors have to say. At Yale University an archive of video interviews with survivors of the Nazi death camps has been developed. Langer (1991), among others, has used this material to attempt to provide a portrait of the horrors. Often the survivors are lost for words. They admit that they can visualise the actual experiences but find it difficult to find the appropriate words. Instead they stare silently at the camera. To give just one example:

"Mr. B., his children sitting next to him, looks down, an utterly forlorn expression on his face, shrugs his shoulders, and whispers barely audibly: 'Nothing to say. Sad.' Then he shakes his head and weeps quietly ..." (p. ix).

Admittedly our society has not been very receptive to listening to the horrific accounts of these survivors. It could be argued that at best this is a social defence mechanism or rather an attempt to deal with collective guilt. Greenspan (1990) described how this social pressure not to disclose ensured that many people remained silent:

"Not only were survivors not heard, but the very act of recounting risked..."
stigma. 'We wouldn't talk about it because we didn't want to be different', 'We didn't want to be pointed to as the 'abnormal people'"... 'We tried to get along, you know, 'I'm American too!'" (see Bruner, 1995).

A useful formulation as to the character of these inchoate stories can be drawn from the work of the Russian Formalists who in their analysis of narrative made the distinction between fabula and subzjet or story and narrative (Rimmon-Keenan, 1983). The fabula or story was the (perhaps) partially formulated construction of the event which could be said to exist in the mind of the person. The character of this was then given coherence and expressed by the speaker as a subzjet or narrative. The character of this subzjet depended upon the speaker and the context but in the speaking the fabula became real. It then entered into social interaction and could be challenged and changed, and possibly influence the character of subsequent social interaction. Adverse events experienced by people could then be partially formulated as fabula. As is discussed later, these fabula can contribute to personal distress if they include negative emotions.

Thus the stories which people tell can be considered recollections of experiences for which there is language. For many experiences, the available language is insufficient to convey the character of the event. Instead, what is presented may be considered a partial representation. It is for this reason that individuals will often admit that they did not understand an event or even themselves until they read about it in a book or saw it in a film (see Plummer, 1995). These accounts of the experiences provide them with a vocabulary.

However, for some events there is no vocabulary or the vocabulary is insufficient. Such is the case with the Holocaust. Language provides a link between the past and the present - between the land of barbarity and the land of contemporary civilization. But with the Holocaust there is no such link. It remains a world apart.

Author of story: WHO is telling the story?
There is substantial variability in people's ability to tell a story. Freeman
(1994) argued that children do not have the linguistic sophistication to describe various experiences and so their memory of events is limited. He refers to what he describes as Ernest Schachtel's (1959) seminal essay "On memory and childhood amnesia" which describes the antagonism "between reviving the past and actively participating in the present life of society". Since adults live different lives from children and use a different language they find it difficult to return to the land of their youth. As Freeman (1994) argues "much of what we remember is sadly bound up with what we are supposed to remember, what the social order tells us is significant" (p 51).

As we develop, our level of sophistication in telling stories grows. Participation in everyday conversation confirms that some people are more able than others to tell dramatic stories. Certain individuals are particularly able to narrate dramatic events or to convey a sense of drama to what others might consider a mundane event. This was the reason why the novelist Henry James suggested that it is not that some people lead more eventful lives but that, rather, some people are more able to tell dramatic tales (see Bruner, 1995).

At another level of sophistication are the professional storytellers. These are individuals who have developed their linguistic and imaginative capacity to such a level that they earn a living from telling stories. Admittedly, the boundary between amateur and professional storytelling can be blurred. One defining characteristic is the capacity to imaginatively convey the reader or the listener to another world. There are certain strategies which expert or sophisticated storytellers can use which enable them to engage the listener. However, even they realize the limitations of their talent. Nadime Gordimer (1995) refers to Joseph Conrad's description of the writer's activity as "rescue work carried out in darkness .. this snatching of vanished phases of turbulence." She also notes the comments of the author Edward W. Said in his *Joseph Conrad and the fiction of autobiography* on the difficulties experienced by the writer:

"To put forth the secret of one's imagination is not to enact a religious event, but to perform a religious rite; that is, the rite implies but withholds the actual event" (see Gordimer, 1995, p. 13).
In spite of the skills of the gifted writer there is always a certain distance between their writing and reality. But there is more, the writer creates a new reality. To quote the American writer Wallace Stevens "a poet's words are of things that do not exist without the words" (see Heaney, 1995, p. 13).

Another factor, mentioned by Blum-Kulka (1993), concerns who actually tells the narrative. She refers to the distinctions made by Goffman (1981) between the Author who selects the words which are used in the story, the Principal who is held responsible for the story, and the Animator who actually articulates the story in a certain setting. In many cases all three roles can be played by the same person but, as Blum-Kukla points out, especially in the case of a child’s story the roles may be taken by different people. Consider the case of the mother taking her sick child to the doctor. The child is the principal actor about whom the story is told. However, the child may remain silent in the consultation in which case the mother can be either the Author (she describes the illness event in her own words) or the Animator (she uses the child’s own words).

Reason for stories: WHY is the story told?
People tell stories for a wide range of reasons. Over 50 years ago Allport (1942) addressed this issue in his critique of the use of personal documents. He identified a long list of what he described as underlying motives which would render the objectivity of personal documents suspect. These included special pleading, exhibitionism, desire for order, literary delight, securing personal perspective, relief from tension, monetary gain, assignment, assisting in therapy, redemption and social re-incorporation, scientific interest, personal service and example, and desire for immortality. These are all personal factors which could influence the character of storytelling. Indeed, it is the very impossibility of removing all of these factors which makes it a personal story. Admittedly, in the reading of these stories the reader can be aware, and be made aware, of the potential influence of such underlying motives. As such the reader can read both the story and the storyteller.

Baumeister and Newman (1994) have
distinguished between interpretive and interpersonal motives which condition the character of the narrative told. The interpretive motives include the need to attribute a sense of purpose to events, a need to provide justification for one’s actions, a need to exert control, and a need to enhance self-worth. The interpersonal motives include the desire to obtain rewards, to have others validate their identity claims, to pass along information, and to attract other people.

**Context of telling: WHERE and TO WHOM is the story being told?**
Stories are not told in social isolation but within a certain social context. The character of this context will influence or even codetermine the character of the story told. Plummer (1995) has provided a summary of the operation of these different social factors (see Fig 1). Within this symbolic interactionist model stories are considered joint actions.

David Maines (1993) also emphasised the argumentative nature of narrative. The characterisation of thought as rhetorical bears many similarities to this characterisation of narrative. The same person can adopt different stances depending upon the context -
Although the narrator tells the story, the character of the story told will depend upon someone to whom it is told and the teller's relationship with him or her. This issue is raised by Cornwell (1984) in the discussion of her study of the health beliefs and practices of working class people resident in the East End of London. The study involved detailed and repeated interviews with a small sample of people. As she gained the confidence of her informants she noted that the character of their replies changed. She interpreted this change as an indication that her informants were deliberately controlling the character of information disclosed so as to maintain a particular public image of themselves:

"In any new social situation where people are unsure of their ground, they become acutely concerned with making sure they know what is going on and with managing their own part in it correctly (Goffman, 1959). The activities of 'managing appearances' and 'controlling information', according to Goffman, are continuous elements of all social interaction. But in novel situations and especially in situations which are unfamiliar and unequal, they are at the forefront of awareness" (p.13).

**Fig. 1** Stories as joint actions

<table>
<thead>
<tr>
<th>LIVES AND EVENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>?</td>
</tr>
<tr>
<td>PRODUCERS</td>
</tr>
<tr>
<td>coaches</td>
</tr>
<tr>
<td>coaxers</td>
</tr>
<tr>
<td>coercers</td>
</tr>
<tr>
<td>story teller</td>
</tr>
<tr>
<td>STORIES</td>
</tr>
<tr>
<td>AS</td>
</tr>
<tr>
<td>TEXTS</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>CONSUMERS</td>
</tr>
<tr>
<td>readers</td>
</tr>
<tr>
<td>viewers</td>
</tr>
<tr>
<td>audience</td>
</tr>
<tr>
<td>listeners</td>
</tr>
</tbody>
</table>
In these problematic situations people put on their "best face". In doing so they are not attempting to mislead the interviewer but at a time of uncertainty they seek security by producing the non-controversial "public accounts". These public accounts Cornwell defines as "the sets of meanings in common social currency that reproduce and legitimate the assumptions people take for granted about the nature of social reality" (p.15).

Conversely, when the research participant gets acquainted with the interviewer and feels comfortable in his/her presence s/he is less guarded in his/her comments. In this situation there is not the same degree of insecurity and the participant feels s/he can reveal more "private accounts". To define these private accounts Cornwell referred to the earlier work of Douglas (1971) who argued that these reflect how a person "would respond if thinking only what he and the people he knows directly would think and do" (p.242).

The character of public accounts reflected the dominant discourse in society. In the case of health and illness the tendency was to cast these in biomedical language which is the acceptable scientific language of our culture. In analysing the content of the public accounts Cornwell commented on the marked care her subjects had taken "not to stray too much from concepts and theories they believed were medical or compatible with medicine." An indication of the nature of these accounts was the frequent
reference to 'them' or 'they say'. In doing so the subjects were admitting a certain uncertainty about the value of these public accounts. Conversely, private theories appealed to personal experience or the experience of friends and family which often contradicted that of the medical establishment.

In collecting accounts the researcher often feels that these private accounts are more authentic - more reflective of the true beliefs of the research participant. The question is what is the key which will allow access to these private accounts. Cornwell (1984) suggests a way of breaking through this wall - it is through encouraging the person to tell stories. As she puts it: "the accounts people gave varied according to whether they had been asked a direct question when they responded with public accounts - or invited to tell a story - in which case they might give private accounts" (p.16).

This provided an opportunity for the researcher to gain a greater understanding of the person due to "a subtle shift of power in the relationship between the interviewer and the interviewee." In giving a public account the interviewee was primarily concerned with the image s/he was presenting. However, when asked to tell a story the focus shifted to the conveying the detail of the story and away from self-presentation.

The power imbalance is an endemic characteristic of the research interview but is even more pronounced when it involves a study of working class people who are keen to present an image of cooperativeness and respectability. Cornwell suggests that this power imbalance reflects the typical research interview situation where the educated middle class researcher is asking the questions and controlling the agenda. In this situation of power imbalance the researcher is inviting a certain account.

Farr (1978) made a similar point in his critique of the work of Herzlich (1974) whose work was concerned with describing the content of social representations of health and illness. She found that laypeople tended to perceive the individual as being naturally the source of health and society or "way of life" as being the source of illness. However, Farr (1978)
indicated that this finding was a reflection of the interview situation within which the study was conducted. This situation invited an attribution bias (Ross, 1977) whereby the interviewee attributed the cause of good events (e.g. health) to internal processes (self) and bad events (e.g. illness) to external processes (society) (see also Murray, 1990).

A similar description could apply to the doctor-patient situation. The working class patient is doubly threatened both by the traditional power imbalance with the middle class doctor but also because he not only wants to present an account which is medically acceptable but also one which will ensure that he is provided with appropriate treatment.

Cornwall's approach was innovative in distinguishing between the private and public accounts of health and illness. This performative model was a change from the more essentialist approach to the study of health beliefs which frequently ignore the context within which data is collected.

However, Radley and Billig (1996) in their detailed assessment of Cornwell's work make the point that private and public accounts interpenetrate. Although story telling may be a means of revealing private personal material, it can also be used to substantiate public accounts. For example, in referring to some biomedical explanation the interviewee may justify his argument with reference to some personal experience.

Radley and Billig (1996) consider the extent to which accounts of health and illness are both ideological and dilemmatic. The focus of their analysis was on the distinction between public and private accounts. This distinction is based on the assumption that there are two main types of account giving - one which reflects private reality and the other which reflects social representations. An analysis of the factors which organize stories about health and illness would suggest a more varied structure.

Further, Radley and Billig (1996) highlight two often neglected aspects of the interview situation which are necessary to consider. The first is the health status of the interviewee and in particular the 'far from watertight' distinction between healthy and ill individuals. How the interviewees define themselves is important to the character of the interview since "the
healthy have much to say about their illness experience, while the sick are often at pains to show their 'normality'" (p.225). The second feature is the health status of the interviewer. Although rarely if at all mentioned it can be assumed that they are healthy individuals. As such the interviewee feels more strongly "the need to legitimate one's position" - "the accounts themselves are situated in a rhetorical context of potential justification and criticism" (p.226).

In a related investigation Balshem (1987) considered women's public and private discourses about cancer. In her study she attempted to involve an audience of working class women in discussion about cancer but was largely met with silence. Subsequently, when she conducted more informal interviews with these women she found they were eager to talk:

"As members of the public audience, community residents were silent, even sullen, while privately, they eagerly invited me into their homes for interviews that radiated with fun and excitement (p.165).

Balshem (1987) argues that the public and private discourses bear the same message which is resistance to authority. In the public context, the residents "assume the stance of the disempowered and alienated student" (p.165) - they looked bored and sullen. In the private context where they had power over the situation they revelled in expressing their more critical viewpoint. This was "an opportunity to enact a performance, to assume a rhetorical stance." In both settings there was performance which conveyed the same message - the issue was how these performances were read.

Balshem also emphasised that the character of the discourse is always shifting: "control of the terms of discourse, the definers of value and belief, is the focus of a potent struggle" (p.166). The working class residents were involved in a struggle to resist the dominant discourse of the medical establishment and to reassert their own discourse based upon hostility towards authority. To quote Balshem: "Maintaining a rebellious consciousness is part of constructing a valued self, valued community, valued life, in a subordinate class position" (p.166). The stories which these residents told were ones which
ridiculed medical knowledge and enhanced belief in local knowledge. This rebellious attitude is backed up by actions: "Medical advice on the prevention, early detection, and treatment of cancer is rejected, and the rebellious discourse may include smoking, eating a high-fat diet, and avoiding a recommended screening examination" (p.167). Although these actions may be inherently unhealthy they are part of a wider means of reasserting control.

Both Cornwell’s and Balshem’s studies emphasize the importance of context in story construction. This context is always present such that it is not possible to say that there is one true story but that rather to understand the text the reader must also be aware of the context.

Medium of storytelling: HOW is the story told?

Although much of the current interest in the character of narrative has concentrated on oral narratives there are other forms of expression. Narratives can be presented in different forms and through different mediums. Linde (1993) in her discussion of the stories which people tell about their lives has suggested three broad categories:

(a) Life-story: these are the oral accounts which we tell to others when invited to do so.
(b) Autobiography: these are the formal written accounts prepared for public consumption.
(c) Memoirs and diaries: these are the private written accounts.

Admittedly, Linde (1993) is referring to the more extended accounts of a life which many people do not have the opportunity of conveying. Instead, in everyday social interaction most people exchange short stories or episodes from a life-story. However, consideration of these categories can contribute to our understanding of the variable character of stories.

Each format adopts a particular style and structure. The life-story is informal and is often filled with contradictions. There is only limited attempt to ensure consistency. Indeed this ability to accommodate such contradictions could be considered one of the defining characteristics of narrative. Blaxter (1993) noticed a similar degree of conflict in the accounts people give of their experiences of health and illness: "They were perfectly
capable of holding in equilibrium ideas which might seem opposed: the ultimate cause in the story of the deprived past, of their current ill health, but at the same time their own responsibility for 'who they were': the inevitability of ill health, given their biographies, but at the same time guilt if they were forced to give in to illness" (p.141).

The autobiography is more formal and attempts to present a more ordered and coherent view of life. Although this format was traditionally restricted to the successful politician or statesman increasingly, as illustrated in the previous chapter, this format has achieved more popular currency. Finally, memoirs often contain a series of more disjointed impressions. Recently, there has been an attempt, particularly by feminist historians, to revive interest in the study of memoirs and diaries. According to people like Jelinek (1986) women are more likely to write journals and diaries while men are more likely to write autobiographies. The discontinuous form of the journal is supposedly more analogous to the often more fragmented and interrupted quality of women's lives. Journals and diaries are often considered typical of genteel upper and middle class Victorian ladies. Admittedly, with the growing interest in the study of narrative the use of journals has become quite popular in a variety of settings from schools and colleges to health centres and homes for seniors. A frequent new addition to adult education courses are classes in journal writing.

Another important aspect to consider in exploring a story is whether it is presented in an oral or a written form. Although both use words to describe experiences, the latter has the tendency to use more literary devices to convey a particular meaning. Langer (1991) in his discussion of the character of "holocaust testimonies" suggests that the processes of writing can reduce the terror associated with particular events:

"Written devices, by the very strategies available to the authors - style, chronology, analogy, imagery, dialogues, a sense of character, a coherent moral vision - strive to narrow space
[between the writer and the reader], easing us into their unfamiliar world through familiar (and hence comforting?) literary devices" (p.19).

Earlier he writes:  
"Written accounts of victim experience prod the imagination in ways that speech cannot, striving for analogies to initiate the particularities of their grim world" (p.18).

Admittedly the boundary between written and oral accounts can also be blurred since it is not uncommon for people to make literary references while providing an oral account. Indeed, this has become commonplace and illustrates the shared character of narrative accounts.

**Structure of story: HOW is the story structured?**

One of the enduring characteristics of narrative is that it has a structure. Indeed this is what distinguishes it from the "scattered debris" of experience. The narrative organises events into a storyline within which is entwined a particular meaning. As Ricoeur (1987) emphasized  
"The act of placing ... extracts a configuration from a succession? (p.66)."

We select and arrange information to create the story.

Linde (1991) in her discussion of life stories uses the term 'coherence' to describe this process. There are a variety of factors which act to create this sense of coherence. First there are personal or psychological demands which encourage us to organize our perception of reality in narrative forms (cf. Bruner, 1990). By giving the experience coherence we also give it meaning and as a consequence reduce the anxiety associated with the uncertainty. Personal coherence in storytelling can also be said to provide a basis of identity. McAdams (1985) has discussed this issue. He argues that:

"An individual's story has the power to tie together past, present and future in his or her life. It is a story which he is able to provide unity and purpose ... individual identities may be classified in the manner of stories. Identity stability is longitudinal.
consistency in the life story. Identity transformation - identity crisis, identity change - is story revision. ... Identity is a life story” (p.18,29).

Secondly, there are the demands of social interaction which would be impeded if the narrative accounts were disjointed. In our interaction with others there are demands to remain consistent and coherent. These demands are internalized in the sense that we feel embarrassed if we are inconsistent or incoherent. There are also social sanctions which encourage us to remain coherent. For example, others would admonish us if we attempt to elaborate on a "tall tale". Blaxter (1993) described the influence of the immediate social context as follows:

"People do not, of course, create their biographies and their identities in a vacuum. It is obvious that the process not only takes place within a cultural context, but is also a continual interaction with others, especially of parents, spouses, other family and neighbours”(Blaxter, 1993, p.139).

Finally, there are the broader cultural demands which lead us to create certain story structures. A variety of researchers have described certain cultural story templates which they argue are endemic in western society and which help organize and structure the stories we live and tell.

Plummer (1995) described the basic plot of the modernist tale as a) taking a journey, b) engaging in a contest; c) enduring suffering, d) pursuing consummation, e) establishing a home. He argued that there are certain common elements in these stories, viz. a) suffering which gives tension to the plot; b) a crisis or turning point or epiphany where something has to be done - a silence broken, c) a transformation - a surviving and maybe surpassing.

Another model is that of Northrop Frye (1957). He was a literary critic who reviewed the underlying structure of western literature. He concluded that there are four main mythic forms: comedy, romance, tragedy, and irony or satire. Kevin Murray (1985) has discussed the application of these
myths to everyday life. He suggests that at least in terms of Goffman's (1959) dramaturgical perspective these myths can not only apply to the actions of actors in the theatre but to human actors in everyday life. "They are, what Goffman (1974) would term, "interpretive frames", which can be applied to both fiction and everyday life" (p.177).

There are several strands to such an argument. On one hand it could be argued that the artist in constructing a plot is accurately representing reality and as such the psychologist should attend closely to his work. Alternatively it could be argued that irrespective of the so-called accuracy of the original plot lines because they have been so widely promoted through literature, etc., they have been assimilated by humans who attempt to act out the plots or at least attempt to use the basic plots in organizing their narrative constructions. As Murray (1985) suggests:

"It is reasonable to suggest ... that when we demand to know about someone in everyday life we are not satisfied until we have been able to cast his or her 'story' into a similarly conventionalized set of forms" (p.177).

As previously mentioned people in their everyday conversation make literary allusions. It is a short step from this to argue that people use literary frameworks to help them structure and interpret reality.

Murray referred to Kitwood's (1980) suggestion that "the two most significant themes in the organization of personal history are success and personal control" (p.179). He continues that "to a certain degree the four myths can be seen as permutations of the presence or absence of these two dimensions' (p.179). For example, "in romance, victory is found by the assertion of the hero's will, so success and control coincide" (p.179). The myths involve different stances towards success and failure in achieving ambitions. "Comedy advises pragmatism and the compromising of individual ambitions to meet the needs of others and the reality of the situation.. By contrast, idealistic action is encouraged by romance, accompanied by hope that the 'adventure' will succeed" (p.179).

Murray argues that these popular myths are located in gossip and
popular culture. As an example of the latter he considers life manuals. Admittedly he accepts that it is still an empirical project to discover the extent of penetration of these myths in everyday life. Plummer (1995) also discusses the issue of such self-help manuals which he claims have become part of women's self-help culture. He argues that they connect with a wider range of women's stories - gothic tales, romance novel, soap operas.

In closing, Murray quotes from Sartre (1965) to the effect that man "lives surrounded by his stories and the stories of others, he sees everything that happens to him through them, and he tries to live his life as if he were recounting it" (p.61).

CONCLUSION
In reviewing the literature on narrative it is apparent that stories can take on a wide variety of forms depending upon various factors. The character of the story told depends upon its focused content, who is telling the story, why the story is being told, where and to whom it is being told, what medium is used to tell the story, and what broad structure is used. Admittedly, these factors have only been introduced in this chapter.

At this stage the reader may be confused with the multiplicity of stories which can be told. The Personal Narratives Group (1989) have also reflected on these issues (see Plummer, 1995; p.167). They summarized their position as follows:

"When talking about their lives, people lie sometimes, forget a lot, exaggerate, become confused, and get things wrong. Yet they are revealing truths. These truths don't reveal the past 'as it usually was', aspiring to a standard of objectivity. They give us instead the truth of our experiences. Unlike the Truth of the scientific ideal, the truths of personal narratives are neither open to proof nor self-evident. We come to understand them only through interpretation, paying careful attention to the contexts that shape their creation and to the world views that inform them [emphasis added]."

This approach emphasizes the context...
in which stories are told and the function for telling. Their meaning is nor readily apparent but depends upon the interpretation of the reader.

In this chapter we have considered these and some other factors. The meaning of stories is never self-evident. Rather they must be interpreted by the reader with reference to the various factors mentioned. This task may seem particularly complex yet it is the process which we use in everyday social interaction. During our socialization we learn the rules of storytelling. The task of the psychologist is to make explicit these rules so that we can begin to grasp the meaning of the different stories told.

To finish it is useful to turn to Paul Ricoeur (1991) who not surprisingly has much to say on these issues. For him, “life is no more than a biological phenomenon as long as it has not been interpreted” (p.27/28). But the storyteller only tells one version, the task of the listener is to create another version. "What Aristotle calls a plot is not a static structure but an operation, an integrating process, which ... is completed only in the reader or in the spectator, that is to say, in the living receiver of the narrated story" (Ricoeur, 1991; p. 25). Unlike with positivist science the narrative approach does not provide a single meaning but instead an "irresolvable plurality of stories" (Wood, 1991, p.4). An acceptance of such plurality need not be considered an limitation but rather an opportunity for change.
REFERENCES


Catani, M (1995). ?Even if you were to tell it, we would not be believed?: A translation from the work of Primo Levi. Contemporary Sociology, 43, 137-160.


Psychologist, 46, 187-197.


Narrative Health Psychology


THE STORIED NATURE OF HEALTH PSYCHOLOGY

It is a tradition at the Annual Conference of the New Zealand Health Psychology Society for the visiting speakers to give a rather humorous after-dinner speech. The following is an outline of the remarks I gave at the conference in Okoroire. In the spirit of the occasion the remarks were light-hearted but I thought it would be useful to include them as an afterword to the previous more considered comments.

In reflecting on what to talk about tonight I considered a variety of topics. I thought I might use the opportunity to make a few general comments on the state of contemporary health psychology. In keeping with the occasion and my own research interest I thought it would useful to organise my comments under story types. As we all know from our visits to bookshops, there are many kinds of literature. While it is possible to have quite sophisticated schemes for describing the different types I thought it useful to use broad and popular categories.

Probably, the most popular types are science fiction, mystery and detective stories, romantic novels and autobiography. Each of these can serve, to a greater or lesser extent, as a metaphor for the character of different types of health psychology or of health psychologists. Let us consider each in turn. As an aid I thought it useful to see how the encyclopaedia defined these different types.

First, science fiction. The Grolier CD-ROM Encyclopaedia describes the growth of this form as reflecting "the impact of science and technology on the imagination and the attendant theories and speculations to which these give rise". Although Frankenstein was published in 1818 it was not until the latter part of the nineteenth century, just about the time of the rise of psychology, that science fiction took off. It seemed to concentrate on two popular themes: adventures into space and into worlds unknown. We all know that one of the impetuses for the rise of psychology in the age of imperialism was with the discovery of new peoples, the ruling classes became interested in developing a means of differentiating one group of people from another. In health
psychology we remain concerned with trying to characterize people who develop different types of illness.

There are, of course the Type As, Bs and Cs. These are like the aliens from planets X, Y and Z. But then there are also those fantastic beings represented by those strange diagrams which frequently pepper health psychology journals. Indeed, when reading the articles it would seem that humans are viewed as similar to these space age creatures. To some researchers, a statistical model becomes a reflection of reality. You can imagine these new species - protruding on a stalk from the left hemisphere is the cluster of normative beliefs while over at the other side are the personality dimensions. Maybe in the new on-line journals, these diagrams will actually come to life or at least light up and move.

Then we have the mystery and detective novels. These are indeed a favourite of mine. They typically detail some dastardly crime and the subsequent intrepid search by the good guys to track down the evil wrongdoer. The encyclopaedia notes that these stories are "modern expressions of literary traditions that are rooted in the history of dark deeds and retribution. In mystery stories a vulnerable character is drawn into a mysterious situation that is revealed to be dangerous as well." (Hopefully, this is not a characterization of my visit.) "Through tenacity, ingenuity, and luck the heroine or hero manages to comprehend and often expose sinister events".

In detective fiction "the central character is often a sceptical, aloof and intellectually aggressive investigator. The story often focuses on the technical details related to the examination of clues, the character of the people involved, the psychology of the criminal, the ambience in which the crime took place, or the unique perspective of the detective." This definitely seems a model for our intrepid health psychologist searching for the clues which will reveal the causes of health and illness.

The encyclopaedia continues: "Most fictional detectives are outsiders who operate in a twilight zone between established authority and the underworld yet display skills and traits drawn from both." Yes, we can certainly imagine some of ourselves in this role. An explorer after the truth, often in conflict
with established wisdom and, even worse, drawing inspiration from such traditionally suspect schools of enquiry as sociology and the humanities.

Last week I was watching one of my favourite television detective shows - Morse. I am sure most of you have watched it. In one scene the ever brilliant Detective Inspector Morse turns to the rather slow Lewis and asks "What are the key features in catching the murderer?". Like a good schoolboy Lewis answers: "Information and confession, sir". The sources of information are of course many - it requires the painstaking piecing together of material collected from different sources. Nowadays the police use computers to aid the processing of so many pieces of data. Then comes the time for the confession. In health psychology, perhaps the emphasis is on the collection of information and less on the confession. Indeed, the confession has often been treated with derision.

With the growth of qualitative research the wheel is beginning to turn. But what if the research participant does not want to confess? Then, perhaps it will be necessary for some health psychologists to stoop to other means of getting at the truth. I recall one amusing incident when an enthusiastic young researcher called to visit one young woman who he wished to interview. She had received his letter, knew about the purpose of study but didn't want to participate. After having travelled a considerable distance to conduct this interview the researcher was not very satisfied with this reply and by force of persuasion inveigled his way into the house and proceeded to conduct an interview. It was a very light-hearted affair but definitely not something to be encouraged.

Then there is the romantic fiction. I was disappointed to find that the encyclopaedia gave very paltry details on this type of literature which is usually considered of an inferior quality. It notes that "the traditional objection to the romance - that it is escapist and immoral - is given further validity by contemporary examples of the form: the sentimental erotic adventures produced for the mass market". Certainly health psychologists would not want to use this denigrated form as a model. But then again, the night is still young and perhaps in New Zealand health psychologists are keen enthusiasts of sentimental erotic adventures, particularly on this day after
Valentine's Day.

Admittedly, in terms of content there are many connections with romantic fiction. Here are the stories of relationships and thwarted and then true love. Despite its supposed poor quality it still appeals to a mass market. There are of course the Mills and Boone novels but many more serious novels contain a romantic element.

In health psychology, until recently we were somewhat wary of studying the role of relationships. Perhaps this was a reflection of the strong Protestant individualism which pervades the discipline. The impact of AIDS has changed all this. Sexual relationships have now become a legitimate study area for health psychologists. (Well, admittedly this was always the reason why some health psychologists have been so keen to attend conferences.)

And so to the final form I want to consider - the autobiography. This is simply defined as "a record of a life written by the subject him or herself." This form really became popular in the Renaissance "as people became more interested in themselves and their relationship to the world." Now it is one of our most popular forms of literature.

In the bookshop near where I live there are often many remaindered autobiographies which I can buy at a reduced price. They often follow the similar theme of a struggle against adversity, overcoming obstacles, doing it your way. There is also the age old search for personal truth which is perhaps mirrored in the work of many health psychologists.

It was in this secondhand book shop that I recently picked up a copy of Alan Bennett's amusing memoirs entitled "Writing Home." This book of recollections by a rather eccentric British playwright was a best-seller in Britain. The book contains many amusing stories. For example, the story about the party game suggested by Bennett's good friend Russell Harty: "Whose underpants would you least like to be gagged by?"

It also contains a transcript of the magnificent filmed account of guests at a small hotel in Yorkshire. This was a great critical success when it was
screened in Britain. It is interesting to note that the film was intended to be an example of participant observation and Bennett refers explicitly to the work of Erving Goffman. In the film Bennett intersperses his evesdroppings on some of the guests with some rather terse comments. For example, "When people are on their best behaviour, they are not always at their best." Or his recollection of his mother's and his rather conservative drinking practices: "We've found an alcoholic drink that we like. It's called Bitter Lemon."

I can't pass up this opportunity to draw attention to a few fascinating autobiographies I have recently read. The first is by the Canadian writer Michael Ignatieff. I am sure some of you will have read his work. Three years ago his account of his mother developing Alzheimer disease was shortlisted for the British Booker Prize and is definitely to be recommended for any health psychologist studying that disease. His most recent work entitled "Blood and Belonging" won the Gordon Montador Award for the Best Canadian Book on Social Issues. However, I would like to consider here his first book entitled The Russian Album. This is a record of his search for his Russian heritage. Bruce Chatwin described this book as "an exemplary Russian performance."

As a trained historian Ignatieff devotes the first chapter of this work to considering the vagaries of historical research. In doing so he describes the process of remembering much more elegantly than many psychologists. I'll quote just one phrase from a more extensive discussion:

?The knitting together of past and present that memory and forgetting achieve is mythological because the self is constantly imagined, constructed, invented out of what the self wishes to remember."

He then leads us on a fantastic tour over the past two centuries of Russian aristocratic life - vivid and enticing. Then he comes to a close. Although he has spent so much time and effort in recreating the past he now puts a distance between it and himself. He writes:

I do not believe in roots. When Natasha [his grandmother] was a little girl she believed she was a green shoot on a great tree descending into the dark earth. But I am the grandchild of her uprooting, the descendant of her disposssession. I am an
expatriate Canadian writer who married an Englishwoman and makes his home overlooking some plane trees in a park in north London. That is my story and I make it up as I go along. This confidence in separating ourselves from our past is not something which we can achieve with ease as we health psychologists are aware.

The lingering influence of our forebears is illustrated well in another autobiography, entitled "Under My Skin" by the writer Doris Lessing. The title of this work summarizes well Lessing's awareness of these hidden forces. She begins by quoting Idries Shah, the Sufi philosopher:

"The individual, groupings of people, have to learn that they cannot reform society in reality, nor deal with others as reasonable people, unless the individual has learned to locate and allow for the various patterns of coercive institutions, formal and also informal, which rule him. No matter what his reason says, he will always relapse into obedience to the coercive agency while its pattern is within him."

Perhaps, this is some advice which we health psychologists should consider. In her search for the pattern under her skin Lessing begins by commenting on the problem of writing about past events:

"Telling the truth or not telling it, and how much, is a lesser problem than the one of shifting perspectives, for you see your life differently at different stages, like climbing a mountain while the landscape changes with every turn in the path."

But this is only a brief extract and she is well worth reading. At the close she reflects back on the process of writing:

"In this book I have been presented - I have presented myself - as a product of all those ... I am slotted into place, a little item on a tree of descent. But that is not how I experienced myself then."

Lessing is illustrating the distinction between the lived experience and the reflected experience. We live in the present but how much of the presence is lived by our past. And in what way can we construct the past so as to build the future. As health psychologists, how much of our discipline's past determines our current approaches. Indeed, to what extent is it possible to move forward without critically reflecting on our past experiences.
To finish I will turn to a story about the life of a psychologist. Recently I had the delight of reading the selected proceedings from an international conference on the history of social psychology which was held in Paris in 1991. One of the consistent themes of these papers is the problematic nature of social psychology in terms of its conceptual content, disciplinary demarcation and transcultural variability. In commenting on the proceedings Ian Lubek concludes by asking the question "Social Psychology(ies): Singular of Plural?" A similar question is apposite for health psychology.

These proceedings also provide me with my final story, this time from the history of British psychology and one ably told by Alan Costall. As many of us recall Sir Frederic Bartlett was instrumental in establishing the British tradition of experimental psychology. Less well known is that he originally wanted to become an anthropologist but was dissuaded from this by W.H. Rivers who advised him that the scientific rigours of experimental psychology were the best preparation for anthropological fieldwork. After the First World War Bartlett assumed the headship of psychology at Cambridge and his students went on to dominate British psychology for at least a generation. Despite his influence on the development of experimental methods Bartlett himself maintained a certain distance from the laboratory. Alec Rodger (1971) recalls Bartlett's response on being challenged about this apparent lack of interest:

"He smiled in his Bartlettian way; his bushy eyebrows shot up, his brow furrowed and his cheeks puffed out. 'I suppose,' he said, 'it is because I think most of the things you do here are dull and rather trivial.'"

Even more revealing and perhaps encouraging for the narrative psychologist are his comments at the close of his career. These are comments which I will use to close this presentation. Apparently, at a reception in Cambridge held to mark his contribution Barlett confessed that his plan for the development of psychology had gone astray. Looking back, he admitted "I wish I had written novels instead."
The author is Professor of Clinical Psychology at Memorial University of Newfoundland. Prior to that he held appointments at the University of Ulster and at St. Thomas’ Hospital Medical School, University of London. He has published a range of articles, chapters and books on various aspects of health psychology. He can be contacted at the following address:

Division of Community Medicine
Memorial University of Newfoundland
St. John’s
Newfoundland
Canada
A1B 3V6

Tel: (709)737-6213
Fax: (709)737-7382
E-mail: murraym@morgan.ucs.mun.ca